Primary Care Commissioning (PCC) has appointed David Colin Thomé as its new chair, replacing Roy Greenhalgh who stepped down in April after three years.

Professor Colin Thomé was until recently national clinical director of primary care at the Department of Health, a post he held for nearly 10 years. He retired as a GP in 2007.

Helen Northall, chief executive, PCC, said: “I am delighted that David has agreed to serve as our chair. He is an outstanding champion of the NHS who constantly brings the debate back to the real point, which is not about processes and systems but about the crucial role of primary care in creating a better NHS for the people it serves. David has experience which will be invaluable in the transition to the new commissioning system and beyond.”

Colin Thomé said: “PCC has always played a valuable part in supporting the development of primary care, so I was very pleased to be asked to take the chair. The directors and staff share my belief that clinical leadership is vital and that, in any healthcare system, primary care is what makes the system tick.”

A GMC review found that one in 20 prescriptions contains an error. Although most are spotted by community pharmacists and “only” 4% of errors have serious consequences, the news underlines the vital importance of good prescribing practice.

For CCGs, sound policies around medicines are crucial to ensuring patient safety and good care. It also makes financial sense as £13bn of the NHS budget goes on prescribing.

As the authorisation process gets underway, CCGs have a further incentive to tackle prescribing. On pages 6 and 7, we make the case for medicines management as part of your authorisation evidence, and set out the wider benefits of getting to grips with your drugs habit.

TYPES OF EVIDENCE RECOMMENDED INCLUDE:
- Organisational and accountability structures
- Terms of reference and memberships for key committees
- Shared care agreements and medicines policies
- Service level agreements and contracts with providers
- Pharmaceutical needs assessments
- Commissioning support service intentions
- Performance management indicators
- QIPP plans and previous performance history.
Clinical commissioners in the west Midlands have successfully piloted the experience-led commissioning (ELC) model to develop an end of life care strategy.

The Healthworks locality of the Sandwell and West Birmingham Clinical Commissioning Group (CCG) drew on insights provided by patient experiences recorded locally and at a national level. It was part of the DH-funded programme of pilots for patient and public involvement.

ELC claims to take user involvement and consultation a step further than the traditional model by bringing users and carers together with commissioning and provider staff to co-design a commissioning strategy and service.

Discussion in six co-design workshops organised for Healthworks was stimulated by the use of short films of people talking about their own experiences of the care provided to dying people and their relatives.

They then considered what improvements could be made to services. When the work was undertaken Healthworks was set to be a standalone CCG with a population of 150,000 but since the merger the lessons are being applied across a commissioning group with a population of 500,000.

GP Niti Pall, who is vice-chair of the locality, said: “We have successfully applied for £500,000 from the two clusters to implement the strategy across the CCG.”

After initial scepticism, Pall says she now firmly believes ELC represents a dynamic inclusive approach to designing services and pathways.

“This feels very real – that we were engaging not just with users but also with providers. It felt incredibly inclusive. You have to step into other people’s shoes and see how things look from their perspective.”

However, the evaluation cautioned that difficult work lies ahead. It said: “The same level of thought, skill and dedication will be needed in the next phase of implementation; and expectations generated in the first phase need to be managed through into the next phases.”

In response, Pall says: “Yes we have raised expectations but people have set out what they want and we are trying to build on what we have already.”

An important example of that is the development of a 24/7 respiratory service to ensure that people with breathing difficulties can be cared for at home rather than dying in hospital. Clinicians and NHS managers told the evaluation team that improvements and new ways of working identified in the strategy could lead to savings through, for example, reduced fewer hospital admissions. This could help fund the new services.

The evaluation said GPs believed that co-designed services are more likely to get patient approval.

The Smart Guides to Engagement have been written and edited by experts who were asked to produce concise, authoritative booklets explaining different aspects of PPE in the context of the changing NHS.

