

Hypertension: new guidelines in practice

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Hypertension is a major public health problem and a leading cause of cardiovascular mortality and morbidity. It is poorly detected and controlled and causes substantial direct and indirect healthcare costs often due to poor concordance.

The new NICE hypertension guidance, developed in collaboration with the British Hypertension Society, was published last year and has 65 recommendations.¹ Of these 36 are new and 12 are key priorities. Most recommendations have evolved from previous guidelines with some partially relaxed. The most noticeable change in regard to drug treatment relates to thiazides and the most radical change is the diagnosis of hypertension.

How do we now define hypertension? Stage 1 hypertension is a clinic blood pressure (BP) of 140/90mmHg or higher and ambulatory blood pressure monitoring (ABPM) or home blood pressure monitoring (HBPM) average of 135/85mmHg or higher. Stage 2 hypertension is a clinic BP of 160/100mmHg or higher and ABPM or HBPM daytime average of 150/95mmHg or higher. Severe hypertension is a clinic BP of 180mmHg or higher or clinic diastolic BP of 110mmHg or higher.

According to the guidance, if the clinic blood pressure is 140/90mmHg or higher, patients should be offered ABPM to confirm the diagnosis of hypertension. ABPM should be used and include at least two measurements per hour during the person's usual waking hours with an average of at least



14 measurements. HBPM is two consecutive seated measurements at least one minute apart. Blood pressure is recorded twice a day for at least four days and preferably for a week. Measurements on the first day are discarded and the average value of all remaining is used.

Physicians should aim for ABPM/HBPM average of $\leq 135/85$ mmHg in patients under 80 years and $\leq 145/85$ mmHg over 80 years. Thresholds for intervention include $\geq 160/100$ mmHg uncomplicated (ABPM/HBPM $\geq 150/95$) or $\geq 140/90$ mmHg (ABPM/HBPM $\geq 135/85$) with target organ damage, diabetes and 10 year CVD risk $\geq 20\%$.

Antihypertensive drug treatment should also be offered to people who have stage 1 hypertension, are aged under 80 years and meet identified criteria and those who have stage 2 hypertension at any age. Also if a patient is aged under 40 years with stage 1 hypertension and without evidence of target organ damage, cardiovascular disease, renal disease or diabetes, then specialist evaluation of secondary causes of hypertension should be considered.

In terms of treatment, the NICE/BHS guidance states that people aged 80 years and

over should be offered the same antihypertensive drug treatment as people aged over 55 years, taking into account any comorbidities. Offer step 1 antihypertensive treatment with a calcium-channel blocker (CCB) to people aged over 55 years and to black people of African or Caribbean family origin of any age. If a CCB is not suitable, for example because of oedema or intolerance, or if there is evidence of heart failure or a high risk of heart failure, offer a thiazide-like diuretic.

Additional recommendations include offering guidance and advice about diet (including sodium and caffeine intake), exercise, alcohol consumption and smoking. Information should also be provided on benefits of drugs and side effects, details of patient organisations as well as an annual review of care.

In conclusion, the NICE guidance advises use of ABPM/HBPM to optimise the diagnosis of hypertension and CCBs now take preference over thiazides in uncomplicated hypertension management. Key messages are that protocol driven prescribing achieves targets, and other risk factors and comorbidities should be considered.

1. NICE. <http://guidance.nice.org.uk/CG127> (accessed December 2011)

Stroke: the way forward

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One in six people will have a stroke in their lifetime. In the UK there are 150,000 new strokes per year, 53,000 deaths from stroke, and 450,000 living with moderate to severe disability. All this leads to a £2.8 billion direct cost to the NHS.

