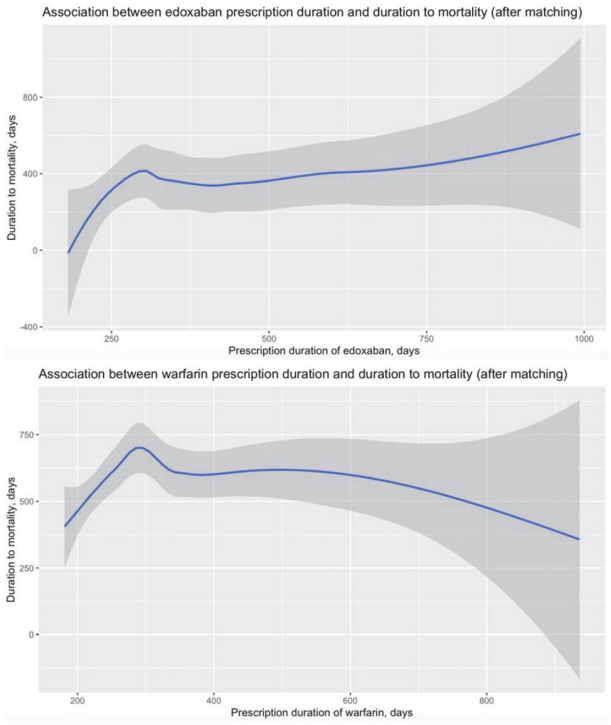


**Abstract 193 Figure 2**

**Conclusions** Edoxaban use was associated with a lower risk of TIA or ischemic stroke after propensity score matching for demographics, comorbidities and medication use.
**Conflict of Interest** None

## 194 THE UCLPARTNERS PROACTIVE CARE FRAMEWORKS – OPTIMISING CVD PREVENTION POST COVID. INNOVATION TO RESTORE AND IMPROVE CARE IN THE HIGH-RISK CONDITIONS AND PREVENT HEART ATTACKS AND STROKES AT SCALE.

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**Introduction** COVID-19 has disrupted pathways of care for over 12 months. Primary care has transformed dramatically with much care being provided remotely. The COVID surges and vaccination programme have reduced capacity further. People with conditions such as hypertension, cardiovascular disease and diabetes depend on regular review and treatment optimisation to keep them well. There is a high risk that continued disruption to proactive care will drive an increase in exacerbations and complications. It is likely this will drive further waves of demand for urgent care over the coming months in primary care, in emergency departments and in hospital admissions.
**Methods** The team of GPs & pharmacists at UCLPartners, with patient and public support, developed proactive care frameworks for six conditions including atrial fibrillation, hypertension, high cholesterol and type 2 diabetes mellitus. The frameworks focus on the 'how to' of delivering care in the new world of primary care post COVID-19. They are built on 4 principles: virtual where appropriate, use of the wider workforce, step change in self-management, and use of digital resources. For each condition, the frameworks include: risk stratification tools; pathways that support remote care and deploy staff such as healthcare assistants and social prescribers to systematically support education, self-management and lifestyle change; scripts, protocols and training to guide these staff in consultations; digital tools; and resources to support treatment optimisation. The frameworks include clinical and project management support for local pathway adaptation and implementation.
**Results** The frameworks have gained wide traction in primary care across England. There have been over 2,700 downloads of the search/stratification tools with evidence of implementation in several regions. In the UCLP geography, North East London and North Central London have adopted the frameworks for roll out across 475 GP practices and 2.8 million people. NHSEngland has now adopted the Frameworks as a key part of the NHS@Home programme with plans to support at scale national roll out. Evaluation is being commissioned.
**Conclusions** The UCLPartners Proactive Care Frameworks provide systematic, evidence-based support to restore services post COVID: stratifying so that higher risk patients can be prioritised and workload managed; maximising remote care; optimising personalisation and support for self-care. By using a population health management approach together with comprehensive resources to support clinical management in real world primary care, the frameworks provide a platform not just to restore services but to optimise treatment and outcomes in the high-risk conditions for CVD. The widespread national traction the frameworks are gaining suggests that despite the pandemic, this brings an opportunity to deliver the NHS Long Term Plan ambitions for CVD prevention and prevent 150,000 heart attacks, strokes and cases of dementia.
**Conflict of Interest** none

## 195 NICE 95 AND NON ANGINAL CHEST PAIN: REASSURING PATIENTS WITHOUT INVESTIGATION

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**Background** NICE 95 guidance (2016) tells us that patients presenting with stable non-anginal chest pain do not require further investigation where clinical suspicion of underlying coronary disease is deemed unlikely. This relies on the clinical acumen of the healthcare practitioner assessing patients with no pre-test probability score recommended in the current guidelines (a change from 2009 guidance). The European Society of Cardiology (ESC), however, recommend the use of a pre-test probability score to aid decision making in such cases. We believe that the current practice of reassuring this group of patients without investigation is safe and that a formalised pre-test probability score does not provide additional reassurance.Method:A retrospective single centre cohort study of all cases assessed in a face-to-face nurse led rapid access chest pain clinic (RACP) where patients were discharged without investigation. Pre-test probability scores were calculated according to the ESC chronic coronary syndromes guideline

(2019) and major adverse cardiovascular events (MACE) reviewed with a mean follow up time of 3.8 years.