The series of 10 guides covers:
- Use of social media
- Working with LINks and local HealthWatch
- Local authority scrutiny
- Improving patient health
- Building public support for change
- Working with lay members and patient representatives.
Patient feedback is playing a greater role in commissioning decisions and service re-design in Staffordshire with the consolidation of a variety of information into one database.

The Model of Insight project brings together reactive feedback such as complaints and the findings of public and patient involvement work such as workshops and focus groups. It is also driven by feedback from patient participation groups in 32 of the area’s 35 practices. It will be strengthened further with the development of a patient congress involving representatives from voluntary groups, condition-specific groups and patients.

The model has been developed by the community relations team at Staffordshire Commissioning Support Services working with North Staffordshire Clinical Commissioning Group (CCG), patients and members of the local Our NHS scheme. Stoke-on-Trent CCG is now also implementing the programme while the cluster’s four other CCGs are likely to do so after resolving IT issues.

Lesley Goodburn, head of community relations with Staffordshire Commissioning Support Services, says it is introducing a retail-style customer relationship management approach to help NHS commissioners and providers respond to patient needs. Goodburn, who has a commercial background herself, says: “This is helping us to understand what the patient is telling us.”

The data from a range of sources is placed under headings that allow comparison against national data and also relate to the five patient experience domains:

- Safe high quality care
- Building better relationships
- Better information with more choice
- Access and waiting
- Clean, comfortable place to be.

Goodburn says that having one comprehensive picture of patient feedback can ensure the patient and public voice is more clearly heard in commissioning and service decision-making and monitoring.

Initially the Model of Insight was used to consolidate access and waiting times data for podiatry, clinical care for orthotics and better information for more choice around continence services. These were chosen because there were high levels of patient feedback – for example, waiting times for podiatry generated a high numbers of complaints.

 Commissioners of these services worked with the community relations team to run patient workshops on these issues before conducting an external review of the three services.

Following that review, patients have worked with commissioners to develop service specifications and monitor the demand and performance of the three services – ensuring that patient experience is driving the commissioning cycle.

The provision of quality and safety information has also improved the performance management of contractors.

The model provides commissioners, contract monitors, quality teams, practices and medical staff with dashboards containing data relevant to their area of responsibility. Goodburn says this should mean that they can review and alter services in a responsive and patient-centred way.

The model has received external recognition, being shortlisted in the Patient Experience Network National Awards and winning a Crème de la Crème Business Award for Outstanding Achievement.

All the CCGs mentioned in this section appear in video case studies due to be released in June to accompany the Smart Guides to Engagement (related story).

Dr Ranjit Gill, accountable officer designate at Stockport CCG, said: “England’s new CCGs will change the NHS’s relationship with the public it serves. People have traditionally been interested in their NHS only when they need it. CCGs will need to get the public to not only take an active interest in their own health, and that of their loved ones, but also of the wider community. These guides will help CCGs help their communities to do that.”

Catherine Briggs, clinical director for primary care and clinical lead for public engagement with Stockport CCG, also welcomed the guides. She said: “Public engagement means both involving patients in decisions about their health and local services and encouraging them to take ownership of their own health. At my practice we probably see less than half of our registered patients on a regular basis. By improving engagement with hard to reach groups, we have a chance to improve the health of our population in new ways.

For example, we have virtual patient groups involved in PRGs to expand consultation beyond the ‘usual crowd’.

“We need to explore how best we can meet the needs of our patients, not just when they are unwell, but preferably when they are well. Only if we achieve this will we achieve a sustainable NHS for the future.”

Julian Patterson, marketing director of PCC, who co-ordinated production, said: “The smart guides cover a range of big topics in a small format peppered with good examples. The guides cover different things, but the underlying theme is that the NHS won’t work without true engagement and involvement of people in their own care and in local decisions about services.

“They also reflect the reality that CCGs don’t have the luxury of years of study. They just want a reliable crib sheet.”

