Lowering Cholesterol.

Saving Lives.

TheAHSNNetwork

ACCELERATED ACCESS COLLABORATIVE

HEART UK THE CHOLESTEROL CHARITY

NHS

Tackling Cholesterol Together

# How to Implement a Cholesterol Framework in Real World Primary Care

**Welcome to the third in a series of webinars as part of the national education programme Tackling Cholesterol Together.**

Delivered in partnership by The NHS Accelerated Access Collaborative (AAC), The AHSN Network and the cholesterol charity, HEART UK

**The webinar will start at 1pm**

September 2021

All programme content, recordings and next webinar and clinic bookings will be housed in the HEART UK pages. Visit the site for the **new** e-Learning modules on Identifying FH in primary care, the Lipid Management Pathway and Statin Intolerance https://www.heartuk.org.uk/tackling-cholesterol-together/home

# Housekeeping

- **This meeting will be recorded** and will be made available in the HEART UK Tackling Cholesterol Together pages
- **There will be time** to stop and ask questions at the end
- **Feel free to ask questions** or upvote questions in the chat function when it becomes available
- **Any questions that we are not able to cover in the Q&A** sections today will be addressed following the event
- **Any questions you provided** during registration will be covered during the session

# Agenda

| | Topic | Presenter |
|---|---|---|
| 01 | **Welcome and Introductions** | Sue Critchley |
| 02 | **The Yorkshire and Humber region's experience of implementing Healthy Hearts Programmes** | Dr Youssef Beaini |
| 03 | **UCLPartners Proactive Care Frameworks** | Dr Matt Kearney and Helen Williams |
| 04 | **Q&A** | Panel |
| 05 | **Close and next steps** | Sue Critchley |

# Objectives of today's Webinar

01

**Dive** into the Yorkshire and Humber region's experience of implementing effective Healthy Hearts Programmes in two CCG areas

02

**Share** learning: how to work smarter not harder to turn around the worst areas for CVD outcomes- even without a set of nationally available frameworks

03

Reflect on **why** the urgent challenge of the COVID-19 pandemic led to a step change in optimising high impact conditions

04

Examine **how** the cholesterol components of the UCLPartners Proactive Care at home frameworks will improve CVD outcomes

02

# The Yorkshire and Humber region’s experience

**Dr Youssef Beaini**

Clinical lead for education for The NHS Accelerated Access Collaborative (AAC) and The AHSN Network national lipids programme in England

# The following slide decks are courtesy of the Bradford District and West Yorkshire Healthy Hearts programmes

NHS
Bradford Districts
Clinical Commissioning Group

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# BRADFORD'S HEALTHY HEARTS


## Live longer, better

# CVD landscape in Bradford in 2014

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- Bradford Districts CCG: 350k population, 40 practices
- Had the **7th worst CVD mortality rate under 75** in England
- Over **28% of all deaths under 75**
- **14.3%** of people have **hypertension**
- Over **21k have cholesterol above 4mmol/l**

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# BRADFORD'S HEALTHY HEARTS

## Bold and clear ambition

- By 2020, we will reduce cardiovascular events by 10% which will result in 150 fewer strokes and 340 fewer heart attacks
- We will no longer be the 7th worst CCG in the country!

# Clinical leadership - strategy

NHS Bradford Districts Clinical Commissioning Group

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- Engagement with directors of Million Hearts USA. Shared learning
- Strategic - governing body, council of representatives, clinical board
- NHS Right Care - the story, workshop, clinical assembly
- Stakeholder involvement: primary and secondary care, pharmacists, voluntary sector, local authority
- Public engagement and patient involvement throughout
- Communications and engagement ++

**Summary: wide-ranging engagement with a broad range of health care stakeholders including the hospital consultants, so GPs and consultants working together**

# BRADFORD'S HEALTHY HEARTS

NHS Bradford Districts Clinical Commissioning Group

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## Programme overview

### Cholesterol

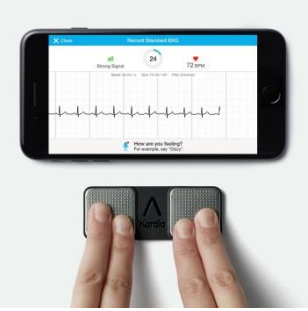
- Simplify statin guidelines
- Statin switches
- Identification of QRISK2 >20% and 10-20% & not on statin

### Hypertension

- Simplified pathway for hypertension diagnosis & treatment
- Hypertension register validation
- Reviewing patients with high blood pressure readings
- Working with BHF for opportunistic BP screening in community

### Atrial fibrillation

- Ensuring appropriate anti-coagulation for stroke prevention
- AliveCor devices for increased detection



# Clinical leadership – delivering outcomes

NHS Bradford Districts Clinical Commissioning Group

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- Secondary care engagement: unified message across primary and secondary care, population approach
- Programme guidelines
- Regular educational and progress meetings, practice engagement at solution finding
- Developing clinical leadership across the system in primary and secondary care; lead clinician in practice (GP, practice nurse, pharmacist)

# Clinical leadership – delivering outcomes

NHS Bradford Districts Clinical Commissioning Group

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- Workload-light for busy clinicians
- Data sharing, IT interventions (searches - streamlined into “work to do” rather than overload with searches; alerts in strategic places with easy access information to explain risk to patients, pop-ups), monthly dashboard, comparative performance
- Consistency and focus – e.g. few measures run repeatedly and then stopped


# Lipids / Statins

# Approach

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- Simplified guidance on statin prescribing
- FAQs on common problems / barriers
- Switch low intensity statins to Atorvastatin
- Start statins for Qrisk >10%

# Total cholesterol range for QRISK2

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**Early results 2015:**
(for QRISK 10-20% and >20%)

- n=2163
- Mean total cholesterol reduction was **0.39 mmol/l reduction in that population**
- **P<0.001 for change**


# Stroke prevention in AF

# Examples of simplified approach: AF

NHS Bradford Districts Clinical Commissioning Group

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- Education and mentoring
- Nominated **clinical champion** in every practice. Regular meetings and public benchmarking against targets. Competitions.
- Complex searches in SystmOne but simple output: **just one list of "work to do"** for patients not on OAC
- Alerts on home screen and icon alerts in record
- Template (see screenshot)
- Use of pharmacists

# CHADSVASc screenshot

NHS
Bradford Districts
Clinical Commissioning Group

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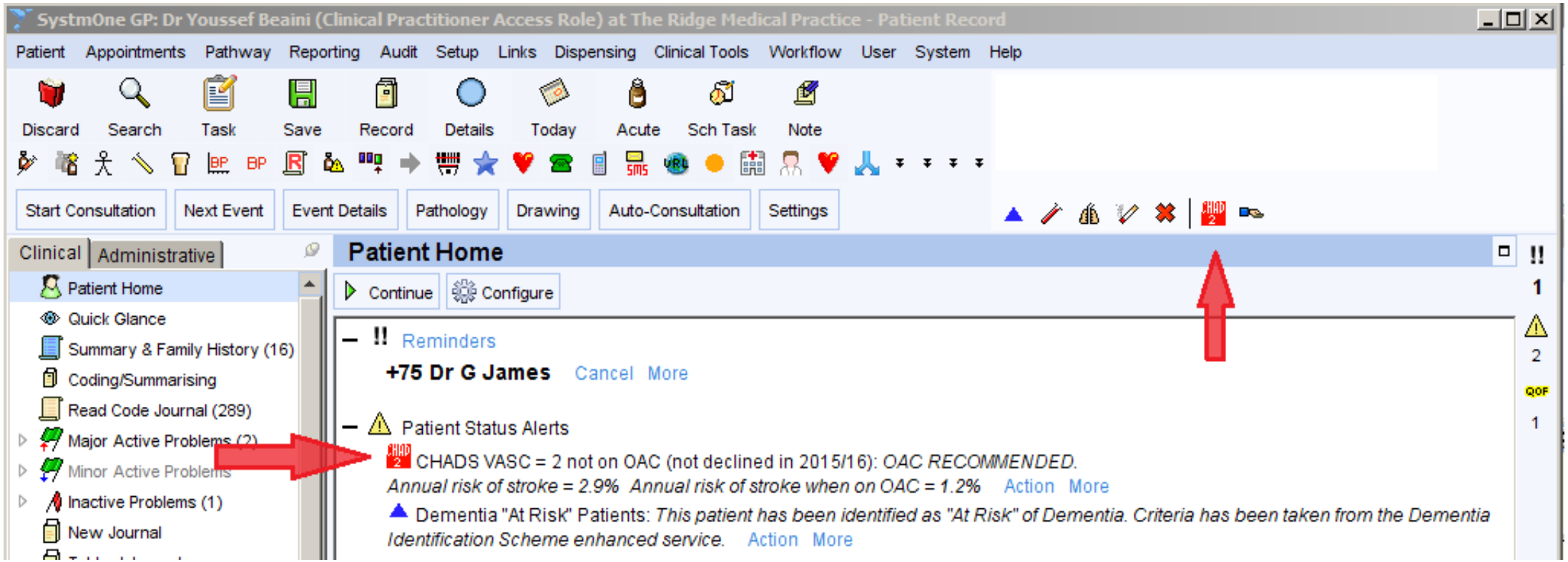

# AF across West Yorkshire (Feb 2016)

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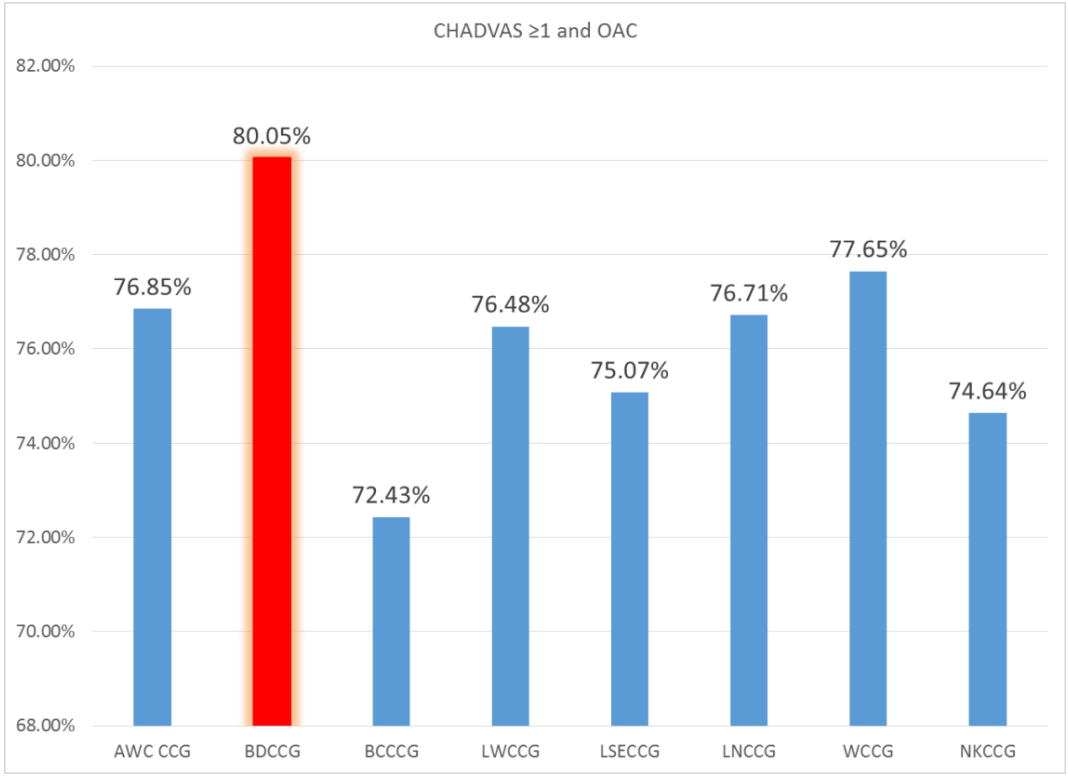


Bradford District (BD) CCG 2016: The highest achievement across West Yorkshire (which is 300-400 GP practices, total pop 1.5 million people).
Now CCG has slipped back in rankings! Others have caught up and surpassed.


# Hypertension

# Combined outcomes

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## To date for Bradford's Healthy Hearts:

- Switched 6000 statins
- QRISK >20%: 4000 started on statins
- QRISK 10-20%: 3000 started on statins
- AF: >1000 started on OAC
- Hypertension: over 2,500 newly diagnosed, 0.7% increase in prevalence. More than 6,800 with BP newly to target (76%)

**Over 24 months, more than 23,000 people had an intervention that improved their health.**

# Quote from BMJ

Bradford Districts Clinical Commissioning Group

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Winner, BMJ awards 2016:

***"Inspirational leadership at scale, taking forward ambitious targets to tackle long standing public health challenges, and the engagement with the public whilst balancing demands on the clinical workforce was impressive."***

West Yorkshire and Harrogate HEALTHY HEARTS

Tackling Cholesterol Together

# West Yorkshire and Harrogate Healthy Hearts

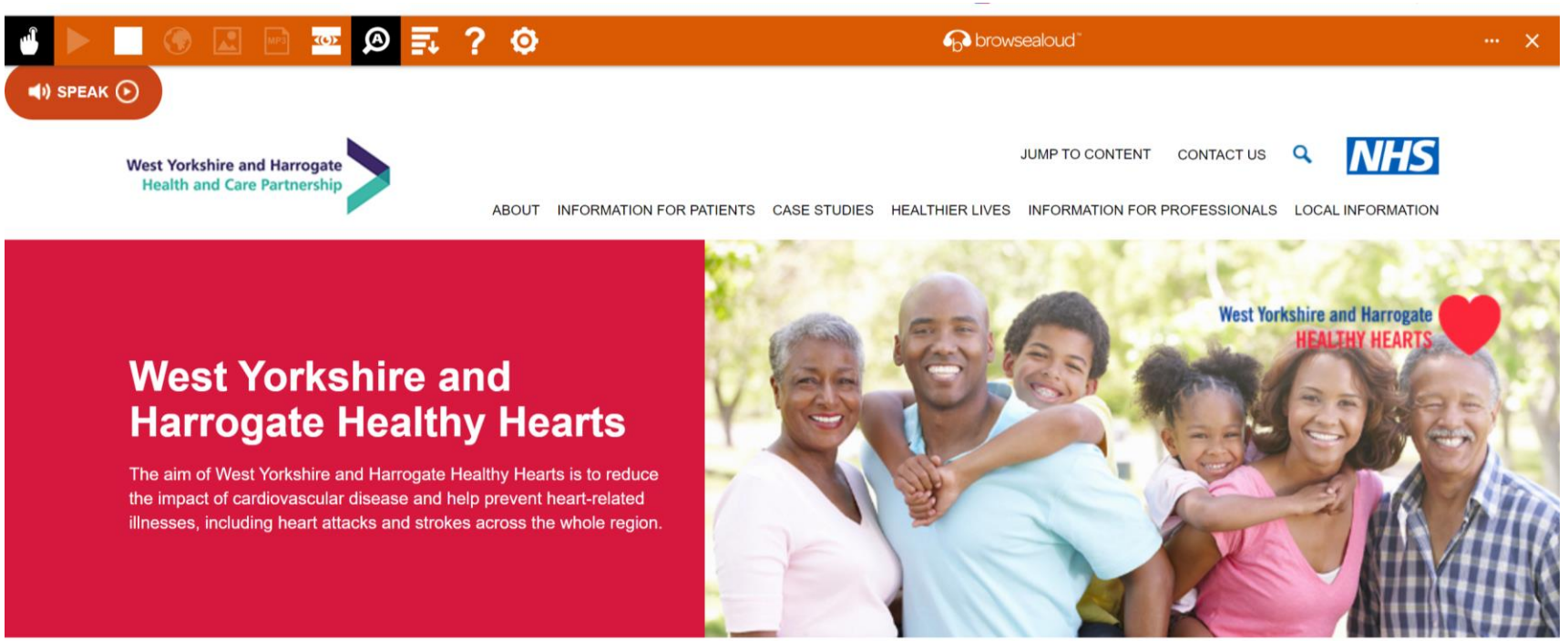
*"Focus on health inequalities in our communities - work at scale and pace to improve the lives of people living across our area"– Health Inequalities Academy*

**Dr Youssef Beaini**

NHS RightCare

YORKSHIRE & HUMBER ACADEMIC HEALTH SCIENCE NETWORK

West Yorkshire and Harrogate Health and Care Partnership




# Together we can beat heart disease

Have you been told you are at risk of developing cardiovascular disease? Then you are in the right place if you want to learn more about what this means and what you can do to improve your health. We are working with GPs and other health and care professionals across West Yorkshire and Harrogate to help reduce the impact of cardiovascular disease. Together we are supporting the West Yorkshire and Harrogate Healthy Hearts initiative to save lives by helping to prevent people from having a heart attack or stroke.

