

Evaluation of West Yorkshire (WY) System Transformation Fund (STF) Lipid Optimisation Project

Leeds Teach Hospitals NHS Trust
(LTHT) and West Yorkshire
Integrated Care Board (WYICB)

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Executive Summary

Project Title: West Yorkshire Integrated Care System (WYICS) Lipid Optimisation Clinical Network

Project Aims:

1. Set up a WY ICS Lipid Optimisation Clinical Taskforce (LOCT).
2. Set up a WY ICS virtual lipid optimisation clinical multidisciplinary team (MDT).
3. Increase capacity in primary care to manage lipid optimisation, especially for patients from the targeted most deprived PCNs.
4. Improving referrals of patients initiated on lipid-lowering therapy for community pharmacies' new medicines service (NMS).

Highlights:

- WY LOCT has now been established under the WY Long Term Condition and Personalised Care Programme and is meeting regularly every 2 months.
- According to CVDPprevent CVDP007CHOL indicator, for West Yorkshire, the percentage of patients with cardiovascular disease (CVD) treated to lipid target increased from 25.9% in Sep'22 to 35.2% in December'23 (9.3% improvement).
- In most deprived areas for each sub-ICB, there were increase in performance for this CVDPprevent metric in the same period.
 - Leeds: 7.97% improvement
 - Bradford: 9.24% improvement
 - Wakefield: 9.45% improvement
 - Calderdale: 9.15% improvement
 - Kirklees: 5.53% improvement
- According to GP data, proportion of patients with CVD and no lipid lowering therapies (LLT) dropped from 14% (Mar'23) to 10% (May'24) in participating PCNs; this reduction was higher than that achieved across the whole ICB where it dropped from 15% (Mar'23) to 12% (May'24).
- 100% (n=13) strongly agreed/agreed that their PCN started routinely and proactively optimising patient lipids.
- Excellent MDT service feedback, with an average rating of 4.78 out of 5, with 5 being "most valuable".
- 92% (12/13) would like to see A&G support to continue from secondary care for lipid optimisation.

Summary:

The integrated lipid MDT has successfully brought care closer to home for our patients with CVD in most deprived PCNs, providing primary care clinicians with direct access to specialist support for lipid optimisation. This project has upskilled primary care in their knowledge and confidence around prescribing of new lipid drugs and embedded transformative change in how PCN improve lipid management. The project acted as a catalyst to bring clinicians and leaders from different health and social care sectors together as a taskforce, to drive improvement for lipid optimisation across West Yorkshire.



Introduction

This project was funded by NHS England through the System Transformation Fund (STF) for lipid optimisation. It was a collaborative project with Leeds Teaching Hospitals NHS Trust (LTHT) to improve lipid optimisation targets for patients with cardiovascular disease (CVD) in West Yorkshire (WY), specifically targeting patients living in the most deprived Primary Care Network (PCN) areas. The project set up a WY Lipid Optimisation Clinical Taskforce (LOCT) network, delivered 4 lipid webinars and upskilled the primary care workforce of targeted PCNs through an integrated lipid MDT service.

This evaluation is being done because NHS England has requested it and to inform future funding decisions for the continuation or expansion of the virtual lipid MDT service.

The report will start by providing a brief background to the service, followed by evaluation questions and key lines of enquiry, our evaluation methods and finally sharing our findings.

This evaluation was completed by Pei-Theng Aizlewood, Mohammad Fazlee, Julia Faulkner, Rizwana Anwar and Samiullah Choudhry (West Yorkshire Integrated Care Board), Alia Awni, Harpal Ryatt, Eunice Ikongo, Abigail Barrowcliff and Rani Khatib (LTHT).

Service background

The integrated lipid MDT service was provided by LTHT from September 2023 to July 2024. It was a full-time service resourced by advanced pharmacists from primary care specialising in lipid optimisation (0.5WTE of band 8a pharmacist), a specialist cardiology nurse (0.5WTE of specialist nurse); with direct support from advanced pharmacist and consultant pharmacist in cardiology and cardiologists/lipidologists from LTHT.

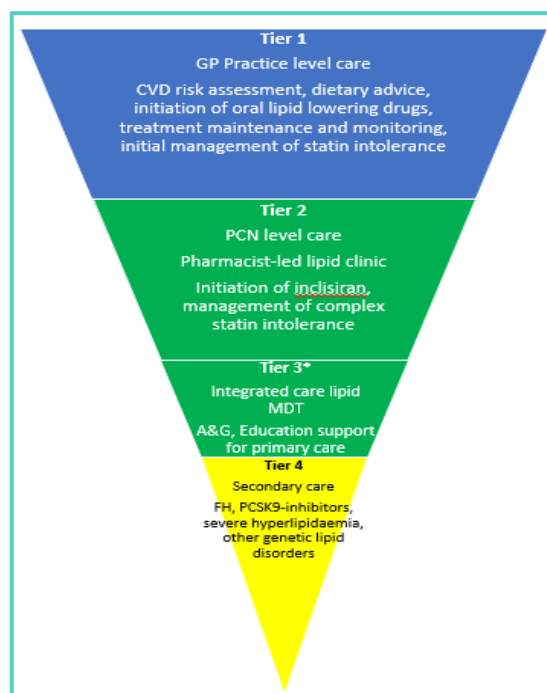
The service users of the integrated lipid MDT were PCNs and a practice workforce of 16 participating PCNs across all 5 places of WYICS (Leeds, Bradford, Calderdale, Kirklees & Wakefield). The 16 PCNs are listed in Table 1 below. York Road PCN was invited to participate but pulled out in December 2023 due to capacity issue. Between April to July 2024, this service was extended to 4 new PCNs but their data had not been included in the evaluation.