The Smart Guides to Engagement are available for download at the NHS Networks website: http://bit.ly/KdbmL4
The emergence of Any Qualified Provider (AQP) and its extension to some community and mental health services has generated a heated debate. Some have seen AQP as a vehicle for expanding non-NHS provision; others as an important tool for innovation and driving up quality.

As someone with a background in commissioning seconded to the Department of Health’s (DH) AQP team, I can see that this debate has generated many urban myths that I hope to dispel.

**MYTH 1: AQP is new and is being imposed through the Health and Social Care Act**

In fact, AQP is not referred to in the act at all and is a continuation of pre-existing policy. Commissioners have been offering choice of provider since 2008, and this has proved very popular with patients. Since the introduction of “free choice” over 358,000 NHS elective procedures have been performed under the Extended Choice Network and the upward trend is continuing.

Patient groups remain supportive of AQP as a means of addressing poor quality provision and limited access among a range of community and mental health services.

**MYTH 2: AQP is mandatory and will apply to most NHS services**

Choice of provider may not be appropriate for all services – one size certainly does not fit all and commissioners have a freer rein than some might realise. From 2013 clinical commissioning groups (CCGs) will decide when not to use competition – including choice of AQP.

Where integration is particularly important, commissioners may decide tendering is the better approach and seek to appoint a sole prime provider, while still offering choice as part of the pathway. This creates a strong incentive to manage people with complex needs and long-term conditions effectively, with a focus on earlier preventative interventions.

**AQP sits within a range of options available to commissioners to secure services. The DH is developing secondary legislation for consultation in the summer. This will provide a clearer statutory underpinning of the current principles and rules for cooperation and competition, including greater clarity for commissioners on requirements around procurement.**

**MYTH 3: AQP is an end in itself**

There has been controversy not just about the aims of AQP, but also its implementation. It was perceived initially by CCGs as too top down. Hopefully, we have reached a turning point on this. 2012 is the last year of transition, during which DH will move forward with implementation - working with the NHS to develop and learn from the qualification processes for those services identified as priorities for early implementation.

Looking ahead, key to its effectiveness will be good engagement with patients and providers to develop outcome-based service specifications and tariffs which incentivise good clinical care. This should help commissioners achieve the desired outcomes and ensure quality and innovation are maintained - without incentivising poor practices or unnecessary increases in supply.

**MYTH 4: AQP will lead to a ‘race to the bottom’ on quality**

All providers will have to meet the specified quality requirements, including those laid down through professional regulation and the terms and conditions of the NHS standard contract.

The NHS of the future will encompass a wide range of providers who may look and operate differently from each other because they are responding to different patient needs. AQP acts as a stimulus to providers and reduces the risk of complacency. More commissioners are using AQP to focus on outcomes and to raise the quality bar - so that only the best need apply to their AQP offer.


(Annabelle Walker is commissioning and service development lead for AQP at the Department of Health.)

**NHS warned about drain on talent pool**

The drain of talent and experience during the lengthy transition to the new NHS structures could set commissioning back a decade, a former NHS leader who has canvassed a range of individuals with senior roles in the transition has warned.

Gina Shakespeare, a former chief executive of Luton Primary Care Trust (PCT) and an independent consultant, conducted a series of interviews with cluster chief executives and human resources directors, CCG board members, PCT leaders and several figures playing national roles in shaping the new NHS and its commissioning workforce. Her work was partly geared to shaping the agenda for a PCC event aimed at helping commissioning professionals identify and secure appropriate posts in the new commissioning landscape.

Interviewees acknowledged that the impact on the commissioning workforce of the reforms and the slow legislative process was substantial, with most seeing it as unprecedented. Most reported that some experienced and talented people were taking redundancy payments and that many others were confused about their future and current role.