West Yorkshire and Harrogate HEALTHY HEARTS

Tackling Cholesterol Together

# Our initiative aims:

- to contribute to **reducing** the risk of cardiovascular disease including heart attacks and strokes in our area by over 10%
- to help **prevent 800 heart attacks** and **350 strokes** over the course of the programme
- to **save** the local health economy more than **£12 million**

# Project Aims

West Yorkshire and Harrogate HEALTHY HEARTS

Tackling Cholesterol Together

## Phase 1 – Hypertension (2019)

- Increasing prevalence and optimise treatment of patients already diagnosed with hypertension

## Phase 2 – Cholesterol (2020)

- Identify those patients with QRISK >10%, and provide treatment
- Optimise statin treatment for those with less than optimal management – both primary and secondary prevention

## Diabetes (2021)

- Reduce CVD risk for diabetes patients at high risk

# Project Deliverables

- Local standardised **treatment guidance** and **how to guides** for optimising the management of patients
- **Clinical searches** to support clinicians to better detect and manage patients
- **Healthy Hearts website** supporting patients and professionals – including information in easy read and accessible formats
- **Comms and Engagement** including Social Media, GP and patient engagement

West Yorkshire and Harrogate
HEALTHY HEARTS

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Recommend use of ABPM for diagnosis.
(HBPM if not available/tolerated).
If Clinic BP >=140/90 confirm diagnosis with ABPM/HBPM.
If Clinic BP >=180/120 consider immediate treatment.

| ABPM (or HBPM) <135/85 | ABPM (or HBPM) >=135/85 | ABPM (or HBPM) >=150/95 | ABPM (or HBPM) >=180/120 |
|---|---|---|---|
| | Lipids • U&Es • LFTs • TFT • HbA1c • ECG • Urine Dip • ACR | | |
| NOT Hypertensive | STAGE 1 Hypertension | STAGE 2 Hypertension | STAGE 3 Severe Hypertension |
| | Hypertensive and if <10% CVD risk* and no target organ damage | Hypertensive and if ≥10% CVD risk* or target organ damage | |
| Offer lifestyle advice and signposting as required | Offer lifestyle advice and signposting (one year review) | Lifestyle advice+ Treat | Lifestyle advice+ Treat | Lifestyle advice+ Treat. Consider referral if accelerated |
| | | *Amlodipine 5mg | 1st, 2nd, 3rd Line Hypertension Therapy | *Amlodipine 5mg + Indapamide 2.5mg |
| | | If not controlled <135/85 HBPM or ABPM | | Consideration can be given to a phased approach when initiating dual therapy at diagnosis(Amlodipine + Indapamide) e.g. start Amlodipine and then commence Indapamide one week later. |
| | | + Indapamide 2.5mg | | |
| | | If not controlled <135/85 HBPM or ABPM | | |
| | | + ARB - Losartan 50mg OD increase to 100mg if needed | | |
| | | If not controlled <135/85 HBPM or ABPM | | |
| | | 4th Line Hypertension Therapy + Spironolactone 25mg daily Monitoring Spironolactone CAN START IF K+ <4.5 AND GFR >45 If K+ >4.5 then use alpha / beta blockers and titrate up | | |

If not controlled check non-adherence, alcohol and lifestyle. Provide signposting to community pharmacy for medication support (MUR/NMS).

Check U&Es at various stages e.g. when changing dose/medication

**Check potassium at regular intervals.**

If low K+ thought due to indapamide:
Mild 3.0 - 3.4 – recheck K+ in 4 weeks.
If still low but mild, continue indapamide
Moderate 2.5 - 2.9 – recheck K+ in 24 hours.
If still moderately low, switch to losartan
Severe <2.5 – Admit

If still resistant hypertension consider repeat HBPM/ABPM and then consider referral for A&G.

Titrate up Amlodipine and Losartan to maximum tolerated before referral to A&G.

REMEMBER AKI SICK DAY RULES


# Treatment Guidance Uncomplicated Hypertension

NHS RightCare

YORKSHIRE & HUMBER ACADEMIC HEALTH SCIENCE NETWORK

West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire and Harrogate HEALTHY HEARTS

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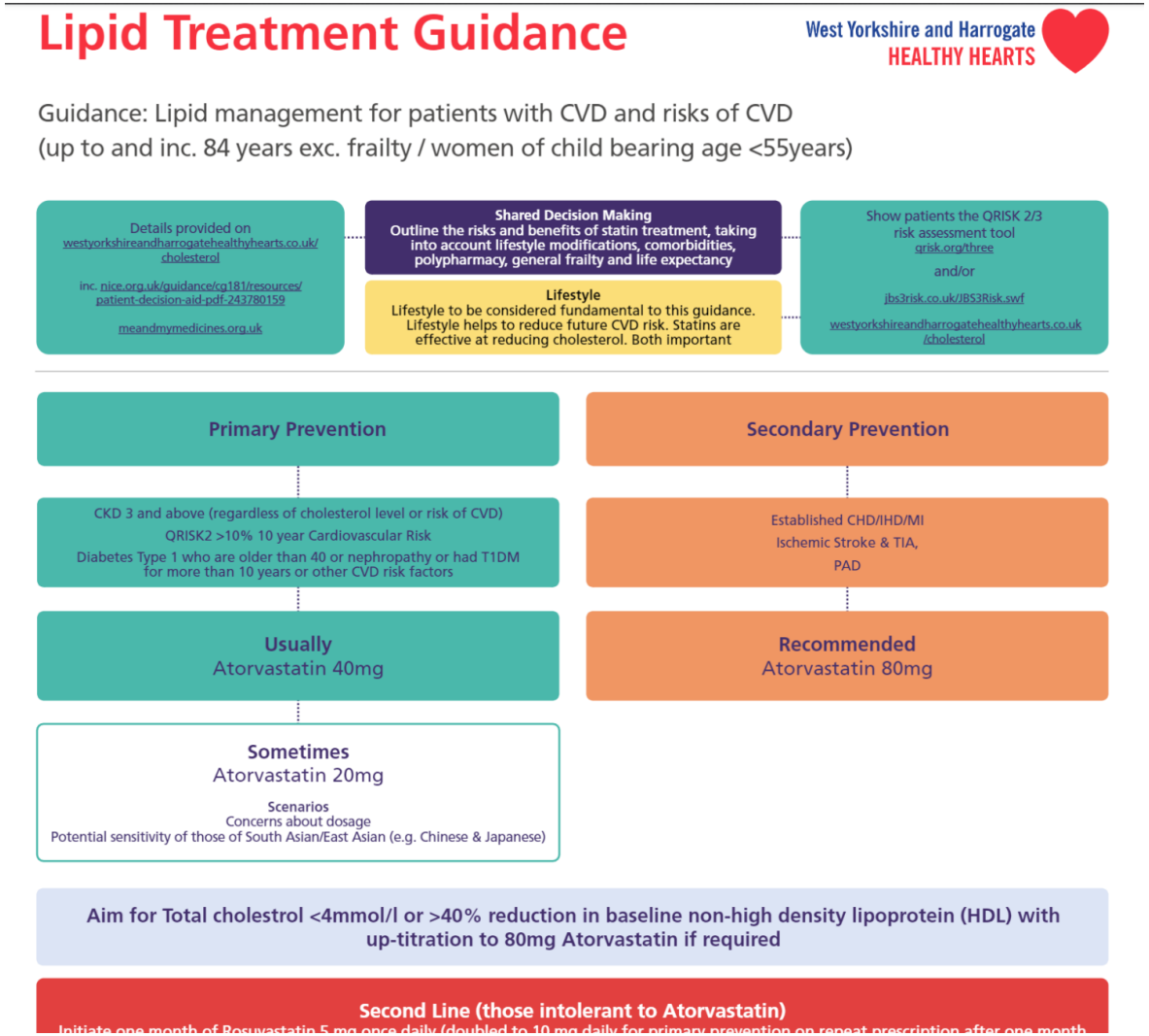
# Designed in 2019

Regional guidance is currently being updated in line with the NICE endorsed NHSE/AAC Summary of National Guidance for Lipid Management for Primary and Secondary Prevention of CVD



## Lipid Treatment Guidance

West Yorkshire and Harrogate HEALTHY HEARTS

Guidance: Lipid management for patients with CVD and risks of CVD
(up to and inc. 84 years exc. frailty / women of child bearing age <55years)

Details provided on
westyorkshireandharrogatehealthyhearts.co.uk/cholesterol

inc. nice.org.uk/guidance/cg181/resources/patient-decision-aid-pdf-243780159

meandmymedicines.org.uk

**Shared Decision Making**
Outline the risks and benefits of statin treatment, taking into account lifestyle modifications, comorbidities, polypharmacy, general frailty and life expectancy

**Lifestyle**
Lifestyle to be considered fundamental to this guidance. Lifestyle helps to reduce future CVD risk. Statins are effective at reducing cholesterol. Both important

Show patients the QRISK 2/3 risk assessment tool
qrisk.org/three

and/or

jbs3risk.co.uk/JBS3Risk.swf

westyorkshireandharrogatehealthyhearts.co.uk/cholesterol

**Primary Prevention**

CKD 3 and above (regardless of cholesterol level or risk of CVD)
QRISK2 >10% 10 year Cardiovascular Risk
Diabetes Type 1 who are older than 40 or nephropathy or had T1DM for more than 10 years or other CVD risk factors

**Usually**
Atorvastatin 40mg

**Sometimes**
Atorvastatin 20mg

Scenarios
Concerns about dosage
Potential sensitivity of those of South Asian/East Asian (e.g. Chinese & Japanese)

**Secondary Prevention**

Established CHD/IHD/MI
Ischemic Stroke & TIA,
PAD

**Recommended**
Atorvastatin 80mg

**Aim for Total cholestrol <4mmol/l or >40% reduction in baseline non-high density lipoprotein (HDL) with up-titration to 80mg Atorvastatin if required**

**Second Line (those intolerant to Atorvastatin)**
Initiate one month of Rosuvastatin 5 mg once daily (doubled to 10 mg daily for primary prevention on repeat prescription after one month

NHS RightCare

YORKSHIRE & HUMBER ACADEMIC HEALTH SCIENCE NETWORK

West Yorkshire and Harrogate Health and Care Partnership

**Aim for Total cholestrol <4mmol/l or >40% reduction in baseline non-high density lipoprotein (HDL) with up-titration to 80mg Atorvastatin if required**

**Second Line (those intolerant to Atorvastatin)**
Initiate one month of Rosuvastatin 5 mg once daily (doubled to 10 mg daily for primary prevention on repeat prescription after one month if no reported side effects) For secondary prevention up to 20 mg once daily, dose to be increased gradually at intervals of at least 4 weeks

Before starting lipid modification therapy take full lipid profile and check ALT

Repeat lipid profile and ALT after 3 months

Show patients targets / progress to help behaviour change

If target not achieved discuss adherence / understanding and timing of dose / diet and lifestyle

If commenced on 20mg atorva, consider increase to 40mg

Total / (HDL) / Non-HDL / Triglycerides.
A fasting sample is *not* needed

Check ALTs at baseline and at 3 months. No further checks required after starting statin unless clinical concern (e.g. liver disease)

**Please consider**
Familial hypercholesterolaemia and Hyperlipidaemia in anyone with a total cholesterol >7.5mmol/L or LDL >4.9 mmol/ - Talk to patients to get family history

Familial hypercholesterolaemia affects c.1 in 325. NHS Long Term Plan commitment to improving the genetically confirmed detection of FH from 7% to 25% by 2024 (January 2019)

See pathway for further information about the above

This is a summary version of the treatment guidance.

2. Measure a full lipid profile after 3 months of treatment (total cholesterol, high-density lipoprotein (HDL) cholesterol, and LDL or non-HDL cholesterol (total cholesterol minus HDL cholesterol). The aim of treatment is to achieve a pragmatic target of <4 mmol/l of total cholesterol (since many practices are only measuring total cholesterol), or ideally, a more precise target of >40% reduction in baseline LDL or non-HDL levels. If the clinician prefers to aim for absolute targets in LDL, the European Society of Cardiology (ESC) targets are a great evidence-based choice:

| | |
|---|---|
| Primary Prevention | LDL-C <3 mmol/L in moderate risk patients |
| | LDL-C <2.5 mmol/L in high risk patients |
| Secondary Prevention | LDL-C <1.8 mmol/L |

## Lipid Guidance Supporting Clinical Information

The guidance and supporting information has been agreed across West Yorkshire and Harrogate Health and Care Partnership. It should not be seen as mandatory and clinical judgement can always be exercised as usual.

1. As well as QRISK2 calculators within S1 or EMIS, clinicians may wish to consider the online JBS3 for lifetime risks or European SCORE Risk Charts (The European cardiovascular disease risk assessment model) when making clinical decisions with patients. QRISK3 to be used where/when available.

2. Measure a full lipid profile after 3 months of treatment (total cholesterol, high-density lipoprotein (HDL) cholesterol, and LDL or non-HDL cholesterol (total cholesterol minus HDL cholesterol). The aim of treatment is to achieve a pragmatic target of <4 mmol/l of total cholesterol (since many practices are only measuring total cholesterol), or ideally, a more precise target of >40% reduction in baseline LDL or non-HDL levels. If the clinician prefers to aim for absolute targets in LDL, the European Society of Cardiology (ESC) targets are a great evidence-based choice:

| | |
|---|---|
| Primary Prevention | LDL-C <3 mmol/L in moderate risk patients |
| | LDL-C <2.5 mmol/L in high risk patients |
| Secondary Prevention | LDL-C <1.8 mmol/L |

3. If muscle pains develop:
   - Check Creatine Kinase (CK).
   - If CK normal and pains intolerable, stop statin for 6 weeks and then re-challenge with statin at the same or lower dose.
   - If truly intolerant to Atorvastatin, try Rosuvastatin as second line.
   - If still intolerant, reducing to once or twice weekly dosing is worthwhile.