PCNs	Place in WYICS
BRADFORD CITY 4 PCN	Bradford
BD4+ PCN	Bradford
THE FIVE PARKS PCN (was previously known as PCN7)	Bradford
BRADFORD NORTH WEST PCN	Bradford
FIVE LANE ENDS PCN	Bradford
BURMANTOFTS, HAREHILLS & RICHMOND HILL PCN (BHR)	Leeds
BEESTON PCN	Leeds



SEACROFT PCN	Leeds
MIDDLETON AND HUNSLET PCN	Leeds
BRAMLEY, WORTLEY & MIDDLETON PCN (BWM)	Leeds
NORTH HALIFAX PCN	Calderdale
DEWSBURY & THORNHILL PCN	Kirklees
WAKEFIELD NORTH PCN	Wakefield
CENTRAL HALIFAX PCN	Calderdale
WAKEFIELD HEALTH ALLIANCE SOUTH PCN	Wakefield
VIADUCT CARE PCN	Kirklees
CHAPELTOWN PCN (Extension)	Leeds
LOWER VALLEY PCN (Extension)	Calderdale
NORTH BRADFORD PCN (Extension)	Bradford
PONTEFRACT AND KNOTTINGLEY PCN (Extension)	Kirklees

Table 1: List of Participating PCNs



These PCNs were from areas with the most deprived Index Multiple Deprivation (IMD) score of 1. CVDPrevent Data in June 2022 shows that West Yorkshire Health and Care Partnership had the lowest percentage of lipid optimisation among patients with CVD compared to others in the region. Health inequalities existed where the most deprived areas had a higher prevalence of poor lipid optimisation. Participating PCNs were given a small amount of funding (£1,614 per PCN) to support this transformation work and had direct access to advice and guidance (A&G) from integrated lipid MDT on lipid queries. Once a month, the integrated lipid MDT set up a 1-hour virtual discussion session for clinicians of participating PCNs to attend and discuss patient cases. Diagram 1 showed the tiered level of care we developed for our lipid pathway in this project.

Diagram 1: Tiered level of approach for lipid pathway across primary and secondary care



With the support of Yorkshire and Humber Health Innovation Network, the service also delivered 4 lipid webinars for everyone across WY based on learning needs identified through learning needs assessment (LNA) done by participating PCNs.

WY LOCT was set up because there was no forum at the WY level to discuss the lipid agenda. The membership consisted of CVD specialists or healthcare professionals with a special interest in CVD or lipids from secondary care and primary care as well as Voluntary, Community and Social Enterprises (VCSE) representatives from each place. They met bi-monthly to share learnings and work together to drive lipid optimisation across the 5 places in WYICS through the mapping of lipid services and standardisation of lipid guidance. The nominated chair of WYLOCT is a consultant pharmacist in cardiology from LTHT.

The total cost of the project was £131,527, with £25,836 given to participating PCNs and the remaining £105,691 given to LTHT cardiology service to provide the virtual lipid MDT service and support primary care in WY to improve lipid optimisation.

Diagram 2 below shows the project delivery timeline.

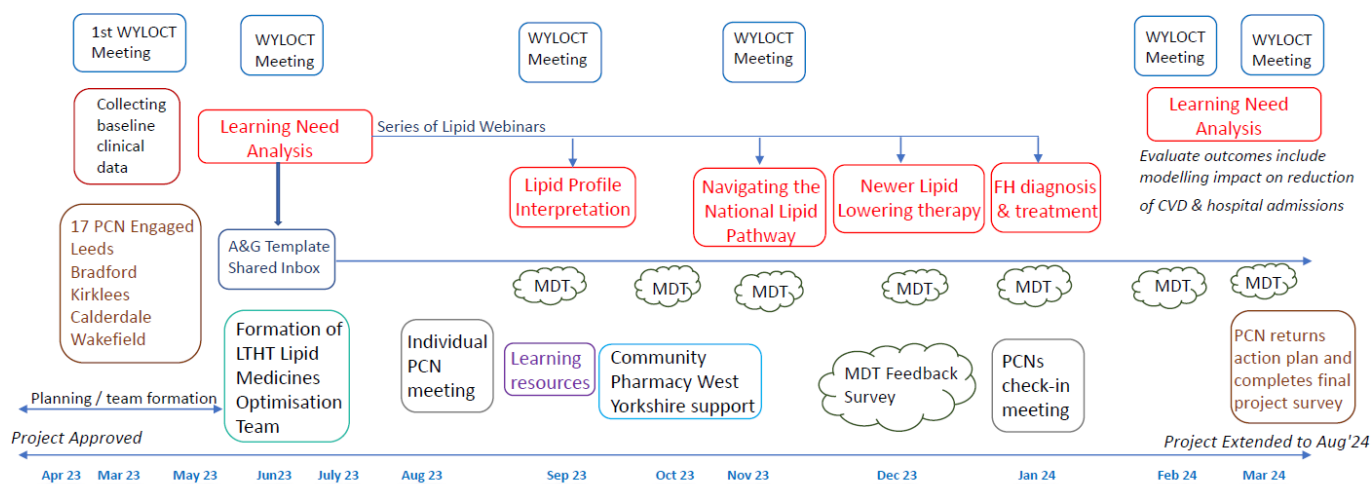


Diagram 2: STF Project Delivery Timeline



Evaluation questions and key lines of enquiry

The evaluation questions were developed in line with our project aims, which were agreed with NHSE.

Evaluation Question	Key Lines of Enquiry
<p>1. The service has upskilled the primary care workforce and increased their confidence to provide optimal lipid management in practice by the service.</p>	<ul style="list-style-type: none"> - Number of patients with optimised lipid levels - Attendees and feedback from training webinars - Levels of confidence and knowledge in lipid optimisation before and after the project. - Confidence of prescribers around the different lipid-lowering therapies (LLTs).
<p>2. The service has improved access to NICE-approved new lipid-lowering therapies in primary care.</p>	<ul style="list-style-type: none"> - Levels of prescribing for each step of the national lipid pathway. - Uptake of inclisiran and bempedoic in participating PCNs
<p>3. The service has improved the outcome of patients with CVD by bringing care closer to home and making it easier for primary care clinicians to access secondary care specialists' advice.</p>	<ul style="list-style-type: none"> - Number of A&G referral cases - Number of virtual lipid MDT sessions and cases discussed - Common A&G themes - Patient outcomes from patients referred to Integrated Lipid Service - MDT feedback survey
<p>4. There is reduced variation in lipid optimisation care across West Yorkshire.</p>	<ul style="list-style-type: none"> - Treatment gap between most deprived and least deprived PCNs - Difference in performance value for lipid-optimised patients with CVD in all 5 places across WY
<p>5. There is a sustainable system transformation and joint working across WYICS.</p>	<ul style="list-style-type: none"> - Impact on PCNs - Membership and output from LOCT - Number of NMS uptake in targeted PCNs



Evaluation methods

We had a variety of evaluation methods, including qualitative data through feedback and quantitative data through analysis of data collected from GP clinical systems. Below is the list of methods:

