Results of survey to understand adoption of new NICE-approved lipid management pathway in primary care

Carried out on behalf of Eastern AHSN

by Solutions for Public Health

August 2022

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This report is based on information provided by third parties. While care has been taken in the preparation of the report, Solutions for Public Health accepts no responsibility for gaps or limitations in the information.

Acknowledgements
With acknowledgment and thanks to all those who completed the survey. This work would not have been possible without your support.

Contents

1 Background

In December 2021, an updated NICE-approved lipid management pathway was published.[1] This year, new NHS England service requirements for PCNs for the management of lipids and identification of familial hypercholesterolaemia (FH) came into effect, reflecting the updated NICE guidance.[2]

Eastern AHSN (Academic Health Science Network) is responsible for supporting the adoption of the updated lipid management pathway across the East of England.

SPH were commissioned by the AHSN to conduct a survey of General Practices in the region to help understand and develop future support for practices.

This report presents the results of the survey.

2 Methods

The survey was designed jointly by Eastern AHSN and SPH to understand:

a) Whether East of England GP practices are aware of the updated lipid management pathway, and whether they have made or are planning to make any changes as a result of the updated guidance
b) Whether practices are implementing or planning to implement the new NHS England PCN service requirements that relate to lipid management and FH
c) Whether the practices use any tools to support lipid management and identification of FH, including which tools and how helpful they are

The survey also included context-related questions, such as whether the practice has a cardiovascular disease (CVD) lead, and how patients are currently identified and managed, for example whether the practice runs bespoke lipid management or CVD prevention clinics.

The full list of survey questions is reproduced in Appendix 1. Note that respondents would not be shown questions where the response to a previous question made the following question not relevant to them. In order to assist completion and analysis of the survey, many of the questions included a list of possible responses, with the option to select more than one, as well as an option to provide additional responses in free text.

Microsoft Forms was used for the survey. It was distributed using an online link by Eastern AHSN to regional and Integrated Care System (ICS) colleagues known to Eastern AHSN, for onward dissemination to primary care colleagues. This included

[1] NHS Accelerated Access Collaborative. Summary of national guidance for lipid management for primary and secondary prevention of cardiovascular disease. 2020, updated December 2021. Available at: Summary-of-national-guidance-for-lipid-management-for-primary-and-secondary-prevention-of-cardiovascular-disea.pdf (england.nhs.uk)
[2] Primary Care Networks – Plans for 2021/22 and 2022/23 - New PCN service requirements. 2021. Annex A - CVD Prevention and Diagnosis (england.nhs.uk)

four NHS East of England colleagues, programme leads and CVD Board members from all four ICSs, ICS communication leads for inclusion in primary care publications, project managers at Oxford AHSN and University College London Partners (UCLP) to disseminate to their networks, and four GP federations throughout the region. The total number of practices reached through these routes is not known. Each contact was followed up to encourage participation. The survey was live for approximately one month.

3 Results

3.1 Respondents

Responses were received from 20 GP practices.

Responding practices named the following as the CCG to which they belonged:

- Cambridgeshire and Peterborough 4
- Ipswich and East Suffolk 4
- Mid-Essex 1
- North-East Essex 7
- West Suffolk 1

(Three practices did not identify a CCG.)

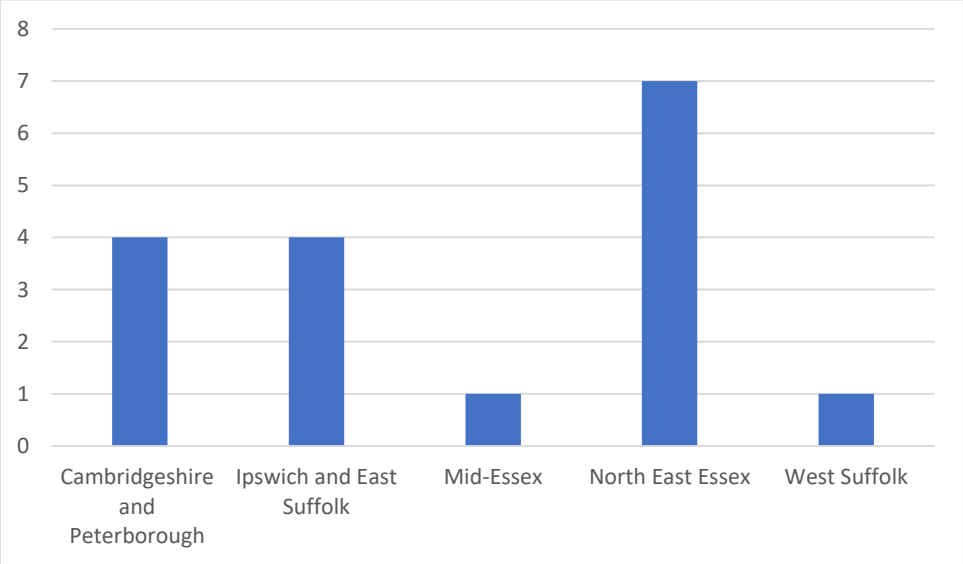


Figure 1: Location (Clinical Commissioning Group) of responding practices (n=17; 3 practices did not identify a CCG)

Twelve of the respondents were GPs, six were Practice Managers, one a Nurse and one a Pharmacist.