Her interviews also highlighted that transitional and new commissioning organisations need an extensive focus on human resources (HR) to ensure they retain such expertise, that people are offered appropriate positions and to avoid expensive legal challenges.
CASE STUDY: VIRTUAL CLINICS

HOW TO TACKLE DIABETES: stop seeing patients

A report published in April predicted that in 25 years diabetes could account for a sixth of the NHS budget. No wonder commissioners are seeking out new ways of controlling the impact on their budgets.

In Plymouth, where diabetes cases have risen by more than one third in seven years, one possible solution was proposed by the long-term conditions team and diabetes consultants at Plymouth Hospitals NHS Trust.

The consultants conduct virtual clinics sitting alongside GPs and practice nurses in practices. Many consultants are adjusting to the idea of the conducting clinics in practices or other community settings but in this case there is a big difference: they do not see any patients. Dr Paddy English, a diabetes consultant at Derriford Hospital, explains: “We work through with the GP and nurse all the patients with indications of either poorly controlled diabetes or hypoglycaemia.

“It is about upskilling GPs as well as reviewing individual cases. There is universal feedback from GPs and practice nurses about the educational value because they are talking about real patients, real problems. We talk about concepts but we are simultaneously applying them with patient notes in front of us.”

The idea emerged as English and his colleagues contemplated the number of people with diabetes locally increasing by more than 1000 a year.

“We realised up to three years ago that we were not going to be able to cope with that and that it was unlikely we would be recruiting additional consultants. I and a colleague looked through referral letters for two clinics so together we discussed 130 patients.”

“We agreed that in quite a lot of cases we did not need to see the patients – the GP, with appropriate advice, could have dealt with them.

We were asking ourselves what we could do that GPs could not; what is our role?”

As well as seeking greater discretion over new referrals, English says the consultants were frustrated that they were unable to divert patients who they no longer needed to see but who did require additional support and monitoring.

The virtual clinics offer a new way of monitoring such patients while also increasing patient confidence that they are being safely discharged back to the care of their GP. The pilots results are encouraging and Sentinel CCG is now considering how the service should be commissioned, including an educational element that featured in the pilots.

Across the 40 virtual clinics, during which the notes of around 600 patients were reviewed, some 139 referrals were avoided. On top of that, 14 patients attending hospital were discharged back to their GP’s care. English acknowledges some patients might feel concerned they are missing out on specialist expertise but says that virtual clinics can also offer reassurance or benefit patients by picking up issues that GPs might not have considered.

“It is true that we will not be seeing some patients who would previously have been referred but by asking GPs to go through their lists and review with us defined groups of patients we are actually considering and seeing patients who would not have been referred in the past – particularly those with hypoglycaemia. It works both ways.”

The CCG acknowledges however that in developing the service, stakeholder engagement – particularly user involvement – will be an important issue.

English says: “This might not save money in the short term but in the long term it makes care of people with diabetes more sustainable and will improve care by supporting the skills of primary care colleagues and see more patients receiving care closer to home. That is all in line with the QIPP agenda.”

He emphasises however that the virtual clinics should be seen as part of a package that practices sign up to – including taking part in regular sessions, based perhaps at cluster level, where groups of GPs engage with a diabetes consultant on a more general basis.

Specialist community diabetes nursing services are another element of the package.

Meanwhile, English and his colleagues can, for the most part, get on with the real reason they are here: seeing the patients in greatest need.

Shakespeare said: “We made large steps forward in World Class Commissioning and so it is important we do not go backwards. This requires the highest standards of HR practice because we could potentially go back a decade by losing good people with experience. Instead we want to build on what we have with the addition of the dynamism that some clinical commissioners are bringing to the stage.”

Key risks identified by the participants included:

• Loss of some of the best and most experienced commissioning staff frustrated at the time taken to pass the legislation and implement the reforms
• Inadequate development and appraisal of staff still unsure if their current role fits with a fully-authorised CCG
• Reduced workforce productivity during transition
• Increased legal costs, poor labour relations and litigation, including employment tribunals, through poor understanding of employment legislation and HR practice
• Replication of PCT practices and approaches rather than transformation because of poor planning in recruitment and fears about redundancy costs.