See further information on statin intolerance

4. Additional Lipid Lowering Agents –There is evidence of reduced mortality in secondary prevention by driving LDL below a target of 1.8mmol/L. GPs may wish to prescribe additional cholesterol lowering medications to achieve this target, as per NICE guidance.

5. In Secondary prevention of CVD, this guidance is for ischemic stroke only, not haemorrhagic – since Atorvastatin can increase risk of haemorrhagic stroke.

6. Provide annual medication reviews for people taking statins. Consider an annual non-fasting full lipid profile to inform the discussion (if needed to assess or support adherence/ response)

7. Women of childbearing potential can still have statin dose optimisation, but they should be invited to speak to a health professional about teratogenic risks of statins and precautions that need to be taken. Statins are contra-indicated in pregnancy and precautions should be continued for 1 month after stopping a statin. Statins are less commonly routinely prescribed to women under the age of 55 as they tend to have lower 10yr CVD risks.

8. Guidance is aimed at <84 years. For people 85 years or older consider Atorvastatin 20 mg as statins may be of benefit in reducing the risk of nonfatal myocardial infarction, taking into account patient choice, comorbidities, polypharmacy, general frailty and life expectancy.

9. Consider A&G/e-consult if high-risk patients and intolerant to 3 different statins e.g. CVD (MI, CVA, TIA, PAD), CKD 3b or more, type 1 diabetes, type 2 diabetes or genetic dyslipidaemias.

# Statin Intolerance

West Yorkshire and Harrogate HEALTHY HEARTS

Tackling Cholesterol Together

## An important clinical challenge

- Statins are the cornerstone for prevention and treatment of cardiovascular disease – they are the only class of lipid modifying agents with a substantial evidence of reduction of morbidity and mortality.
- There is a growing concern that clinicians are labelling patients as 'statin intolerant' too quickly.
- Up to 75% of people started on a statin will discontinue treatment within 2 years[1].
- In clinical trials, statins were found to be largely well tolerated (often with a similar adverse effect profile to placebo), however this is not reflected in clinical practice[1].
- Statin-associated muscle symptoms are one of the principal reasons for statin non-adherence and/or discontinuation. However, not all patients with such symptoms, if statins related, should lead to a label of 'statin intolerance'.

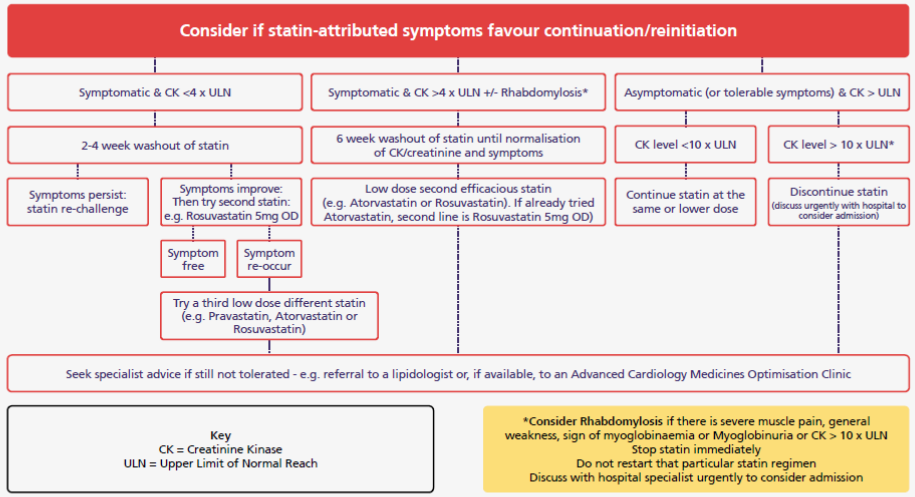
## What can you do?

- **Educate the patient on their benefits** and that it is highly likely that side effects can be dealt with successfully.
- **Identify factors that increase risk of side effects and address** - modify dose, swap to a suitable statin as appropriate (e.g. check for drug, herbal or food interactions with statins, renal failure, liver impairment etc).

**Golden Principal - Re-challenge**

- If intolerant to Astorvastatin on rechallenge, use Rosuvastatin 5mg OD as per WY Healthy Hearts Treatment Guidance
- Do not routinely monitor CK unless clinically indicated
- Refer to a specialist for further advice.

## What if a patient experiences muscular side effects?




## Will this approach work?

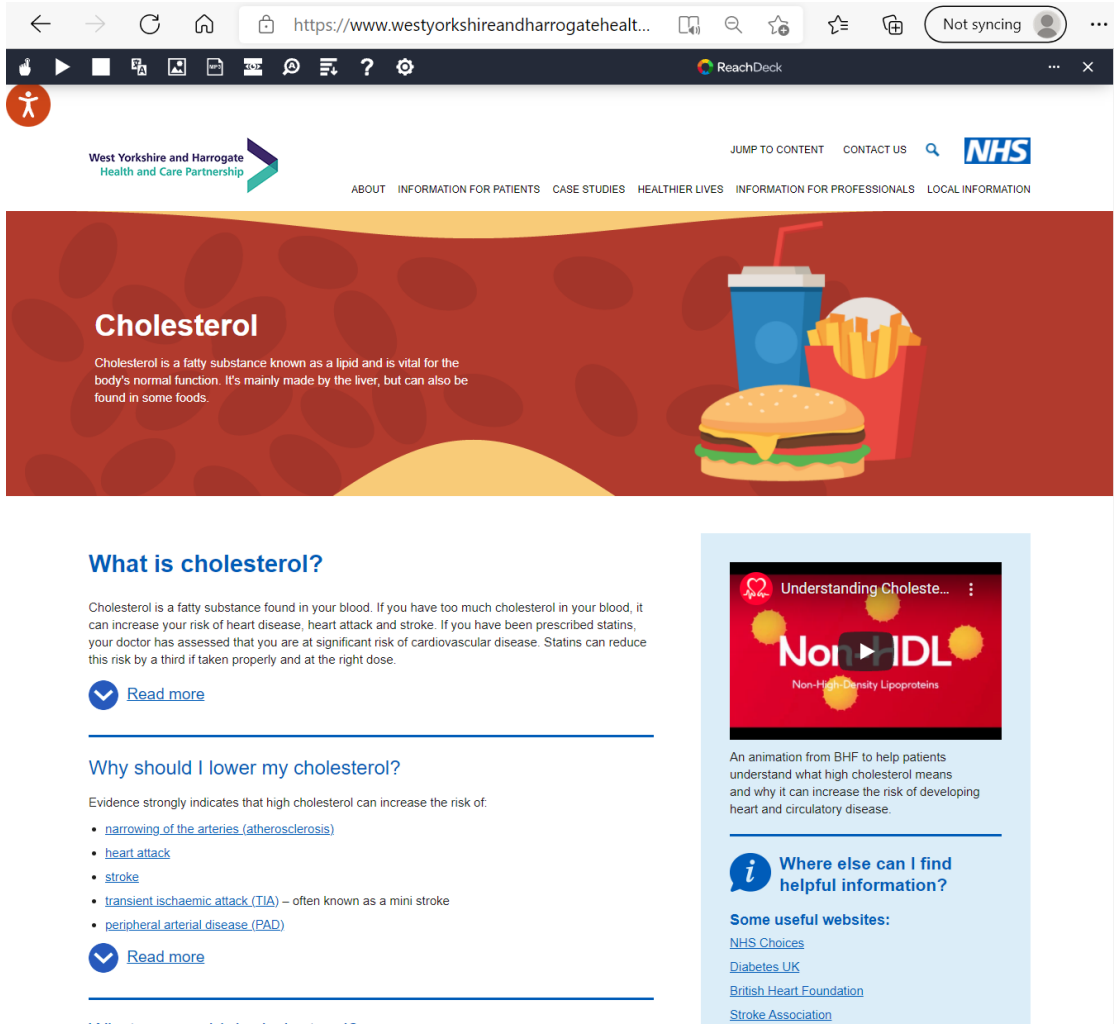
- A retrospective cohort study in 107,835 patients[4].
- 17.4% had statin related events - in around 60% statins were discontinued at least temporarily.
- On re-challenge 92.2% were still on a statin >12 months later.

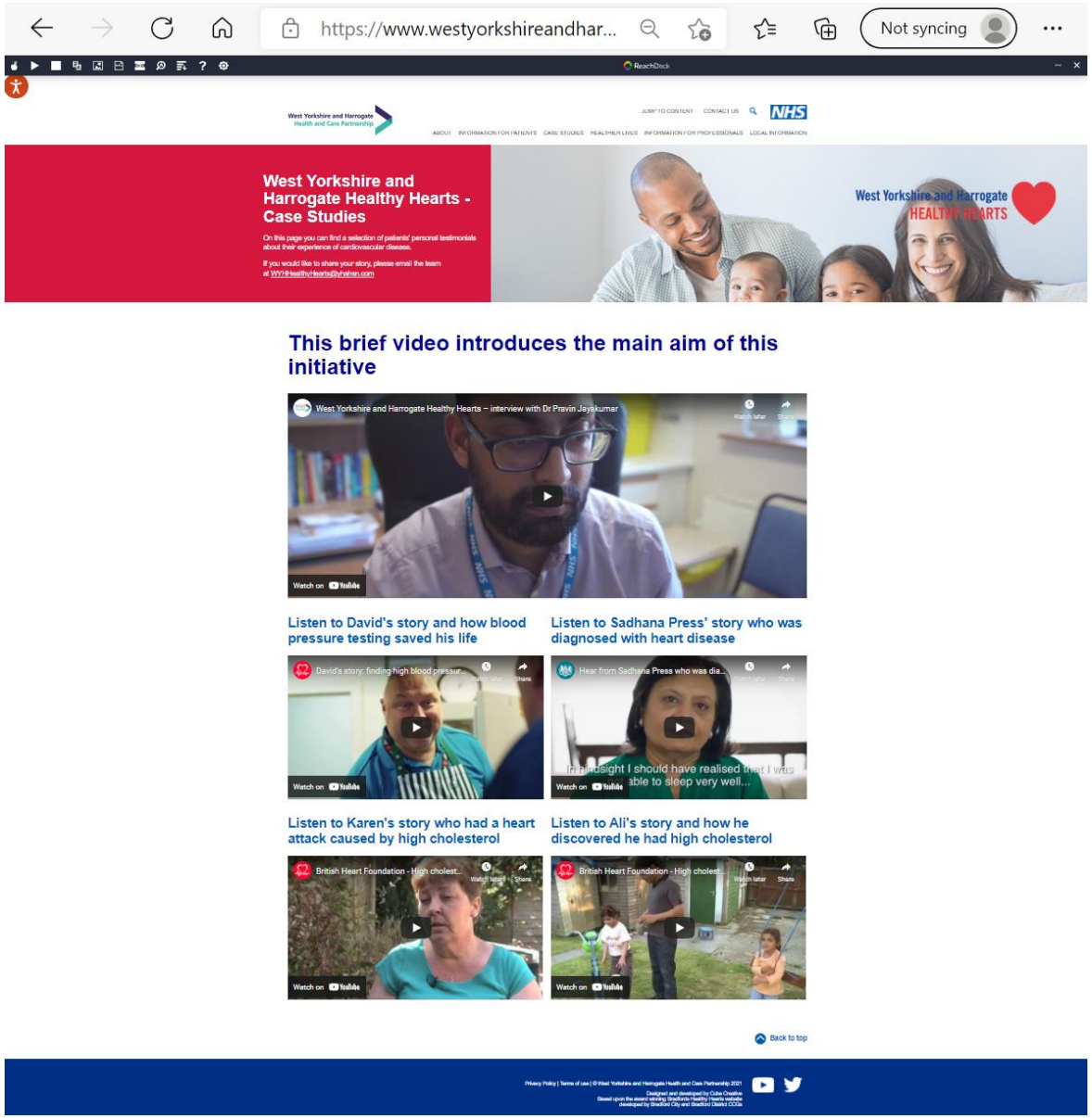
## Summary

- Always strive to continue maximally tolerated dose of statin.
- Always apply repetitive de/re challenges - therapy with a lower dose statin is preferred to no statin.
- If someone is truly statin intolerant – seek specialist advice for further management options.

# Website

- Patient information
- Clinician information
- Multiple languages
- Accessibility options
- FAQs
- Videos of local clinicians
- Case studies of local patients