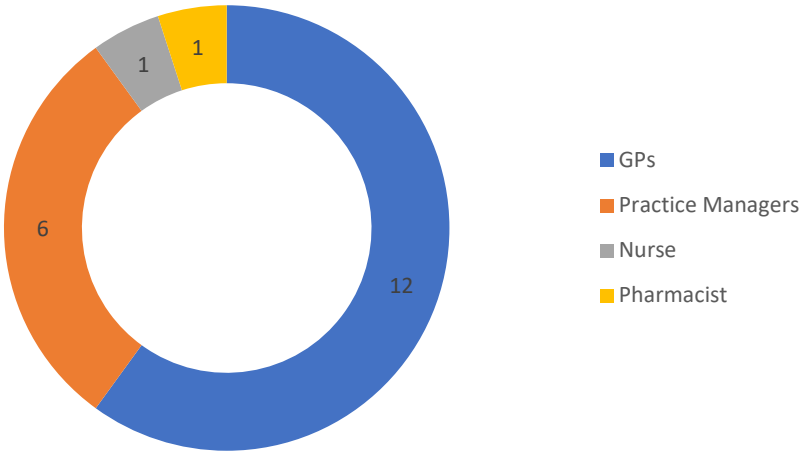


Figure 2: Role profile of responders (n=20)

Eleven of the responding practices reported that they have a CVD lead for the practice. In nine, this is a GP, in one a nurse, and in one there is both a nurse and a pharmacist lead for CVD.

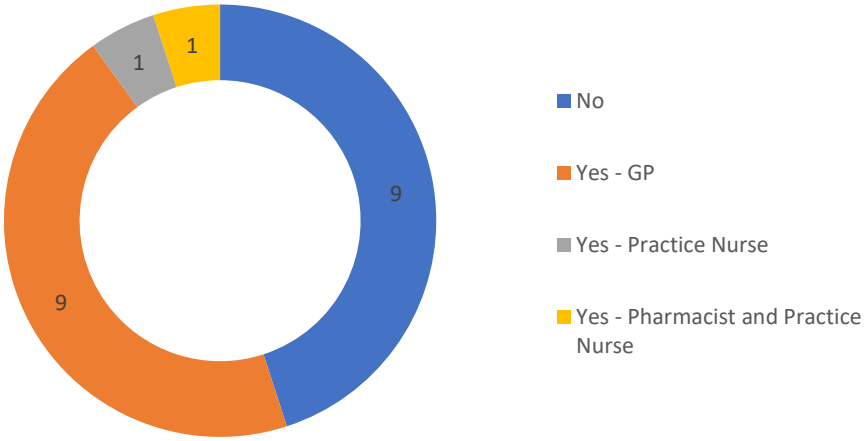


Figure 3: Role profile for practice CVD leads (n=20)

3.2 Awareness of the updated lipid management pathway

Of the 20 respondents, 12 reported being aware of the new lipid management pathway and guidance whereas eight were not aware of this.

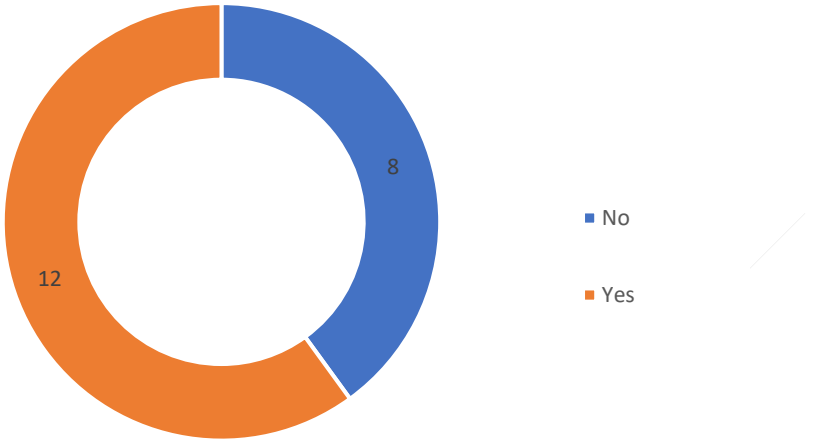


Figure 4: Responder's awareness of the new lipid management pathway and guidance (n=20)

Of the 12 who were aware of the new pathway, four had made changes to the lipid management and FH identification pathways in the practice after the new pathway was published, and five planned to make changes, with three practices reporting not making or planning to make any changes.

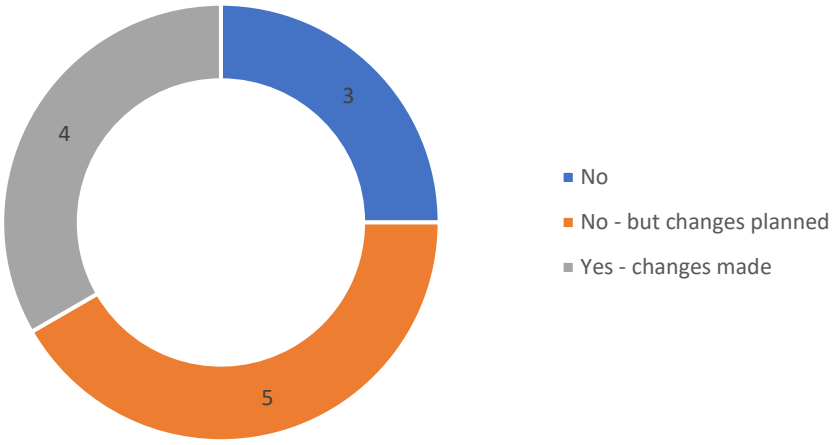


Figure 5: Changes made by practice to their lipid management and familial hypercholesterolemia identification pathways after publication of the new pathway. (n=12; the 12 practices that were aware of the new lipid management pathway)

