

CAN YOU HEAR US ?



LISTENING TO UNDERSTAND DEAF PEOPLE'S EXPERIENCES OF COMMUNICATION IN HEALTHCARE

Background:

1 in 6 of the UK adult population are affected by hearing loss, estimated to rise to 1:5 by 2035 (Action on Hearing Loss 2015). Hearing impairment is 2nd most prevalent disability in UK (HearingLink 2011). However, as an invisible disability, it often goes unnoticed, making it easier for those living with hearing loss to be ignored or forgotten (Davis 2005). D/deaf people encounter inequalities and barriers when accessing healthcare (SignHealth 2013) There are proven poorer health outcomes in deaf population (Edmond et al 2015). Exploring the lived experiences of these seldom heard service users is instrumental to instigate change FOR and WITH the people directly affected (McLaughlin et al 2004, Beresford 2013, Sheppard 2014)

Aim:

- To explore the lived experiences of deaf people when accessing health care through public engagement.
- To identify and understand issues these service users encounter and utilise these to instigate collaboration for changes within Emergency Care.

Method:

Utilising UK Standards for Public Involvement Framework (UPSID 2019), I implemented a consultation as part of a qualitative participatory approach (NHIR 2021), formatted as an informal social lunch with a small, diverse group of members from the deaf community at their local club. I engaged with service users, with help from a British Sign Language (BSL) interpreter, and held conversations about challenges the deaf community experience accessing healthcare. An initial meeting took place pre event, with 'enablers' (Ocloo et al 2021) from the Wilts and Dorset Deaf Association, during which the project purpose, strategy and communication needs were discussed.

What went well ?

- Engaged with community members with direct knowledge / experience
- Increased understanding of what barriers exist and how this impacts on the participants
- Meaningful – focused on issues relevant to the community
- Fostered trust to build rapport
- Gained insight
- 'Enablers' consulted and very keen – enthused the community
- Communication methods planned
- Event took place in a relaxed setting
- Participants very keen to talk to me

What were the challenges ?

- Gaining trust of 'gatekeepers' / participants
- Community lack of knowledge of public involvement in research and what it means
- High expectations from participants
- Difficulties in finding an interpreter
- Time constraints
- Temptation to push questions rather than have conversation
- BSL is observable by all in the group, no privacy
- Tangents – complaints about NHS food
- Emotional burden
- Personal bias / pre conceived thoughts
- Loss of control over the event organisation

Key findings from engaging with the deaf community :

Lip reading / written word is not always helpful – BSL is pictorial not grammatical

Significant lack of deaf awareness among health care staff

Communication needs vary on an individual basis - spectrum of hearing impairment

Lack of provision of interpreters in the local NHS trust

Video relay interpreting unpopular with BSL users

A particular trust in Wiltshire had multiple positive comments from the deaf community

Conclusion:

The consultation approach worked well for this particular public engagement event.

Reflection on strengths and challenges of my chosen approach has informed my future strategy.

Through this approach I have gained some insight to the issues that are important to this group of service users and have direction to explore these issues further. I have begun to build relationships and trust with the representatives and service users. I plan to conduct further consultations and formulate research questions with the deaf community. I plan to disseminate my findings from this public engagement to key stakeholders within my organisation and feedback to the deaf community, encouraging collaboration between partners.

EMERGENCY PHYSIOTHERAPY WORKS

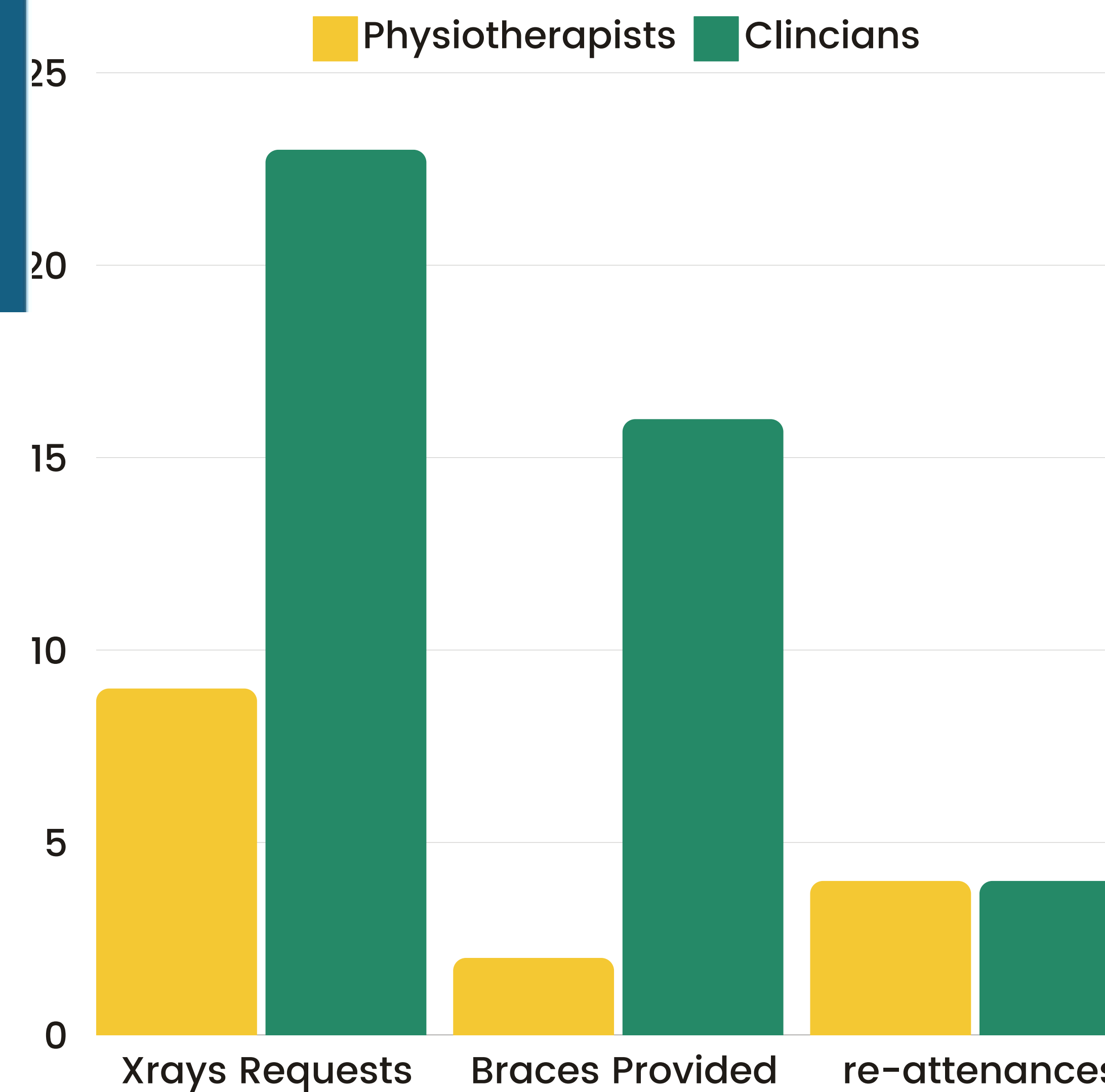
A proof of concept pilot exploring the benefits of integrating emergency physiotherapy practitioners into Urgent Care Services within Dorset Health Care NHS Foundation trust.

