SHIPLEY MEDICAL PRACTICE, for and on behalf of the Affinity Care Primary Care Network

SHIPLEY MEDICAL PRACTICE, for and on behalf of the Affinity Care Primary Care Network - Executive Summary

Project Name: Pharmacist-led ASCVD and Lipid PC Model of Care with Affinity Care Primary Care Network – Collaborative Working Project

Project Summary:

The main objective of the Project is to improve the quality of care for patients and support the early identification, review, and medical optimisation of patients with Atherosclerotic Cardiovascular Disease (ASCVD) in response to the needs of the PCN.

The service will be pharmacist led and focus on timely identification of patients with ASCVD including full management reviews and treatment option discussions aiming to achieve:

1. Identification of sub-optimally treated patients who are not achieving recommended targets for lipid management

2. Identification of patients who have previously not tolerated or refused alternative lipid modification therapies

3. Review treatment options in a consultative way with patients

4. Counsel and optimise patients where appropriate

Planned Milestones:

1. Collection of baseline data, in line with the measure of success
2. Confirmation of workforce recruitment
3. Collection of 3 months clinical activity data
4. Collection of 6 months clinical activity data
5. Collection of 9 months clinical activity data
6. Collection of 12 months clinical activity data
7. Development of business case
8. Analysis of project data, and submission of Final Project Report

Expected Benefits:

Anticipated benefits for patients:

- Improved access to lipid management care leading to optimal diagnosis and management of ASCVD treatments.
- Enhanced experience and counselling around ASCVD with ongoing management of the condition.
- Improved access to appropriate medication for suitable patients to preserve health and prevent long-term events
- Easier access to lipid management care closer to home in the PCN setting
- The additional capacity will provide additional time and support from PCN HCP with their lipid management, focusing on patients who may have previously not attended GP appointment or been lost to follow-up. Thus, levelling health inequalities within the PCN

Anticipated benefits for partner organisation:

- Increased proportion of ASCVD patients reviewed by primary care
- Increased proportion of ASCVD patients receiving expert and timely review closer to home
- Reduction in ASCVD referral rates to secondary care
- Increased proportion of patients receiving guideline-directed pharmacotherapy
- Insight into benefits of primary care pharmacist led lipid management clinics in primary care and demonstration of benefit via development of business case for substantive funding
- Support aligned to NHS Long Term Plan, CDVPREVENT, and Network Contract DES

Anticipated benefits for Novartis:

- Insight on the appropriate use of ASCVD licensed medicines in line with NICE guidelines, including Novartis's medicine
- Enhanced reputation, and supporting Novartis' vision that no patient should have to wait for an extraordinary life by supporting high quality Collaborative Working with the NHS which addresses the problem of health inequalities
- Ethical, professional, and transparent relationship between Novartis and the NHS

Start Date & Duration: July 2022 – 13 months

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SHIPLEY MEDICAL PRACTICE, for and on behalf of the Affinity Care Primary Care Network - Outcomes Summary

Project Name: Pharmacist-led ASCVD and Lipid PC Model of Care with Affinity Care Primary Care Network – Collaborative Working Project

Partner Orgnasitaion(s): SHIPLEY MEDICAL PRACTICE, for and on behalf of the Affinity Care Primary Care Network

Completion Date: February 2024

Outcome Summary:

The project successfully implemented a local pharmacist-led Lipid strategy/protocol for the identification and management, including medicine optimisation, of patients within a primary care setting. This project delivered on the aim to demonstrate the value of dedicated Pharmacist time spent on proactive lipid management, proven by the adoption of the project work into day-today practice.

Key Project Outcomes Data:

The service achieved the following delivery outcomes:

- In excess of 578 patients were reviewed and optimised in dedicated lipid clinics. Additional patients were also reviewed and optimised in Long-term-condition clinics and CVD clinics.
- 50% reduction in number of patients with ASCVD, Raised Lipids, No statin, from 516 to 256.
- 45% increase in number of patients with ASCVD being proactively managed on therapies beyond statin.
- Reduction in appointment wait times from 8 weeks to 2 weeks.
- 8 PCN pharmacists upskilled to deliver ‘Gold Standard of Lipid Optimisation Care’.

Outcomes:

The outcomes for the project were as follows:

Patients:

- Communication with patients about ‘know your number’ campaign, supporting patient empowerment,
- Expansion of ‘know your number’ campaign into primary prevention patient cohort,
- Focus on non-engaged patients by increasing number of touch-points, allowing patients to be more involved in managing their own healthcare,
- Patients empowered to make informed decisions,
- Increase in number of patients re-engaging with GP Practice, patients feel included in decision making, changed perception of primary care.

Healthcare Professionals and Organisations:

- Place-based model of care now achieved, bringing care ‘Closer to Patients Home’ fully aligned to improving the treatment of patients through in-depth review of services, benchmarking, presenting data driven evidence base to support change.
- Embedding of importance of lipids within proactive multi-morbidity management, team understand that review is not complete until lipid review is completed.
- Pathway now incorporated in day-to-day practice:
    - Developed protocol in system to recognise at filing blood test results proposed actions in Pop-Ups,
    - Incorporation of lipid review and management into multi-morbidity reviews,
- Ensuring lipid profile is included in individual patient plans (link to ‘know your number’ campaign for BP, HF, and Lipids)
- Lowest rate of inappropriate referrals to secondary care within local area.

Conclusion:

The pilot project was a proof of concept for place-based model of care, which is now to be rolled out across Bradford to support the ambition of reduce unwarranted variation in care quality and aligns to strategic imperative of the ICS to reduce of health inequalities.

The legacy of the project is the embedding of project level activity into the day-to-day activity within the PCN. Upskilling of the primary care workforce to proactively and confidently manage ASCVD patients in primary care, has subsequently increased confidence levels of patients to make informed decisions about their own health management and also increased engagement of patient cohorts who may have lost confidence in their local practice.

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