For practices that had made or planned to make changes, seven explained the changes they were making as follows:

- Ensuring all clinicians are aware of the new recommendations
- Carrying out QRISK®3 or QRISK®2 calculations for patients aged over 40 years[3]
- Auditing FH diagnoses and referrals
- Using System One template letters regarding cholesterol and QRISK/statin offer, that also highlight to clinicians to think about FH in certain scenarios
- Active referral of patients with QRISK higher than 10% to PCN pharmacist, increased use of ezetimibe in addition to statins for high risk patients, use of NHS health checks, audits of patients with FH premature heart disease, undecided on use of inclisiran[4]
- Not using QRISK 2 in patients with high lipid profiles especially if a relative had CVD under the age of 60
- Planning work at a PCN level using Additional Role Reimbursement Scheme (ARRS) funded pharmacists and technicians

3.3 Implementation of new NHS England PCN service requirements

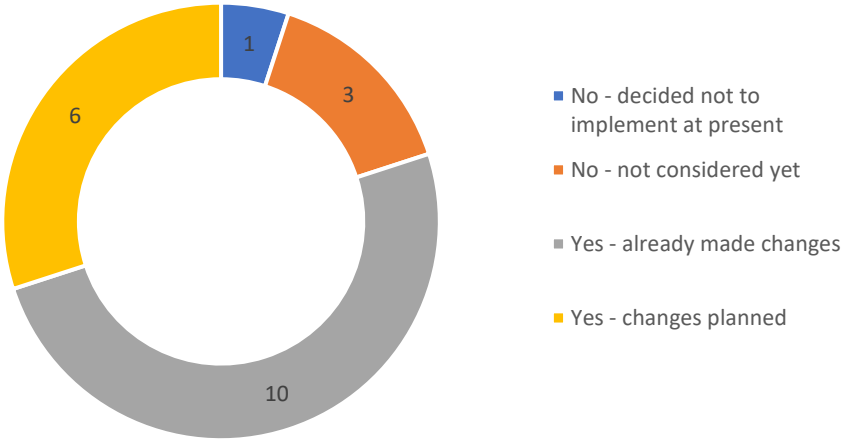
There are two main aspects relating to lipid management within the new NHS England PCN service requirements. These, and responses relating to them are as follows:

a) **Offer of statin treatment to patients with a QRISK 2 or 3 score of ≥ 10:**

Ten practices had started to implement this service requirement, while six more planned to do so. Three practices had not considered this yet and one had decided not to implement it at present.

[3] QRISK® is a tool used to calculate a person's risk of developing a heart attack or stroke over the next 10 years. https://qrisk.org/three/

[4] Inclisiran is one of the options recommended for secondary prevention of cardiovascular disease if maximum tolerated dose of statin does not control non-HDL-C/LDL-C well enough after 3 months. Summary-of-national-guidance-for-lipid-management-for-primary-and-secondary-prevention-of-cardiovascular-disea.pdf (england.nhs.uk) and Overview | Inclisiran for treating primary hypercholesterolaemia or mixed dyslipidaemia | Guidance | NICE



b)

Figure 6: Practices offering statin treatment to patients with a QRISK 2 or 3 score of ≥ 10 (n=20)

b) **Identification of patients at high risk of FH:**

Of 16 respondents, four practices had started to implement this service requirement, while seven more planned to do so. Four practices had not considered this yet and one had decided not to implement it at present (the same practice that had decided not to implement the change to the statin treatment threshold).

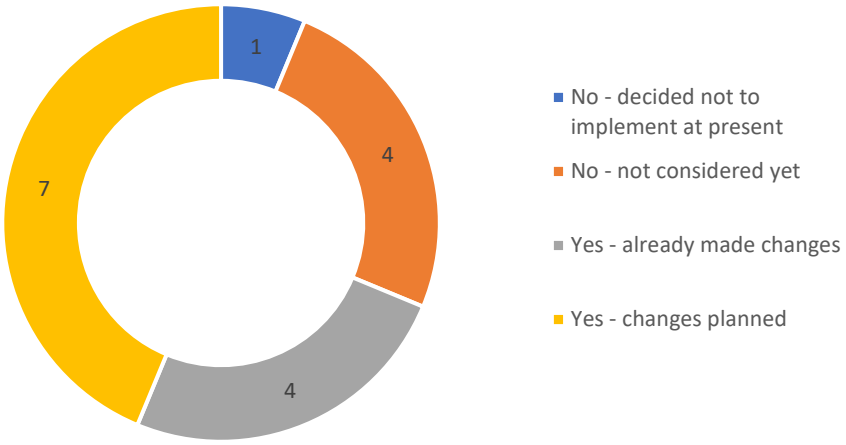


Figure 7: Practices implementing the Identification of patients at high risk of familial hypercholesterolemia (n=16; 4 practices did not respond to this question)

Several practices suggested that they were already providing these services:

"We have been treating QRISK >=10% for several years already"

"We were already discussing statin if qrisk over 10%, raising awareness of familial hypercholesterolaemia in the practice team"

"Already doing this"

"Referral to local lipid clinic"

Four practices reported running or planning to run searches:

"We will run a search to identify qualifying patients"

"Regular searches to highlight suspected FH cases"

"Set up an IT audit and alerts to assist"

"Looking forward to having our lipid case finding tool later this month"

Other changes planned included the following:

- One practice planned "to offer statins to patients identified" (no further detail provided)
- One practice planned to use the PCN pharmacist and technician but commented that they "need fewer pharmacy PCN DES requirements in order to release time for this work"
- One practice planned to use "help of practice PCN pharmacists, increased use of ezetimibe, audits of patients with read coded FH premature heart disease, etc."