INTRODUCTION

30% of patients presenting to Weymouth Urgent treatment centre present with a musculoskeletal (MSK) problem, such as fractures, sprains, strains and non-traumatic joint pains. The UTC is currently staffed with nurses, paramedics, doctors and health care assistants.

Physiotherapists are MSK specialists, and their advanced assessment skills are highly valuable to patients presenting to the UTC. Early physiotherapy input reduces unnecessary X-ray imaging, and needless splinting for acute injuries.

'THIS SERVICE IS EXACTLY WHAT I NEEDED TO BOTH UNDERSTAND AND SELF-MANAGE MY RECOVERY FROM THE SHOULDOER INJURY'.



RESULTS

Represented in yellow, Emergency physiotherapists demonstrated a significant reduction in both the number of X-rays requested, and number of splints provided for patients presenting with acute traumatic limb pain.

The reduced number of X-ray requests represent a cost saving of £3390, as just one X-ray with report costs £223. An additional £134.12 was saved through the reduction in the number of joint immobilisation splints provided.

Results also represent improved patient safety through reducing exposure to unnecessary radiation. Additionally, in most circumstances joint immobilisation would not be indicated for acute sprains and strains. Prolonged immobilisation is thought to be harmful, whereas early mobilisation of limbs has been found to decrease pain, swelling and stiffness, and earlier return to work has been demonstrated.



METHODOLOGY



An Emergency physiotherapy practitioner (EPP) was integrated into the Weymouth UTC for 4 months.



An audit was completed reviewing 50 patients assessed by the EPP, compared with 50 patients assessed by the remaining clinical team.

- Number of X-rays requested
- Number of brace or splints provided
- Number of patient reattendance



Patient and staff satisfaction questionnaires were also gathered.



100% of patients were either highly satisfied or satisfied with their appointment with the emergency physiotherapist

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Matifat et al, 2023. Advanced practice physiotherapy care in emergency departments for patients with musculoskeletal disorders: a pragmatic cluster randomized controlled trial and cost analysis

Nash, C. 2004. Resting injured limbs delays recovery: a systematic review. Journal of Family Practice, 54 (9)

Sutton et al, 2015. Primary-contact physiotherapists manage a minor trauma caseload in the emergency department without misdiagnoses or adverse events: an observational study

'REASSURING TO HAVE SOME GOOD ADVICE TO SELF-MANAGE MY INJURY AND GET BACK TO FULL HEALTH, MUCH NEEDED SERVICE, THANK YOU'

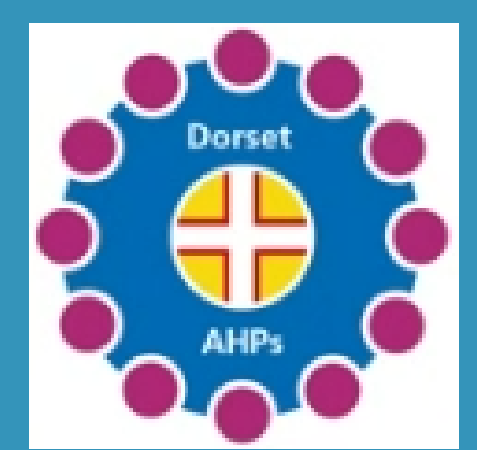
STAFF FEEDBACK

'Having an emergency physiotherapist on the team enriches the diversity of the team and improves patient care through greater knowledge of conditions and the development of management plans. Additionally, it has been useful to update my practice which has led to me reducing my use of splints'

'The EPP has been a valuable specialist to have in the UTC. Patients feel very happy having been assessed immediately by a physio, and given advice directly after the injury to help aid recovery sooner, often physio input comes too late'

RECOMMENDATION

- Integrate Emergency Physiotherapy practitioners into Urgent Care Services across Dorset Healthcare.
- Develop current workforce through the provision of Emergency physiotherapy placements in line with the MSK physiotherapy Education framework.
- Support the current workforce in undertaking relevant masters levels learning
- Utilisation of the South West Urgent Care Physiotherapy competencies



CHALLENGES

INTRODUCTION

The publication of the NHS England Musculoskeletal (MSK) First Contact Practitioner (FCP) Roadmap (2020) presented massive challenges for the Dorset Healthcare system. Including:

- A **diverse FCP provider landscape** (4 provider trusts + clinicians directly employed by a GP practice or Primary Care Network).
- **Rapidly expanding workforce** due to the full funding available to PCNs via the Additional Roles Reimbursement Scheme (ARRS).
- Significant **workforce challenges in terms of recruitment, education, and clinical supervision**.
- The creation of senior level clinical posts in primary care produced **workforce threats for the established MSK services** employing physiotherapists.



FELLOWSHIP OBJECTIVES

The fellowships were created to integrate the requirements of the Roadmaps educational agenda with the Network Contract Directed Enhanced Services and the Care and Quality Commission requirements for quality assurance.

Aim: to support all stakeholders across Dorset in producing sustainable and robust FCP services.

Initial fellowship objectives

- ❖ Identify requirements for supervision of FCPs
- ❖ Develop an FCP workforce strategy, training and development plan
- ❖ Facilitate a clinical dashboard for FCP service performance
- ❖ Standardise Service Level Agreement (SLA)

Iterative fellowship objectives

- ❖ Proposal for FCP Supervision fellowship
- ❖ Explore inequality of radiology requesting rights
- ❖ Plan for early career exposure to primary care
- ❖ Create a proposal for an Osteoporosis clinical fellowship.

ACTIVITY

- **Surveyed business managers and Dorset FCPs** on workforce projections, FCP training needs, and existing supervision models.
- **Delivered webinars and seminars** to clinical directors, business managers, GPs and FCPs to **improve understanding of the FCP role**.
- Engaged with local Higher Education Institutions and collaborated with the AECC University College to **create a course with roadmap recognition**.
- **Horizon scanning with Dorset Allied Health Professions faculty**, for funding opportunities to upskill the FCP workforce.
- **Formed and chaired Pan Dorset FCP data group**, to agree data point definitions and FCP Key Performance Indicators.
- Engaged with Dorset Information and Insights Service to **develop data dashboard**.
- Produced '**Challenges Faced During the implementation of the FCP Roadmap in Dorset**' report
- **Represented Dorset** at the Southwest Outpatient Transformation AHP meetings, for feedback to national bodies.