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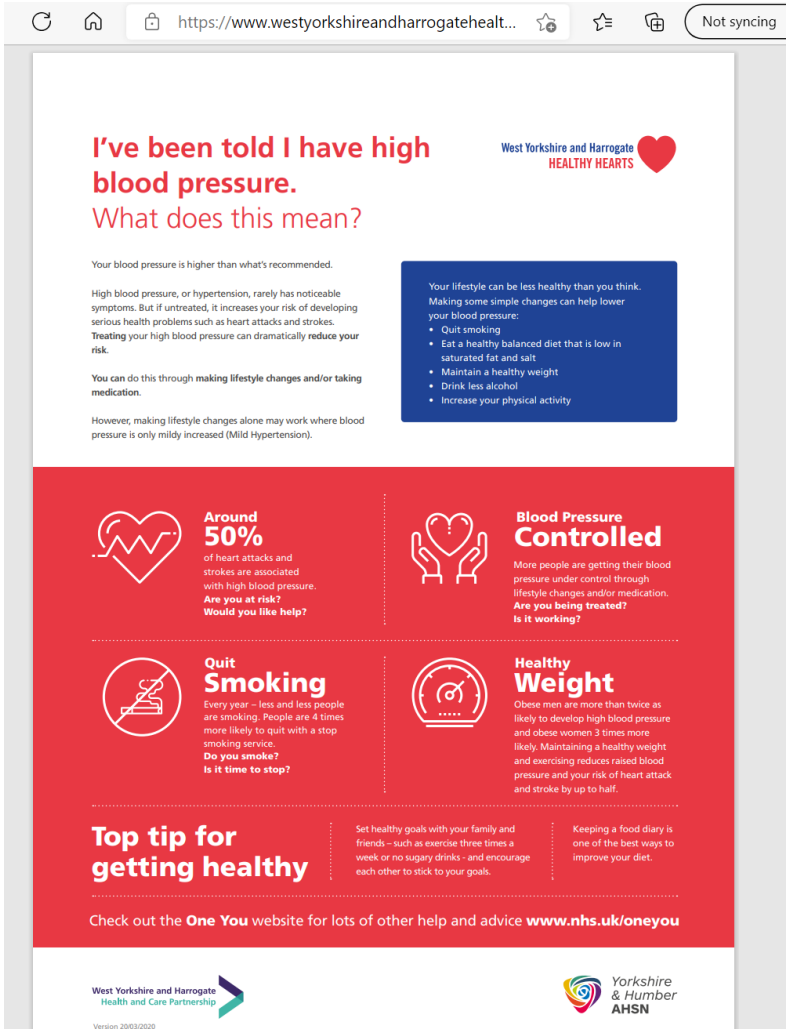
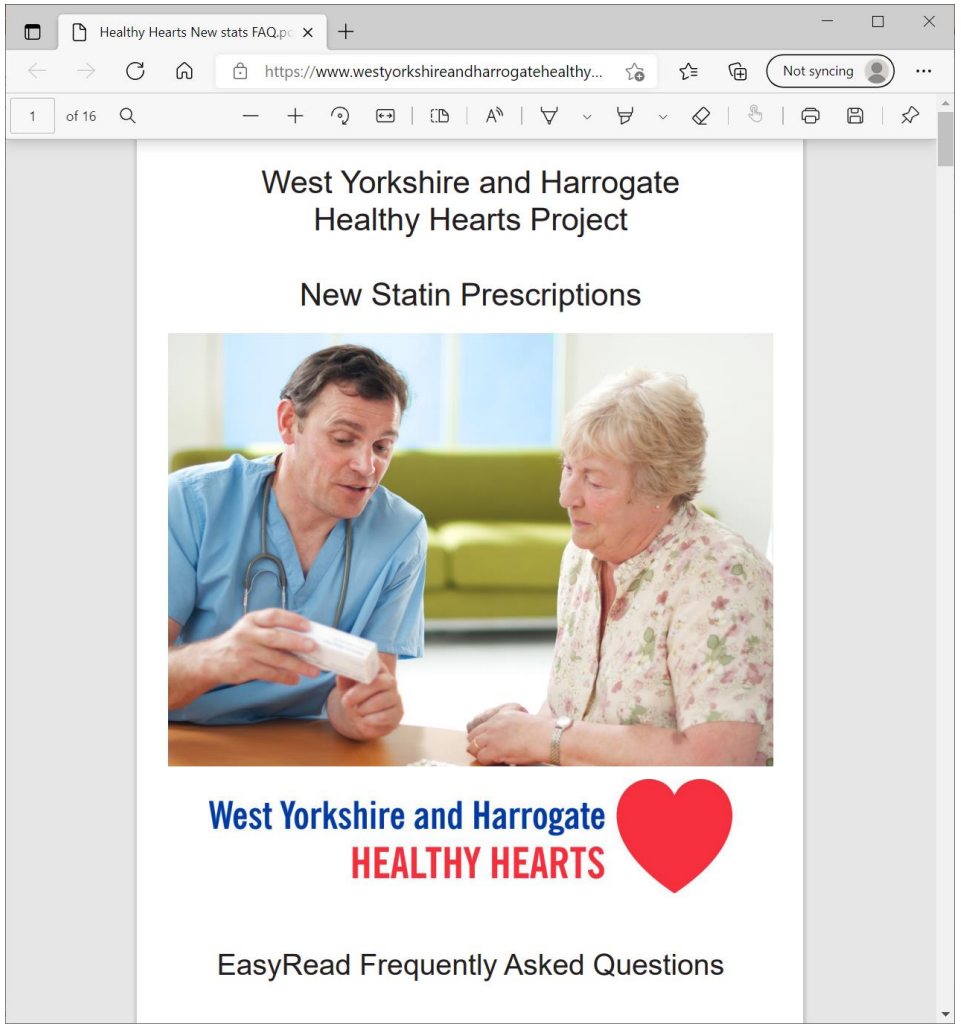
# Website

Patient information resources that can be signposted by clinicians before, during or after consultations



# Website

- Shared decision making
- Simple messages



# New Statin Medication

West Yorkshire and Harrogate HEALTHY HEARTS

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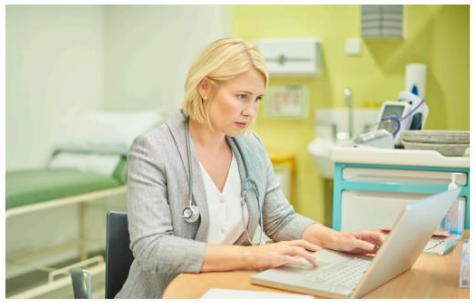
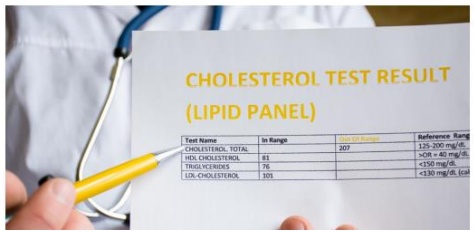
Our Medical Practice is always working to provide a better service.



This means we regularly check your records to make sure you are getting the best service.




Our records show that your cholesterol is high.

Cholesterol is a fatty substance that is made by our own livers.

It is also found in some of the food we eat.

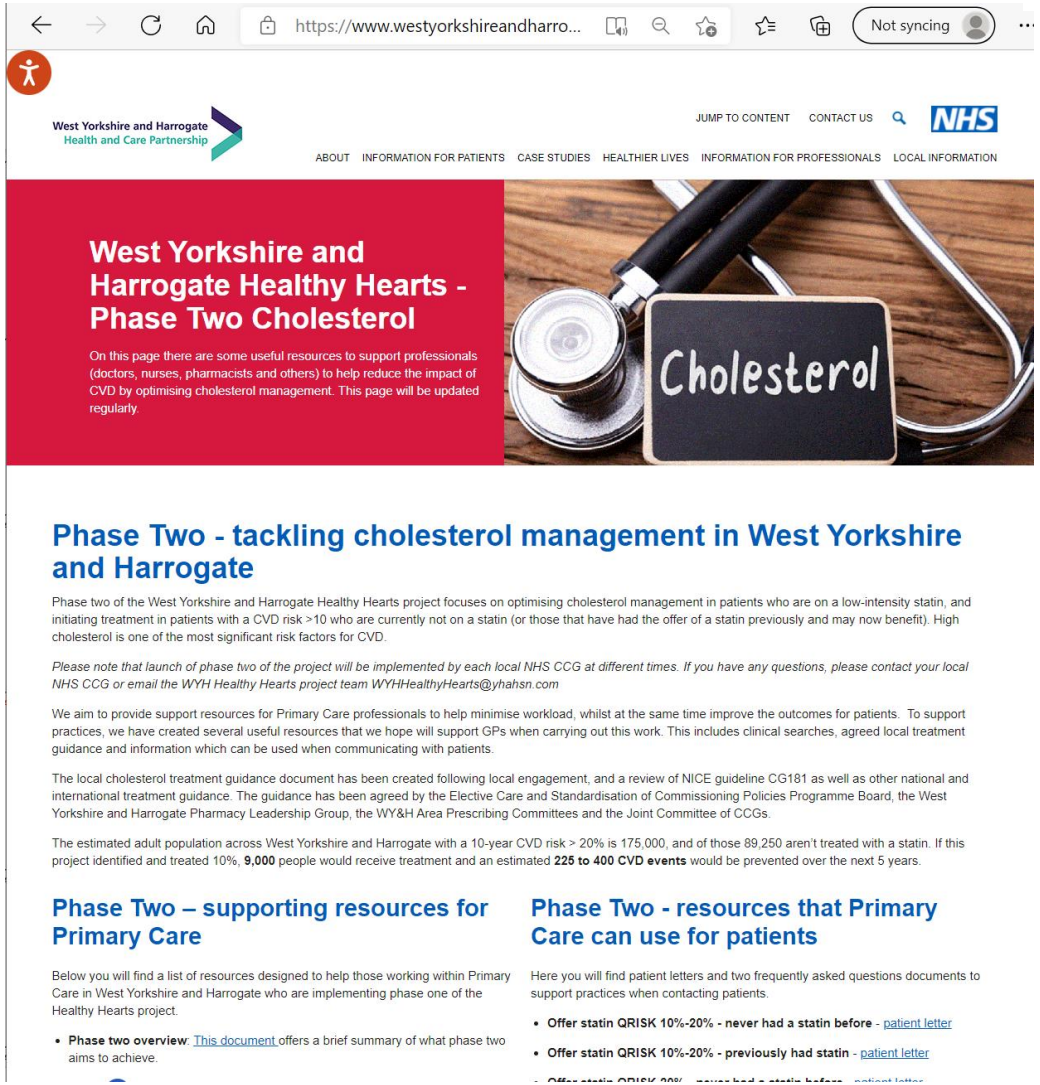
You need cholesterol to have a healthy body.


There are two types of cholesterol.

Good cholesterol is called **high density lipoprotein (HDL)** and bad cholesterol is called **low density lipoprotein (LDL).**

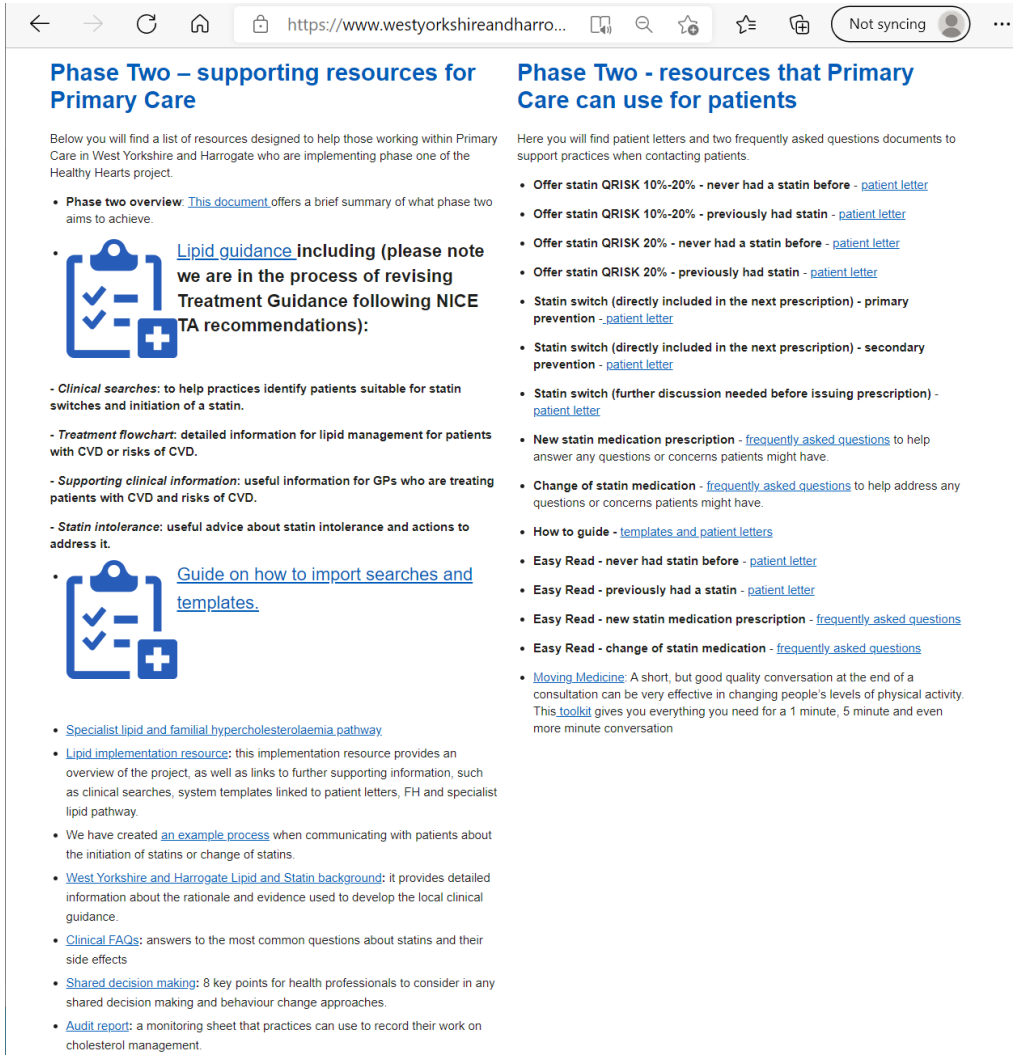
# Website

Comprehensive resources for professionals



# Website

Comprehensive resources for professionals



https://www.westyorkshireandharro... Not syncing

## Phase Two – supporting resources for Primary Care

Below you will find a list of resources designed to help those working within Primary Care in West Yorkshire and Harrogate who are implementing phase one of the Healthy Hearts project.

- **Phase two overview**: This document offers a brief summary of what phase two aims to achieve.
- Lipid guidance **including (please note we are in the process of revising Treatment Guidance following NICE TA recommendations):**

**- *Clinical searches*: to help practices identify patients suitable for statin switches and initiation of a statin.**

**- *Treatment flowchart*: detailed information for lipid management for patients with CVD or risks of CVD.**

**- *Supporting clinical information*: useful information for GPs who are treating patients with CVD and risks of CVD.**

**- *Statin intolerance*: useful advice about statin intolerance and actions to address it.**

- Guide on how to import searches and templates.

- Specialist lipid and familial hypercholesterolaemia pathway
- Lipid implementation resource: this implementation resource provides an overview of the project, as well as links to further supporting information, such as clinical searches, system templates linked to patient letters, FH and specialist lipid pathway.
- We have created an example process when communicating with patients about the initiation of statins or change of statins.
- West Yorkshire and Harrogate Lipid and Statin background: it provides detailed information about the rationale and evidence used to develop the local clinical guidance.
- Clinical FAQs: answers to the most common questions about statins and their side effects
- Shared decision making: 8 key points for health professionals to consider in any shared decision making and behaviour change approaches.
- Audit report: a monitoring sheet that practices can use to record their work on cholesterol management.

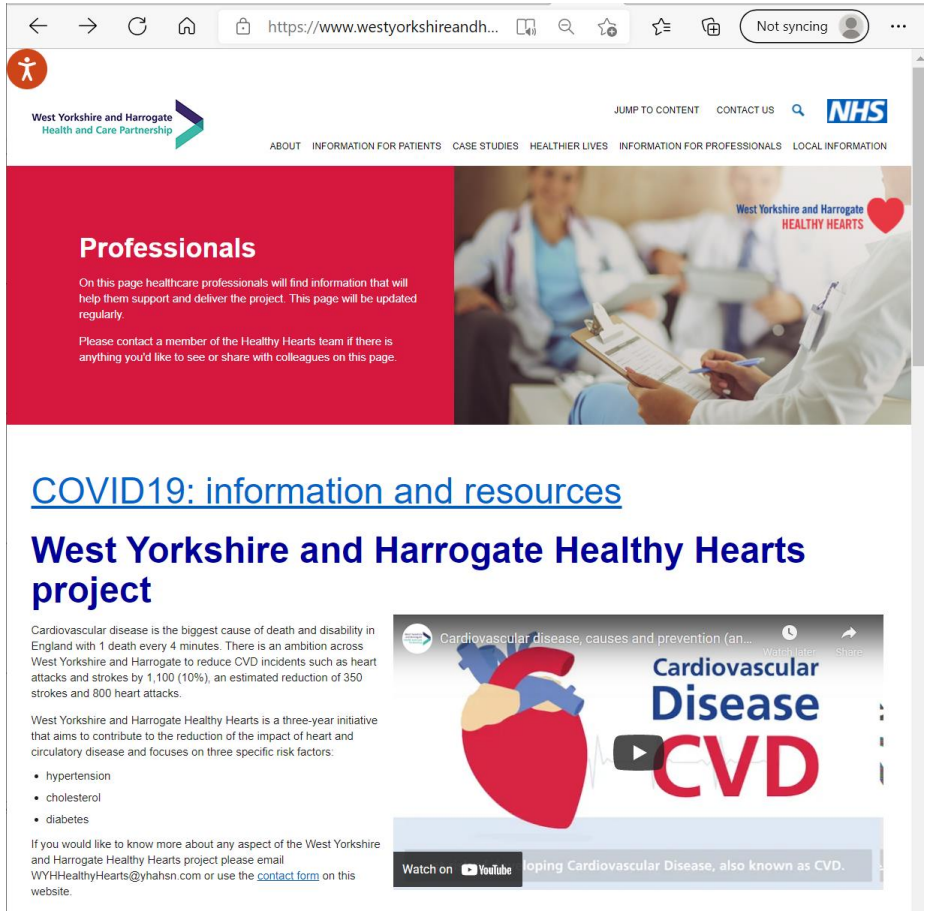
## Phase Two - resources that Primary Care can use for patients

Here you will find patient letters and two frequently asked questions documents to support practices when contacting patients.