Shakespeare added that the interviews had confirmed the long-standing need for improving the status and remuneration of commissioning professionals compared to those working in the acute sector.

The interviews helped shape the programme for PCC'S Supporting the Commissioning Workforce Through Transition one day conference to be held in London on 22 May.

It can be difficult to make the links between the plethora of documents and guidance surrounding medicines management and the new world of clinical commissioning.

Medicines cost the NHS £12.9bn in 2010 and will account for around 14% of spending by clinical commissioning groups (CCGs).

PCC has drawn together two key documents that should help emerging CCGs respond to the crucial challenge of ensuring medicines optimisation.

Last autumn the Department of Health (DH) published Developing Clinical Commissioning Groups: Towards Authorisation (http://bit.ly/LODO6r). This described the six overarching domains that CCGs will need to demonstrate achievement against to gain authorisation as a statutory commissioning body.

A few months earlier, the National Prescribing Centre (NPC) published An Organisational Competency Framework to Ensure the Effective Delivery of Medicines Management Functions and Responsibilities (http://bit.ly/JfhrU7). This was intended to help emerging CCGs maintain and develop effective medicines management and ensure that the commissioning and use of medicines remains safe, effective and financially viable.

The current authorisation guidance does not specifically mention medicines management processes but strong links can be made between the two documents (see table).

<table>
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<tr>
<th>CCG Authorisation Domains (DH)</th>
<th>NPC Competencies for Medicines Management</th>
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| • Clinical (multi-professional) focus | • Supports and develops people
| • Engagement                      | • Medicines expertise                     |
| • QIPP                            | • Optimises medicines through commissioning |
| • Governance                      | • Medicines oversight                     |
| • Collaborative working           | • Effective partnerships                  |
| • Leadership                      | • Strategic overview                      |

The PCC publication CCG Authorisation: the Role of Medicines Management (http://bit.ly/K2BvZ0) links the 48 underpinning indicators within the competencies developed by the NPC with the DH authorisation domains. This allows commissioners to identify where medicines management might impact their journey towards authorisation.

It also provides clear examples of the evidence that CCGs should have - or should be developing - to support their authorisation applications (see box, page 1).

Some of the indicators are predictable, particularly around the use of new drugs, QIPP, prescribing budgetary management and analysis, and clinical governance.

However, some will be less obvious to CCGs. These include:

• Meeting the requirements of the NHS constitution around access to medicines
• Working with health and wellbeing boards
• Working in partnership with commercial bodies and ensuring robust governance arrangements
• Care pathway developments and performance management for medicines use – ensuring professional expertise is available in all service redesign
• Horizon-scanning for new developments that may affect future medicines use or expenditure (including disinvestment opportunities)
• Safety and governance around controlled drugs
• Meeting the legal and professional requirements for medicines use through robust commissioning.

Clusters, CCGs and strategic health authorities are currently discussing a number of models around the future of medicines management functions.

CCGs are beginning to look at those functions which can be or should be provided at local CCG level - and which should be considered between groups of CCGs. Some might even be commissioned over a much larger area from commissioning support services (CSSs).

CCGs, in conjunction with their existing medicines management teams, should be taking this opportunity to identify the risks and benefits of the various models. Now is the time for commissioners to be talking to stakeholders so they can make firm plans for medicines management in the new commissioning world.

In doing so, they will have to shape future roles that meet the demands of the newly branded medicines optimisation agenda. Medicines optimisation, simply put, encompasses the functions and roles associated with medicines management. However it also brings an increased focus on how people actually use their medicines, achieving safer and effective care, and delivering the outcomes specified in the NHS Outcomes Framework.

Achieving that aim is thought to be worth more than £1bn in reduced waste and improved patient outcomes.