RESULTS / DELIVERABLES

- ✓ Proposal and **recommendations on FCP supervision** fellowship, status and training across professions.
- ✓ **Gap analysis** of current versus future requirements for FCP workforce
- ✓ Collaborated with AECC University College on **development of successful tender** for level 7 Roadmap Post graduate Certificate.
- ✓ Successful tender for **fully funded courses** by NHS England achieved
- ✓ Creation of an **FCP clinical activity dashboard** consistent for national and locally agreed clinical templates
- ✓ Publication of '**Dorset recommendations for what should be included within service level agreements for FCP posts**'



ONGOING WORK

- ✓ Initial **FCP x-ray protocol** agreed with one trust – aiming for harmonisation of radiology requesting protocols and reducing the need for multiple quality assurance audits for the same individual clinician.
- ✓ Proposal of **local repository for educational resources** from the community of practice to be available to new early career FCPs
- ✓ Primary care **osteoporosis fellowship** job description written
- ✓ Collaboration with Dorset General Practice Alliance Board on sustainability in primary care, and developing **early career AHP exposure to primary care**

CONCLUSIONS

The personal growth of the FCP fellows is not to be underestimated. This role provided funded 'headspace' to look at developing the new roles from many perspectives and encourage networking across the system. During the fellowship, the primary care voice became increasingly valued across the newly formed Integrated Care System.

The impact of the fellowship can be kindly summarised by some of our key stakeholders:

"The fellowship has allowed for thorough collaboration and co-production between clinical practice and academia. Their work has allowed us to provide high-quality demand-led educational opportunities and support the health workforce in Dorset."

Dr Michelle Holmes, AECC University College Senior Lecturer (Workforce Development)

"The fellowships have been invaluable. Without their involvement it would have been very challenging to meet the requirements of the PCN's whilst at the same time supporting individuals and organisations... the fellows have been very influential in the strategic development of this workforce."

Hilary Hall, Allied Health Professions Lead, Dorset ICS.

"Open and honest communication with practice is central to the success of workforce education for the future. Liz and Chris have been instrumental in the design of our provision, really supporting our vision of asking what is needed rather than telling our partners what we can offer"

Dr Claire Nadaf, AECC University College Head of Academic Enterprise and Engagement

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Health Education England, 2021. *First Contact Practitioners and Advanced Practitioners in Primary Care: (Musculoskeletal) A Roadmap to Practice*. [Online] Available at: https://www.hee.nhs.uk/sites/default/files/documents/MSK%20July21-FULLABLE%20Final%20Aug%202021_2.pdf

NHS England, 2019. *Network Contract Directed Enhanced Service. Contract specification 2020/21 - PCN Requirements and Entitlements*. [Online] Available at: <https://www.england.nhs.uk/publication/network-contract-des-contract-specification-for-2023-24-pcn-requirements-and-entitlements/>

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Soluble FMS like tyrosine kinase 1/placental growth factor (sLft-1/ PIGF) and pre-eclampsia (PET) ratio: A determinant of maternal & fetal outcomes?

Dr. Georgina Stuart-Mullin, Dr. Rebecca Wiltshire, Dr. Asha Gibbs, Sandra Courtiour, Miss Latha Vinayakarao

Introduction

Pre-eclampsia is a common complex multisystem disorder affecting 4.6% of pregnancies worldwide, being associated with over 500,000 fetal/neonatal and over 70,000 maternal deaths globally each year¹. It is characterised by new hypertension (>140/90 mmHg) after 20 weeks accompanied by either proteinuria, acute maternal kidney injury, liver dysfunction, neurological symptoms, haemolysis, thrombocytopenia or fetal growth restriction.

Confirming the diagnosis can be especially challenging in women with pre-existing hypertension or proteinuria. In addition, there is a variable spectrum of severity and rate of disease progression. Close monitoring and blood pressure treatment can be employed to prolong pregnancy, but the ultimate 'cure' is delivery, the timing of which can be challenging to limit maternal and fetal morbidity and mortality.



NICE recommends soluble FMS like tyrosine kinase 1/placental growth factor (sLft-1/ PIGF) ratio testing alongside clinical assessment to aid diagnosis and inform management. As of July 2022, the sLft-1/ PIGF test is now recommended by NICE for ruling in and ruling out pre-eclampsia².

University Hospitals Dorset (UHD) is an NHS Foundation Trust located on the south coast of England serving a population of over 800,000. Within the Trust, St Mary's maternity hospital acts as the high-risk care centre for East Dorset with over 4000 deliveries per year. The unit has specific guidelines regarding assessing risk of PET, confirming suspected PET and management once diagnosis is established, these utilise a PET risk ratio based on sLft-1/ PIGF and Protein Creatinine ratio (PCR) with the aim of providing safe standardised evidence-based care³.



Objective

Our objective was to review, from a Trust perspective, the efficacy of sLft-1/ PIGF and PET ratios as an antenatal screening tool, used alongside the urinary PCR, to determine the likelihood of patients developing PET and associated severe adverse maternal and fetal outcomes.

Methods

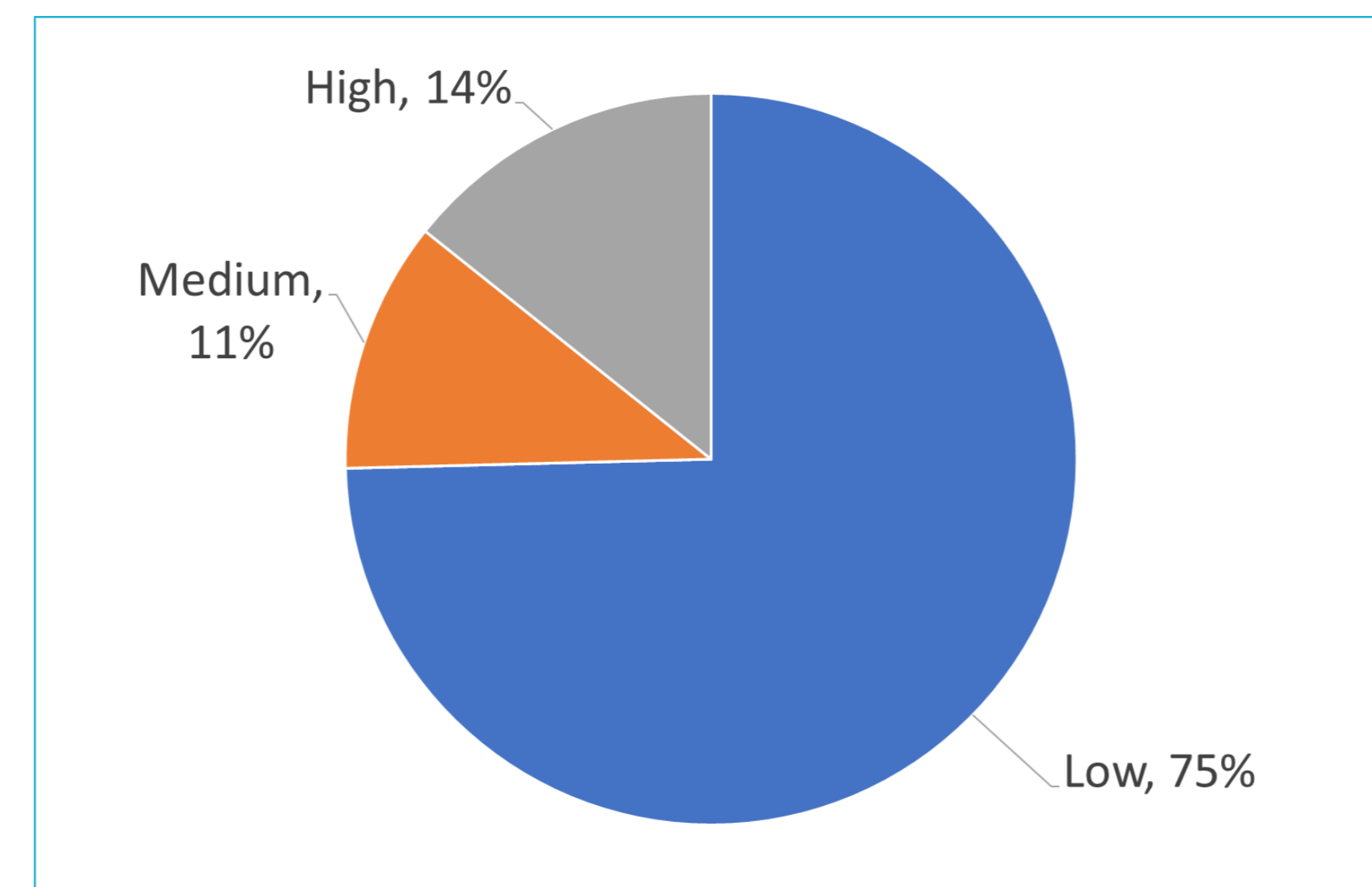
Retrospective audit looking at the use of the Soluble FMS like tyrosine kinase 1/placental growth factor (sLft-1/ PIGF) and Pre-Eclampsia Toxaemia (PET) Ratio blood tests antenatally to assess if the Low, Medium and High-risk categories could accurately predict the risk of developing PET as well as predicting outcomes such as inpatient admissions, NICU admissions and severe maternal outcomes. The audit also looked at the use of urinary PCR tests alongside this blood test.