Stroke survivors can be left with a wide range of impairments and disabilities including motor and gait problems, fatigue, depression, personality change and incontinence. Yet studies have found that functional outcome and survival was significantly greater in those patients treated in a rehabilitation stroke unit.¹

The challenge for us today is how can we maximise therapeutic input when patients are discharged from stroke services earlier than ever and frequently find themselves receiving less than an adequate amount of rehabilitation? It is unlikely that this can be achieved by employing more therapists, assistants/volunteers in the current economic climate. We can however use technology such as computers to encourage daily practice of therapeutic activities. Carers can continue the therapist role, or patients can take responsibility for practising their own therapeutic activity. It may also be possible to achieve this with a re-organisation

It is important therefore for patients to have immediate admission to a stroke unit, be treated by a multidisciplinary stroke team and receive as much rehabilitation as possible.



The multidisciplinary stroke rehabilitation team includes a physiotherapist, occupational therapist, speech therapist, nurse, doctor and psychologist. Their early involvement can help increase activities of daily living such as washing, dressing, mobility, feeding and basic kitchen tasks.

Repetitive targeted therapy has also been shown to be effective. Repetitive task training is the practice of specific tasks and improves lower limb function and function in daily activities. Stroke patients using more equipment/environmental adaptations had significantly more independence at one year after stroke.¹

Hidden deficits with therapy include self confidence, cognitive problems, extreme fatigue, depression and anxiety. Depression is common and 30% of patients will become depressed in the first 12 months, which can be helped with antidepressants and cognitive behavioural therapy. Other common cognitive deficits include memory, orientation,

verbal skills, visuospatial ability, abstract reasoning, attentional skills and this limits participation in rehabilitation and can have profound effect on every day tasks.

Dressing after stroke is an another important issue with 36% unable to dress one year after stroke but a dressing strategy can help with this.

The Department of Health and the NHS recognise that more should be done to meet the “long-term needs” of people with stroke. The UK Stroke Survivor Needs Survey² is a cross sectional survey of patients one to five years post stroke that aims to provide information that can be used to improve services to help people deal with the long-term effects of stroke. It found that 54% of those surveyed had an unmet need for stroke information such as holidays for the disabled, benefits, driving, personal aids and housing adaptation etc; 59% had unmet pain needs; 39% emotional needs; 52% decreased or a loss of work activities and 42% reported negative change in their relationship with spouse.

To conclude, stroke rehabilitation can improve functional recovery but it is important that we attend to the hidden deficits that can make life so difficult for stroke survivors. There needs to be greater emphasis on life after stroke and long term stroke care needs to be actively managed.

1. Drummond AE, Pearson B, Lincoln NB, Berman P. Ten year follow-up of a randomised controlled trial of care in a stroke rehabilitation unit. *BMJ* 2005; **331**: 491–92
2. McKeivitt et al. Self-Reported Long-Term Needs After Stroke. *Stroke* 2011; **42**: 1398–1403

Diabetes: preventing hypoglycaemia

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Hypoglycaemic episodes in older patients are common but are poorly recognised by healthcare professionals. Patients also are not very good at recognising a hypoglycaemic episode. A study in the *BMJ* found that patients with diabetes and their partners disagree about the frequency and nature of hypoglycaemic episodes.

It also found that questioning patients alone does not provide an accurate record of clinical hypoglycaemic episodes and that patients' relatives and partners should participate in future studies of this type.¹

Another study found that older men are less likely to notice sympathetic symptoms of hypoglycaemia before developing neuroglycopenia than young men.

This effect of normal ageing may contribute to the risk of severe hypoglycaemia in older diabetic patients treated with sulfonylureas and insulin.²

The most common symptoms of hypoglycaemia are poor concentration, confusion, sweating, trembling, weakness, incoordination, unsteadiness and light headedness.

Episodes of hypoglycaemia are particularly dangerous in the older population. To reduce the risk of hypoglycaemia, relaxation of the HbA(1c) goals has been proposed for frail elderly patients but a study found that hypoglycaemia was



very common even in folk with high HbA1c.³

Effects of hypoglycaemic episodes include dementia, cardiac ischaemia, QT changes, long stay in hospital, falls associated with low HbA1c, and falls/fractures associated with insulin use.

