



Improving the identification and management of patients with cardiovascular disease and primary hypercholesterolaemia/mixed dyslipidaemia in Nottingham and Nottinghamshire.

**This was a joint working project between
Nottingham University Hospitals NHS Trust & Sanofi.**

This Project was as part of the Accelerated Access Collaborative (AAC). The AAC was formed in response to the independently chaired Accelerated Access Review published in October 2016. The AAC brings industry, government and the NHS together to remove barriers to uptake of innovations, so that NHS patients have faster access to innovations that can transform care.

The Project completed at the end of 2021 following delays due to the COVID-19 Pandemic

Below is a summary of the outcomes against the original objectives.

Please briefly outline the key objectives and outcomes the project set out to achieve as stated in your application. How has the project has performed against these?		
Proposed objective / outcome	Status <i>Achieved, Partially Achieved, Not achieved</i>	Narrative
Improving identification of patients with established cardiovascular disease (CVD, secondary prevention) eligible for PCSK9 inhibitors in primary care	Achieved and ongoing	The project is affected by the delays related to Covid-19 (vaccination programme, isolation) and blood tube shortage issues.
Training Primary Care Network (PCN) Pharmacist to identify these patients in the community and screen for eligibility to refer the patient to secondary care	Achieved	All the participating PCN pharmacists have attended the upskilling education programme
Employing the lipid clinic nurse to increase access to patients	Achieved	Lipid clinic nurse was appointed and carried out nurse led clinics
What have been the key achievements and highlights of the project?		
<p>Identifying the primary care working group has been the key as the project is best led and delivered in primary care. Educating the PCN Pharmacists to undertake medication review has made a huge difference in patient management. In accordance and adherence to local/national guidelines, a significant number of patients had been able to switch to a different statin/add another medication, have had adherence assessed and where necessary, been referred to secondary care for better lipid management. Most of this work has been done by PCN pharmacists who are best placed to undertake medication review. We have also demonstrated that this approach is workable and very efficient way to bring any transformation in healthcare. This project has highlighted that the majority of patients needed a compliance check and reinforcement to make sure they adhere to the treatment regimen and this can be achieved with upskilling the non-medical staff like pharmacists or nurses which will lead to better patient management with limited resources available in healthcare.</p>		

Upskilling the pharmacists has been a key achievement of this project. We worked with the Nottinghamshire Area Prescribing Committee pharmacist to update the guidelines, and this was incorporated into the teaching delivered to the pharmacists. The teaching had to be delivered virtually which has been recorded and can be used again in future. The data search was set up with a template to capture all the data needed. Once it was identified that the patient needed referral to the lipid clinic, it followed the current existing pathway of referral using choose and book without the need to reinvent a new referral pathway.

The data capture template has been set up which can be used in each of the participating PCN networks to make sure the same data is captured. This can be used again in future to further identify the patients beyond the completion of the project.

Before the commencement of the project, there were 118 patients receiving PCSK9 inhibitors at Nottingham University Hospitals (NUH). Recent data shows that there are 203 patients who have received PCSK9 inhibitors. Although the increase in PCSK9 prescription is not directly related to this project, it has certainly led to more awareness and more patients being referred for consideration of PCSK9 inhibitors in line with local or national guidance.

What challenges and issues were encountered and how did these impact on the project performance?

Although the official start date of the project was 01/04/2020, the groundwork of identifying the patients did not start until Nov 2020. This is related to multiple reasons as highlighted below.

We identified that there is difficulty in accessing the patient data in primary care without having a data sharing agreement between the secondary care trust and primary care. The initial plan was to employ a secondary care clinical pharmacist who would work in the community. However, it was later realised that the clinical pharmacist would not have access to all the data required and hence we had to change the approach. Setting up this data sharing agreement proved a challenge as the agreement needed to be signed on behalf of each GP practice and needed the permission of the data controller from each practice. After considerable networking, we were able to identify a primary care team to do the search, identify appropriate patients within each GP practices and intervene as required.

There was pushback from the commissioners as the project aimed at optimising lipid management for patients but the GP commissioners were not involved in the initial phase of the project. The increase in the medication cost would not have been budgeted for. We had some negotiation with the help of high-cost drugs interface pharmacists and, as the project was delayed until quarter 2 of 2020-21 financial year, the approval for this project was given.

The main obstacle has been the outbreak of Covid-19 Pandemic. This resulted in the whole project being paused for 3 months in 2020. When it was restarted, most of the initial work has been concentrated on identifying the suitable primary care organisation to deliver the project. Once the primary care team was identified and a search template was set, further work was delayed as many patients have not had their routine blood monitoring. This resulted in the PCN Pharmacists being unable to do compliance checks or intervention checks before deciding on onward referral to the secondary care.

The project was further hampered by the redeployment of the staff to undertake COVID vaccination. Although the pilot PCN continued to do the search, intervene and make onward referrals where appropriate, the other PCNs were not yet ready to start the project. The upskilling teaching session had to be rescheduled due to staff redeployment to the vaccination process which resulted in considerable delay. The project was also affected slightly by the blood tube shortages when all the routine monitoring of bloods was cancelled for 4-6 weeks. Patients couldn't be assessed for response to treatment before being referred to secondary care.

What are the key lessons learned that you think would be valuable for other adopting sites to know if they attempted a similar pathway transformation?

The project application was made by the secondary care team, but the main work needed to be done in primary care. It is important to have these key stakeholders (e.g high-cost drugs interface pharmacists, primary care lead, data controller, PCN pharmacists) on board very early into the project, preferably at the application stage itself, to ensure the process can be smooth.

Having a working pathway is important to avoid any delay in project initiation. If a new pathway needs to be set up, it needs careful planning at the earliest stage.

Data sharing agreement takes longer than expected and it is always better to utilise existing processes.

What are the next steps now the project has concluded? How will the change be embedded and made sustainable? Are you planning further developments to build on the work of the project

The hope is that this project would lead to a legacy effect where the PCN pharmacists would incorporate lipid optimisation into their routine medication reviews. This will help with identifying high risk patients early and taking appropriate action. The project has laid the foundation to

identify the cohort of patients in primary care which will enable other lipid lowering therapies in primary care to be prescribed when appropriate.
 The previously delivered online education talk has been recorded and can be made available for new interested PCN Pharmacists to upskill their approach.

In what demonstrable way has the project tackled health inequalities?

The project has been initiated in one of the most deprived PCNs in the county. This has helped to achieve improvement in lipid management in this cohort of patient who would not have benefited without this project.

The project has been aimed at improving lipid management in secondary prevention cases who are considered to be high risk of future events. In addition to medication review and compliance check, patients were advised about smoking cessation, lifestyle modification and diet management which has helped to tackle the health inequalities.

Quantitative feedback

Total number of patients reviewed	51265 (Total population size)
No of patients with suboptimal lipid control identified	166
No of patients excluded (frail, end of life etc.)	61
No of patients identified to intervene by PCN Pharmacist	105
No of patients not engaged	21
No of patients with changes to statin therapy and number of patients who have been put on a high intensity statin	35
Patients with commencement or addition of ezetimibe	13
Patients referred for PCSK9i eligibility	5
Number of patients requiring PCSK9i	1
% eligible patients whose Cholesterol is optimised	75.3 %