Data from 13/01/22 to 31/03/22 was gathered from BadgerNet and EPR, looking at 63 patients who had the sLft-1/ PIGF blood test when presenting to maternity triage and to antenatal appointments during pregnancy. NICE guidance recommends further research before testing on those pregnant with multiple babies⁴, therefore we only recorded data from singleton pregnancies.

The data was then analysed looking at the PET risk ratio, dividing into low risk, medium risk and high risk as per UHD trust guidelines which state if PET ratio < 38 (low) there is 0.4% risk of PET in 7 days and <3% risk of PET in 28 days, if PET ratio < 38-85 (medium) there is a 20% risk of PET in 7 days, and if PET ratio >85 (high), there is a >50% risk of PET in 7 days. Data on urinary dipstick results, urinary Protein-Creatinine Ratio (PCR), rates of inpatient admissions, rates of caesarean sections, and rates of adverse maternal outcomes and NICU admissions, as well as the rates of developing PET after the test were all analysed for each group (low, medium, high).

Results

Figure 1: PET Risk Category based on 1st sLft-1/ PIGF Test



Of the 63 women audited, 47 (75%), 7 (11%) and 9 (14%) were assigned a low, medium and high-risk category respectively. 28% of low-risk women had hypertension at testing compared with 71% (medium risk) and 78% (high risk).

Medium risk women had the greatest burden of inpatient admissions and also had higher rates of NICU admissions at 57% compared to 44% for high risk and 11% for low-risk women and had the greatest risk of actually developing PET: 57%, compared to 44% of high-risk women and 4% of low-risk women. The only woman developing a severe maternal outcome had a high-risk PET ratio and a PCR>30. All babies (n=2) born at 28 to 31wks were to women in the high-risk category compared to 85% (n=47) of babies born at >37wks being to women in the low-risk category.