- **Offer statin QRISK 10%-20% - never had a statin before** - patient letter
- **Offer statin QRISK 10%-20% - previously had statin** - patient letter
- **Offer statin QRISK 20% - never had a statin before** - patient letter
- **Offer statin QRISK 20% - previously had statin** - patient letter
- **Statin switch (directly included in the next prescription) - primary prevention** - patient letter
- **Statin switch (directly included in the next prescription) - secondary prevention** - patient letter
- **Statin switch (further discussion needed before issuing prescription)** - patient letter
- **New statin medication prescription** - frequently asked questions to help answer any questions or concerns patients might have.
- **Change of statin medication** - frequently asked questions to help address any questions or concerns patients might have.
- **How to guide** - templates and patient letters
- **Easy Read - never had statin before** - patient letter
- **Easy Read - previously had a statin** - patient letter
- **Easy Read - new statin medication prescription** - frequently asked questions
- **Easy Read - change of statin medication** - frequently asked questions
- Moving Medicine: A short, but good quality conversation at the end of a consultation can be very effective in changing people's levels of physical activity. This toolkit gives you everything you need for a 1 minute, 5 minute and even more minute conversation

# Website

- Covid resources specific to CVD prevention/treatment during pandemic
- Make every contact count
- Use of remote monitoring



# Progress to date

West Yorkshire and Harrogate HEALTHY HEARTS

Tackling Cholesterol Together

**Hypertension (2019):**

- ✓ *more than **8,500 additional patients** added to hypertension **registers***
- ✓ ***C20,000 additional patients** having their BP controlled to **below 140/90**.*
- ✓ *Estimated **300 CVD events** prevented in next 5-10 years*

**Cholesterol (2020):**

- ✓ **5,000 patients**, whose cholesterol was not controlled have had a switch of statin to a high intensity statin
- ✓ **1,000 patients** have been newly started on a statin for primary prevention
- ✓ Estimated **600 CVD events** prevented in next 10 years

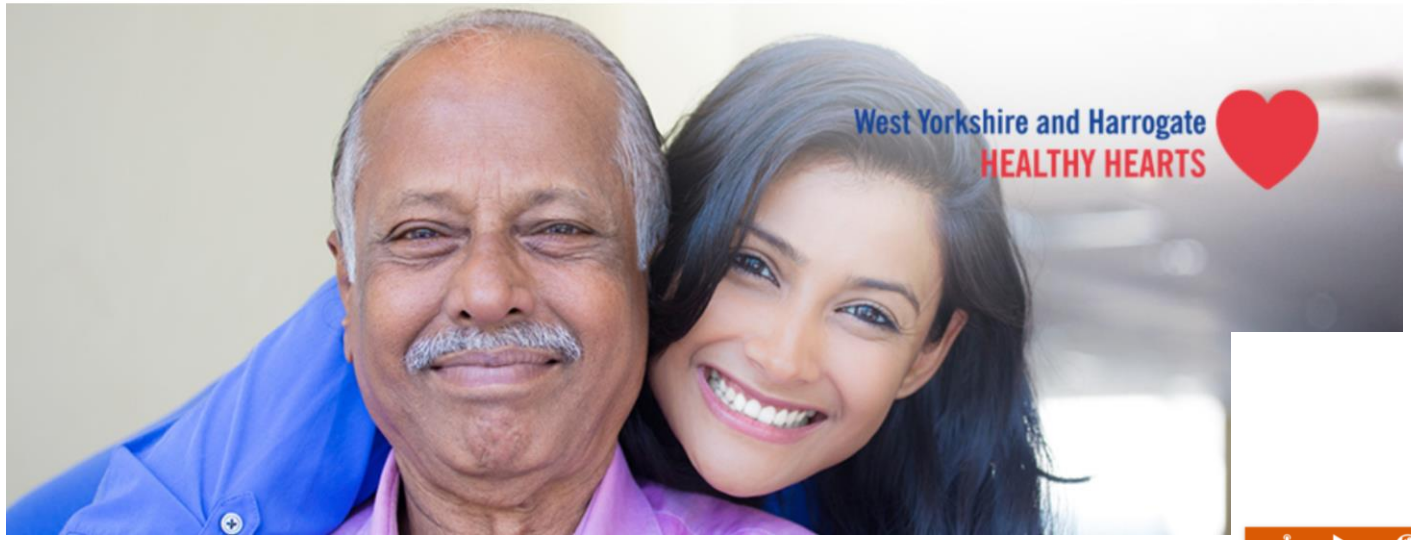
***We do know COVID has had an impact on the positive progress that was being made with this project***

West Yorkshire and Harrogate Health and Care Partnership

JUMP TO CONTENT CONTACT US NHS

ABOUT INFORMATION FOR PATIENTS CASE STUDIES HEALTHIER LIVES INFORMATION FOR PROFESSIONALS LOCAL INFORMATION

West Yorkshire and Harrogate Healthy Hearts aims to help reduce the risk of heart attack and stroke for people at highest risk




West Yorkshire and Harrogate HEALTHY HEARTS

Tackling Cholesterol Together

## What is Browsealoud?

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It provides your web visitors with instant access to supportive features, helping to reduce barriers between your digital content and your diverse online audiences.

It's a simple addition to any website, offering an easy and effective way to provide your visitors with a better online experience.

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@WYHHealthyHeart

www.westyorkshireandharrogatehealthyhearts.co.

NHS RightCare

YORKSHIRE & HUMBER ACADEMIC HEALTH SCIENCE NETWORK

West Yorkshire and Harrogate Health and Care Partnership

# Next steps

- Re-engage with primary care as pandemic comes under better control
- Focus on work-load-light interventions or interventions that free up resource within primary care
- Continue to promote the **Healthy Hearts website** that has information for both professionals and clinicians
- Remind Primary Care of the **Healthy Hearts resources** that are available for use now on both Cholesterol and Hypertension

# West Yorkshire and Harrogate Healthy Hearts

*THANK YOU*

TheAHSNNetwork ACCELERATED ACCESS COLLABORATIVE HEART UK THE CHOLESTEROL CHARITY NHS

03

# UCL Partners Proactive Care Frameworks


**Dr Matt Kearney**

General Practitioner. Programme Director Proactive Care and CVD Prevention at UCLPartners. National Clinical Director for Cardiovascular Disease Prevention, 2016-2019

TheAHSNNetwork ACCELERATED ACCESS COLLABORATIVE HEART UK THE CHOLESTEROL CHARITY NHS

# 03

# UCL Partners Proactive Care Frameworks

**Helen Williams**

National Specialty Adviser for Cardiovascular Disease Prevention at NHS England and Improvement

# The following slide deck is courtesy of the UCLPartners Proactive Care Frameworks


UCLPartners

# UCLPartners Proactive Care Frameworks Transforming CVD Prevention

Dr Matt Kearney and Helen Williams

# COVID-19: Impact on Care and Outcomes in Long Term Conditions

UCLPartners

## Urgent Challenge

1. Pandemic resulted in overnight change in primary care: universal shift to remote care, reduced face to face access and high clinical demand (COVID surges and vaccination)
2. Disruption of routine, proactive care in high impact conditions such as CVD, hypertension, diabetes, COPD, asthma
3. Adds to the pre-existing longstanding challenge of late diagnosis and suboptimal treatment in these conditions
4. Risk of deterioration/exacerbation in high impact conditions driving further waves of demand for urgent care and increasing premature mortality and morbidity

## Opportunity

1. Restore and transform proactive care for people with long term conditions
2. Drive a step change in self care and personalised care
3. Mobilise wider primary care workforce to support remote care and self management
4. Optimise clinical care and reduce variation

# UCLP Proactive Care Frameworks

UCLPartners has developed a series of real world frameworks to support proactive management of long-term conditions in post-COVID primary care to drive reduction in admissions and premature mortality in CVD and respiratory disease.

- Led by clinical team of GPs and pharmacists
- Supported by patient and public insight

## Core principles:

1. Virtual where appropriate and face to face where needed
2. Mobilising and supporting the wider workforce (including pharmacists, HCAs, other clinical and non-clinical staff)
3. Step change in support for self-management
4. Digital innovation including apps for self management and technology for remote monitoring




# UCLP Proactive Care Frameworks Overview: Cardiovascular Conditions

**Healthcare Assistants/Health & Wellbeing Coaches and other trained staff**

| | |
|---|---|
| **Self management e.g.** | Education (signposting online resources), self care (eg BP measurement, foot checks, red flags), signpost shared decision-making resources (eg statins, anticoagulants) |
| **Behaviour change e.g.** | Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol |
| **Support holistic care** | Identify wider needs and signpost to e.g. social prescriber, care coordinator |
| **Gather information e.g.** | Up to date bloods, BP, weight, smoking status, run risk scores: QRISK, ChadsVasc, HASBLED |

**Risk Stratification & Prioritisation**

- **Atrial Fibrillation**
- **Blood Pressure**
- **Cholesterol**
- **Diabetes**

**Prescribing Clinician**

**Optimise therapy and mitigate risk**

1. Review blood results, risk scores & symptoms
2. Initiate or optimise therapy
3. Check adherence and adverse effects
4. Review complications and co-morbidities
5. CVD risk – BP, cholesterol, pre-diabetes, smoking, obesity

# UCLP Proactive Care Frameworks: the Components

1. Comprehensive **GP stratification tools** built for EMIS and SystmOne
2. **Pathways** that prioritise patients for follow up, support remote delivery of care, and identify what elements of LTC care can be delivered by staff such as Health Care Assistants and link workers.
3. **Scripts and protocols** to guide Health Care Assistants and others in consultations.
4. **Training** for staff to deliver education, self-management support and brief interventions. Training includes health coaching and motivational interviewing.
5. **Digital and other resources** that support remote care and self care.
6. **Project management** and support for local clinical leadership

The UCLP Proactive Care Frameworks focus on
The HOW of doing things differently

# Why focus on Lipids

1. High cholesterol causes cardiovascular disease and accounts for a third of all heart attacks.
2. Lifestyle change is key to cholesterol lowering. Where this is ineffective or in people at highest risk (e.g. pre-existing CVD or familial hypercholesterolaemia (FH)), drug therapy with statins and other medications is very effective.
3. Every 1mmol/l reduction in low-density lipoproteins (LDL) cholesterol reduces risk of a cardiovascular event by 25% [1].
4. People with high cholesterol who also have other risk factors (e.g. high blood pressure, diabetes, smoking) are at significantly greater risk of CVD and have most to gain from a reduction in cholesterol.
5. FH is high risk but very treatable. Half of men with FH will have a heart attack or stroke before age 50 and a third of women before age 60. Statins are highly effective at reducing this risk.

The following 4 slides offer a phased approach to lipid management guided by clinical priority, together with a pathway for FH case finding and management.

# Cholesterol – Secondary Prevention (pre-existing CVD)

UCLPartners

**Healthcare assistants/other appropriately trained staff**

**Gather information e.g.** Up to date bloods, BP, weight, smoking status

**Self-management e.g.** Education (cholesterol, CVD risk), BP monitors (what to buy, how to use), signpost to shared decision making resources

**Behaviour change e.g.** Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol

**Stratification**

| **Priority One** | **Priority Two (A)** | **Priority Two (B)** | **Priority Three – routine follow up** |
|---|---|---|---|
| Not on statin therapy | On suboptimal intensity statin* | On suboptimal statin dose** | Sub-optimal non-HDL (>2.5mmol/l) levels despite maximal statin therapy |

**Prescribing clinician**

**Optimise lipid modification therapy and CVD risk reduction**

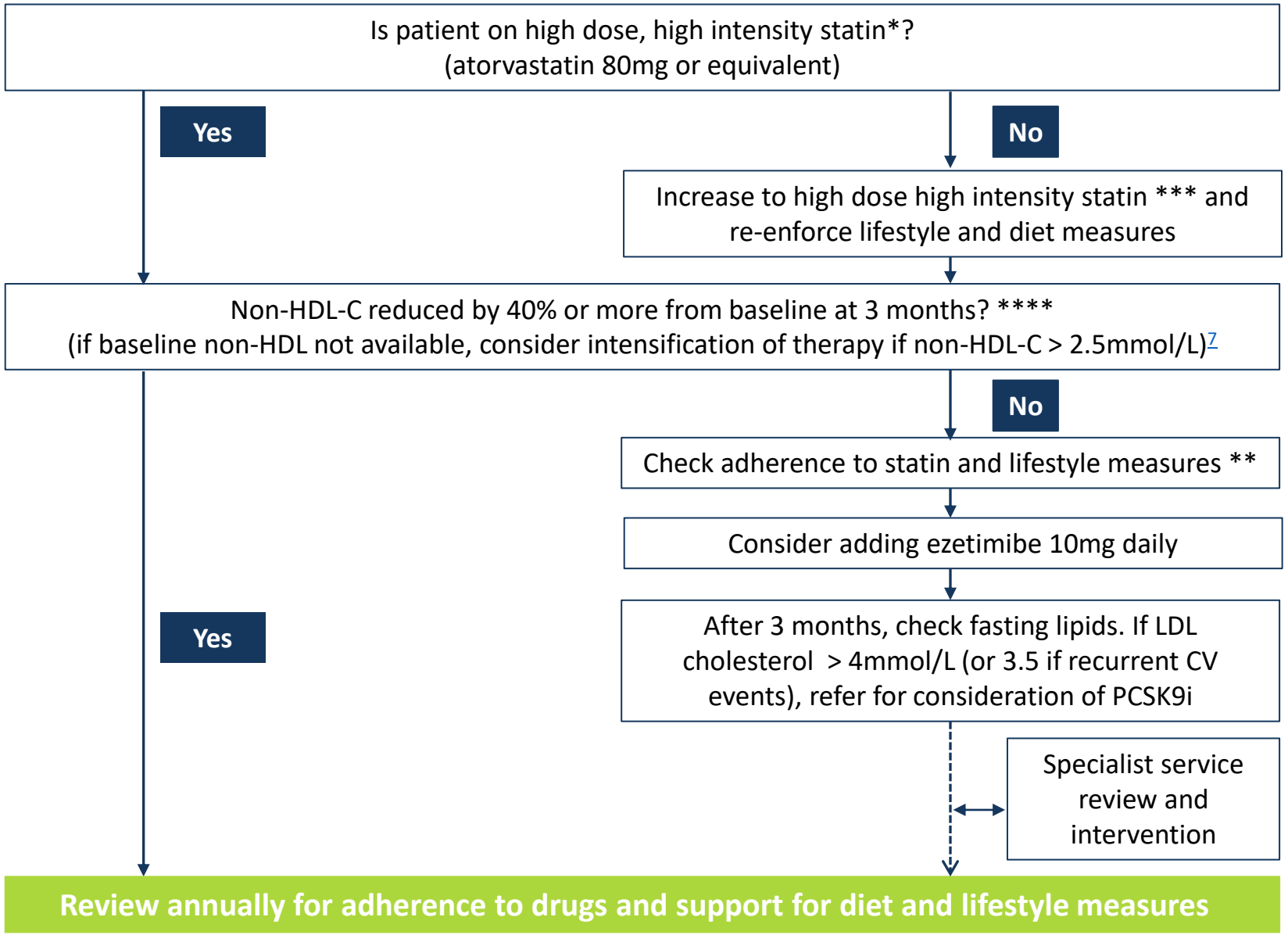
1. Review CVD risk factors, lipid results and liver function tests
2. Initiate or optimise statin to high intensity – e.g. atorvastatin 80mg
3. Titrate therapy against reduction in LDLc/non-HDLc (statin>ezetimibe>PCSK9i)
4. Optimise BP and other comorbidities
5. Use intolerance pathway and shared decision-making tools to support adherence
6. Arrange follow-up bloods and review if needed

