



UCLPartners Proactive Care Framework:

Atrial Fibrillation – Managing AF and Cardiovascular Risk

Supporting Primary Care to Restore and Improve Proactive Care



- COVID-19 has placed unprecedented pressure on our health system. This brings an added risk to people with long term conditions who need ongoing proactive care to stay well and avoid deterioration. Disruption to routine care may worsen outcomes for patients, increase their COVID risk and result in exacerbations that further increase pressure on the NHS – driving demand for unscheduled care in GP practices and hospitals.
- As primary care transforms its models of care in response to the pandemic, UCLPartners has developed real world frameworks to support proactive care in long term conditions. The frameworks include pathways for remote care, support for virtual consultations and more personalised care, and optimal use of the wider primary care team, e.g. healthcare assistants (HCA), link workers and pharmacists.
- Additionally, the frameworks include a selection of appraised digital tools, training and other resources to support patient activation and self-management in the home setting.
- This work has been led by primary care clinicians and informed by patient and public feedback.
- The UCLPartners frameworks and support package will help Primary Care Networks and practices to prioritise in this challenging time and to focus resources on optimising care in patients at highest risk. It will support use of the wider workforce to deliver high quality proactive care and improved support for personalised care. And it will help release GP time in this period of unprecedented demand.

UCLPartners Proactive Care Frameworks

UCLPartners has developed [a series of frameworks](#) for local adaptation to support proactive management of long-term conditions in post-COVID primary care.

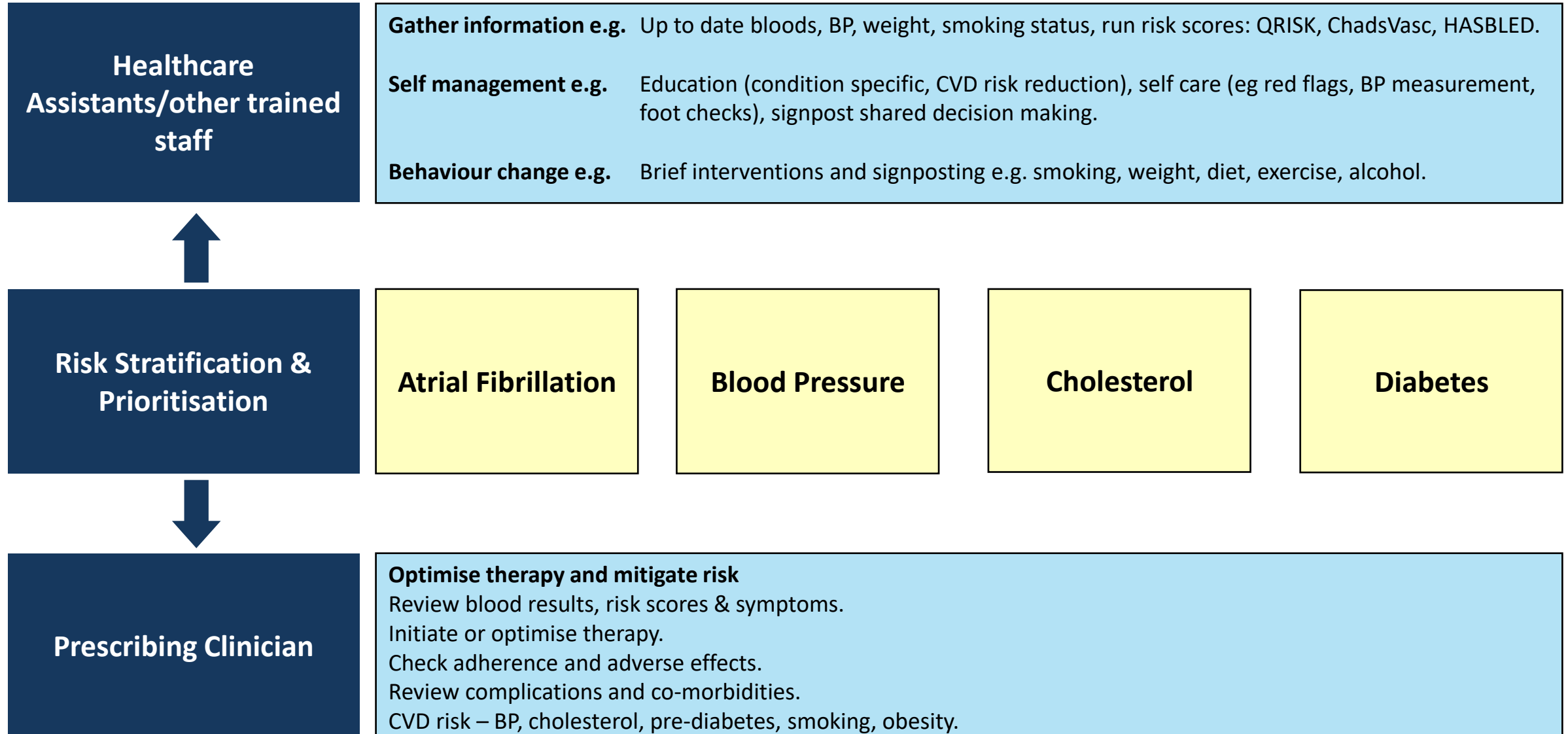
- Led by clinical team of GPs and pharmacists.
- Supported by patient and public insight.
- Working with local clinicians and training hubs to adapt and deliver.