Method	Description	Sample size
WY GP Clinical System Data	Clinical system searches to gather information on the targeted patient population to monitor the level of lipid optimisation and uptake of new LLTs. This data report was required by NHS England. The data was collected and analysed quarterly in March 2023, June 2023, September 2023, December 2023, and May 2024. (Appendix 6)	Patients with CVD in WY
Monitoring of A&G and MDT activities	LTHT monitored the number and types of A&G that were referred to their services. (Appendix 5)	72 referrals were received
Learning Needs Assessment (LNA)	The LNA contained structured 24 questions to help identify current competency and confidence in lipid-lowering therapies. The workforce of participating PCNs was encouraged to complete one before and after the project. (Appendix 4)	Pre-project LNA: 46 responses Post-project LNA: 27 responses
MDT Feedback Survey	A survey was shared with service users to gather feedback on the virtual lipid MDT service.	18 responses
PCN Impact Survey	In March 2024, all participating PCNs were invited to complete a survey to assess the impact the project had on their transformation in improving lipid optimisation.	13 out of 16 completed responses
Lipid Webinar Feedback Survey	After each lipid webinar, participants were asked to provide feedback on how useful they found them. (Appendix 1)	53 responses (from all 4 lipid webinars)
Anonymised Patient Outcome from A&G	For patients who had been referred to lipid MDT via A&G, changes in their lipid levels were analysed retrospectively to provide clinical outcome data.	13 patient cases
WY NMS Data	Data provided by Community Pharmacy West Yorkshire (CPWY) on NMS activities reported by community pharmacies in WY. (Appendix 3)	Community Pharmacies (CPs) in WY. PCNs were encouraged to add script notes or use the NMS referral template from CPWY, to make CPs aware a new medicine was being started and thus eligible for the NMS service.



Findings

Evaluation question 1: The service has upskilled the primary care workforce and increased their confidence to provide optimal lipid management in practice by the service.

1.1 Number of Patients with Optimised Lipids Levels

We assumed that by increasing confidence and knowledge of the primary care workforce to provide optimal lipid management, the percentage of patients with optimised lipid levels would increase over time. Table 2 below shows lipid optimisation outcome measures for our participating PCNs, data collected from GP clinical system searches.

Measures for patients with CVD	March'23 (%)	December'23 (%)	May'24 (%)
% with non-optimised lipids	60	59	59
Proportion with no LLT	14	12	10
Inclisiran uptake per patient	0.02	0.3	0.49
Bempedoic acid & ezetimibe uptake per patient	0.02	0.26	0.41

Table 2: Lipid Optimisation Outcome Measures for Participating PCNs

There were 21,310 patients with CVD (60%) from the targeting PCNs with non-optimised lipids (LDL-C > 1.8mmol/L or non-HDL-C > 2.5mmol/L) in March 2023; in December 2023, this reduced to 19,663 (59%). **In comparison to the average change across the ICB, the participating PCNs increased the number of patients optimised by 1 percentage point more than the ICB's average accounting for 333 additional patients optimised.** 'A patient with CVD who has a predicted risk of major vascular events of 45% within the next 10 years, lowering LDL-C level by 1 mmol/L would result in absolute risk reductions of approximately 10%' ([Silverman et al., 2016](#)); equating to a Number Needed to Treat of 10 to prevent 1 major cardiovascular event. Assuming all 333 patients lowered their LDL-C by 1mmol/L, **it could potentially prevent 33 major vascular events** and potentially save £495,000 of CVD events cost over 10 years (cost of CVD event saved £13,000 to £15,000, BMJ Volume 146, Issue 1, June 2023).

At the end the data analysis period in May 2024, 59% of WYICB patients with CVD as well as that of our participating PCNs still had non-optimised lipids. There was 16% reduction (3512 less) in number of patients with non-optimised lipids from participating PCNs. Refer to Appendix 2 for data on individual participating PCNs' number of patients with non-optimised lipids.

There were variations between the PCNs, with Central North Halifax showing the highest reduction of number of patients with non-optimised lipids levels at 20%, followed by Wakefield Health Alliance North PCN at 19% reduction, then North Halifax PCN and Viaduct Care PCN at 15% reduction respectively. There were PCNs with low percentage reduction (lowest being 4%). As it could take at least 3 months for a repeat blood test to demonstrate improvement in lipid level from a new lipid therapy, this could explain the lag in showing a bigger positive impact for these PCNs. Some PCNs also reported challenges implementing these changes in practice due to staff capacity and conflicting priorities, especially over the winter pressure.



Proportion of patients with CVD and no LLT dropped from 14% (Mar'23) to 10% (May'24) in participating PCNs; this reduction was higher than that achieved across the whole ICB where it was 15% in Mar'23 and dropped to 12% in May'24. See Appendix 6 for full evaluation of GP data.

1.2 Webinar Feedback (Appendix 1)

A total of 264 people attended 4 lipid optimisation webinars organised by the project team. The themes of the webinars were designed based on learning gaps identified through the Learning Needs Assessment (LNA) completed by the clinicians from our targeted PCNs. The learning topics covered the national lipid pathway, interpreting lipids and relevant blood tests, deep dive into new LLTs and familial hypercholesterolaemia (FH). The webinars were available for anyone to attend, it was not limited to only our participating PCNs. Refer to Appendix 1 for a breakdown of statistics and details of the webinar feedback. We had 51 responders who completed the feedback survey for all 4 webinars, **on average 93% said the webinars covered their learning needs and they all had a positive impact on their level of knowledge.**

1.3 Levels of confidence and knowledge in lipid optimisation before and after the project including prescribing of lipid-lowering therapies (LLTs)

To evaluate levels of confidence and knowledge before and after participating, responses from the LNA were shown in Chart 1. We aimed to see a shift from left (red/orange) to right (blue/dark blue) in the chart. This shows an improvement in competency, after project participation (advice and guidance responses and attending MDTs and webinars).

Left (shown as red/orange) shows HCPs require a full education programme" or currently have "basic" knowledge on the subject (such as statins or inclisiran).

The right (shown as blue/dark blue) shows that HCP self-declares "confidence" or an "expert" in knowledge of the topic.