# Borough search: CVD Secondary Prevention

Total Population: ~446,000
Secondary prevention population: 9,232

| Priority Group | Definition | No. of patients | % |
|---|---|---|---|
| **PRIORITY 1** | CVD - Not on statin | 2,384 | 26% |
| **PRIORITY 2a**<br>**PRIORITY 2b** | CVD - Not on high intensity statin<br>CVD - Not on appropriate dose of statin | 1,103<br>4,108 | 12%<br>44% |
| **Priority 3** | CVD - Not at target | 528 | 6% |

# Optimisation Pathway for Secondary Prevention




**Optimal High Intensity Statin for secondary prevention**
(High intensity statins are substantially more effective at preventing cardiovascular events than low/medium intensity statins)

| | |
|---|---|
| Atorvastatin | 80mg |
| Rosuvastatin | 20mg |

* Dose may be limited if:

- eGFR<30ml/min
- Drug interactions
- Intolerance

** If statin not tolerated, follow statin intolerance pathway and consider ezetimibe 10mg daily +/- bempedoic acid 180mg daily

*** See statin intensity table

**** NICE Guidance recommends a 40% reduction in non- HDL cholesterol

# Statin Intensity Table – NICE recommends Atorvastatin and Rosuvastatin as First Line

| Approximate Reduction in LDL-C | | | | | |
|---|---|---|---|---|---|
| Statin dose mg/day | 5 | 10 | 20 | 40 | 80 |
| Fluvastatin | | | 21% | 27% | 33% |
| Pravastatin | | 20% | 24% | 29% | |
| Simvastatin | | 27% | 32% | 37% | 42% |
| Atorvastatin | | 37% | 43% | 49% | 55% |
| Rosuvastatin | 38% | 43% | 48% | 53% | |
| Atorvastatin + Ezetimibe 10mg | | 52% | 54% | 57% | 61% |

**Low/moderate intensity statins** will produce an LDL-C reduction of 20-30%

**Medium intensity statins** will produce an LDL-C reduction of 31-40%

**High intensity statins** will produce an LDL-C reduction above 40%

**Simvastatin 80mg** is not recommended due to risk of muscle toxicity

# Richard

- Richard has stable angina and a history of angioplasty and stenting
- He is not currently treated with a statin and is therefore picked up by the UCLP secondary prevention searches as a priority one patient
- You can’t see any record of a statin in his notes
- His last recorded lipids are:
  - Total cholesterol 5.4mmol/L
  - Triglycerides 1.4mmol/L
  - HDL cholesterol 0.9mmol/L

# Richard

The HCA contacts Richard to:

- Gather information — Blood results, BP, weight, smoking status
- Self-management — Education on cholesterol and CVD risk
- Behaviour change — Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol

Richard explains that he did try a statin after his Percutaneous Coronary Intervention (PCI) and did not get on with it due to muscle pains so the HCA refers the patient to you.

You arrange a remote consultation with Richard

- ***How would you approach the discussion with Richard regarding taking a statin?***

# Statin Intolerance Pathway

## Important considerations

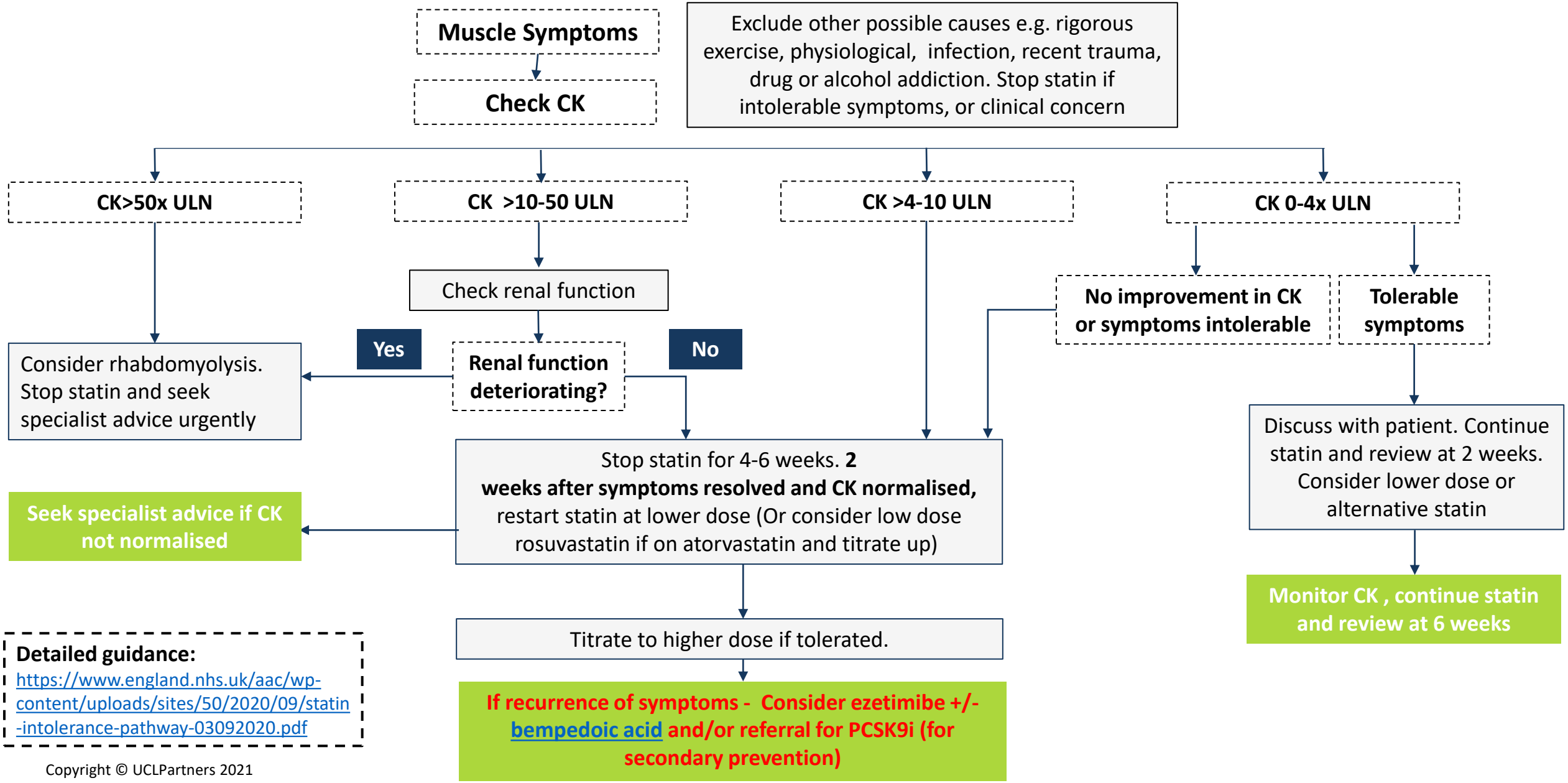
- Most adverse events attributed to statins are no more common than placebo*
- Stopping statin therapy is associated with an increased risk of major CV events. It is important not to label patients as ‘statin intolerant’ without structured assessment
- If a person is not able to tolerate a high-intensity statin, aim to treat with the maximum tolerated dose
- A statin at any dose reduces CVD risk – consider annual review for patients not taking statins to review cardiovascular risk and interventions

## A structured approach to reported adverse effects of statins

1. Stop for 4-6 weeks.
2. If symptoms persist, they are unlikely to be due to statin
3. Restart and consider lower initial dose
4. If symptoms recur, consider trial with alternative statin
5. If symptoms persist, consider ezetimibe +/- bempedoic acid

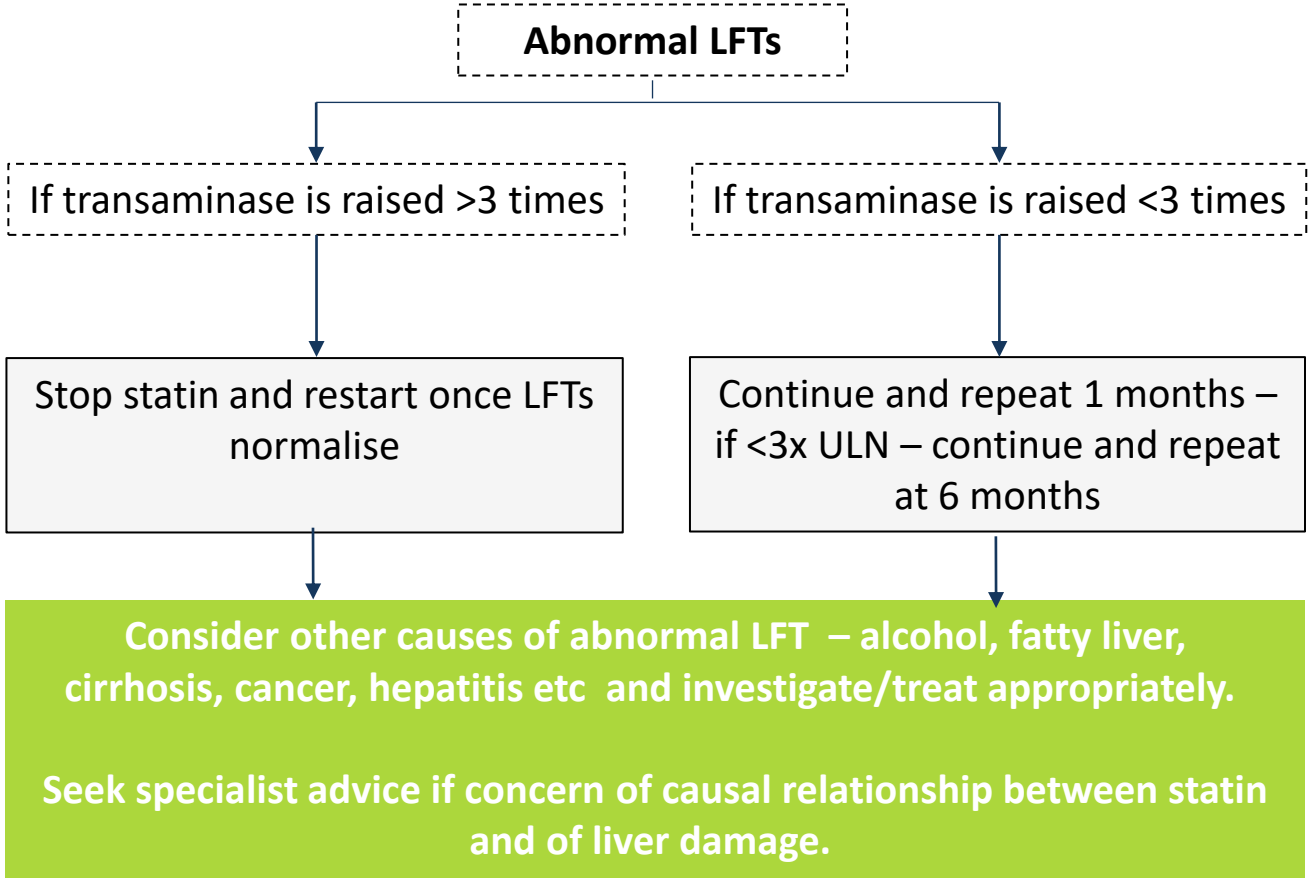
*(*Collins et al systematic review, Lancet 2016)*

# Muscle Symptoms Pathway




**Detailed guidance:**
https://www.england.nhs.uk/aac/wp-content/uploads/sites/50/2020/09/statin-intolerance-pathway-03092020.pdf

# Abnormal Liver Function Test Pathway




- Do not routinely exclude from statin therapy people who have liver transaminase levels that are raised but are less than 3 times the upper limit of normal.
- Most adults with fatty livers are likely to benefit from statins and this is not a contraindication.
- Check liver function at baseline, and once between 3 months and 12 months after initiation of statin therapy.

