

**Glasgow's chronic disease management programme****Date**

Ongoing

**Location**

Hospital and Primary Care settings in Greater Glasgow NHS Board.

**Key Partners**

Clinicians in hospital and primary care.  
Departments of Public Health and Health Promotion, GGNHSB.  
Local Authorities.  
New Opportunities Fund.  
Smoking Concerns.

**Contact**

Caroline Morrison  
Consultant in Public Health  
Medicine

Greater Glasgow NHS  
Board, Dalian House,  
350 St Vincent Street,  
Glasgow G3 8YZ

Tel 0141 201 4722  
[caroline.morrison@gghb.scot.nhs.uk](mailto:caroline.morrison@gghb.scot.nhs.uk)

**Summary of project and achievements**

A local enhanced scheme within the new GP contract is being rolled out, offering an annual review to all patients with coronary heart disease, carried out by their practice nurse.

The review is to ensure that patients do not fall through the net between hospital and general practice – we know that things can be missed as patients go between the two services.

The review covers symptoms – if these are getting worse or are stopping the patient doing things they want to, we encourage a review of medication or referral to see whether angioplasty or even surgery would be appropriate. Obviously some people will be content having more frequent angina or angina provoked by less activity than others – some of us would like to climb Munros and some of us are content to walk the dog!

The review covers blood pressure, cholesterol and blood sugar – all things that require to be controlled to reduce a patient's risk of having the disease progress perhaps to a heart attack (or another if they have had one already).

There are several drugs which we know will also reduce risk – aspirin, b-blockers such as atenolol and ACE inhibitors. The review ensures that patients have been offered these drugs and that a reason is recorded if the patient is not taking each of them. These, of course, include patient preference.

The practice nurse will discuss any difficulties the patient has in stopping smoking, in eating more healthily, in getting more physically active, in getting nearer to a more suitable weight and in moderating alcohol consumption. This will include finding out whether depression is hindering the patient making appropriate efforts.

Improving any of these behaviours has been shown to reduce blood pressure and to lower cholesterol as well as reducing overall risk. But we all know that changing our health related behaviours is difficult. So we have also set up services to support anyone who wants to try.

There is a "Hearty Eating" programme – group sessions held locally which cover food labelling, cook and taste sessions, menu planning within a budget, shopping trips and much more. The aim is to have fun and support a whole family approach to changing eating habits.

Greater Glasgow has an exercise referral scheme open to those with coronary heart disease. This programme is run with a collaborative approach between the hospitals (to ensure appropriate exercise prescription and safety), our local authority partners' leisure services (there are staff who have been through the British Association of Cardiac Rehabilitation training), and Greater Glasgow's Department of Health Promotion.

A new weight management programme, partly funded by NOF, is starting with a pilot service in October and rolling out across the area next spring. The group sessions will be held locally and in collaboration again with our local authority partners' leisure services through a scheme called "Slimming it Up" – providing good links to encourage exercise perseverance. Overweight occurs because there is an imbalance between the calories we eat and those we use up in physical activity so increasing our physical activity levels is a fundamental part of weight management.

Smoking Concerns, the organisation in Glasgow that co-ordinates smoking cessation activity, has provided LHCC based group interventions to support smoking cessation and community pharmacies provide one to one support for quitters. Each of these is based on the provision of free or prescription priced NRT.

The whole Chronic Disease Management Programme is based on a structured interview using computer screens to ensure nothing relevant is missed. At the end of the interview the patient is offered their own report with some idea about where the problems are and what they and their doctor and nurse are going to do to address them. We have also developed patient literature to help patients understand their disease and the benefits of getting involved in helping to manage it.

Audit data are to be extracted electronically and anonymously each 6 months and the information will be fed back to practices and LHCCs as well as being looked at across the whole area. Payment depends on patients having completed records. A few practices (7 of around 210) have not signed up to the scheme, and since we do not wish to disadvantage patients in these practices we are piloting offering the service through a group of practice nurses working on a sessional basis in these practices.

This approach is intended to offer a joined up system for patients, ensuring they get access to new treatments as they come along, access to any they have missed out on previously and also to make sure that they have the opportunity to discuss all aspects of their care for coronary heart disease and get support to manage any aspects, on an annual basis.