Why cardiometabolic disease prevention matters to every physician

The RCP is hosting a series of cardiometabolic disease prevention summits to explore how doctors and healthcare teams can better prevent one of the UK's leading causes of illness, premature death and health inequality.

Disclaimer: *Boehringer Ingelheim Ireland Ltd has provided funding for this independent programme. Boehringer Ingelheim Ireland Ltd has had no editorial involvement in, or influence over, the agenda, meeting content, or selection of speakers. Lilly has provided sponsorship funding to support these summits and has had no influence over their content or the selection of speakers.*

Across the NHS, physicians are increasingly caring for patients with complex, overlapping conditions. Multiple health conditions are now commonplace, with cardiovascular, renal and metabolic disease often clustering together and amplifying risk over time. Patients move between services and specialties, frequently receiving high-quality care for individual conditions, but rarely experiencing that care as joined-up or preventive. For clinicians, this can be frustrating; responding to immediate problems while knowing that future illness is already beginning to take shape. All too often, missed chances to avoid the first clinical manifestation of cardiometabolic disease in patients are followed by progression to multisystem complications that lead to disability and premature mortality.

Professor Andrew Krentz, cardiometabolic prevention summit co-lead, said:

> 'Prevention should ideally begin with primordial prevention, which aims to avoid the emergence of cardiometabolic risk factors.'

Cardiometabolic disease sits at the centre of this challenge. Its impact on individuals, services and communities is profound, yet much of it is preventable. Tackling it effectively means rethinking prevention, not as a one-off intervention or the responsibility of a single specialty, but as something that cuts across almost every area of medicine.

The cardiometabolic prevention summits were established in response to this challenge. They bring together physicians from across specialties, primary care colleagues, allied professionals, system leaders and patients to explore how prevention can work better in everyday practice. The programme aligns with the direction of travel set out in the NHS Long Term Plan, supporting a shift away from reactive care, stronger integration around the person and greater emphasis on prevention at scale.

Rather than promoting a single model or solution, the summits were designed as a space for shared learning and open discussion, grounded in real clinical experience. Across the first two summits, conversations have ranged from the drivers of cardiometabolic disease to examples of services already working differently, and more effectively, in parts of the country.

Patient voices have been central throughout. Their experiences of navigating fragmented care have highlighted both the limitations of current systems and the difference that coordinated, person-centred approaches can make.

The aim of the summits has not been to produce a blueprint, but to draw out principles that can be adapted across specialties, settings and local contexts.

Atoshi George, patient speaker, said:

> 'It feels like each part of my care works separately, and you feel like you're the one who's supposed to be the expert.'

Working our way out of silos

A recurring theme has been that traditional, siloed models of care no longer reflect clinical reality. Cardiometabolic disease develops over many years, influenced by biological, social and environmental factors, and often affects multiple organ systems simultaneously. Yet care pathways remain largely organised around single conditions and short-term episodes.

This fragmentation leads to missed opportunities for early intervention, unnecessary duplication and uneven outcomes, particularly for people living in deprived communities and for those whose risk is consistently under-recognised. Prevention cannot sit with cardiology or primary care alone. It depends on a whole-system approach which enables clinicians in different settings to identify risk earlier, act with confidence and work more effectively together.

Speakers and case studies showed how multidisciplinary approaches, often involving pharmacists, nurses and allied professionals alongside physicians, can make a real difference. By addressing multiple risk factors together and clarifying responsibility for follow-up, teams have improved medicines optimisation, reduced duplication and helped patients better understand and manage their own risk. For physicians, this reinforces the value of collaboration and

generalist thinking, even within highly specialised roles.

Professor Indranil Dasgupta, consultant nephrologist, Heartlands Hospital, Birmingham, said:

> 'I sometimes use the ancient Indian fable of the six blind men and the elephant: we specialists working in silos are dealing with different parts of the same beast: cardiovascular, renal, metabolic disease. We need to move from working in silo to a holistic approach.'

Looking for cardiometabolic disease in unexpected places

Another strong strand of discussion focused on the importance of a lifecourse approach to cardiometabolic prevention, particularly for women. Events such as pregnancy complications, gestational diabetes and menopause are well-recognised predictors of future cardiometabolic risk, yet are often overlooked once immediate care has ended.

The summits highlighted how physicians across specialties encounter these moments, sometimes unexpectedly, and how greater awareness could support earlier intervention. Taking a women's health lens does not add complexity for complexity's sake; it helps clinicians recognise risk more accurately and support patients at key points in their lives.

Dame Lesley Regan, women's health ambassador for England, said:

> 'Women are twice as likely to die from cardiovascular disease as from cancer, yet that's not what they think will kill them.'

How we can deliver good cardiometabolic care

Despite the scale of the challenge, the summits have also highlighted what good cardiometabolic care looks like in practice. Effective services shared common features; early identification of risk, multidisciplinary teams with clear roles, continuity for patients, and better use of data to support clinical decision making.

Patient experience ran through these examples. Patients valued fewer appointments, clearer explanations and reassurance that someone was overseeing their care as a whole, rather than focusing on individual conditions in isolation. These approaches improved outcomes while reducing confusion and treatment burden.

Digital systems and data were a major focus of the second summit and were seen as important enablers of more effective cardiometabolic prevention when they actively support clinical decision making and patient care. Discussions centred on the challenge of translating large volumes of data into clear, usable insight that helps clinicians identify risk earlier, prioritise action and work more effectively across teams.

Examples shared at the summit showed how better use of data, including population-level dashboards, remote monitoring and decision support tools, can improve follow-up and reduce variation. However, there was clear agreement that digital must follow clinical workflows, not add burden, and that systems must be designed with equity, usability and human care in mind.

RCP digital health clinical lead, Dr Anne Kinderlerer, said:

> 'Digital systems and data are no use to us unless they enable us, with our patients, to make evidence-informed decisions about risk and about what matters to them.'

What happens next?

For most physicians, cardiometabolic disease prevention does not require a radical change in practice. It is about noticing risk earlier, feeling able to raise it, and knowing how and when to connect patients with the right support. Every contact, whether in acute settings, outpatient clinics or the community, is an opportunity to reduce future illness.

This work is not about asking clinicians to do more in already pressured systems. It is about enabling teams to work differently, with shared language, clearer pathways and the confidence and permission to act at the right time.

The RCP's cardiometabolic disease prevention programme is continuing to develop. Learning from the summits is now informing practical resources, including a toolkit to support clinicians across specialties and career stages to embed prevention into everyday practice.

By bringing together insight from across the system, this work aims to support physicians to deliver care that is more joined-up, equitable and preventive, and to reduce the long-term burden of cardiometabolic disease for patients and communities.

The most recent cardiometabolic prevention summit took place on 11 May 2026 and will focused on strengthening education and training for cardiometabolic disease prevention. The summit explored where learning gaps exist, what prevention competencies physicians need regardless of specialty, and which training approaches are most effective, drawing on clinical experience from across the system.

Dr Anita Banerjee, cardiometabolic prevention summit co-lead, said:

> 'We've got to start talking about cardiometabolic disease, but now it's time for action.'

To find out more about the cardiometabolic disease prevention programme, or to get involved, email Improvement@rcp.ac.uk.

This feature was produced for the June 2026 edition of *Commentary* magazine. You can read a web-based version, which includes images.