# Shared Decision-Making Resources

| Benefits per 10,000 people taking statin for 5 years | Events avoided |
|---|---|
| Avoidance of major CVD events in patients with pre-existing CVD & a 2mmol/l reduction in LDL | 1,000 |
| Avoidance of major CVD events in patients with no pre-existing CVD & a 2mmol/l reduction in LDL | 500 |

| Adverse events per 10,000 people taking statin for 5 years | Adverse events |
|---|---|
| Myopathy | 5 |
| Haemorrhagic Strokes | 5-10 |
| Diabetes Cases | 50-100 |

Shared decision-making resources:

- BHF information on statins
- Heart UK: Information on statins
- NICE shared decision-making guide

Collins et al 2016 Lancet Systematic Review Lancet 2016; 388: 2532–61

# Cholesterol – Primary Prevention (no pre-existing CVD)

UCLPartners

**Healthcare assistants/other appropriately trained staff**

| | |
|---|---|
| **Gather information:** | E.g. up to date bloods, BP, weight, smoking status, run QRisk score.* |
| **Self-management:** | Education (cholesterol, CVD risk), BP monitors (what to buy, how to use), signpost to shared decision making resources |
| **Behaviour change:** | Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol |

**Stratification**

**Priority One**

One of:
- QRisk ≥20%
- CKD
- Type 1 Diabetes

AND
- Not on statin

**Priority Two**
- QRisk 15-19%

AND
- Not on statin

**Priority Three**
- QRisk 10-14%

AND
- Not on statin

**Priority Four**
- On statin for primary prevention but not high intensity

**Prescribing clinician**

**Optimise lipid modification therapy and CVD risk reduction**

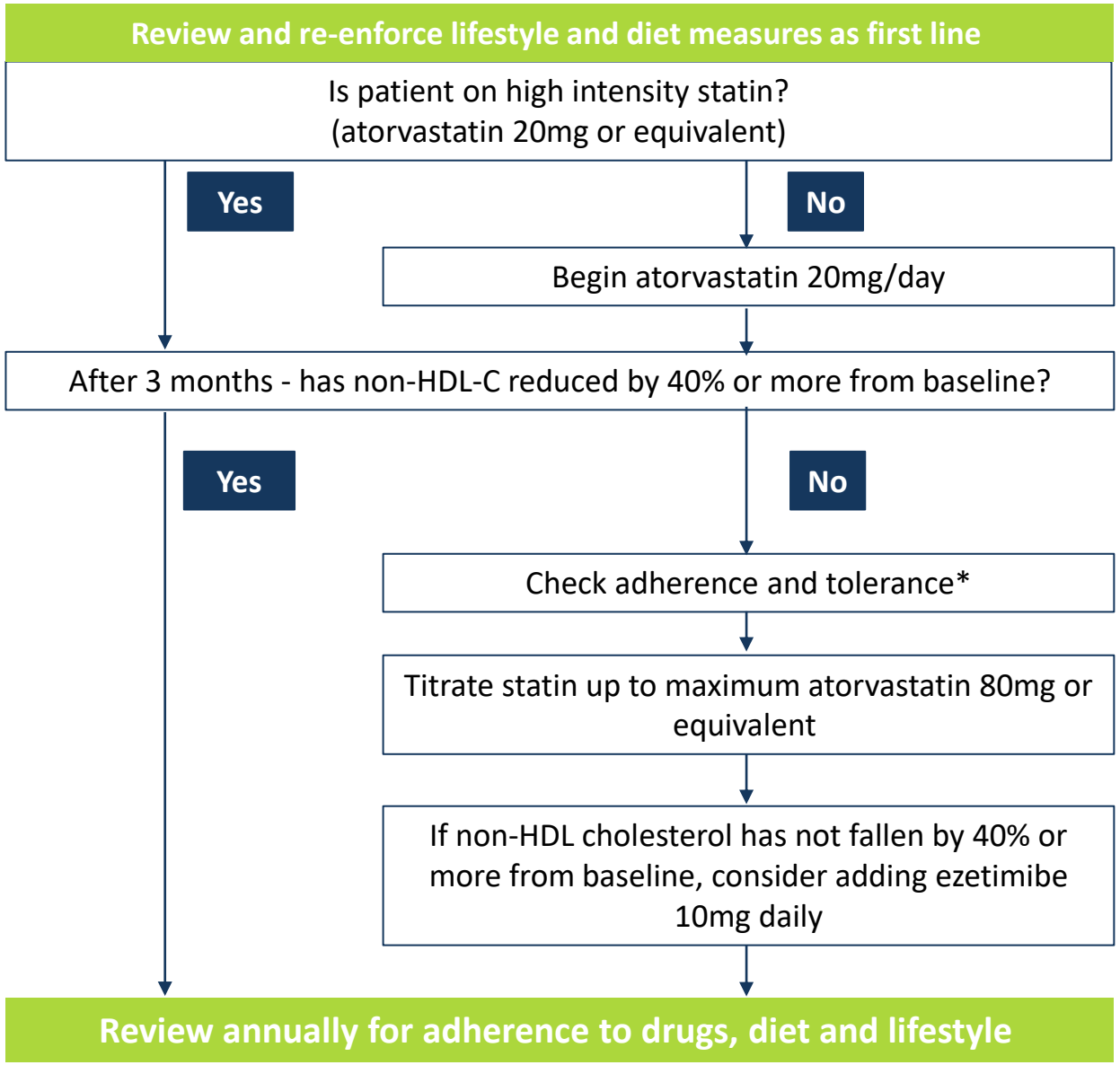
1. Review QRisk score, lipid results and LFTs
2. Initiate or optimise statin to high intensity – eg atorvastatin 20mg
3. Titrate therapy against reduction in LDLc/non-HDLc (statin>ezetimibe)
4. Optimise BP and other comorbidities
5. Use intolerance pathway and shared decision-making tools to support adherence
6. Arrange follow-up bloods and review if needed

# Borough search: CVD Primary Prevention

Total Population: ~446,000
Primary prevention population: 95,595

| Priority Group | Definition | No. of patients | % |
|---|---|---|---|
| **PRIORITY 1** | Highest risk (Qrisk >20%) of CVD - Not on statin | 5,547 | 6% |
| **PRIORITY 2**<br>**PRIORITY 3** | Qrisk 15-19% - Not on statin<br>Qrisk 10-14% - Not on statin | 3,368<br>6,925 | 4%<br>7% |
| **Priority 4** | On statin for primary prevention but not HI | 750 | 1% |

# Optimisation Pathway for Primary Prevention




| Optimal High Intensity statin for Primary Prevention (High intensity statins are substantially more effective at preventing cardiovascular events than low/medium intensity statins) | |
|---|---|
| Atorvastatin | 20mg |
| Rosuvastatin | 10mg |

* If statin not tolerated, follow statin intolerance pathway and consider ezetimibe 10mg daily +/- bempedoic acid 180mg daily

UCLPartners

# Familial Hypercholesterolaemia

# Familial Hypercholesterolaemia
# Simplifying Detection in General Practice

1. 92% of people with Familial Hypercholesterolaemia are undiagnosed.
2. Many patients with very high cholesterol levels have not been screened for FH.
3. The UCLP Familial Hypercholesterolaemia Framework:
   - Simplifies the process using NICE thresholds and Simon Broome criteria
   - Provides a pragmatic, semi-automated solution for case-finding in general practice

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# Familial Hypercholesterolaemia Pathway

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*Simon Broome Criteria
SB 1+2 = Definite FH
SB 1+3 = Possible FH

Case find under 30 years:
TC >7.5 or LDL-C >4.9 or non-HDL-C >6.0

Case find 30 years or over:
TC >9.0 or LDL-C >6.4 or non-HDL-C >7.5

S/Broome* 1

HCA Fasting lipids plus LFTs, TFTs, Renal, HbA1c

Known/coded FH

TG <2.3

TG >2.3

Investigate raised TG
Refer if indicated

HCA Text family history questionnaire
1st degree relative MI <60
2nd degree relative MI <50

Negative

? Tendon Xanthomata
PCN Nurse or pharmacist
Face to face or remote assessment

Negative

Positive S/Broome* 3

Positive S/Broome* 2

Refer if not DNA confirmed or if no family testing done
Nurse/Pharmacist Desktop Review

Exclude secondary causes of high TC and refer DNA testing
Nurse/Pharmacist Desktop Review

Unlikely FH: Manage as appropriate for 1°/2° prevention
Aim to reduce non-HDL chol by at least 40%
Support behaviour change, titrate high intensity statins, consider other therapies and manage other CVD risk factors
Treatment in primary care

Not FH

Specialist service and FH Nurse

Genetic counselling and DNA test

No FH mutation

FH mutation

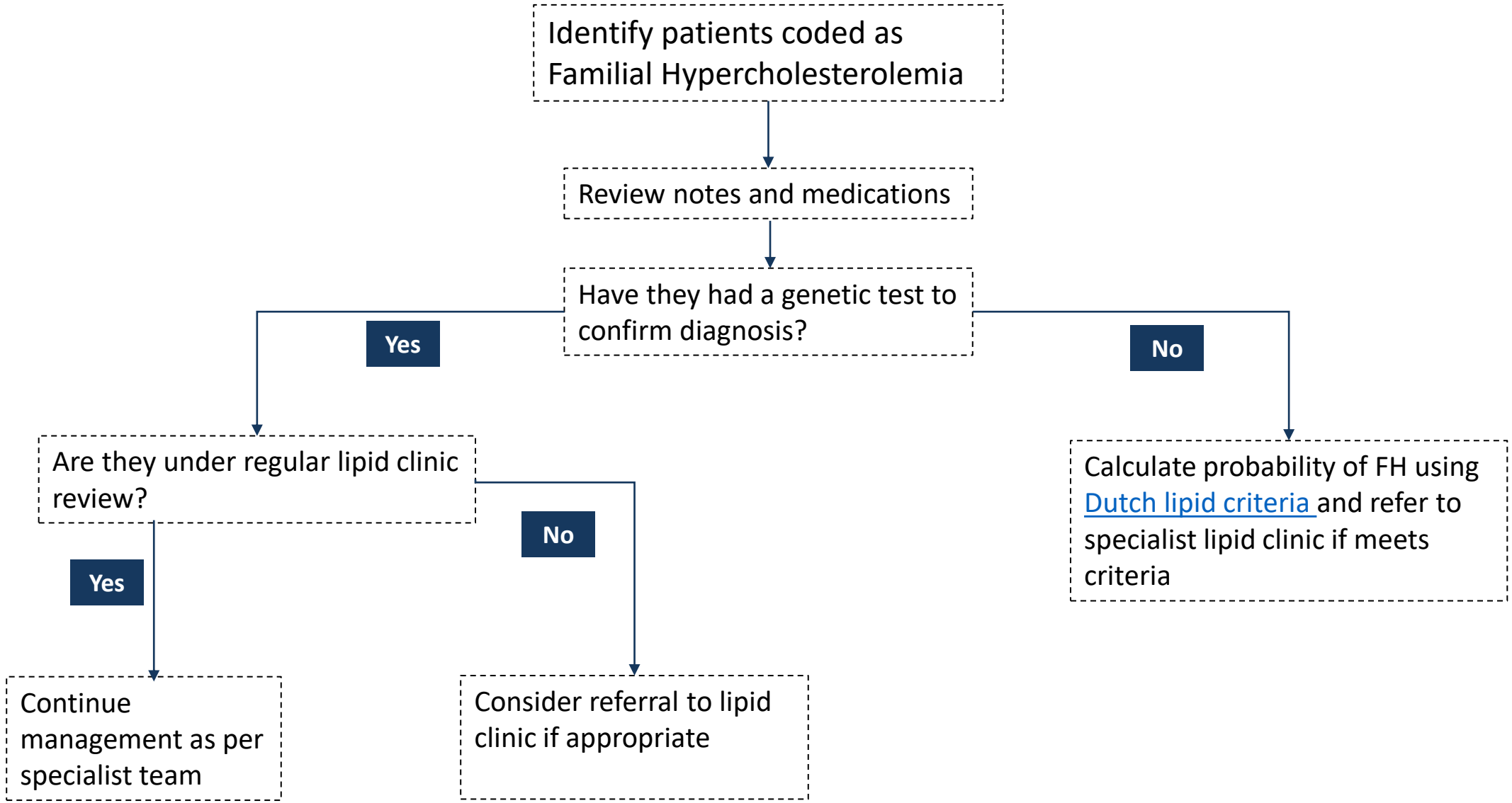
Treatment

Cascade testing for family members

Confirmed FH

FH: Aim to reduce LDL by 50% or more
Titrate high intensity statins, consider other therapies, support behaviour change and manage other CVD risk factors
Treatment in primary care with specialist support

# Desktop Review for People with Coded FH



# Familial Hypercholesterolaemia Family History Questionnaire

*We have reviewed your cholesterol results and would like some information on your family history to help inform your treatment. Please answer the following questions:*

1. Have any of your first-degree blood relatives (mother, father, brother or sister) had a heart attack under the age of 60? **Yes/ No**

   If Yes, which relative (mention how they are related to you) and how old were they when they had the heart attack?

2. Have any of your second-degree blood relatives (grandparents, aunts, uncles, nephews, nieces and half brothers and half sisters) had a heart attack aged 50 or under? **Yes/ No**

   If Yes, which relative (mention how they are related to you) and how old were they when they had the heart attack?

# Dutch Lipid Clinic Criteria

| | | |
|---|---|---|
| **Family history** | | |
| First-degree relative with known premature coronary and/or vascular disease (men aged <55 years and women aged <60 years) or<br>First-degree relative with known low-density lipoprotein-cholesterol (LDL-C) above the 95th percentile for age and sex | | 1 |
| First-degree relative with tendinous xanthomata and/or arcus cornealis or<br>Children aged <18 years with LDL-C above the 95th percentile for age and sex | | 2 |
| **Clinical history** | | |
| Patient with premature coronary artery disease (ages as above) | | 2 |
| Patient with premature cerebral or peripheral vascular disease (as above) | | 1 |
| **Physical examination** | | |
| Tendon xanthomas | | 6 |
| Arcus cornealis prior to 45 years of age | | 4 |
| LDL-C (mmol/L) | | |
| | LDL-C ≥8.5 | 8 |
| | LDL-C 6.5–8.4 | 5 |
| | LDL-C 5.0–6.4 | 3 |
| | LDL-C 4.0–4.9 | 1 |
| Deoxyribonucleic acid (DNA) analysis: Functional mutation in the low-density lipoprotein receptor (LDLR), apolipoprotein B (APOB) or proprotein convertase subtilisin/kexin type 9 (PCSK9) gene | | 8 |
| **Stratification** | | Total score |
| Definite familial hypercholesterolaemia (FH) | | ≥8 |
| Probable FH | | 6–7 |
| Possible FH | | 3–5 |
| Unlikely FH | | <3 |

*ApoB*, apolipoprotein B; DNA, deoxyribonucleic acid; FH, familial hypercholesterolaemia; LDL-C, low-density lipoprotein-cholesterol; *LDLR*, low-density lipoprotein receptor; *PCSK9*, proprotein convertase subtilisin/kexin type 9

# Resources for clinicians – supporting co-morbidity management

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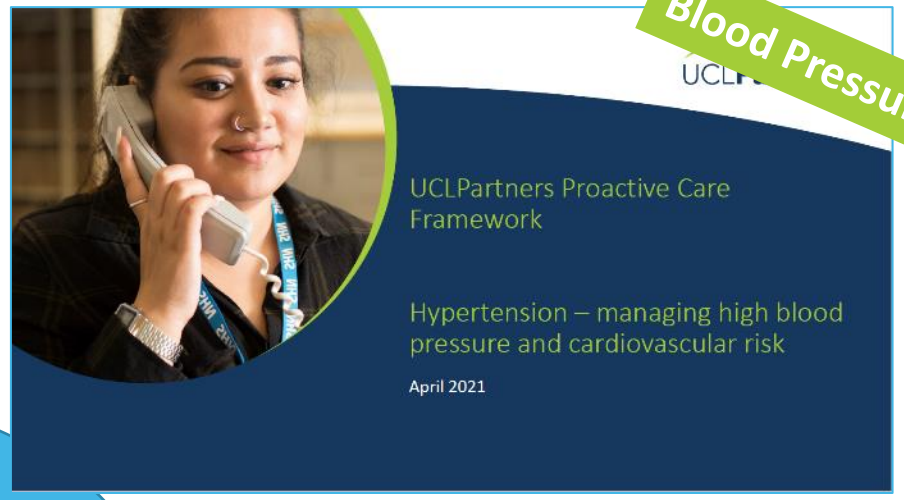
Atrial Fibrillation