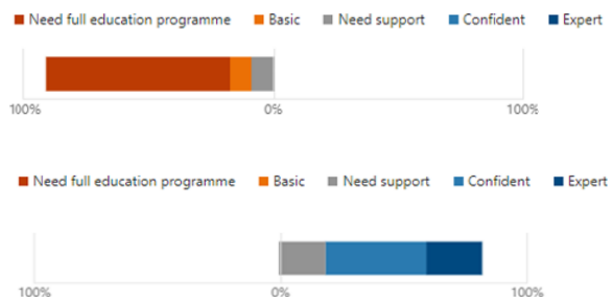


Chart 1: An example of response from LNA

In general, we observed positive increases and shifts from left to right in the use of LLTs, especially statins, ezetimibe, bempedoic acid, and inclisiran. In addition, there was a positive shift in understanding lipid profiles and targets, interpreting secondary causes, when to initiate LLTs in CVD, understanding of FH and an increased awareness of how to navigate the standardised national lipid pathway.

Following the project, the number of individuals requiring a full education program for PCSK9i monoclonal antibodies was reduced by half, and there was an increase in confidence. There was no "Expert" knowledge which may be due to being secondary care drugs and PCNs would not be administering them. Icosapent ethyl saw similar improvements with no "Expert" knowledge. Despite this being included as part of a webinar, there has been no "confidence" shown in responses.



Icosapent ethyl requires patients to be on statins and have a fasting triglyceride above ≥ 1.7 mmol/L and LDL-C between 1.04 and ≤ 2.6 mmol/L. The project focused on LDL-C lipid optimisation and cases usually had LDL-C above 2.6 mmol/L, so there was limited use of icosapent ethyl. Please see the Appendix 4 for the full results.

The common themes for A+G queries can be found in section 3.2. Through analysing the frequency of the A+G themes over time in conjunction with the delivery of webinars and MDT support and following the evaluation of the pre-and post-project LNA analysis, it is evident that there has been a noticeable increase in confidence and utilisation of the national lipid pathway.

Evaluation question 2: The service has improved access to NICE-approved new lipid-lowering therapies in primary care.

Table 3 below shows data collected from participating PCNs on the number of secondary prevention patients prescribed lipid-lowering therapies, who were previously untreated or sub-optimally treated. **According to Table 2 (above) and Table 3, the service has improved levels of prescribing for each step of the national lipid pathway, including uptake of NICE-approved new drugs like inclisiran and bempedoic in participating PCNs.** Compared to initiation of PCSK9-inhibitors, there was evidence of higher uptake of inclisiran and bempedoic acid via population health approach with lipid management remaining predominantly in primary care.

Of the 'in scope' population above, how many i) previously untreated ³ , or ii) sub-optimally treated ⁴ , secondary prevention patients ¹ were:	Apr'23	Dec'23	May'24
prescribed statins?	i) 38 ii) 2790	i) 123 ii) 2897	i) 168 ii) 3123
prescribed high-intensity statins?	i) 372 ii) 9483	i) 842 ii) 11253	i) 1122 ii) 12270
prescribed ezetimibe (monotherapy)?	i) 24 ii) 963	i) 110 ii) 1537	i) 158 ii) 2169
prescribed ezetimibe with bempedoic acid?	i) 1 ii) 17	i) 13 ii) 74	i) 18 ii) 113
prescribed a PCSK9-inhibitor?	i) 0 ii) 0	i) 0 ii) 1	i) 0 ii) 1
prescribed inclisiran?	i) 2 ii) 14	i) 15 ii) 84	i) 20 ii) 136

Table 3: Level of Prescribing for Participating PCNs

There were variations across participating PCNs in improving access to inclisiran. Of the 16 participating PCNs, only 50% of them (n=8) had inclisiran prescribed from their PCN when EPACT2 data was analysed in January 2024. The uptake of inclisiran in participating PCNs was lower than expected.



Evaluation question 3: The service has improved the outcome of patients with CVD by bringing care closer to home and making it easier for primary care clinicians to access secondary care specialists' advice.

3.1 Number of A&G referral cases

The template was designed to support their history-taking and relevant investigations for lipid optimisation/QOF consultations. A completed example was provided to demonstrate the level of detail or information required for an accurate A+G response. To reduce administrative time, patient information could be prepopulated/extracted from patient records using mail merge function. The service had received:

- 72 referrals
- 64 interventions (A+G response)
- 8 referrals were considered inappropriate, as the referring PCN was not enrolled in the STF project or the referral template was incomplete. If the PCN was not involved in the STF project, they were advised to use their local lipid referral pathway. The referrer was asked to complete the missing fields, where the template was incomplete.

Clinicians were invited to join MDT sessions to discuss cases, ask questions to lipid experts or attend for learning. A total of 8 virtual MDT sessions were delivered between September 2023 to June 2024 with 31 cases being discussed. Referrals were broken down into each PCN. The highest referring PCNs were Dewsbury and Thornhill PCN (15 referrals), BHR PCN (13 referrals) and Seacroft PCN (12 referrals). However, 5 of 16 PCNs did not submit any A+G referrals giving an average of 4 referrals per PCN. Please see Appendix 5.

64 A&G to the integrated care lipid team meant potentially saving £19,200 in out-patient hospital appointment costs (at £300 per appointment).

3.2 Common A&G themes

The Table 4 below shows the common themes for A+G queries. This illustrates that in addition to a target cohort for secondary prevention, PCNs utilised the available support to address various queries outside of the target cohort. These queries included topics related to primary prevention and FH patients.