**Results** A total of 1221 cases were reviewed between March 2015 and November 2018. 73 patients were excluded where they were referred on for further cardiologist assessment (54) or where insufficient data was available (19). Of the remaining 1148, 44 patients (1% per year) went on to be diagnosed with coronary artery disease, 26 of which had no prior history of IHD. 25 patients presented as an emergency with acute coronary syndrome. We observed a total of 19 deaths (0.44% per year) that could have been attributable to cardiac disease however our follow up is limited to locally available data. 38 patients were re-referred for investigation of chest pain; 33 of which had normal investigations and 5 patients were reassured and discharged again without investigation. Only 43% of patients seen and discharged without investigation had a low risk pre-test probability score of <5% with 21% having a high pre-test probability score. Whilst the majority of adverse events were seen in those with intermediate and high pre-test probabilities, overall adverse event rate remained low over a long follow up period.

**Conclusion** Whilst a pre-test probability score may help to determine which patients are more likely to go onto develop coronary disease, the majority of patients discharged with non anginal pain were in the intermediate and high risk groups. We recognise that clinical suspicion of coronary disease is an important part of the decision making process and that this model relies on the clinical skill of the specialist nurses in RACP clinics. We have demonstrated that where chest pain is non-anginal in character, patients can be safely reassured and discharged without investigation with a low adverse event rate over a long follow up period, supporting the current NICE 95 guidance.

**Conflict of Interest** None

## 196 PATIENTS PRESENTING WITH ACUTE CORONARY SYNDROMES HAVE UNREPORTED CORONARY ARTERY CALCIUM ON HISTORICAL CT IMAGING

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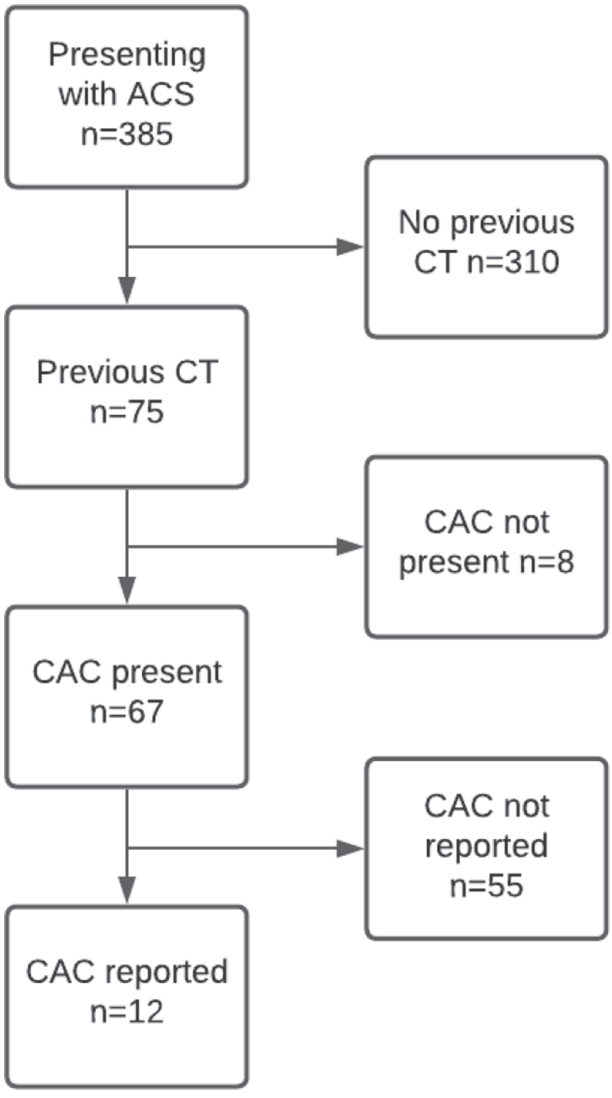
**Introduction** Ischaemic heart disease (IHD) remains the leading cause of mortality globally1. The presence and extent of coronary artery calcification (CAC) is a strong predictor of cardiovascular events, and CAC scoring has been shown to be more predictive of cardiovascular events than other traditional risk assessment scores2. Incidental coronary calcification can be detected and quantified on non-gated CT chest scans covering the heart in the field of view3. This finding is typically not reported4 and hence an opportunity to optimise cardiovascular risk assessment and treatment is missed. The Society of Thoracic Radiology have previously highlighted that incidental coronary calcification should be reported on CT chest scans5. We sought to investigate patients presenting to our centre with an acute coronary syndrome (ACS) event with historical CT imaging demonstrating coronary artery calcification.

**Methods** We retrospectively reviewed case records for all patients referred to our centre for an invasive coronary angiogram following their first known admission with an ACS event. ACS were defined according to contemporary guidelines from the European Society of Cardiology. We reviewed a 3 month period prior to the COVID-19 pandemic (01/01/2019 - 31/03/2019). The national imaging database in Scotland (PACS) was interrogated to identify previous CT imaging that includes the heart in the field of view. The presence of coronary calcification was confirmed and quantified using an ordinal scoring method previously described3. The clinical radiology reports for the scans were reviewed to determine the frequency of CAC being reported. Demographic information was collected from our electronic patient record (Clinical Portal) including the presence of risk factors for IHD. Prescribed medication prior to admission was also recorded using the on-admission medicines reconciliation documented in the electronic patient record.

**Results** 385 patients with first presentation of ACS were identified (figure 1). 75 (19%) had a prior non-gated CT chest imaging. The most common indication for CT was for investigation of possible malignancy. The mean interval from CT imaging to ACS admission was 36 months.CAC was present on 67 (89%) scans. The mean ordinal score was 4.04, corresponding to moderate CAC. The distribution of CAC by coronary artery revealed the majority of disease to involve the left anterior descending artery (table 1). Only 12/67 (18%) of




**Abstract 196 Figure 1** Study population