Core principles:

1. Virtual where appropriate and face to face when needed.
2. Mobilising and supporting the wider workforce (including pharmacists, HCAs, other clinical and non-clinical staff).
3. Step change in support for self-management.
4. Digital innovation including apps for self-management and technology for remote monitoring.



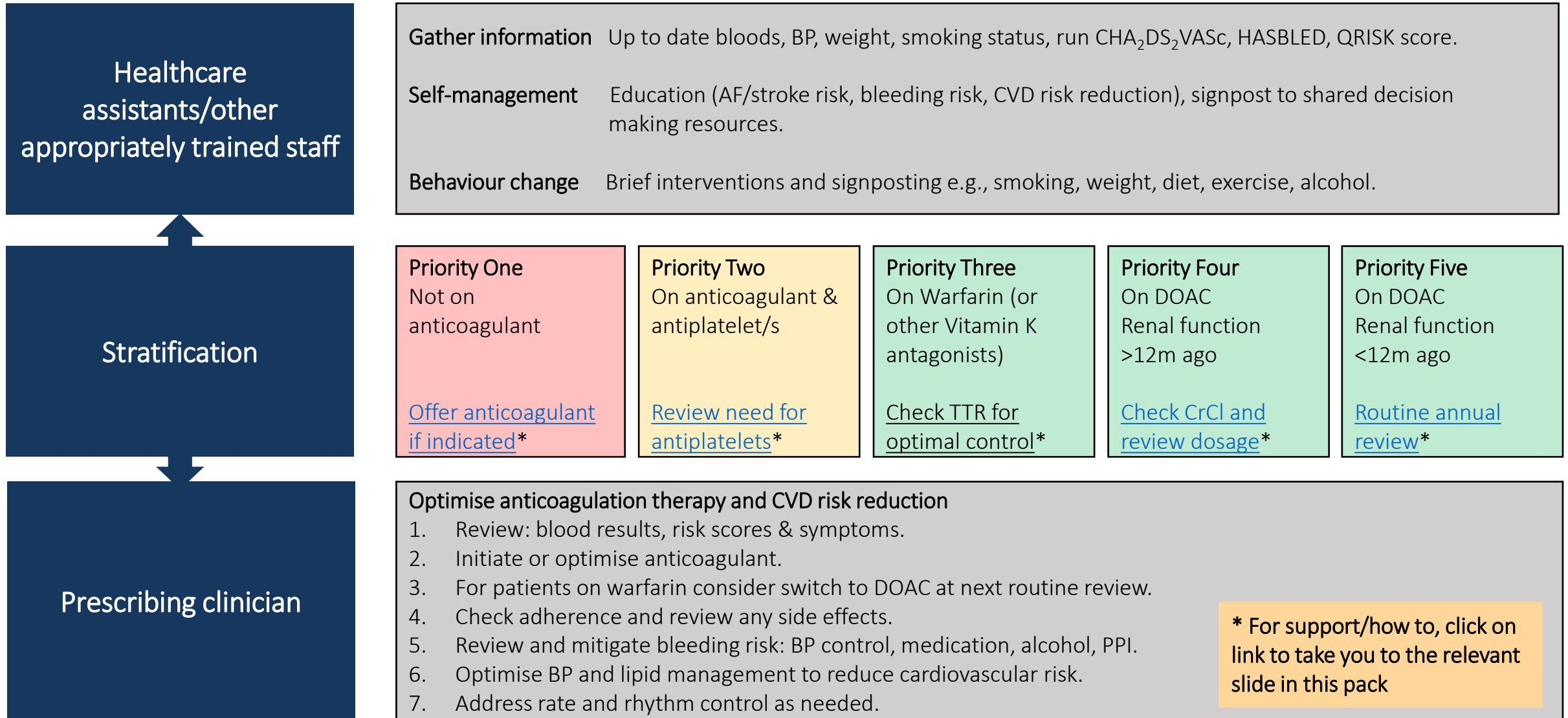
CVD High Risk Conditions – Stratification and Management Overview