<u>Referral Theme</u>	<u>Number of referrals</u>	<u>Period of occurrence</u>	<u>Comments</u>
Fibrates	3	Throughout project	Low number of referrals, no longer on national pathway guidance, prescribing support provided at MDTs



Deranged liver function tests (LFTs)	5	October 2023 to December 2023	Following productive discussions at MDTs and citing the support provided in the national lipid pathway, there were no further A+G queries regarding abnormal LFTs after December 2023.
Ezetimibe	5	Throughout project	Low number of referrals overall. The support provided at MDTs and webinars, and post-project LNA showed an increase in "confidence" and "expert" knowledge.
High triglycerides (TGs)	5	Sept 2023 to December 2023	Following productive discussions at MDTs and referring to the support on the national lipid pathway, there have been no further inquiries about high triglycerides after December 2023.
Familial Hypercholesterolemia (FH)	6	Sept 2023 to January 2024	Following productive discussions at MDTs, referencing the supporting content on the national lipid pathway and providing an FH webinar in January 2024, there have been no further FH queries after January 2024.
Inclisiran	9	Throughout project	These lipid-lowering therapy queries were covered at MDTs and webinars. The post-project LNAs showed an increase in "confidence" and "expert" knowledge.
Bempedoic acid	10	Throughout project	
Statins	22	Throughout project	

Table 4: A&G Referral Themes



3.3 Patient outcomes from patients referred to Integrated Lipid MDT Service

From a total of 64 interventions, we compared the lipid profiles before referral to the MDT and after the intervention in 13 cases. Of the 13 cases, 10 were secondary prevention patients, 2 were primary prevention and 1 a FH query. A comparison of the pre-and post-intervention lipid profiles for the 13 cases can be seen in Table 5:

Lipid Profile	Average Pre-MDT (mmol/L)	Average Post-MDT (mmol/L)	Reduction
Non-HDL-C	4.6	3.7	20%
LDL-C	3.2	2.5	22%
TGs	3.5	3	14%

Table 5: Pre-and post-intervention lipid profiles for 13 cases followed up by MDT.

We were unable to access this information for all 64 cases as either the patient was not yet due their 3-month post-intervention repeat blood test, had not yet started the recommended treatment, was undergoing beta quantification to check eligibility for inclisiran, was awaiting FH assessment or advised to prioritise diabetic or thyroid control first.

Example patient case studies:

Case 1 – Secondary Prevention

Intervention: Weekly rosuvastatin challenge of statin intolerance titrating up to 20mg weekly dose.

Outcome: See lipid profile below, achieved LDL-C target of less than 1.8mmol/L

Lipid Profile	Pre-MDT (mmol/L)	Post-MDT (mmol/L)	Percentage Change
Non-HDL-C	3.3	2	- 39 %
LDL-C	2.8	1.4	- 50 %
TGs	1.2	1.4	+ 14 %

Case 2 – Secondary Prevention

Intervention: Add inclisiran to atorvastatin 80mg and ezetimibe 10mg.

Outcome: See lipid profile below, achieved LDL-C target of less than 1.8mmol/L

Lipid Profile	Pre-MDT (mmol/L)	Post-MDT (mmol/L)	Percentage Change
Non-HDL-C	3.7	1.9	- 49%
LDL-C	2.6	0.6	- 77 %
TGs	2.9	3	+ 3 %



3.4 MDT Feedback Survey

PCNs were asked to complete an MDT feedback question between November and December 2023. We received a total of 18 responses. This consisted of 5 questions to understand how valuable participants found the MDT, what was going well, areas for improvement and suggestions for the future.

The lipid MDT had excellent feedback from the PCN workforce with a “how valuable are you finding the MDT” rated as 4.78 out of 5, with 5 being “most valuable”. 78% (14/18) of MDT feedback survey respondents rated the MDT sessions most valuable (5 out of 5).

Feedback quotes included:

- *“Sending in cases prior to MDT but also being able to answer questions during the MDT.”*
- *“Learning from others.”*
- *“Case studies were quite interesting and showed how learnings could be applied and put into practice.”*
- *“Thought-provoking with many insights applicable to clinical practice.”*

For areas of improvement, suggestions from responses included:

- *“The template to fill out for the MDT is quite detailed.”*
- *“I just couldn't attend them all due to work commitments.”*
- *“When the person who referred the case is not present, it makes it a bit more difficult to understand to get the full story.”*

In response to the comment on a detailed template, a mail merge feature was introduced to pre-populate patient information into the template, thus reducing the time for the referred to input this data. Details of how to use this feature were circulated to all PCNs in January 2024.

Regarding general attendance and having the referrer present at the MDT to discuss their case, we aimed to provide 4 weeks' notice for when the next MDT will take place and provided a 10-minute time slot over a 1-hour lunchtime session for the referrer to attend and discuss their case. Our intention was to encourage maximum attendance. The day of the MDT meeting usually falls on a Tuesday, which is when most secondary care lipid specialists are available.

Evaluation question 4: There is reduced variation in lipid optimisation care across West Yorkshire.

The project targeted support to PCNs from the most deprived areas of West Yorkshire (WY) with an Index Multiple Deprivation (IMD) score of 1 with an aim to reduce variation and narrow the health inequalities gap. According to the latest CVDPrevent Data, the CVDP007CHOL indicator measured the percentage of patients aged 18 and over with CVD, in whom the most recent blood cholesterol level was non-HDL cholesterol less than 2.5mmol/l or LDL-cholesterol less than 1.8mmol/l, was 35.2% in December 2023, increased from 25.9% in September 2022 for whole of WY; the difference between most deprived and least deprived deciles narrowed very slightly from 3.97 (September 2022) to 3.74 (December 2023).

In December 2023, Wakefield sub-ICB value of 36.87% was the highest for this CVDP007CHOL metric, followed by Bradford District and Craven sub-ICB at 35.31%, Kirklees sub-ICB at 35.23%, Leeds at 34.77% and the Calderdale sub-ICB value of 33.25% was the lowest. However, Diagram 3 below showed



Wakefield sub-ICB had the greatest gap between the most and least deprived quintiles, and Bradford District and Craven sub-ICB the smallest.