The practice that had decided not to implement the requirements at present commented that it was considering the guidance and that clinician time to implement the requirements was an issue.

3.4 Tools to assist with lipid management and FH identification

Eleven of the 20 practices reported using a tool to assist with lipid management and/or FH identification, and seven reported not using a tool (two did not respond to this question).

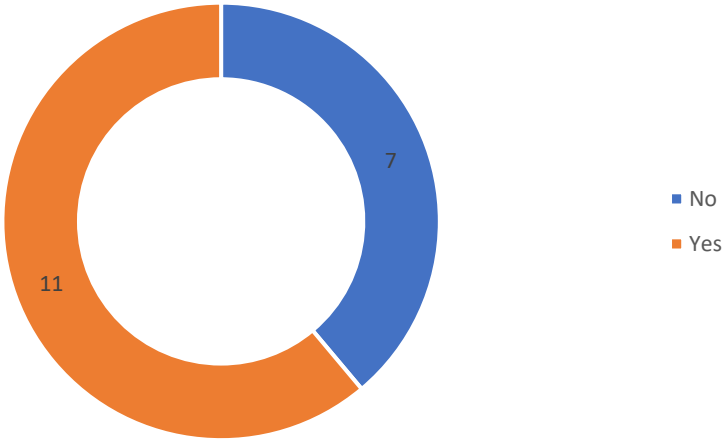


Figure 8: Practices using tools to assist with lipid management and familial hypercholesterolemia identification (n=18; 2 practices did not respond to this question)

Of the 11 that use a tool:

- Six practices use the **Ardens**[5] tool:
  - Three reported using the Ardens tool to generate lists, two of which reported that the tool is very good/very helpful
  - One practice that used the Ardens tool to generate lists also used it ad hoc
  - One practice that used the Ardens tool to generate lists also used it for decision support and advice re appropriate prescribing. They reported that the tool is very helpful
  - A fourth practice reported using the Ardens tool to support the consultation and for decision support, and reported that the tool is very helpful
  - A fifth practice reported using The Ardens tool for coding
  - The sixth practice that used the Ardens tool did not provide any further detail regarding its use of the tool

  Two practices commented on missing functionality relating to the Ardens tool:
  - One comment was the need for a "more obvious maximum tolerated therapy code so it's not missed each year."
  - One noted that missing functionality included the "ability to set text with information to mobiles / emails with advice / electronic self reviews for patients who prefer IT solutions".

- Three practices use **QRISK®**:
  - One used QRISK® to generate patient lists and commented that the tool "under estimates"

[5] https://www.ardens.org.uk/

- Two used QRISK® for decision support – both reported that it is very helpful, while one commented that functionality is missing in relation to younger patients

- One practice uses **Eclipse Live**[6] to generate patient lists (no further comments provided)

- One practice uses templates and System One searches (no further comments provided)

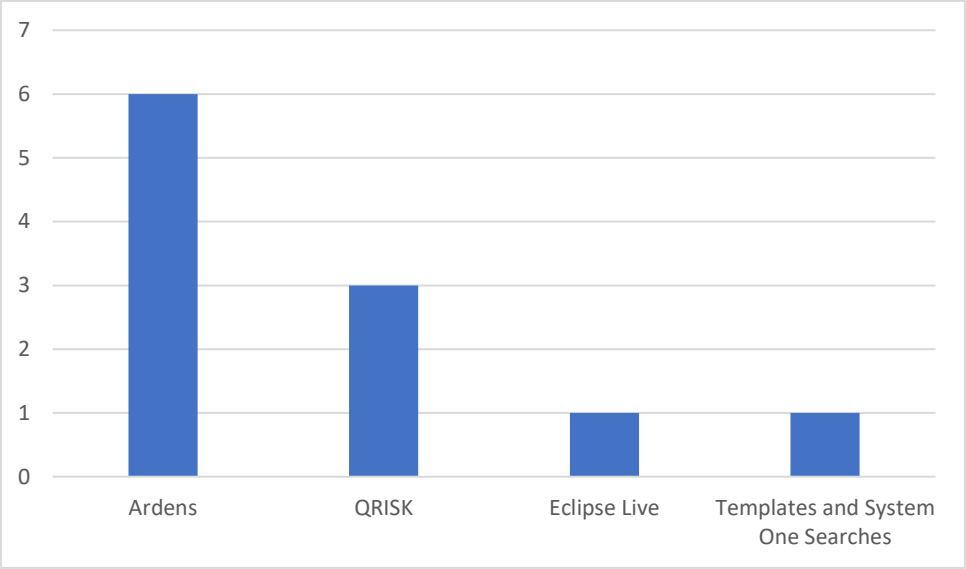


Figure 9: Types of tools used to assist with lipid management and/or familial hypercholesterolemia identification (n=20; 9 did not report using a tool)

3.5 How patients with FH are currently identified

Responding practices listed the ways in which patients with FH are currently identified, with 13 practices listing more than one way (note that the first four points below were listed in the survey for respondents to select). These included:

- Ad hoc appointments and blood tests: 16 practices
- New patient checks/health checks: 13 practices
- Routine medication reviews: 10 practices
- Cascade testing from other family members: 7 practices
- Audit or running audit lists: 2 practices
- NHS Health Checks: 1 practice

(Note that some practices may have interpreted the first option ("New patient checks/health checks") to include NHS Health checks.)