Figure 2: Frequency of Risk Markers at 1st sLft-1/PIGF Test by PET Risk

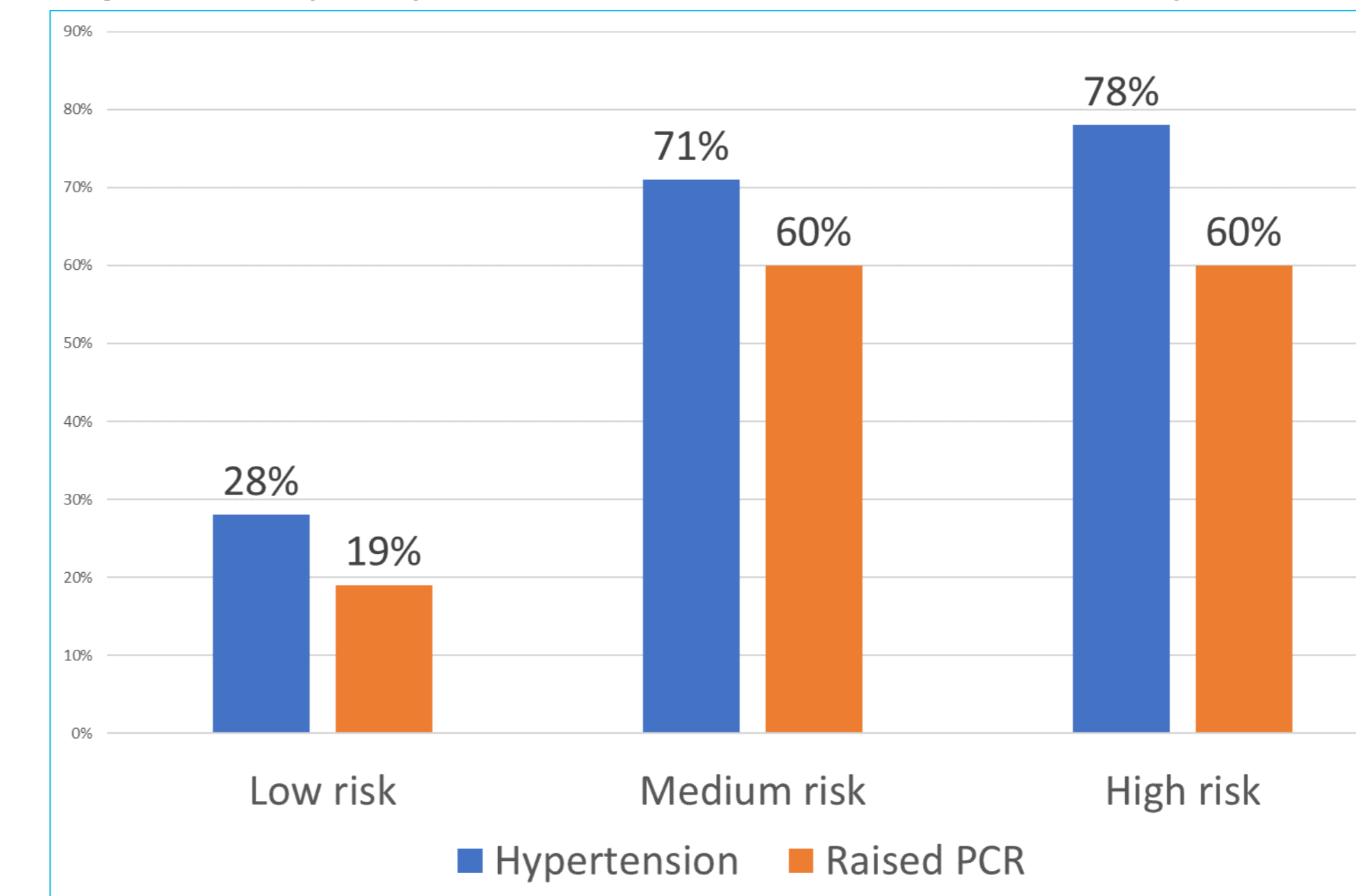
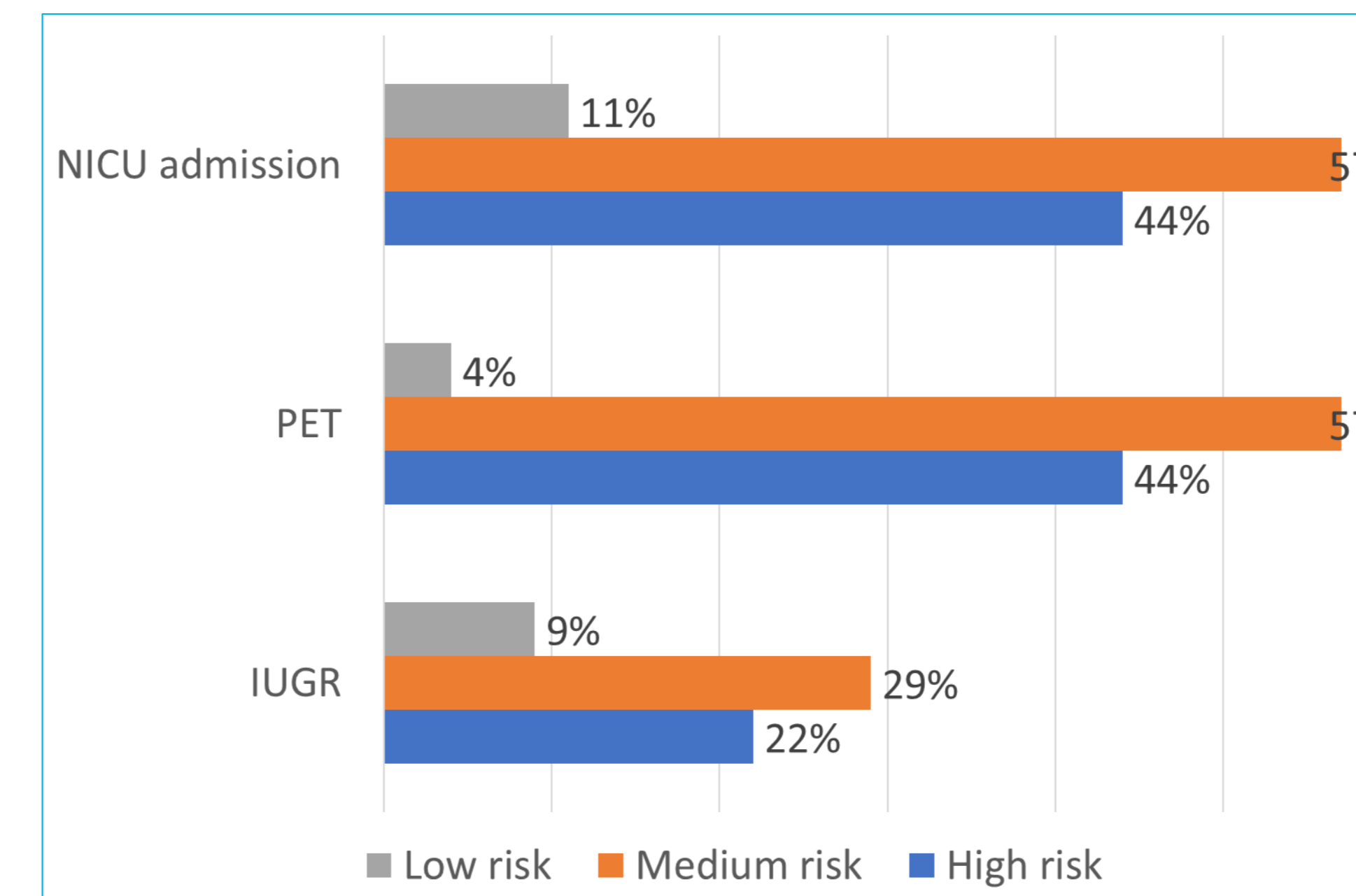


Figure 3: Outcomes by PIGF Risk Category (at 1st sLft-1/PIGF Test)



Conclusion

This was only a small sample from our local unit, but the data aligned with national standards. Categorisation of women to a low-risk group based on sLft-1/PIGF ratio and PET ratio correlated with a low risk of developing PET. Women in the high and medium risk groups were more likely to develop PET and experience adverse maternal and fetal outcomes. The PET ratio seemed most effective at successfully identifying those women who were low risk, as only 4.26% of the low-risk PET ratio women developed PET. In our study grouping women in this way was safe and aided effective clinical decision making.

Recommendations

Our intention is to extend the data collection. By extending the sample window we will be better able to measure if results remain consistent with national guidance and will be able to measure the sustainability of the test in the long run. The sLft-1/PIGF test is now recommended by NICE for ruling pre-eclampsia in and out², our study reflects NICE recommendations, therefore we will continue to use PET ratio as a prediction model, alongside clinical correlation, to rule in and out preeclampsia patients.

Further steps involve education (supported by Roche) of doctors and midwives on the usefulness of the test and practical application of results. The results of the audit will be presented and discussed at the local and potentially Wessex wide governance meeting. Ideally to further investigate sustainability, a data set following this education would be gathered to measure the effect of this.

NICE recommends further research on repeat testing and if this improves outcomes², and therefore for our further data collection we will look specifically at if those who had multiple tests had different outcomes.

References

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- University Hospitals Dorset NHS Foundation Trust. 2020. Pregnancy Induced Hypertension (PIH) and Pre-eclampsia (PET) Version 1

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Reducing Short Acting Beta-2 agonist (SABA) overuse in Asthma using Digital intelligence within a Primary Care Network (PCN)