The ACCORD (Action to Control Cardiovascular Risk in Diabetes) trial⁴ and the ADVANCE (Action in Diabetes and Vascular Disease: Preterax and Diamicron Modified Release Controlled Evaluation) trial⁵—sought to determine the effect of the lowering of glucose to near normal levels on cardiovascular risk. Although the ACCORD and ADVANCE trials both compared intensive and standard glucose lowering targets in type 2 diabetes, the trials differed substantially. The ADVANCE trial looked at severe hypoglycaemic episodes in all subjects and found it was a marker of frailty and future adverse events. The ACCORD trial⁵ also found patients who suffer from severe hypoglycaemic episodes on the standard control were more likely to die than those with severe hypo on “tight” control.

Risk factors for hypoglycaemia include change in agent, type of agent, hospitalisation, comorbidities, elderly single male, alcohol, cognitive impairment and increasing age. Therefore it is important to ensure an adequate diet and follow up in-patients at 4-6 weeks. To avoid hypoglycaemia, one needs an accurate assessment of the patients, good knowledge of glucose levels and of the risks of different drugs. Insulin errors are still very common so good communication with carers and other healthcare professionals is needed.

Which drugs to use depends on what you are trying to achieve, the monitoring available and the ability to give insulin. One can find evidence to do whatever one wishes in regard to diabetes treatment.

1. Heller S, et al. *BMJ* 1995; **310**: 440
2. Matyka K, et al. *Diabetes Care* 1997; **20**(2): 135-41
3. Munshi MN, *Arch Intern Med* 2011; **171**(4): 362-4.
4. The ADVANCE Collaborative Group *N Engl J Med* 2008; **358**: 2560-72
5. *N Engl J Med* 2008; **358**(24): 2545-59

End of life care: implementing best practice for all

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When Dame Cicely Saunders set up the first hospice 50 years ago she viewed end of life care as a road to success that is always under construction. This is an increasingly pivotal time for end of life care and a number of key initiatives have recently taken place that will change its delivery to patients and affect our everyday practice.

My favourite definition of palliative care comes from Dame Cicely: “You matter because you are you and you matter to the last moment of your life. And we will do all we can to not only to help you to die peacefully but to live until you die.” For me this is the philosophy for medicine not just palliative care. You can see the influence of the hospice moment and Dame Cicely’s vision when you pick up the *British Medical Journal* and almost whole editions are given over to end of life and palliative care and 10 years ago this wouldn’t have happened.

Certainly, when she started St Christopher’s Hospice in 1967 she said: “The NHS is so far removed from my vision of the care that I think we can deliver to patients and families that I need to develop my model outside of it.” She did say her vision was that it would come back and be integrated into the NHS in the future and I think this is exactly where we are 50 years later.



One important consideration at the moment is where should people die? A lot of evidence and research says most people would like to die in their normal place of residence—which includes care homes. There is a big push at policy level saying we want people to have the choice of where they die in our society.

The End of Life Strategy report¹ shows that hospital deaths over the past three years have gone down from 56% to 53%, which is going in the right direction. And there is a huge amount of work going on to push it down further. It was the first National Strategy in this country around how people should die and the services they should expect. End of life care is everyone’s business and it is part of all our roles. This is a huge paradigm shift in our medical thinking.

Research with patients has shown that given the choice, 80% would prefer to have the conversation with their GP about end of life care. So we really need

to educate and empower GPs to have these conversations and the National Council for Palliative Care has pulled together materials to try and encourage these discussions.²

There has also been a big step forward with advanced care planning and priorities for care in the future for patients. End of life care supportive care registers are going to become universal around the country. The acute hospital needs to understand the supportive care register and know when to use it. The Amber Care Bundle was developed to improve the quality of care of patients who are at risk of dying in the next one to two months but may still be receiving active treatment. It is a decision making tool, which we want to encourage wards to use and also rapid discharge home pathways so if a patient wishes to die at home we need a system to enable this to happen.