PCC provides bespoke support to CCGs developing medicines management policy and programmes. Contact marion.todd@pcc.nhs.uk.
CCGs should be in no hurry to break up existing local decision-making structures in their enthusiasm to gain better clinical control of prescribing.

The advice comes from Sue Ashwell, a pharmacist with a long career in medicines management and Dennis Cox, a doctor and legal adviser.

Ashwell and Cox emphasise they are not simply suggesting that existing ways of doing things are set in stone. However, faced with a wide range of prescribing-related challenges, CCGs’ initial focus should not be on tampering with local arrangements - such as area prescribing committees and exceptional case panels - if they are working.

CCG leaders will also need to better understand the risks that are managed through these arrangements, they believe.

Ashwell argues effective systems and processes should be left in place for a transitional period of at least 12 months. This would provide breathing space for CCGs to concentrate on performance management of prescribing practices locally and ensuring consistent buy-in to a formulary for the medicines to be prescribed for the more common conditions seen in practices.

They emphasise the importance of sharing what Ashwell terms collective brain power. This means establishing or retaining committees or panels covering larger populations to consider policy on drugs whose use is not rare but which typical GP practices will prescribe only a few times a year.

Cox, a GP and medical director for legal firm Capsticks as well as one of the RCGP’s clinical commissioning champions, says CCGs need to be cautious when tackling the complicated issues around exceptional cases or new treatments.

“You have to remember the legal scrutiny that decisions by committees or panels could face. You have to prove that you have gone through the right processes and you need expertise to ensure you have crossed the Ts and dotted the Is.”

This applies whether the criteria or decisions have been set by an individual CCG or been accepted by the CCG following the deliberations of a group covering a wider population.

Ashwell, a former PCT chief pharmacist turned consultant, is concerned that the emphasis on localism will see area prescribing committees sidelined until people recall their value in reaching consensus on expensive and less commonly-prescribed drugs. They also allow GPs to influence the choices of specialists before prescribing costs are passed to CCGs.

“If I could have one wish it is that the CCGs hang on to expertise in pharmaceutical decision-making for wider communities. These sorts of committees bring together consultants, GPs and pharmacists, and facilitate discussion. Consultants working in the same field might initially have perfectly logical differences of opinion but they can come to a consensus and agree on (prescribing) criteria.

CCGs wishing to “aggregate brain power” should fund specialist teams or committees covering a very large population area to evaluate and make recommendations on new or expensive medicines and devices, they argue.

While they agree it is difficult to specify the geographical area or population such a committee or team would ideally cover, the pair say that it would probably be above federation level and below the four NHS Commissioning Board regional offices.

Cox suggests these would evaluate and make decisions on the use of new drugs that would have a significant cost for the CCG, or that would significantly affect a care pathway.

Ashwell explains: “This will be a structure for advising particularly on less common treatments – drugs used in district general hospitals but not specialist commissioning. We need people to be examining the evidence for the treatment, talking to the consultants and reaching informed decisions.

“However, clinical and prescribing leads need training and support in the CCG to help them understand and communicate the process that underpins local recommendations about prescribing.”

The pair suggest that there should be “a sense of coherence” in terms of the community of practices and population involved.

Ashwell says: “The critical issue is getting people to feel comfortable with the decisions made: CCG clinical leaders are going to have to sell those decisions.”

She points to the four neighbouring PCTs in southern England currently involved in the high-profile legal case involving the use of Avastin for the treatment of wet AMD. “The four PCTs worked together with specialists to consider the evidence and make that recommendation,” Ashwell says.

On a positive note, Cox argues that the new commissioning structure should promote greater GP buy-in to the decisions that are reached on prescribing criteria and the use of new or expensive drugs.

“With the CCGs you are going to have doctors saying this is what we know works and therefore we expect our constituent practices to follow it. Also, they are membership organisations so GPs who might have railed against a PCT guideline are more likely to accept the conclusions of GP colleagues.”