Why the Focus on Atrial Fibrillation and Cardiovascular Risk?

- 1 Atrial fibrillation (AF) leads to a 5-fold increased risk in stroke and is responsible for 20% of all strokes. Anticoagulation reduces the risk of stroke by up to two thirds¹.
- 2 If not anticoagulated, 25% of people who experience an AF-related stroke will die and over 50% of people will be left with moderate to severe disability². Each stroke costs the NHS and social care over £45k over 5 years³.
- 3 For most people, the benefits of anticoagulation significantly outweigh the risks.
- 4 More effort should be made to address modifiable bleeding risk factors to allow patients to be safely anticoagulated; proton pump inhibitors are underused and should be considered in all patients at high risk of bleeding.
- 5 People with AF are more likely to also have high blood pressure, high cholesterol, obesity or smoke. These factors should be addressed routinely to reduce the risk of heart attack, peripheral arterial disease, and dementia.

Stratification and Management of Atrial Fibrillation (AF)



Pathways and Resources

1. Initiating Direct Oral Anticoagulants (DOACs)
2. Assessing stroke and bleeding risk
3. DOACs: Calculating creatinine clearance
4. DOACs: Dosing in non-valvular atrial fibrillation
5. DOACs: Reviewing condition management
6. DOACs: Choice of formulation
7. Anticoagulation in people taking antiplatelet therapy
8. Warfarin: Time in therapeutic range (TTR) monitoring
9. Warfarin to DOAC switching

Initiating Direct Oral Anticoagulants (DOACs)*

Action

- 1 Check the patient has Non-Valvular AF
- 2 Check CHA₂DS₂VASc
- 3 Ensure no contraindications to therapy
- 4 Check:
 - Bloods for renal function, LFTs, clotting and FBC
 - Bodyweight
 - Creatinine Clearance (CrCl)
- 5 Check bleeding risk with HASBLED score or ORBIT score, in line with local guidance
- 6 Shared Decision Making (SDM) - agree which DOAC to initiate. Correct choice of dose
- 7 Counsel patient and agree a plan for follow up including monitoring blood tests

Resource

DOAC contraindicated if mechanical prosthetic valve or known moderate to severe mitral stenosis

Offer anticoagulation if [CHA₂DS₂VASc](#) ≥ 2 (consider if = 1 in men)

DOAC contraindicated if pre-existing clotting disorder, pregnant, breastfeeding or planning pregnancy, mechanical heart valves – seek specialist advice.