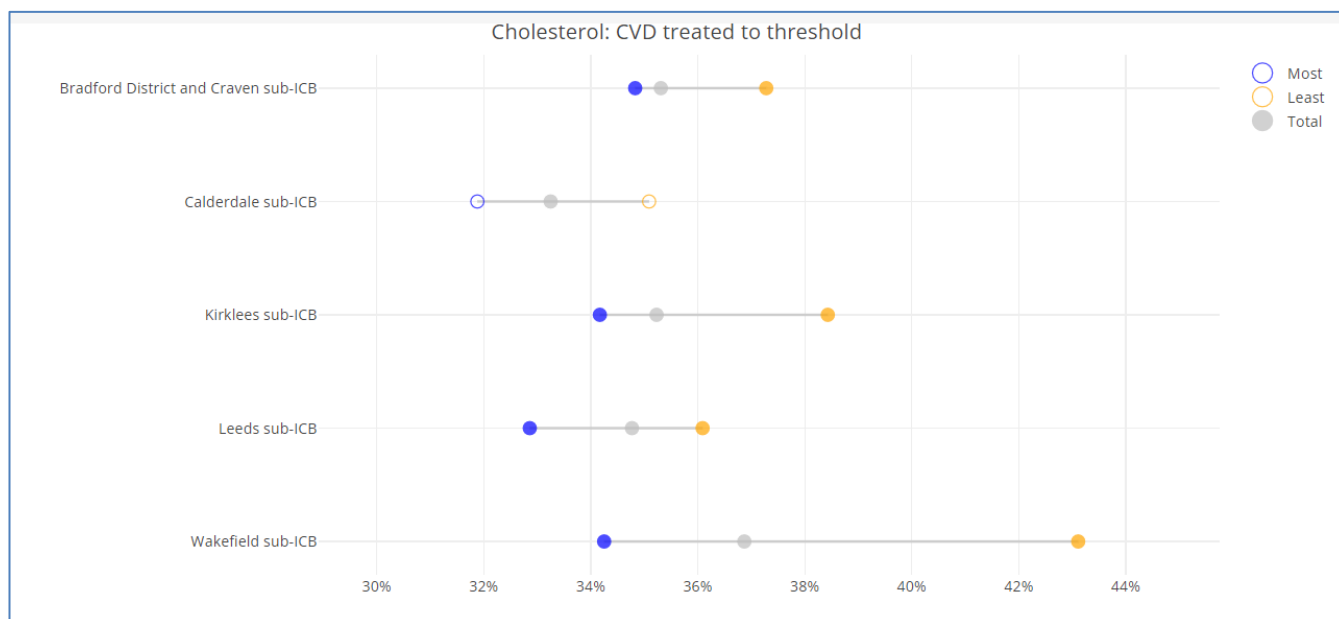


Diagram 3: CVDP007CHOL Inequalities Data (For each sub-ICB location on the dumbbell chart, the performance for patients from the most deprived deprivation quintile was represented by the blue dot, patients from the least deprived quintile by the orange dot, and overall performance by the grey dot.)

Looking at CVDP007CHOL metric for most deprived areas in each sub-ICB, for period between September 2022 and December 2023: Leeds increased from 24.89% to 32.86%, Bradford increased from 25.59% to 34.83%, Wakefield increased from 24.80% to 34.25%, Calderdale increased from 22.73% to 31.88% and Kirklees increased from 28.64% to 34.17%. **This project working across WY had successfully narrowed the gap between different sub-ICBs.** As seen from Diagram 4 below, the gap between the highest value sub-ICB and lowest sub-ICB had narrowed from September 2022 to December 2023.

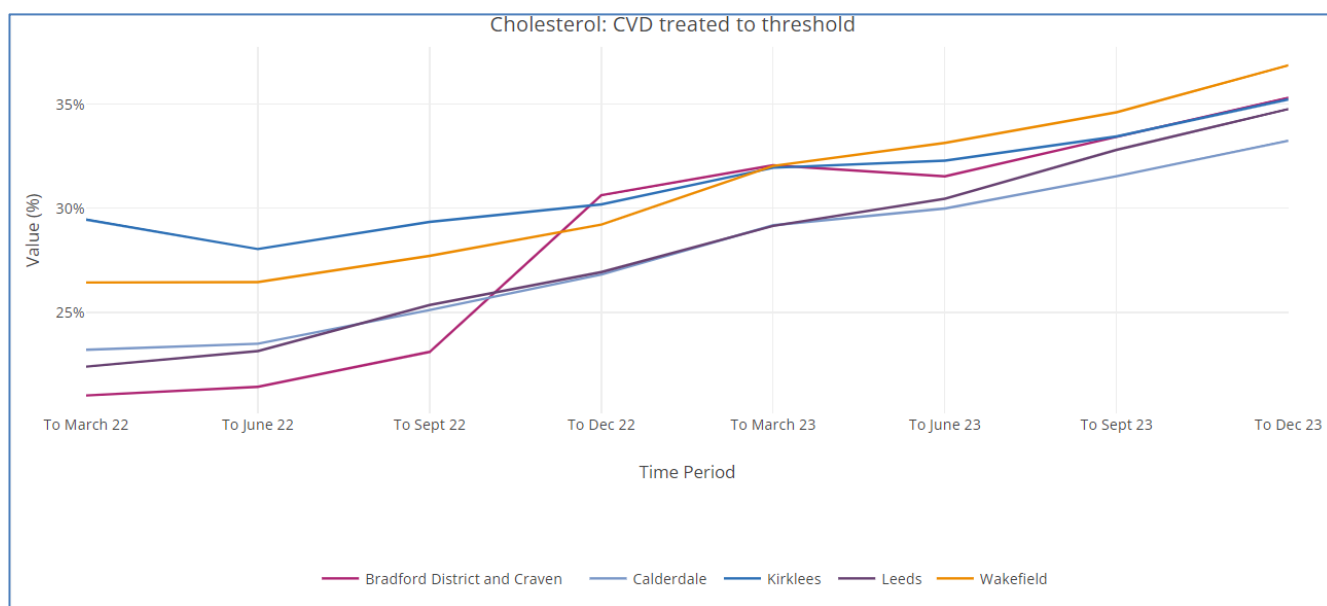


Diagram 4: Changes Over Time for Sub-ICBs in West Yorkshire in their CVDP007CHOL Indicator Value.



Evaluation question 5: There is a sustainable system transformation and joint working across WYICS.

5.1 Impact on PCNs

All 16 participating PCNs were invited to complete a PCN impact survey between March and May 2024 designed by the project team to evaluate the impact of this project on PCNs to improve lipid management. 13 PCNs completed the survey. Results of the survey:

- 85% (n=11) strongly agreed/agreed that their PCN and practice workforce were upskilled to utilise the full lipid pathway. The remaining PCNs reported slight progress was made.
- 100% (n=13) strongly agreed/agreed that their PCN and practice workforce were more confident managing statin intolerance.
- 100% (n=13) strongly agreed/agreed that their PCN started routinely and proactively optimising patient lipids. 5 PCNs had set up a lipid clinic, 3 PCNs reported practices undertaking lipid management as part of the annual CVD review and 2 PCNs had reported the use of PCN clinical pharmacists to support with lipid optimisation.
- 31% (n=4) strongly agreed/agreed that their PCN routinely initiates inclisiran.
- 46% (n=6) strongly agreed/agreed that their PCN had created extra phlebotomy capacity to manage increased lipid blood tests.
- 77% (n=10) strongly agreed/agreed that their PCN proactively signpost patients to community pharmacy for New Medicines Service
- 92% (n=12) would like to see A&G support to continue from secondary care for lipid optimisation. The 1 PCN that did not agree explained that they would like to see our integrated MDT and A&G approach continue, but not the traditional A&G referral to cardiology that would take a long time.