Sally Merson & Jennifer Chaloner - Weymouth and Portland PCN, Dorset

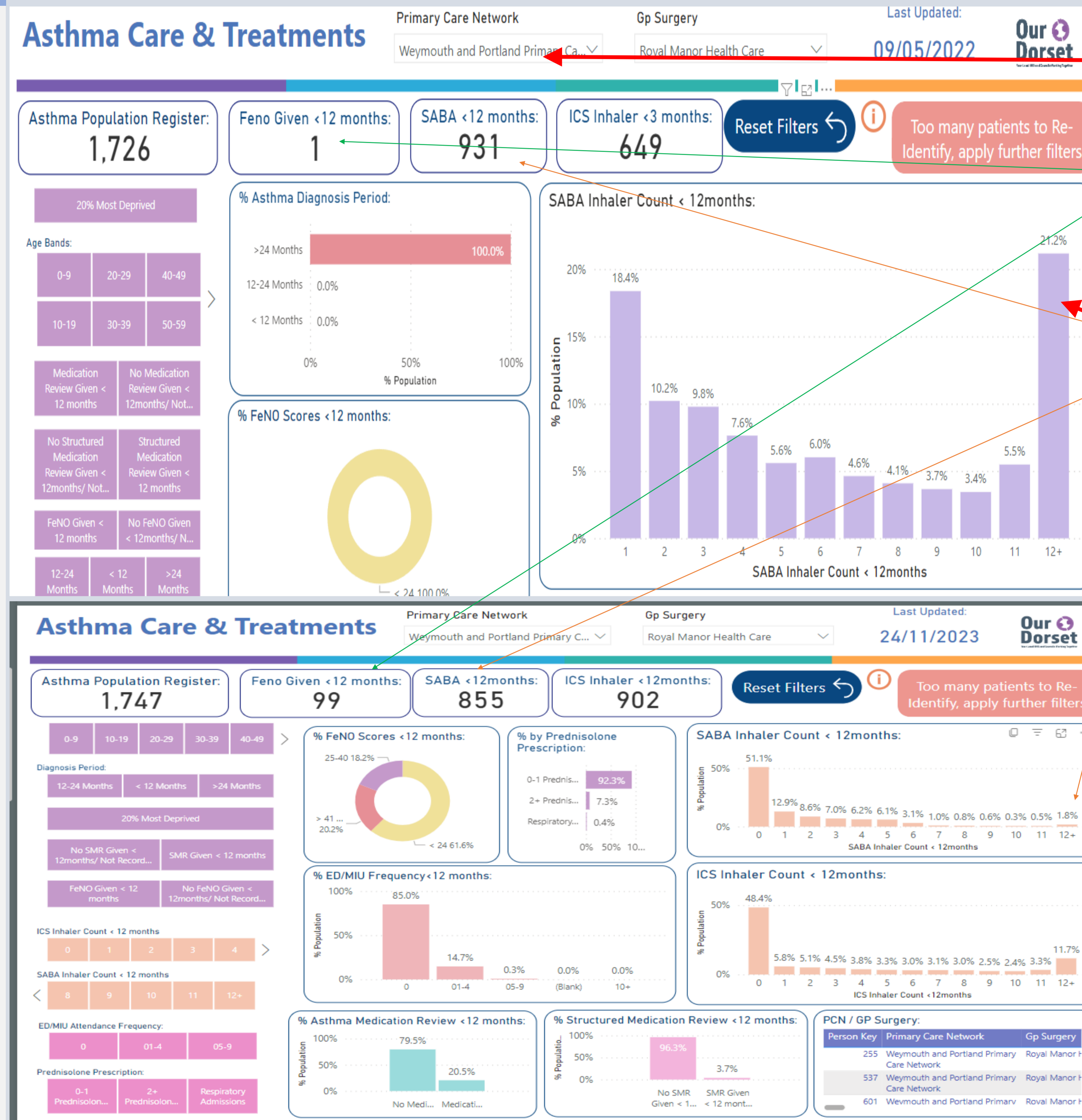
Introduction

The prescribing of salbutamol inhalers for the relief of asthma symptoms varies significantly across England. Within the Dorset Integrated Care System (ICS) in 2022, the Weymouth and Portland Primary Care Network was found to be an outlier in overprescribing SABA to the asthma population, within the highest decile for SABA prescribing nationally. It is also an area of significant deprivation. The aim of the project was to understand what was driving the large numbers being issued, and how we could help reduce this. Dorset Integrated Care System (ICS) has adopted a population health management (PHM) approach to the management of chronic conditions since 2019, with the creation of a detailed database, the Dorset Intelligence, and Insight Service (DiIS). This draws information from multiple sources, including primary and secondary care. The clinical and demographic characteristics of the population 104,000 asthma patients in Dorset can be viewed at the ICS, PCN, GP practice and individual patient level, using pseudonymised data. The data is updated daily. Open prescribing data was also used to benchmark the locality surgeries against countywide and national data.

Methodology

All 6 surgeries within the PCN were invited to participate in the project. DiIS searches for each surgery were undertaken for patients who had a coding of asthma and had been issued with more than 12 Salbutamol inhalers in the preceding 12 months, this search was repeated every 2-3/12. One surgery – the Royal Manor Surgery - engaged very well with the PCN respiratory team to help support the project. The interventions included:

- Education of administrative staff on asthma to allow them sufficient knowledge to understand when requests were issued for repeats.
- Flagging of nurse practitioners when patients were requesting monthly repeats.
- Use of DiIS data by practice nurses to target patient for reviews, and explore why repeats were requested, including mental health issues, automatic ordering, poor asthma control and understanding of condition.
- Joint clinics with specialist nurses including FeNO testing.
- Where appropriate, switching to MART regimes
- Reduction of durations for medications to 90 days
- Text messages to patients when repeat requesting to book in for an asthma review.
- Development of a video to send to patients explaining why the project was running.
- Engagement of local pharmacies and the PCN pharmacy team to review at repeats.