[6] https://www.eclipselive.org/

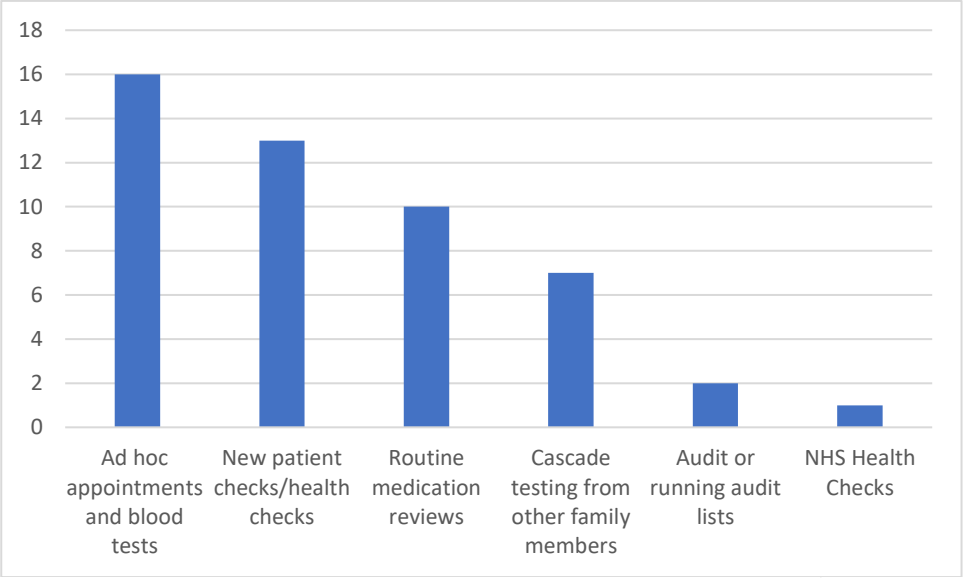


Figure 10: Practice method for the identification of patients with familial hypercholesterolemia (n=20)

Practices were also asked who delivered any bespoke clinics if detection of FH was through bespoke clinics. In response, two mentioned a Pharmacist (one provided no further detail, the other referred to audit), one mentioned the Practice Nurse (likely to relate to the new patient checks/health checks which are provided by that practice), and seven responded that the question was not applicable to their practice.

3.6 How patients treated with statins for prevention of CVD are currently managed

For patients treated with statins for **primary prevention** of cardiovascular disease, practices identified the routes through which this was managed, with eight practices listing more than one route (all listed in the survey for respondents to choose from), including:

- Annual medication review only if requesting repeat prescriptions: 11 practices
- Annual review, whether taking medication or not: 9 practices
- Ad hoc appointments and blood tests for example when attending for another issue: 7 practices
- Bespoke lipid management clinics or cardiovascular disease management clinics: 3 practices

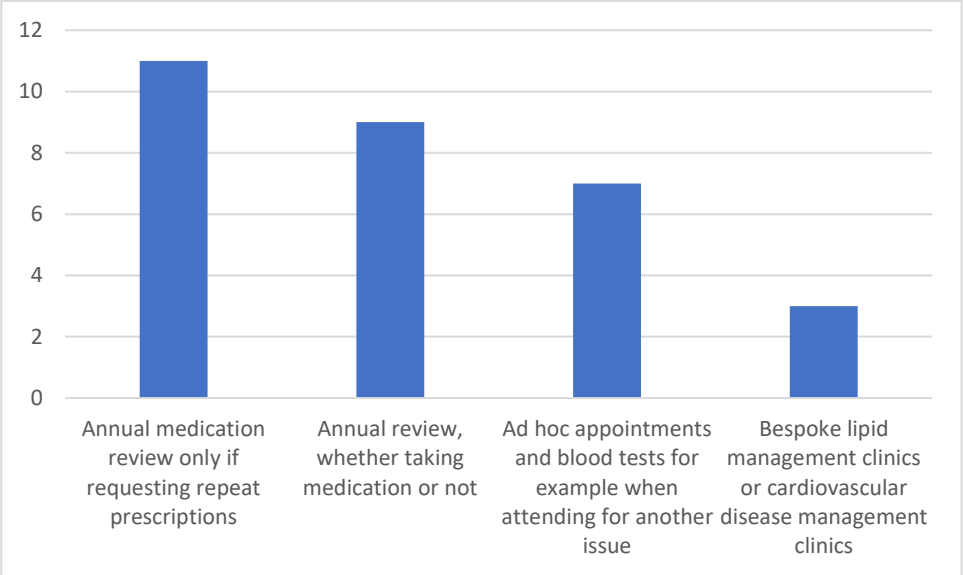


Figure 11: Practice management of patients treated with statins for primary prevention of cardiovascular disease (n=20)

When asked who delivered any bespoke clinics for this purpose, one mentioned the Practice Nurse, one mentioned a Pharmacist, one mentioned both a Pharmacist and a GP, and six reported that this was not applicable to their practice.