There was good evidence from the result of the survey to demonstrate the positive impact the project and virtual lipid MDT service had on transformation change in PCNs to improve lipid optimisation.

5.2 Joint System Working

The WY LOCT network had 43 registered members in the first year of formation (April 2023 to March 2024). The membership consisted of clinicians (doctors, nurses and pharmacists) from primary, secondary care and community care, public health teams and programme managers from all 5 places of the WYICS. WY LOCT met every 2 months to support the lipid optimisation agenda for WY. Examples of topics discussed were mapping of lipid pathway and lipid services in WY, development of WY Inclisiran FAQ and harmonisation of lipid guidance to recommend for use across WY.

From April 2024 onwards, **WY LOCT has been embedded within the WYICB Long Term Condition and Personalised Care Programme, to continue supporting the system to work together and meet the national and local priorities for lipid optimisation.**

We worked with Community Pharmacy West Yorkshire (CPWY) to raise awareness of the project with community pharmacies in the targeted PCNs. This is to ensure when patients were referred to the community pharmacies for NMS on their new lipid-lowering therapy, the referrals would be



welcomed and accepted. PCNs were also advised by CPWY on how to increase the success rate of referrals by using resources like referral letters developed by CPWY. The table in Appendix 3 shows NMS data tracked by CPWY. We were unable to breakdown the data into which class of drug the NMS were for, but apart from a slight decrease observed in one PCN (Viaduct Care), all other participating PCNs, the number of NMS done by their community pharmacies had increased in February 2024 compared to February 2023 (in rolling 11 months data).



Conclusions and recommendations

In summary, this was an innovative approach led by a place (Leeds) for whole of WY through collaborative working with other places and strong provider leadership from LTHT. It could have benefited from having project management support and better governance at WYICB board level. This integrated MDT approach has been used in Leeds in other areas like heart failure and atrial fibrillation. We demonstrated that it can be scaled up and has helped break down geographical boundaries between places. Furthermore, this approach is welcomed and valued by the participating PCNs and has achieved positive outcomes for patients living in most deprived areas.

The project was set up to upskill and provide a sustainable model for primary care teams' support with lipid optimisation and was not to replace traditional secondary care A+G referrals. The integrated approach and use of the referral template improved the knowledge and confidence of clinicians. **The project demonstrated that having an integrated MDT and A+G service, with access to secondary care specialist support, could ease the pressures on secondary care and additionally support primary care with QoF.** The established WY Lipid Optimisation Clinical Taskforce (LOCT) is now in place to bring together clinicians and further improve ways of working. Furthermore, the relationship at place with targeted PCNs had improved.

The A+G service received 64 eligible referrals of which 31 were discussed at virtual MDTs. This demonstrated a need for support on lipid optimisation, despite there being national and local guidelines in place (such as the national lipid pathway) and the usual local secondary care A+G routes. Common themes from A&G referral led to the production of 'Frequently Asked Questions', which should aid clinicians in their lipid management in the future. Queries such as those on FH, deranged liver function tests and managing high triglycerides stopped following discussions and shared learning at virtual MDTs and webinars. **This showed the positive impact of learning the virtual MDT discussion and webinars provided.**

Excellent MDT feedback and positive impact on PCNs to transform lipid optimisation in their local practices have demonstrated how valuable this project had been to the participating PCNs. Listening to their feedback, we recommend sustaining an integrated lipid MDT and A&G service to continue supporting primary care to do more lipid optimisation.

There were estimated potential savings of £495,000 in CVD event prevention costs over 10 years and £19,200 in out-patient hospital appointment avoidance costs. The cost of the project was approximately £110,000 in 12 months. **Hence financially over 10 years, it would show positive value for money due to efficiency savings moving care closer to home and enabling the primary care workforce to do lipid optimisation.**

Working across West Yorkshire, the project successfully narrowed the treatment gap between different sub-ICBs according to CVDPrevent data for the 'CVD treated to lipid threshold' indicator. The participating PCNs from the most deprived areas increased the proportion of patients with CVD on LLT, and this was more than that achieved by the whole of ICB; they also kept on track with the whole ICB in terms of optimising patients with CVD to lipid targets. **WYICB had improved its performance in this area and did not widen the health inequality gap.** The health inequality gap on



CVDPrevent between the most and least deprived areas was reduced by 0.23%. We had a target to reduce it by 2%, so more work still needed to be done to overcome further barriers (assuming clinicians had been upskilled and empowered to drive lipid optimisation).

The referral template could have acted as a barrier to referrals with the requirement to provide detailed patient information. If no template was required, then we might have experienced a significantly higher number of A+G referrals or clinicians attending MDTs to discuss their cases. However, due to the complex nature of lipid optimisation and the influence of secondary causes, thorough history-taking and investigations were required before an A+G response could be given.

Restrictions in data sharing across West Yorkshire and between primary and secondary care limited the ease of accessing information from patient's records, hence the need for a detailed referral template. Allowing secondary care clinicians access to GP practice systems such as SystmOne and EMIS would reduce the duplication of data onto a referral template and allow more efficient responses and potentially fewer administrative processes for referring clinicians.

The last significant barrier in certain PCNs was the challenges with inclisiran. In West Yorkshire and nationally there are PCNs with reservations about initiating inclisiran in primary care, due to lack of long-term cardiovascular outcomes and safety data and a lack of resources to administer the injection. This concern had been shared by the British Medical Association, the Royal College of General Practitioners and certain local medical committees.

Should the project be expanded, **the importance of the referral template requires further emphasis.** It is a key source of upskilling the clinician. The ability to use the mail merge feature from the start of the project would improve the referral process. To address the lack of experience in prescribing icosapent ethyl, we recommend adding focus on triglyceride management for the secondary CVD prevention cohort.