Treatment and Care Towards the End of Life³ is another very powerful document, which underpins good end of life care. It identifies a number of challenges in ensuring that patients receive such care, and provides a framework to support healthcare providers in addressing the issues in a way that meets the needs of individual patients.

1. DoH. National End of Life Care Programme <http://www.endoflifecareforadults.nhs.uk/> Accessed 12/02/2012
2. www.ncpc.org.uk Accessed 12/02/2012
3. www.gmc-uk.org/End_of_life.pdf_32486688.pdf Accessed 12/02/2012

Heart failure: improving outcomes

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The NICE heart failure guidance¹ was updated in 2010 and looked at the optimisation of diagnostic strategy by aiming to make diagnosis of heart failure simpler and faster.

Optimising diagnosis can be done by measuring serum natriuretic peptides, use of echocardiography and referring patients to the specialist multidisciplinary heart failure team. So what is a specialist? According to the guidelines it is “A physician with subspecialty interest in heart failure (often a consultant cardiologist) who leads a specialist multidisciplinary heart failure team of professionals with appropriate competencies from primary and secondary care.”

The treatment strategy has also been optimised by the guidance with organised first-line and second-line care. Both ACE inhibitors and beta-blockers licensed for heart failure are first line treatment. An ARB is offered if a patient is intolerant of ACE inhibitors.

Organisation of care is done by ensuring an integrated approach to care delivered by a multidisciplinary team. But a guideline is as good as the prevailing environment into which it emerges. There have been other important developments in heart failure that can help build on the NICE guidance.

The NICE Quality Standards on heart failure were published



in July 2011.² It features 13 statements that define high quality patient care. These include offering people with stable chronic heart failure and no precluding condition or device a supervised, group exercise-based cardiac rehabilitation programme that includes education and psychological support. It also states that people admitted to hospital because of chronic heart failure are provided with a personalised management plan that is shared with them, their carers and their GP. The standard also states that people with moderate to severe chronic heart failure, and their carers, have access to a heart failure specialist and a palliative care service.

There is also the White Paper: *Equity and Excellence: Liberating the NHS 2010*.³ This states that “service must be focused on outcomes and the quality standards that deliver them. Providers will be paid according to their performance.”

Commissioners can improve services (through service specification and measuring performance) and they may use quality standards to ensure high-quality care. They can also use key performance indicators as part of

a tendering process to incentivise provider performance, which can only be a good thing. But the challenge is who will do all of this? What will be the role of elderly care/complex care as the majority of heart patients are not on cardiology wards. The cardiology (and heart failure nurse) teams rarely cover patients outside their speciality wards and heart failure is the commonest cause of admissions in patients over 65 years. In addition, they often have complex multidisciplinary needs.

Improving outcomes can be done by confirming the diagnosis of heart failure patients quickly. Then treatment can be optimised by taking the service to the patient or the patient to the service (such as heart failure wards). Specialist input is essential to optimise discharge, follow up and transfer of care.

1. NICE heart failure guidance. <http://guidance.nice.org.uk/CG108>
2. www.nice.org.uk/guidance/qualitystandards/chronicheartfailure/home.jsp
3. Equity and excellence: Liberating the NHS. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353 Accessed 12/2/12

The NSF for Older People: what went wrong, what was saved, what next?

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The National Service Framework (NSF) for Older People¹ was a ten year plan for improving health and care services for older people in England. It was published in March, 2001. I was Chair of the External Reference Group for the development of the NSF (1998–9) and National Clinical Director, responsible for its implementation during the period of 2000–8.