For full list of contraindications see SmPCs at www.medicines.org.uk

[Creatinine clearance calculation](#)

All DOACs contraindicated if CrCl < 15ml/min

Dabigatran contraindicated if CrCl < 30ml/min

Apixaban, Edoxaban, Rivaroxaban, are not recommended if CrCl < 15ml/min

Address modifiable risks identified by [HASBLED or ORBIT score](#) to reduce bleeding risk. Review other medication – [including antiplatelets](#) and NSAIDs; consider PPIs

[DOAC dosing](#)

[DOAC monitoring](#)

Provide written information, an anticoagulant alert card and point of contact should issues arise

***NICE guidance 2021 recommends DOACs first line. If DOAC is unsuitable, consider warfarin following local pathways for initiation & monitoring**

Stroke Risk			
CHA ₂ DS ₂ VASc		CHA ₂ DS ₂ VASc Score	Number of AF-related strokes avoided per 1,000 AF patients treated with anticoagulant therapy per year*
Congestive Heart failure	1		
Hypertension	1		
Age >75 years	2		
Diabetes	1	1	4
Prior stroke/TIA	2	2	17
Vascular disease	1	3	25
Age 65-74 years	1	4	38
Female	1	5	57

Interpretation

1. Offer anticoagulation to all patients (male or female) with CHA₂DS₂VASc ≥ 2
2. Consider anticoagulation in all men with CHA₂DS₂VASc = 1
3. Antiplatelet monotherapy (Aspirin/Clopidogrel) is not recommended for stroke prevention in AF

Bleeding Risk Assessment

Bleeding Risk (HASBLED)

HASBLED Score		HASBLED Score	Number of major bleeds caused per 1,000 AF patients treated with anticoagulant therapy per year*
Uncontrolled hypertension (systolic >160mmHg)	1		
Abnormal liver function (Bili >2x ULN or AST/ALT/ALP >3x ULN)	1		
Abnormal renal function (Creat>200µmol/L, dialysis, transplant)	1	1	4
Prior stroke/TIA	1	2	12
History of major bleed or predisposition (anaemia)	1	3	15
Labile INR (on warfarin (TTR<60%))	1	4	21
Age >65 years	1		
Medication usage predisposing to bleeding (Antiplatelets/ NSAIDS)	1		
Alcohol (>8units/week)	1		

Interpretation

- HASBLED ≥3 indicates a higher bleeding risk
- Address modifiable bleeding risk factors to reduce HASBLED score e.g. lower BP, review concomitant drug therapy, reduce alcohol intake
- Consider a proton pump inhibitor to reduce upper GI bleeding
<https://www.mdcalc.com/has-bleed-score-major-bleeding-risk>

Bleeding Risk - ORBIT

ORBIT Score**		ORBIT Score	Risk level	Number of major bleeds caused per 1,000 AF patients treated with anticoagulant therapy per year
Haemoglobin <13 mg/dL for males and <12 mg/dL for females, or haematocrit <40% for males and <36% for females	2			
Age >74 years	1	0-2	Low	24
Bleeding history - Any history of GI bleeding, intracranial bleeding, or haemorrhagic stroke	2	3	Medium	47
GFR <60 mL/min/1.73 m ²	1	4-7	High	81
Treatment with antiplatelet agents	1			

**NICE 2021 indicated that ORBIT is the best tool for bleeding risk assessment, other tools may need to be used until it is embedded in clinical pathways and electronic systems

Interpretation

- Address modifiable bleeding risk factors to reduce bleeding risk e.g. lower BP, review concomitant drug therapy, reduce alcohol intake
- Consider a proton pump inhibitor to reduce upper GI bleeding
<https://www.mdcalc.com/orbit-bleeding-risk-score-atrial-fibrillation>