For patients treated with statins for **secondary prevention** of cardiovascular disease, practices identified the routes through which this was managed, with five practices listing more than one route (all listed in the survey for respondents to choose from), including:

- Annual review, whether taking medication or not: 13 practices
- Annual medication review only if requesting repeat prescriptions: 5 practices
- Ad hoc appointments and blood tests for example when attending for another issue: 4 practices
- Bespoke lipid management clinics or cardiovascular disease management clinics: 3 practices

One practice also reported providing this service through cardiovascular or hypertension reviews (as well as though annual reviews (whether taking medication or not) and through ad hoc appointments and blood tests.

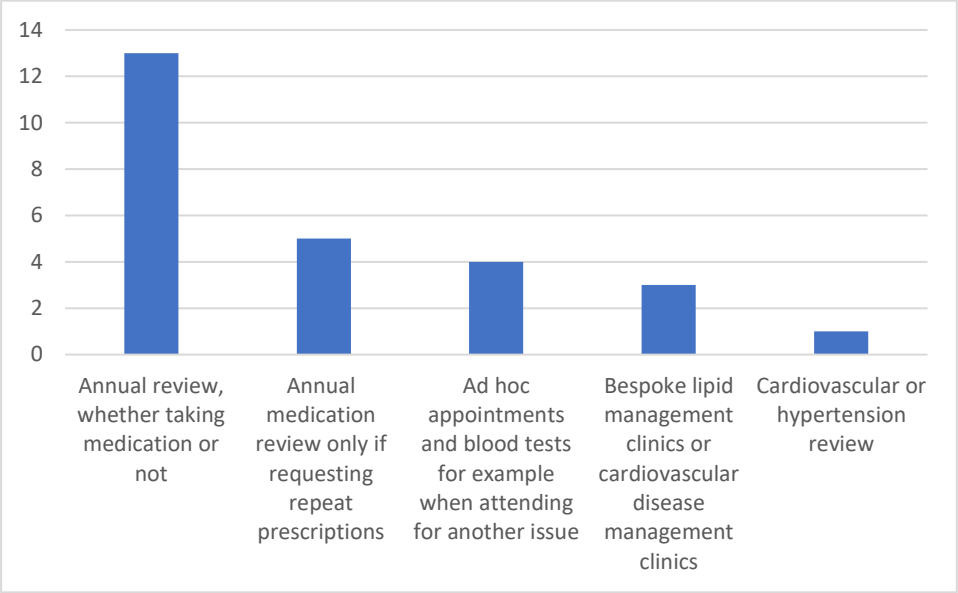


Figure 12: Practice management of patients treated with statins for secondary prevention of cardiovascular disease (n=20)

When asked who delivered any bespoke clinics for this purpose, three mentioned the Practice Nurse, two mentioned both a Pharmacist and a GP, and four reported that this was not applicable to their practice.

3.7 Other comments from practices on support that would be helpful

There were four further comments regarding what support might be helpful for the practice in terms of lipid management and FH identification. Three of these related to capacity within primary care:

> *"We remain capacity constrained through inability to recruit GPs or Practice Nurses. The new lipid pathways are a lot of additional work which is not really offset by the PCN staff nor local arrangements."*

> *"Feel if we are expecting more clinic and F2F review, need a massive increase in estates investment and extra admin and clinical staff."*

> *"Feel overwhelmed by numbers of unidentified patients who would benefit from statins for primary prevention especially those hidden patients at higher risk due to underlying risk factors eg poverty, poor diet, etc"*

One practice highlighted a need for support regarding patients seeking inclisiran:

> *"Patients are seeking Inclisiran and practice would very much appreciate support in this area."*

One practice suggested that a single holistic review would be easier for patients than multiple clinics:

> *"Also patients struggle with multiple bespoke clinics, preferring a 'one stop' holistic review"*

3.8 Written protocols or pathway for management of lipids and/or FH identification

Of the 20 practices that responded:

- 3 had written pathways or protocols for both FH identification and lipid management (one updated in 2022; one being updated this year following new guidance; the update date not stated for the third practice which reported that the protocol was part of the bespoke SystmOne template that they use)
- 1 had written pathways/protocols for lipid management only (not for FH identification), and this had been updated 12 months earlier
- 14 reported not having written pathways/protocols for FH identification or lipid management

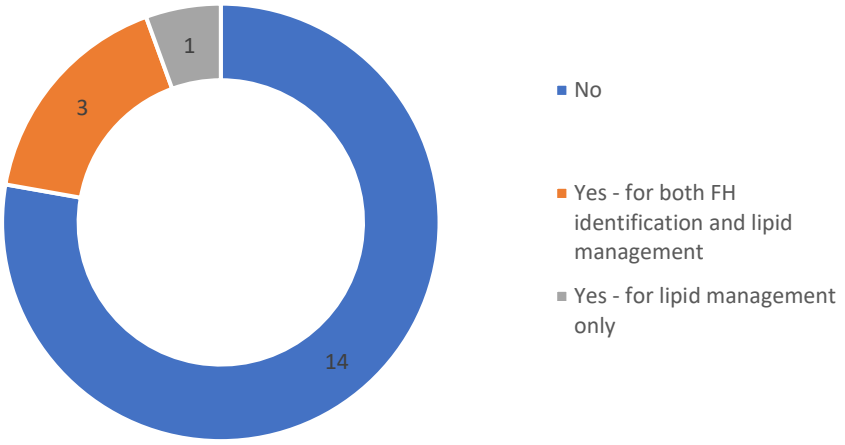


Figure 13: Number of practices with protocols or pathway for management of lipids and/or familial hypercholesterolemia identification (n=18, 2 did not respond to this question)