By 2008, we had made good progress towards meeting many of the ambitions set out in the NSF. Age equality in healthcare was on its way to becoming embedded in legislation. Best practice models in end of life care had been adapted from cancer care and applied to the care of older people at the end of their lives, particularly in hospitals and care home settings. A person centred approach for the social care of older people had been promoted through the introduction of direct payments and personal budgets and the development of new models of long-term care. Dignity in Care had become a top priority in healthcare, backed up by more rigorous inspection and regulation. Stroke and dementia had become top clinical priorities alongside heart disease and cancer. There were new drivers to improve care for older people with fragility fractures. Older people had the highest ever levels of uptake of disease prevention services and the promotion of healthy active life from middle to old age was being



driven through lifestyle advice in the mass media. These achievements were by no means inevitable, and indeed could easily have been lost as a result of a series of threats to NSF implementation in 2003/4.

Change was heralded by a reorganisation of structure and a change of priorities within the Department of Health (DoH). The NSF for Older People had been a top level priority policy of an integrated Health and Social Care Directorate in DoH. In 2003 the Directorate was split into a new Social Care Directorate (with responsibility for the NSF for Older People) and a Health Care Directorate (with responsibility for the Cancer Plan and the NSF for Heart Disease).

Soon to follow was the restructuring of NHS management in, “Shifting the Balance of Power”, with the creation of about 300 Primary Care Trusts and 28 Strategic Health Authorities. The implementation plan and structure for the NSF, based on national, regional and local partnerships between health and social care services, was broken.

In response to the narrower set of DoH priorities, the Modernization Agency withdrew funds for the NSF for Older People,

to concentrate the resources on the modernisation of cancer and heart disease services and access targets in primary care and A&E services.

Rejecting advice to abandon much of the NSF ambitions, I continued to visit front-line services to support local efforts to implement the NSF, while developing a new strategy to ensure better support from the centre. The period 2004–8 was the most challenging for implementing the NSF. Indeed, it might well have gathered dust as a worthy document, like many other policy ambitions, which could not survive changes in political interest and organisational structure. However, by aligning NSF Standards with newly emerging priorities I believe we were successful in achieving most of its ambitions.

The NSF for Older People delivered substantial and embedded changes to culture, system and practice in the health and care for older people, during a benign, and then hostile policy environment. With renewed media and political interest in the impact of ageing populations I believe there are fresh opportunities to build on the legacy of the NSF. This includes not only continuing work in key areas of the NSF, such as ensuring dignity in care, and the development of better care for people with dementia and their families, but also to break new ground in promoting vital ageing, early intervention in primary care and in cutting the costs of frailty.

1. NSF for Older People. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066 Accessed 12/2/12
2. Philp I, Appleby L. (2005). Securing Better Mental Health for Older Adults. Department of Health: London. *Lancet* 2001; **358**: 1033–41

Dementia: are we winning the war?

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There are four priority areas in dementia, which are good quality early diagnosis and intervention for all, improved quality of care in general hospitals, living well with dementia in care homes and reduced use of antipsychotic medication.

Two thirds of people with dementia never receive a diagnosis; the UK is in the bottom third of countries in Europe for diagnosis and treatment of people with dementia. In addition, only a third of GPs feel they have adequate training in diagnosis of dementia.

In regard to improved quality of care in general hospitals, 40% of people in hospital have dementia. The excess cost is estimated to be £6 million per annum in the average general hospital and comorbidity with general medical conditions is high meaning people with dementia stay longer in hospital.

Dementia is often not perceived to be a life-limiting illness yet increasing numbers of people will die with dementia, many in the acute hospital. The rising prevalence of dementia will have an impact on acute hospitals. Extra resources will be required for intermediate and palliative care and mental health liaison services.¹

In the context of a degenerative disorder, such as AD, any one of the following outcomes may be considered a treatment success:



- Improvement followed by a slower decline
- Stabilisation followed by a slower decline
- A slower decline compared to the natural progression of the disease
- The greatest benefits may be seen when treatment is started early, and patients are maintained in the milder stages of AD.²

Dementia management includes optimising physical health with written and verbal information on the condition, treatment and support options. An ongoing personalised care plan, named care coordinator, individual needs addressed and early assessment for neuropsychiatric symptoms are also needed.