To improve virtual MDT attendance, a list of dates can be provided in advance with varying days of the week and times. This can also be more frequent and regular (fortnightly), and where possible be first mechanism to feedback to referrers (rather than email response to A&G). The project set a 5-day turnaround time for responding to A+G queries and this appeared satisfactory to the service users. However, delays occurred if further patient information was required or if a draft A+G response needed approval from a lipid expert. To increase the efficiency of providing an A+G response, the lipid team could meet to discuss and approve the response with a specialist present, rather than agreeing through the exchange of emails. Having a set date to achieve this accounts for annual leave or other priorities to avoid unnecessary delays in responding to the referrer's query.

Lastly, we have shown that primary care pharmacists can be upskilled to provide A+G on lipid management. The secondary care team have specialist nurses involved in lipid management. Commonly GP practices have diabetic nurses and often lipid optimisation is linked to diabetes control. **We recommend bringing practice nurses into the skill mix of lipid optimisation and involving them further in future integrated lipid MDT.**



Appendix 1 Webinar Attendance and Feedback

Webinar	Number attended	Number of recordings being sent to registrants	Number of feedback responses	Has the webinar covered their learning needs?	Level of knowledge before and after (score of 1 to 5, 1 being lowest and 5 being highest)	Impact on Learning
1 – 18/9/23 Interpretation of Lipid Profiles and Other Lipid Optimisation Tests webinar	138	238	38	95% said Yes	2.82 (average before); 4.08 (average after)	Positive
2 – 7/11/23 Navigating the National Lipid Pathway	42	69	2	100% said Yes	3 (average before); 4 (average after)	Positive
3 – 6/12/23 New Lipid Lowering Therapies: A Practical Deep Dive	64	114	8	75% said Yes	3.13 (average before); 4.25 (average after)	Positive
4 – 11/1/24 Familial Hypercholesterolaemia	20	23	5	100% said Yes	2.6 (average before); 4.4 (average after)	Positive



Appendix 2 Number of Patients with Non-Optimised Lipids from Participating PCNs

Time period	Mar-23		Jun-23		Sep-23		Dec-23		May-24		
PCN	<i>Patient count</i>	<i>% of CVD register</i>	<i>Patient count</i>	<i>% of CVD register</i>	<i>Patient count</i>	<i>% of CVD register</i>	<i>Patient count</i>	<i>% of CVD register</i>	<i>Patient count</i>	<i>% of CVD register</i>	% Change in number of patients with non-optimised lipids
WHOLE ICB (Total)	74540	60%	74378	61%	70152	59%	69532	60%	66439	59%	-11
IN SCOPE PCNs (Total)	21310	60%	21213	61%	19887	59%	19663	59%	17798	59%	-16
BD4+	1081	56%	1048	56%	1033	56%	1006	56%	962	56%	-11
Beeston	767	53%	818	58%	789	57%	771	57%	709	55%	-8
Bradford North West	916	47%	903	47%	875	47%	876	48%	859	49%	-6
Bramley, Wortley & Middleton	668	57%	692	60%	676	60%	676	62%	624	59%	-7
Burmantofts, Harehills & Richmond Hill	1082	55%	1142	59%	1114	59%	1075	59%	1038	59%	-4
Central Halifax	1825	69%	1755	68%	1693	67%	1562	64%	1468	62%	-20
Dewsbury & Thornhill	1218	68%	1190	68%	1083	62%	1113	65%	1054	64%	-13
Five Lane Ends	762	47%	755	47%	729	47%	721	48%	693	48%	-9
Middleton & Hunslet	725	53%	766	57%	736	56%	707	55%	680	54%	-6
North Halifax	1837	74%	1809	73%	1760	73%	1713	72%	1554	69%	-15
Bradford City 4	806	50%	790	50%	750	48%	754	50%	690	47%	-14



Five Parks	1581	58%	1535	58%	1482	58%	1519	58%	1435	57%	-9
Seacroft	887	55%	923	58%	905	58%	856	57%	795	55%	-10
Viaduct Care	1897	71%	1850	71%	1196	47%	1427	58%	1612	68%	-15
Wakefield Health Alliance North	1750	70%	1721	70%	1667	69%	1573	66%	1416	62%	-19
Wakefield Health Alliance South	2550	63%	2487	63%	2395	61%	2338	61%	2209	60%	-13
York Road	958	51%	1029	57%	1004	56%	976	56%	-	-	N/A



Appendix 3 NMS Data

PCN	Place	NMS (11 Months Apr 22 to Feb 23)	NMS (11 Months Apr 23 to Feb 24)	% Increase (21/22 = baseline)
BD4+ PCN	Bradford District and Craven	2264	3984	76.0%
Bradford City 4 PCN	Bradford District and Craven	3677	5972	62.4%
Bradford North West PCN	Bradford District and Craven	1451	2087	43.8%
Five Parks PCN	Bradford District and Craven	1764	2621	48.6%
Five Lane Ends PCN	Bradford District and Craven	2094	3535	68.8%
Central Halifax PCN	Calderdale	2378	5246	120.6%
North Halifax PCN	Calderdale	1510	3082	104.1%
Dewsbury and Thornhill PCN	Kirklees	4638	5421	16.9%
Viaducts Care PCN	Kirklees	3892	3835	-1.5%
Beeston PCN	Leeds	1970	2271	15.3%
Bramley, Wortley & Middleton PCN	Leeds	1981	2585	30.5%
Burmantofts, Harehills & Richmond Hill PCN	Leeds	1644	3661	122.7%
Middleton and Hunslet PCN	Leeds	3790	4254	12.2%
Seacroft PCN	Leeds	4135	20847	404.2%
Wakefield Health Alliance North PCN	Wakefield	1774	2690	51.6%
Wakefield Health Alliance South PCN	Wakefield	2971	4004	34.8%



Appendix 4 Review of Pre- and Post-Learning Needs Analysis



Review of pre and post learning needs analysis

Appendix 5 A+G Referrals Numbers by PCN

Referring Primary Care Network	Number of A+G referrals
BD4+	0
Beeston	7
BHR	13
Bradford City 4	0
Bradford North West	0
BWM	3
Central Halifax	0
Dewsbury	15
Five Lanes Ends	1
Middleton and Hunslet	0
North Halifax	0
Seacroft	12
Five Parks	2
Viaduct	4
Wakefield South	4
Wakefield North	1
Rejected	7
York Road	1
North Bradford PCN (Extension)	2
Total	72

Appendix 6 Data Collection from GP Clinical System

With thanks to Leeds Data Quality Team and Business Intelligence Team



GPDATA