3.9 Current clinical priority areas for the practice

Of the 20 practices that responded, most listed a combination of clinical priority areas that had been listed in the survey, including:

- Blood pressure: 19 practices
- Diabetes: 19 practices
- Asthma: 15 practices
- COPD: 14 practices

- Atrial Fibrillation: 14 practices
- Lipid management: 14 practices

Three of the practices reported additional clinical priority areas: one practice listed epilepsy and mental health, one listed heart failure, and one listed "Medicine." In addition, one reported that

"overwhelming acute work means capacity extremely limited".

This practice only listed diabetes as their clinical priority area.

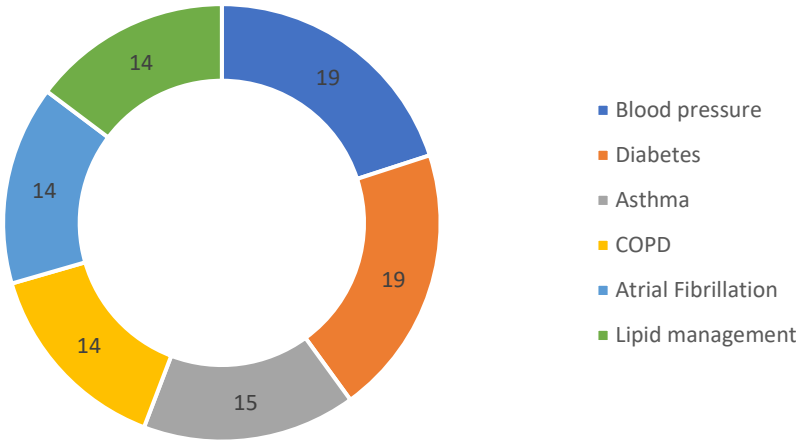


Figure 14: Current clinical areas of priority (n=20) (in addition, 1 practice mentioned epilepsy and mental health, one mentioned heart failure, and one mentioned "Medicine")

4 Summary and discussion

Although the response rate was relatively low, this survey provided useful insights into the implementation of the updated FH identification and lipid management pathway and related NHS England PCN requirements. It illustrates the range of levels of implementation in practices, some of the difficulties encountered, how tools are currently being used to support FH identification and lipid management, as well as how useful the tools are and how they could be improved.

In summary, 20 practices in the East of England responded to the survey. The majority of respondents were GPs, followed by Practice Managers. Roughly half of the practices have a CVD lead for the practice, usually a GP. Practices reported having multiple clinical priority areas, with the most common being blood pressure and diabetes (19 practices each), and 15 of the 20 reported that lipid management was one of their clinical priorities. It is not clear to what extent the 20 responding practices are representative of GP practices across the East of England.

Primary care awareness of updated pathway requirements. 12 of the 20 respondents were aware of the new pathway, and among these, four had made changes and five planned to make changes to their practice pathways, including a range of different types of changes. In relation to the new PCN requirements, 16 of the practices were already or were planning to offer statin treatment according to the new requirements, and 11 were already implementing or planned to implement the FH identification requirement. However, the practices that responded may be practices that are more aware of and/or more engaged in FH identification and lipid management than non-responding practices.

Tools to support FH identification and lipid management. Six practices reported using the Ardens tool to support this work, three of which reported that it was very helpful/very good. Three used it to generate lists, while two used it for decision support. Suggestions for improvement included having a more obvious maximum tolerated therapy code, and having the ability to text information to patients and to provide electronic self reviews. Three practices used QRISK, one to generate lists and two for decision report (both reported the tool being very helpful for this). Comments included that QRISK "under estimates" (no further details provided), and that there is functionality missing relating to younger patients. One practice used Eclipse Live and one used templates and System One searches. None reported using the CDRC tool.

Identification of patients with FH. Practices reported using combinations of different ways to identify patients with FH, including new patient checks, health checks, ad hoc, routine medication reviews and cascade testing.

Lipid management. Management of statins for prevention of CVD was similarly through a combination or routes, particularly medication reviews, annual reviews and ad hoc appointments.

Protocols. Only three practices had written pathways or protocols for both FH identification and lipid management and one practice had a protocol for lipid management only.

Capacity and other issues/suggestions. There were a number of comments relating to capacity issues in primary care that make this work difficult. One practice also highlighted a need for support with patients seeking inclisiran, and one practice suggested that a 'one stop' holistic review , rather than multiple bespoke clinics, would be preferable to patients

5 Appendix 1 – Survey questions

Below is a copy of the survey that was distributed to practices for completion.

Survey to understand primary care adoption of new NICE-approved lipid management pathway

New NHS England service requirements for PCNs commenced this year for the management of lipids and identification of familial hypercholesterolaemia (FH). In addition, the updated NICE-approved lipid management pathway was launched December in 2021.

Eastern Academic Health Science Network (AHSN) is responsible for supporting the adoption of this pathway across the East of England.