PCN select

Use of FeNO testing

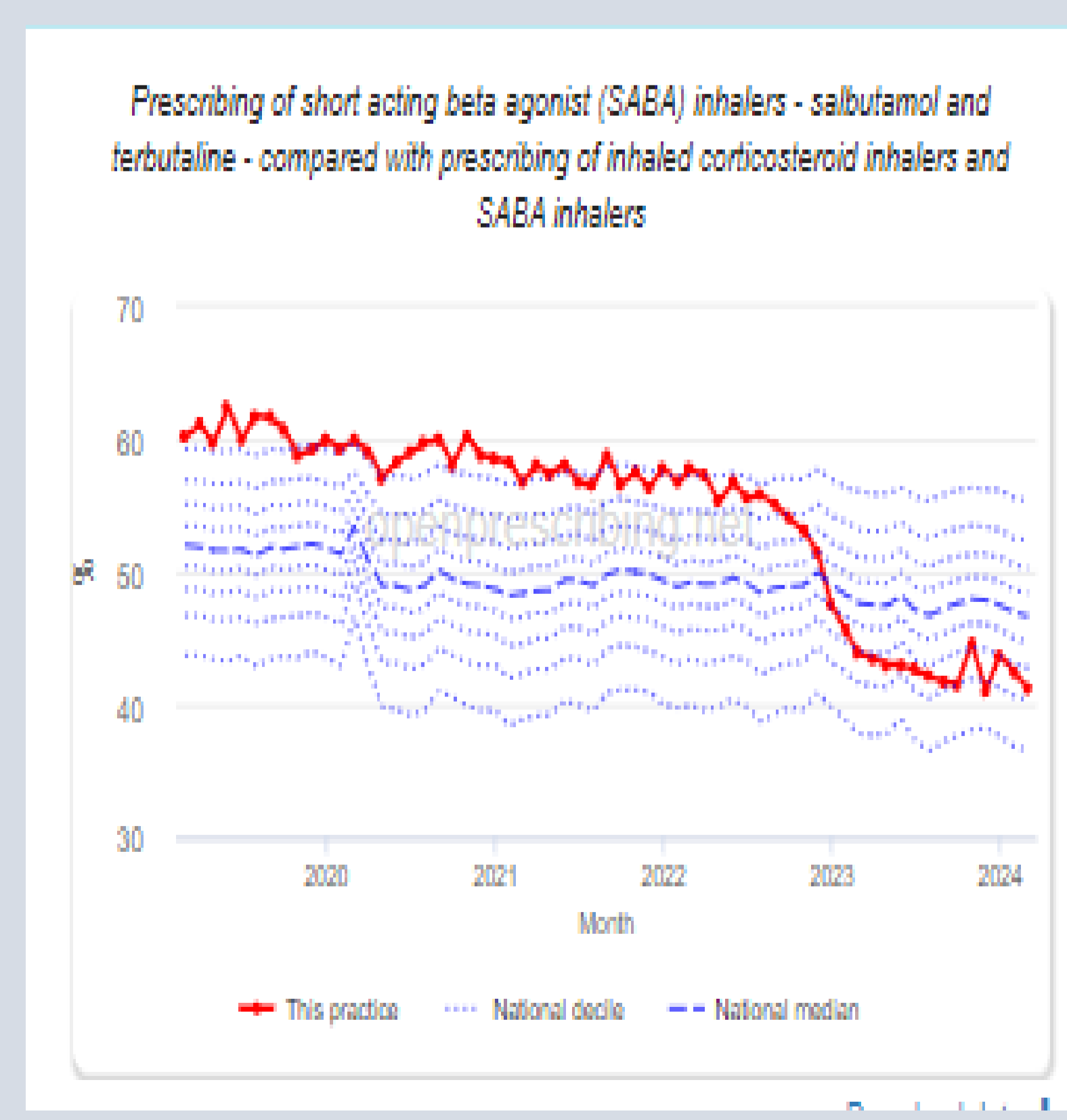
12+ SABAs Issued

Screenshots of DiIS shows change in SABAs issued over a twelve-month period in one surgery, results were taken at start of project and after 16 months. The starting total in one surgery was 931 SABAs and 649 ICS issued over a twelve month period, after 16 months this had reduced to 855 SABA and increased ICS use to 902 issues

Screen Shot from open prescribing information 2021 – 2024. Blue national average. Royal Manor Surgery.

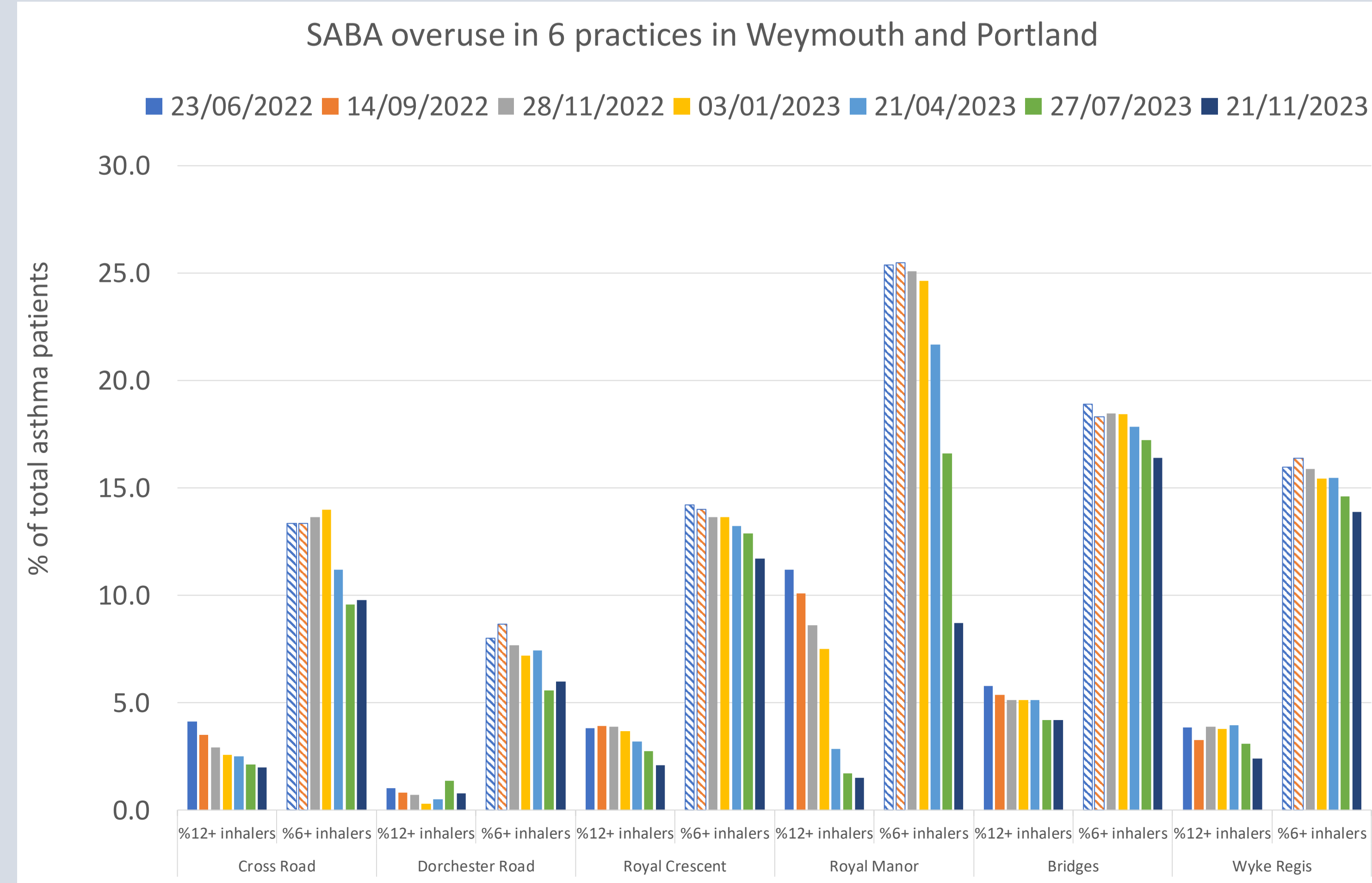
Conclusions

The use of a population-based approach informed by data enabled us to identify an area of social deprivation where asthma management could be improved. A series of simple interventions enabled an improvement in care as evidenced by significant reductions in SABA prescribing, alongside increases in prescribing of inhaled corticosteroids. Environmentally, the impact is also significant, with NHS Dorset Pharmacy team calculating the carbon-savings in just one month equalled **101,479km** in a medium sized diesel car.