DOACs: Calculating Creatinine Clearance

eGFR should not be used to guide dosing decisions for DOACs¹

Use actual bodyweight (within 1 year) to calculate Creatinine Clearance (CrCl)

- If weight < 50kg or > 120kg or if BMI >40 : seek specialist advice

Use renal function checked within last 3 months

Calculate CrCl using Cockcroft Gault equation

- Be cautious with calculators integrated into GP IT systems as they may default to ideal bodyweight resulting in underdosing of DOAC
- Use [MDCalc](#)

CrCl	Monitoring interval
>60ml/min	Annually
30-60ml/min	6-monthly
<30ml/min	3-monthly

Adjust DOAC dose if necessary

See slide on [DOAC dosing in NVAf](#)

DOACs: Dosing in Non-Valvular Atrial Fibrillation

	Apixaban*	Dabigatran*	Edoxaban*	Rivaroxaban*
Standard dose	5mg BD	150mg BD	60mg OD	20mg OD
Reduced dose	2.5mg BD	110mg BD	30mg OD	15mg OD
Criteria for dose reduction	2 or more of: <ul style="list-style-type: none"> • Age ≥80 • Body weight ≤60kg • Cr ≥133µmol/L Or CrCl 15-29ml/min	1. Age ≥80 2. On verapamil 3. Consider ↓dose: <ul style="list-style-type: none"> • Reflux/gastritis • Age 75-80 • CrCl 30-50ml/min • “Bleed risk” 	1 or more of: <ul style="list-style-type: none"> • CrCl 15-50ml/min • Body weight ≤60kg • On ciclosporin, dronedarone, erythromycin, ketoconazole 	CrCl 15-49ml/min
Contraindicated / Not recommended	CrCl <15ml/min	CrCl <30ml/min	CrCl <15ml/min	CrCl <15ml/min

Check for common drug interactions & possible contraindications	Bleeding risk increased by
Antifungal agents	NSAIDs
Rifampicin	Antiplatelets
Phenytoin and anti-epileptics	Long term oral steroid use
Antiretrovirals	Antidepressants: SSRIs/SNRIs
Chemotherapy	

* SmPCs all available at www.medicines.org.uk;

DOACs: Reviewing Management

This review template is designed for review 1 month after initiation and according to the monitoring interval

Eligibility	Monitoring interval	Parameter
<ul style="list-style-type: none">All patients on DOAC	Annually	FBC, Renal & Liver function (calculate CrCl, weight)
<ul style="list-style-type: none">CrCl 30–60 mL/min	6 monthly	Renal function
<ul style="list-style-type: none">Patients over 75 years and / or frail	6 monthly	FBC, Renal & Liver function, weight
<ul style="list-style-type: none">CrCl 15–30 mL/ml	3 monthly	Renal function
Eg: intercurrent illness that may impact on renal or hepatic function	Individually agreed	Renal & Liver function +/- FBC

Annual clinical review* to include:

- Stroke risk assessment using CHA₂DS₂VASc
- Review of QRISK and manage CVD risk factors
- Addressing bleeding risk
- Check adherence
- Medicines review and check appropriate dosing
- Missed/delayed dose advice
- Alert card check

* Follow local DOAC clinical review protocols where available

DOACs: Choice of Formulation

Consideration	Option	Most suitable DOAC
Frequency of tablets/capsules	One tablet once a day	Edoxaban/rivaroxaban
	One tablet or capsule twice a day	Apixaban/dabigatran
With or without food	Take with or without food	Apixaban/dabigatran/edoxaban
	Take with food	Rivaroxaban
Use of a compliance aid (dosette box)	Suitable to go in compliance aid (Cannot use dabigatran in dosette box)	Apixaban/edoxaban/rivaroxaban
Swallowing difficulties or feeding tube	CAN be crushed	Apixaban/edoxaban/rivaroxaban
	Capsules CANNOT be opened	Dabigatran
Lactose intolerant patient		Dabigatran/edoxaban