This survey will help us to understand and develop support for local practices with this. Any information you are able to provide will help. We understand that you are busy - please submit a response even if you are only able to answer some of the brief questions.

This survey should take no more than 10 minutes to complete.
The survey is open until 9am on the 11th July 2022.

Please note that data collected will not be used to assess performance and no patient identifiable data should be provided.

Thank you for taking the time to complete this survey. If you have any questions or would like further information about this work, please contact xxx.

Section 1: Introductory Details

1) In which CCG is your practice located?
Please leave blank if you prefer

2) What is your role in the practice?
Please tick more than one option if appropriate
- Cardiovascular disease lead for the practice
- General Practitioner
- GPSi Cardiology
- Health Care Assistant
- Nurse
- Patient Co-ordinator
- Pharmacist
- Practice Manager
- Other [free text box]

3) Does your practice have a cardiovascular disease lead?

Please tick more than one option if appropriate

- Yes - GP
- Yes – Pharmacist
- Yes – Practice Nurse
- No
- Other [free text box]

Section 2: Awareness and Implementation of New Lipid Management Guidance

4) Are you aware of the new lipid management pathway and guidance? https://www.england.nhs.uk/aac/publication/summary-of-national-guidance-for-lipid-management/

- Yes
- No

5) Did your practice make any changes to lipid management and FH identification pathways in your practice after the new pathway was published?

- Yes – changes made
- No – but changes planned
- No

6) If yes or planned, what changes did you make or are you planning to make?

7) Are you implementing the following new NHS England PCN service requirements?
"Offer statin treatment to patients with a QRISK2&3 score >= 10%"
"Identify patients at high risk of Familial Hypercholesterolaemia."
https://www.england.nhs.uk/wp-content/uploads/2021/08/B0828-ii-annex-a-pcn-plans-for-21-22-and-22-23.pdf

	Yes – already made changes	Yes – changes planned	No – not considered yet	No - decided not to implement at present
Offer statin treatment to patients with a QRISK2&3 score >= 10%				
Identify patients at high risk of Familial Hypercholesterolaemia.				

8) If statin treatment or FH identification changed, what changes have you made or are you planning to make?

9) If there are no changes or planned changes to statin treatment or FH identification, what is the reason and is any support needed?

Section 3: Tools to assist lipid management & FH identification

10) Do you use a tool to assist with lipid management/FH identification? This may include templates/forms/questionnaires/checklists/ decision support systems or any other type of tool (e.g. CDRC, Ardens, FamCat 2, UCLP, Custom searches, Eclipse Live).
- Yes
- No

11) What tools do you use to assist lipid management/FH identification? Please name the tool(s).

12) What do you use this tool for (e.g. to generate patient lists, decision support etc.)?

13) How helpful is it?

14) What functionality is missing?

Section 4: FH Patient Management

15) How are patients with FH currently identified in your practice?
Please tick all that apply
- During routine medication reviews
- During new patient checks/health checks
- Through ad hoc appointments and blood tests
- Cascade testing from other family members
- Through bespoke lipid management clinics or cardiovascular prevention clinics
- Other [free text box]

16) If through bespoke clinics, who runs the clinics?
Please tick all that apply
- Pharmacist
- GP
- Practice Nurse
- Not applicable
- Other [free text box]

17) How are patients who are treated with statins for primary prevention of cardiovascular disease currently managed in your practice?
Please tick all that apply
- Five-yearly review, whether taking medication or not
- Annual review, whether taking medication or not
- Annual medication review only if requesting repeat prescriptions
- Through ad hoc appointments and blood tests for example when attending for another issue
- Through bespoke lipid management clinics or cardiovascular disease management clinics
- Other [free text box]

18) If through bespoke clinics, who runs the clinics?

Please tick all that apply

- Pharmacist
- GP
- Practice Nurse
- Not applicable
- Other [free text box]

19) How are patients who are treated with statins for secondary prevention of cardiovascular disease currently managed in your practice?
Please tick all that apply

- Five-yearly review, whether taking medication or not
- Annual review, whether taking medication or not
- Annual medication review only if requesting repeat prescriptions
- Through ad hoc appointments and blood tests for example when attending for another issue
- Through bespoke lipid management clinics or cardiovascular disease management clinics
- Other [free text box]

20) If through bespoke clinics, who runs the clinics?
Please tick all that apply

- Pharmacist
- GP
- Practice Nurse
- Not applicable
- Other [free text box]

Section 5: Additional Comments

21) Please describe any other information about your practice's use of the current pathway for lipid management/ FH identification or the new PCN requirements that may assist in understanding what support might be helpful for your practice.

22) What are your practice's current clinical priority areas?
Please tick all that apply

- *Blood pressure*
- *Diabetes*
- *Lipid management*
- *Atrial* Fibrillation
- *COPD*
- *Asthma*
- *Other*

23) Does your practice have a written protocol or pathway for management of lipids and/or for FH identification?
If yes, if you are able to, please could you email it to xxx

- Yes - for lipid management only
- Yes - for FH identification and referral only
- Yes - for both FH identification and lipid management

- No

24) If yes, please say when it was last updated (approximately).

Thank you for completing this questionnaire. We will use the information received from practices to improve support to practices in this important clinical area.

If you have any questions about the survey or work in this area, please contact xxx

Further details can be found at https://www.easternahsn.org/about-us/our-projects/cardiovascular-disease-cvd/