Ashwell agrees: “This is promoting the message doctor to doctor, saying this is the right thing to do, and explaining how the decisions were reached, then emphasising that this is about working together to make the money go further.”
PUTTING ANGINA PATIENTS AT THE HEART OF THEIR OWN CARE

At a time when any self-respecting speech about the NHS must contain the words “patient-centred”, Mike Chester should be basking in a warm glow generated by the sense that the world has finally caught up with him.

He isn’t.

Having spent more than a decade seeking to instil a patient-centred approach to angina care within the NHS – for the benefit of both patients and NHS budgets – the cardiologist worries that the term’s ubiquity risks devaluing it unless commissioners start to demand real change.

The tone and content of last year’s NICE guidance on angina – with its emphasis on patient education and involvement in decision-making – should see a dramatic decline in the use of expensive interventions such as angioplasty and heart bypasses.

The impediment to achieving that, Chester suggests, is self-delusion on the part of doctors. Too many claim to champion patient education and involvement while withholding vital information about the risks and benefits of complex interventions. Many people with angina are also left feeling that they are a walking heart attack waiting to happen.

“There is a contradiction between what consultants say they do and the truth that around 20% of procedures carried out for cardiac patients are inappropriate and 80-90% are unnecessary. There will be a significant decline in angioplasty if the CCGs are tough enough to insist that interventions will be undertaken only after the NICE guidelines have been followed.”

He warns, however, that CCGs will need to challenge deeply engrained custom and practice amongst cardiologists who have “great difficulty understanding how patients can know what is best for them”.

Anxious and ill-informed patients, he says, are consenting to radical interventions for angina in the belief the condition is damaging their heart and that the interventions will significantly reduce the risk of heart attacks and premature death.

The alternative is genuine patient-centred angina care which allows individuals and their families to make informed decisions about both their lifestyles and treatments – a situation which produces a dramatic fall-off in radical interventions.

He told a recent PCC event: “It is about spending an hour to 90 minutes with a patient and giving them a cup of tea. You explain that angina does not damage the heart and the effect on them is like Botox – you see the worry lines go.”

The consultant and colleagues can advise the individual and family on the condition and its management.

Patients, suddenly confident they do not face an imminent heart attack, start taking their recommended aspirin dose and, with a few adjustments, start living a normal life – one that incorporates fitness activities they had previously feared would trigger a heart attack.

Heart attacks and mortality fall.

The model, he insists, is applicable to all long-term conditions.

Chester says: “Patients are not stupid. They are frightened and ignorant. If you address that they will engage with you in discussing a treatment pathway for them that makes sense. The savings from that one intervention (the discussion) are enormous.”

It was as a senior lecturer and clinician in Liverpool at the turn of the millennium that Chester first started to develop a genuinely patient-centred service; something he refined and carried over as director of the National Refractory Angina Centre (NRAC) at the Royal Liverpool and Broadgreen University Hospitals NHS Trust.

Researchers following 271 patients enrolled at NRAC reported a dramatic fall in days spent in hospital, producing savings of around 70%. In the two years after enrolment at NRAC, there were eight heart attacks amongst the patient group – compared to 32 in the two years before enrolment. Overall mortality was lower than comparable groups of patients treated with surgery.

Chester says the average annual cost of intervention-based treatments comes in at around £6000, treble the cost for “optimal conservative care”.

In his experience, 90-95% of patients enrolled in a patient-centred angina programme opt for continuing conservative self-care.

Many of those decisions come after seeing research showing marginal benefit from radical interventions but significant additional risk, says Chester, who is fond of suggesting that similar research results for any drug therapy would devastate the pharma company’s share price.

Despite his warnings over the mind set that dominates his profession, Chester believes that the NHS might finally be moving in the right direction – not least because of the demands for cost savings.

“If you look after patient-centredness the spreadsheet will look after itself. The vast majority of patients want to be active participants in their own care and eventually that will mean costs will fall.”

Further information is available from www.angina.org