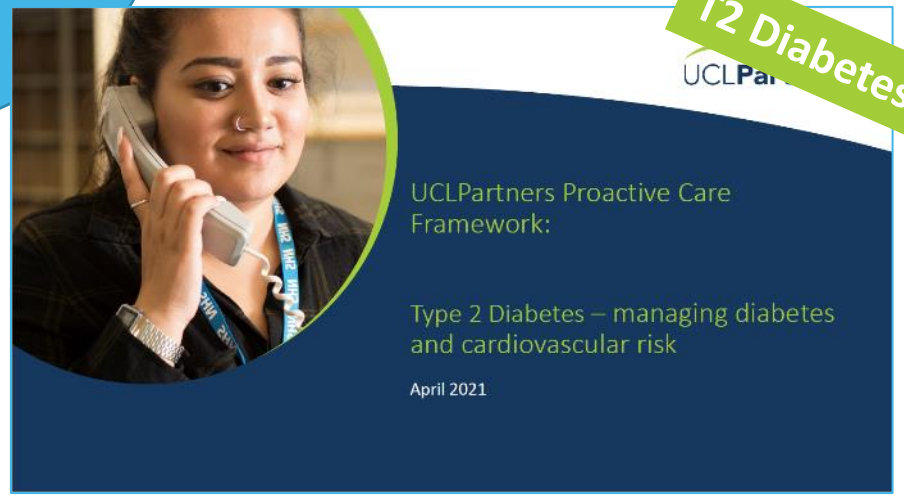

Blood Pressure




BP & Lipid management included in pathways for AF, BP, cholesterol and T2 Diabetes

Cholesterol


T2 Diabetes

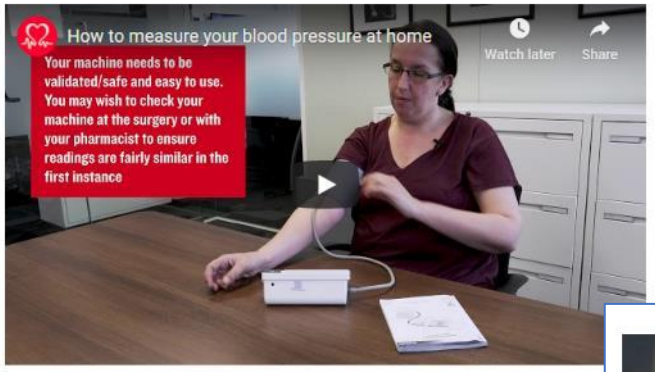


# Resources for patients – supporting education and self-management

UCLPartners

## What is high blood pressure (hypertension)?


## How to check your blood pressure using a blood pressure machine




## Find out about cholesterol


**What is cholesterol?**

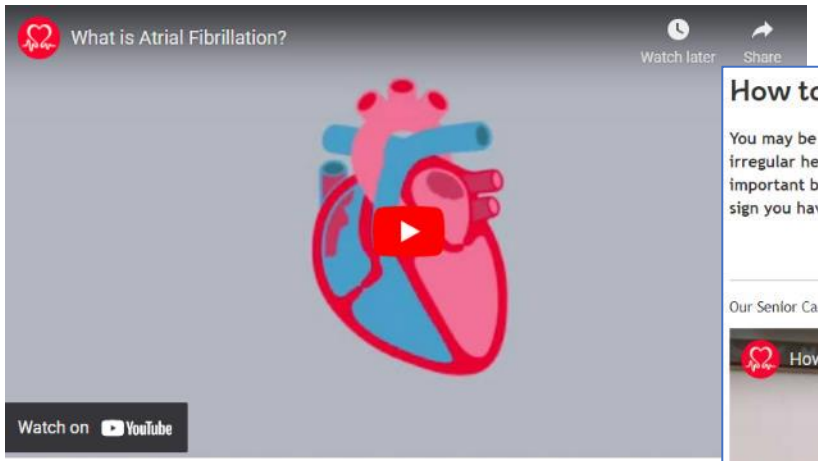
Cholesterol is a blood fat which plays a vital role in how all of our cells work. It's also needed for digestion, to make Vitamin D, and to make hormones which keep your bones strong. Learn more.

**Having high cholesterol**

Too much cholesterol in the blood can lead to diseases of the heart and blood vessels. High cholesterol can be caused by lifestyle but can also be inherited, and most people don't know they have it.


**Cholesterol tests and results**

Anyone can have high cholesterol, even if you're young, slim and otherwise healthy. You can't feel it, so the only way to find out your cholesterol level is to get a cholesterol test.




## How to check your pulse

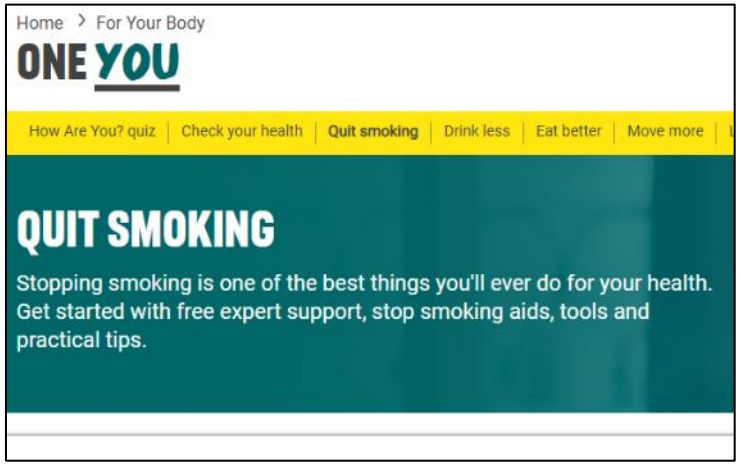
You may be able to tell if you have a regular or irregular heart beat by checking your pulse. This is important because an irregular heart beat may be a sign you have a heart condition.

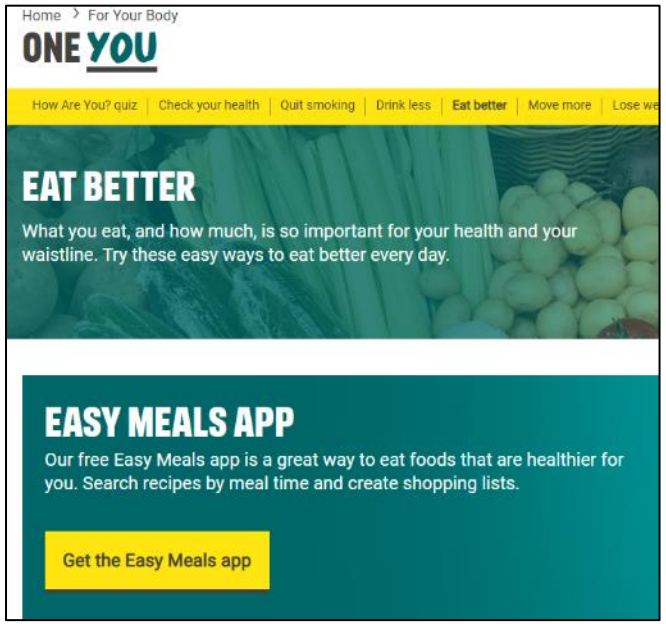
Our Senior Cardiac Nurse, Emily McGrath, shows you how to check your pulse:

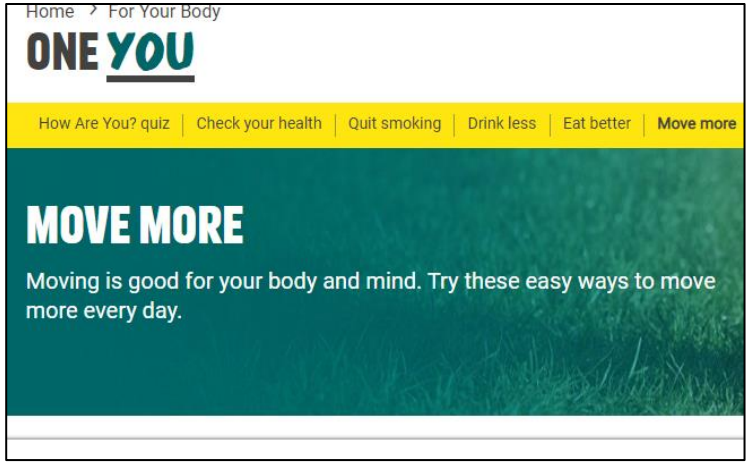

## Reduce your cholesterol

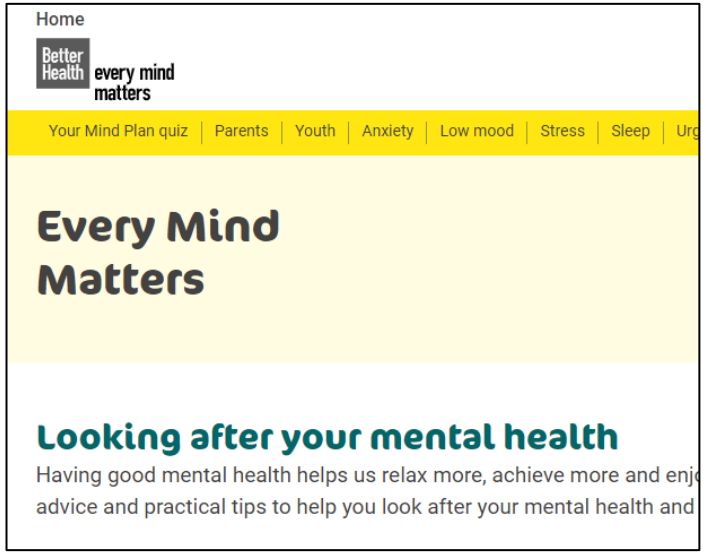
Our experts answer the 5 most common questions to help you reduce your cholesterol.

# Resources to support behaviour change

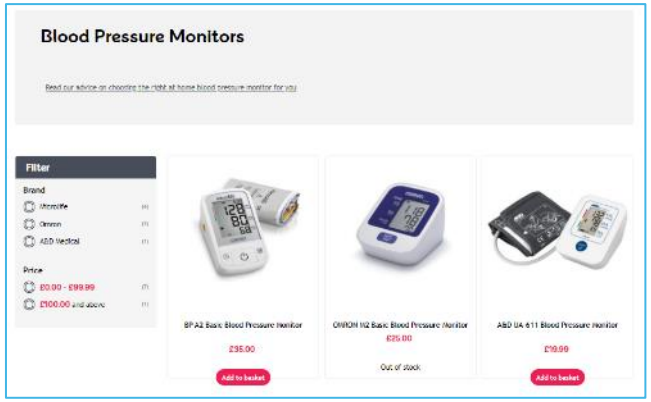


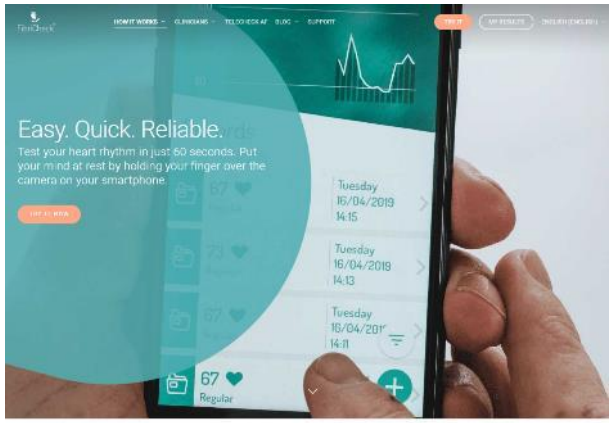



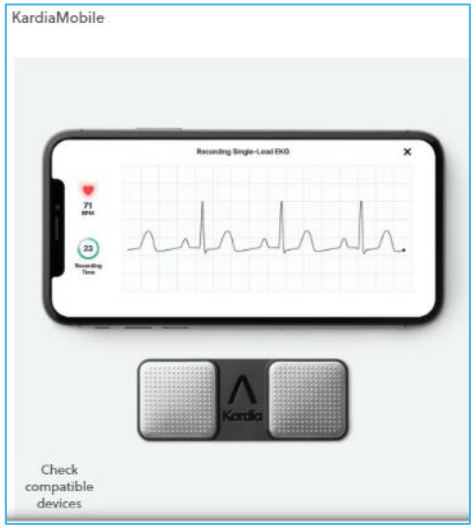



# Resources to support remote management




# Implementation support is critical

| | |
|---|---|
| **Adapting to your local context** | • **Programme and project management** to adapt and embed the frameworks in Primary Care Networks<br>• Support for **local clinical engagement and leadership**<br>• Adaption of the frameworks to **reflect local pathways**<br>• Facilitated **Community of Practice/shared learning forums** to enable peer support across local systems |
| **Workforce training and support** | • Support to **identify training needs**<br>• Training **tailored to each staff grouping** (e.g. HCA/ pharmacist etc) and level of experience<br>• **Communications training and support** – encompassing motivational interviewing and health coaching principles to support the primary workforce to deliver the protocol<br>• **Best practice in virtual consultations** – practical training and support to deliver high quality remote consultations<br>• **Condition-specific training** – we are working with local Training Hubs to provide training on each of the conditions covered by the frameworks |
| **Data and evaluation** | • Support to use **search tools**<br>• Support with **coding and data collection approaches** to enable implementation |
| **Digital Support Tools** | • Sign-posting to **digital resources** to support remote management and self management FOR each condition<br>• **Digital implementation** support: how to get patients set up with the appropriate digital tools |

# National Uptake of the UCLP Proactive Care Frameworks

## Wide traction and growing uptake in primary care across England:

- Widely welcomed by GPs in London and elsewhere
- Over 4,000 downloads of the search tools
- 6 other AHSNs supporting local rollout

## NHSE/I has adopted the UCLP frameworks into new national programme – (*NHS Proactive Care @Home* Programme) with 4 funded pilot implementation ICS sites:

- North East London
- North Central London
- Cheshire and Merseyside
- Leicester, Leicestershire and Rutland

## Phase 2 of national roll out: 8 additional ICSs in 2021-22 supported by regional personalised care programme funding

# UCLPartners Proactive Care Frameworks/NHS Proactive Care @Home

1. Support GPs and their teams to do things differently post COVID
2. Restore routine care post pandemic
3. Transform care across the pathway
4. Risk stratify patients and prioritise those with greatest need
5. Enable the wider primary care workforce to optimise self care and remote care
6. Optimise clinical care, reduce variation and improve outcomes

UCLPartners

# Thank you

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www.uclpartners.com
@uclpartners

# 05 Q&A

## Next steps: Join us for the next webinar: A Focus on FH: Wednesday 13th October 12.45-2.15pm

**Dr Jaimini Cegla** Consultant in chemical pathology and metabolic medicine at Imperial College Healthcare NHS Trust

**Professor Nadeem Qureshi** Professor of Primary Care, University of Nottingham

**Mahtab Sharifi** Consultant Chemical Pathologist, St Georges' Hospital NHS Trust

All programme content, recordings and next webinar bookings will be housed in the HEART UK pages. Visit the site for the new e-Learning modules on Identifying FH in primary care**,** Statin Intolerance, and the Lipid Management Pathway

Lowering Cholesterol.

Saving Lives.

TheAHSNNetwork ACCELERATED ACCESS COLLABORATIVE HEART UK THE CHOLESTEROL CHARITY NHS

Tackling Cholesterol Together

# Thank you

**This webinar has now finished.**

Today's slides and recording will be available after the webinar on the HEART UK pages. Visit the site for the **new** e-Learning modules Identifying FH in primary care, Statin Intolerance, and the Lipid Management Pathway

All programme content, recordings and next webinar bookings will be housed here: https://www.heartuk.org.uk/tackling-cholesterol-together/home

***Some content in this deck is based on slides created and provided by Amgen UK in scientific exchange to our speakers, which have been adapted for this talk***