Results

Royal Manor Surgery	May 22	Nov 23
Total asthma population	1726	1747
Patients issue 12+ SABA in preceding 12/12	198	29
Total Patients issued ICS in preceding 12/12	649	902



Anthony Young ANP, Alice Bendea ANP trainee, Dr Rajan Pooni, Professor Christopher Boos

Background

Hyperlipidaemia is a leading cause of premature cardiovascular disease (CVD). It is responsible for a quarter of all deaths in the UK. The National Institute of Clinical Excellence (NICE) Lipid Modification guidance (2023)¹ has shown that the lipid management of people with established CVD remains suboptimal CVD prevent data reporting that whilst 80 % of patients with CVD are treated with statins optimal dosing is achieved in only 33%.² The reasons for this include inadequate adherence and dosing of evidence/guideline-recommended lipid-lowering treatment. Contrary to recommended best practice there has not been an integrated secondary (2°) prevention lipid service for patients with established CVD in East Dorset.

Innovation

We designed an Advanced Nurse Practitioner-led 2° prevention lipid service specifically designed to better identify, treat and follow-up patients hospitalised with atherosclerotic CVD. Its primary focus was to implement a structured and evidence/guideline-based lipid modification service for patients with established CVD. Central to the service was the management of hyperlipidaemia and other patient CVD comorbidities in order to deliver shared (nurse and patient) care focussed on patient education, lifestyle improvements and optimisation of lipid lowering treatment.

Our primary aim was to substantially improve the identification of patients with hyperlipidaemia and CVD and optimise their management with best practice lipid lowering treatment within our catchment area. This service also sought to signpost patients to additional ancillary CVD services such as LIVE Well Dorset and patient support groups with continuous audit and bench marking to measure service performance.

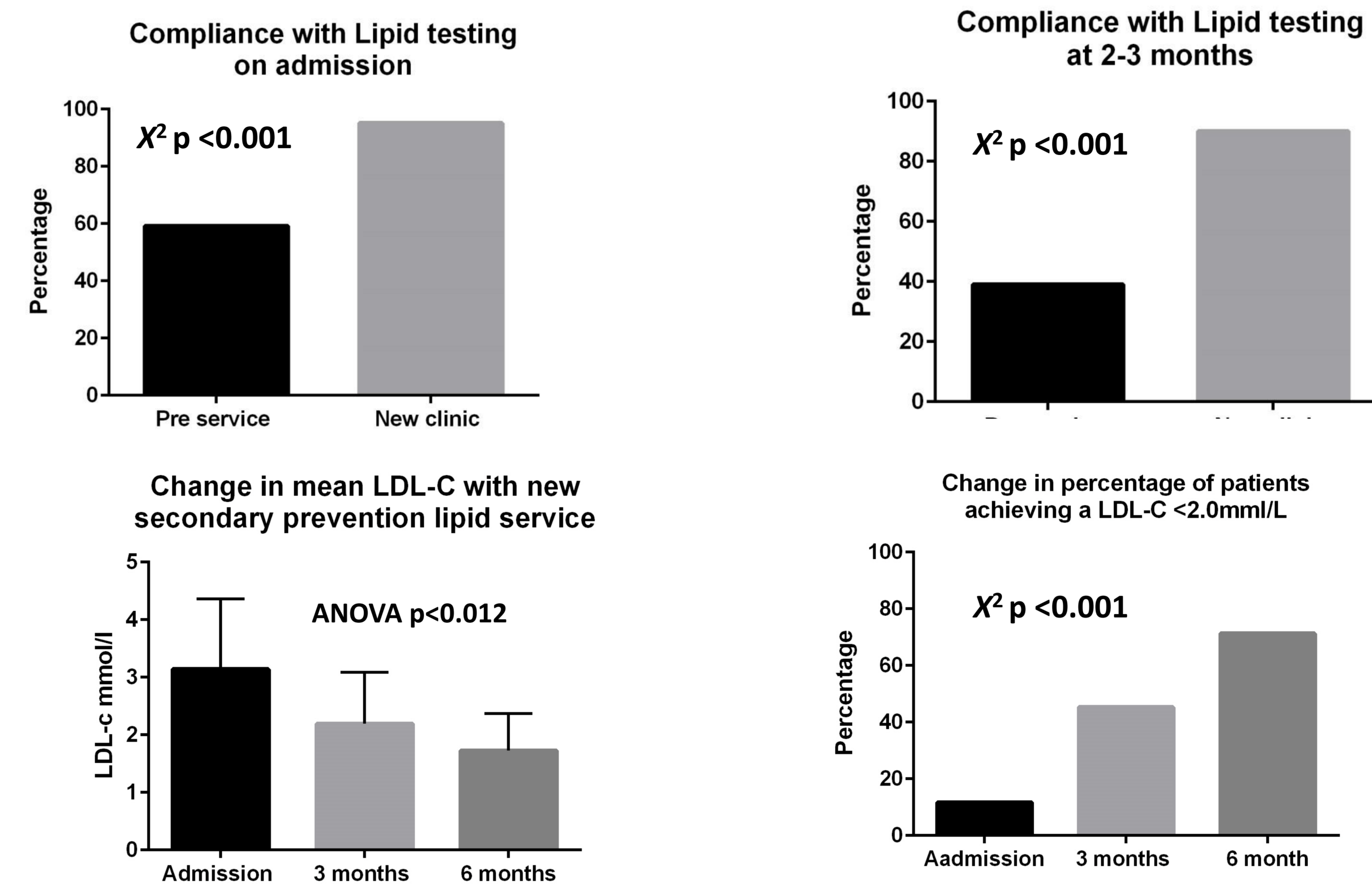


Figure 1 – Impact of New lipid service on Lipid management and targets

Key Challenges and Learning

The earliest challenge was to obtain robust funding and clinical support from secondary and primary care colleagues and managers to allow this service to proceed. Following a detailed proposal and a pre-service audit data of existing 2° prevention lipid lowering services we received two-year funding from industry with full clinical support owing to our identified need for improvement.

The service model consisted of an initial face-to-face clinic at 3 months post hospitalisation for an acute coronary syndrome or need for coronary revascularisation followed by telephone consultation at 6 and 12 months post admission. Close liaison with IT, cardiac rehabilitation and coronary care unit staff) was conducted to maximise patient identification. Comprehensive letters to GPs and colleagues were generated to ensure clear communication and several visits to a tertiary hyperlipidaemia clinic was conducted to gain experience in the optimal use of PCSK-9 inhibitors and other injectable lipid modification treatments. A database was set up to ensure to allow regular audit and benchmarking. Treatment targets were set at an LDL Cholesterol (LDL-C) of <2.0 mmol/l based on the latest 2023 NICE CVD Lipid Guideline recommendation.

Impact and Outcomes

- 54 consecutive patients pre service were compared with 154 consecutive post service patients with the ages (mean 63.3 years) being very similar
- Key impacts of this new service include
 1. a significant increase in patient lipid testing
 2. >50% and significant fall in LDL-C
 3. Sig increase in patients achieving an LDL-C target of <2.0mmol/l from 11.7% at admission to 71% at 6 months (RRI=5.3; $p < 0.001$)
 4. >5-fold increase in use of injectable therapy

Next Steps

- To grow the sample size
- Ongoing robust audit on full repeated measures data out to one year of follow-up
- To seek ongoing funding to grow the service to meet the full demand
- Ensure this service becomes a standard NHS service in the future

References

1. Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline [NG238] Published: 14 December 2023; <https://www.nice.org.uk/guidance/ng238>
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