Guidance for the management of AD has changed over the years. In 2001, NICE recommended the use of drugs as per licence (acetylcholinesterase inhibitors for mild and moderate disease). Whereas in 2006, it stated that the drugs should not be used in mild disease and only in moderate disease. Memantine was not recommended. Now the latest NICE guidance 2011 states use of acetylcholinesterase

inhibitors as per licence and memantine for moderate disease if acetylcholinesterase inhibitors are contraindicated and as per licence for moderate and severe disease.³

Another major issue is the management of behavioural symptoms in AD. Two thirds of people in care homes have dementia. Dependency is increasing and behavioural disturbances are highly prevalent and are often treated with antipsychotic drugs.

There are an estimated 180,000 people with dementia on antipsychotic drugs. In only about one third of these cases are the drugs having a beneficial effect and there are 1800 excess deaths per year as a result of their prescription. Non-pharmacological management includes support and counselling, psychosocial interventions, behavioural therapy as well as staff training.

1. Sampson et al. *Br J Psych* 2009; **195**: 61-66
2. Feldman H, et al. Symptomatic treatments for Alzheimer's disease. In: Gauthier S, editor. *Clinical Diagnosis and Management of Alzheimer's Disease*. 2nd rev. ed. London: Martin Dunitz, 1999:249-268.
3. www.nice.org.uk

Managing new prescribing frameworks and the evolving role of NICE

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The cost of healthcare is going to continue to go up if the Government doesn't draw the line somewhere. Expenditure is currently hitting the £112 billion mark, which is 10% of the gross domestic product of the country.

Things are changing though and for the first time the healthcare system is being reformed without any investment. The new message is that quality without efficiency is non-sustainable. The Government is trying to save money in the healthcare system in three ways. The first is through staffing—at the moment if someone leaves, then the post is frozen followed by an evaluation about whether that post was needed at all. The second is through tariffs—there is now a financial disincentive for commissioning GPs to keep sending people to outpatients. In hospitals too, the tariff for activity is deflating by 2–4% per year and this actually means hospitals won't survive doing what they have been doing. The third is service redesign where we start changing how patients work with healthcare staff.

What is interesting is that although things have changed in the healthcare system many times before, this time it is different. We are going to see a commercialisation of healthcare that cannot be reversed. Whereas previously



we had a traffic light system of authorisation of drugs, in Surrey now we have 11 different consortia emerging where before we had one PCT. The consortia are beginning to flex their muscles about what they are commissioning. This means consultants will need to look at the authorisation of what is funded by the patients' consortia before prescribing based on clinical need. This is the direction that healthcare is going.

Surrey PCT is the second biggest in the country and now a third of it is under the care of Assura Medical, which is owned by Virgin Healthcare. What does this mean to the people there? We don't know! This is the beginning of managed care. In London United Health, the largest managed care company in the US, are buying surgeries. GPs are starting to get fed up with the change in the NHS and will take the salary without the complications.

My CEO is currently tendering to private companies because they need to move to a seven day service to meet customer needs. This Government has opened the doors and greased the rails to privatisation. They will say we didn't do it we left it to the GPs and your family doctor is now running the show.

Things are changing with patients too, who are now more commercialised. Patient choice in the NHS was never meant to be like a supermarket but this is what has happened.

We now have NICE quality standards, which are a set of specific, concise statements and associated measures. They set out markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Eventually there will be 150 NICE Quality Standards and all eyes are moving to them as they are going to dictate the flow of funding to services.

There is also the Quality, Innovation, Productivity and Prevention (QIPP) programme, which is a national strategy involving all NHS staff, patients, clinicians and the voluntary sector. It aims to improve the quality and delivery of NHS care while reducing costs to make £20 billion efficiency savings by 2014/15. These savings will be reinvested to support the front line. Quality, innovation and prevention all costs money and I've shown you today that there is no money. Every new drug that comes in—even if it is good quality and innovative—if it doesn't pay for itself, it won't get funded.

Reporter: Alison Bloomer; Photographs: John Harrison; Transcription: Rachel Scott