Anticoagulation in People Taking Antiplatelet Therapy

- Antiplatelet therapy is not recommended for stroke prevention in AF; oral anticoagulants should be used.
- Some patients with AF are on antiplatelet therapy as treatment for vascular disease. See guidance below

Indication for antiplatelets	Antiplatelet	Action when initiating anticoagulation for AF
Primary prevention of CVD	Antiplatelet monotherapy	Stop antiplatelet therapy (antiplatelet therapy not recommended for primary prevention of CVD)
Secondary prevention of CVD <ul style="list-style-type: none"> • Stroke / Transient Ischaemic Attack (TIA) • Stable coronary heart disease (CHD) • Peripheral arterial disease (PAD) 	Antiplatelet monotherapy or Low dose rivaroxaban with aspirin	Stop antiplatelet therapy Increase DOAC dose (to AF stroke prevention dose) and stop aspirin
Patients within 12 months of an ACS or stent placement (cardiac or vascular)	Aspirin plus clopidogrel, ticagrelor or prasugrel	Seek specialist advice to agree the preferred drug regimen. Triple therapy (dual antiplatelet plus anticoagulant) duration must be clearly defined.
Patients more than 12 months after an ACS or stent placement (cardiac or other vascular)	Antiplatelet monotherapy	Stop antiplatelet therapy
	2 antiplatelets	Seek specialist advice

When using an anticoagulant plus an antiplatelet – add a proton pump inhibitor (PPI)

Adapted from: <https://b-s-h.org.uk/guidelines/guidelines/oral-anticoagulation-with-warfarin-4th-edition/> Page 318-319 and <https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Atrial-Fibrillation-Management> Page 61

Warfarin: Time in Therapeutic Range (TTR) monitoring

- For effective stroke prevention with warfarin, time in therapeutic range (TTR) should be maintained $\geq 65\%$
- INR should be checked at least 12 weekly in patients with stable INR – target INR in AF is 2.5 (range 2-3)
- All patients should have TTR calculated at each INR visit
- Reassess anticoagulation if poor control as shown by:
 - 2 INR values > 5 or 1 INR value > 8 within the past 6 months
 - 2 INR values < 1.5 within the past 6 months
 - TTR less than 65%
- If possible, address modifiable factors that may contribute to poor control:
 - Adherence, illness, interacting drugs, diet and alcohol consumption

If anticoagulation control cannot be improved, consider switch to DOACs, and discuss with the patient

Warfarin to DOAC Switching

- 1 Confirm the indication for warfarin is stroke prevention in AF
- 2 Exclude patients with contraindications to DOACs
- 3 Involve the patient in a [shared decision](#) to switch from warfarin to a DOAC
- 4 Check bodyweight and bloods for INR, renal function, LFTs, and FBC
- 5 Calculate CrCl using [Cockcroft Gault equation](#)
- 6 Decide which [DOAC to use](#) and what [dose](#)
- 7 Advise patient when to stop the warfarin and start the DOAC:
 - INR should be <2.5 before initiating DOAC
 - DOAC may need to be withheld or 24-48 hours after stopping warfarin depending on the measured INR
- 8 Provide written information, an anticoagulant alert card and ensure they have a point of contact should issues arise

Guidance for the safe switching of warfarin to direct oral anticoagulants (DOACs) for patients with non-valvular AF and venous thromboembolism (DVT / PE) during the coronavirus pandemic

26 March 2020

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Endorsed by: Royal College of General Practitioners, British Haematology Society

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[Click for detailed guidance on safe switching](#)

Hypertension in Patients with Atrial Fibrillation

Detection and Management of Hypertension in Patients with Atrial Fibrillation

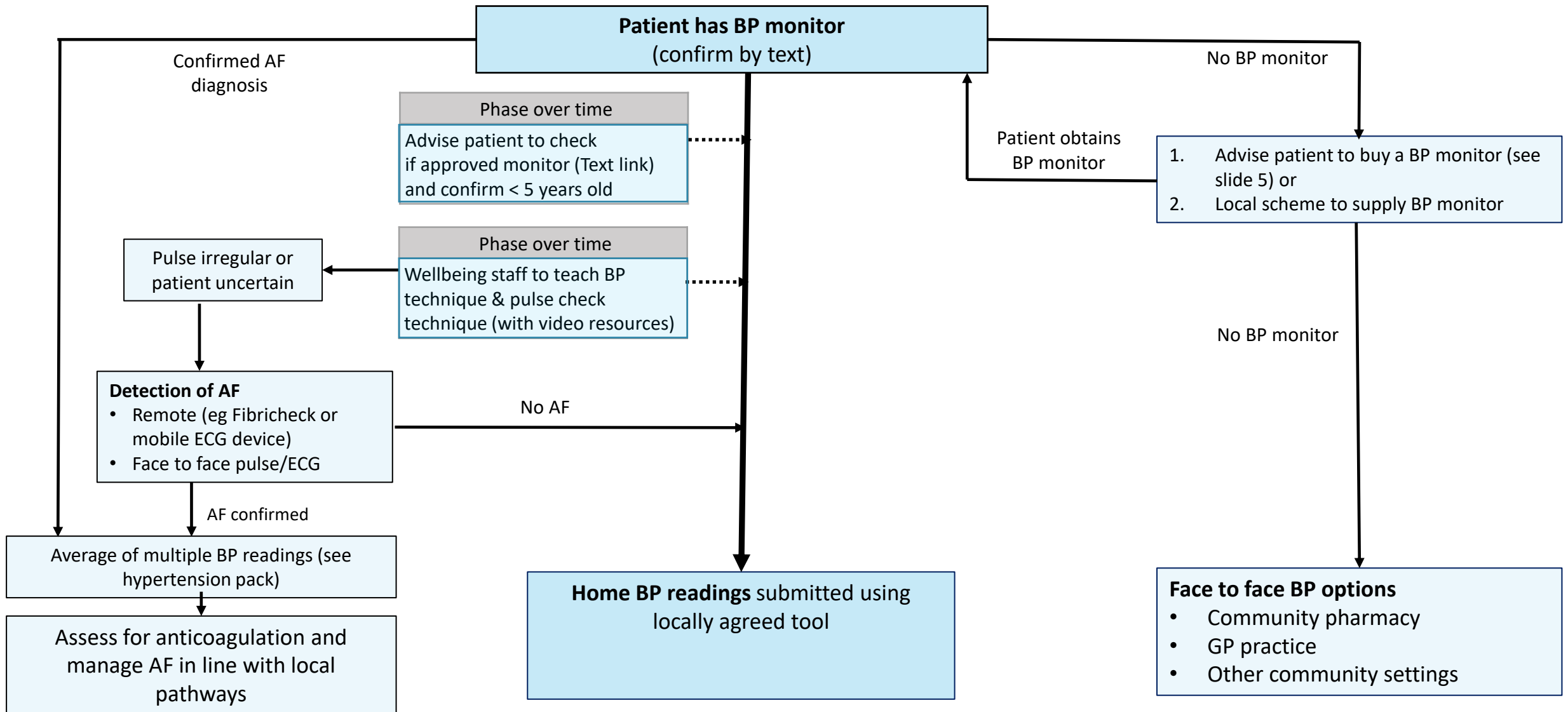
Blood pressure should be checked in patients with AF to identify undiagnosed hypertension. If hypertension is suspected due to a high BP reading, the diagnosis should be confirmed using ABPM or home BP checks over 7 days.

Checking BP in patients with established hypertension:

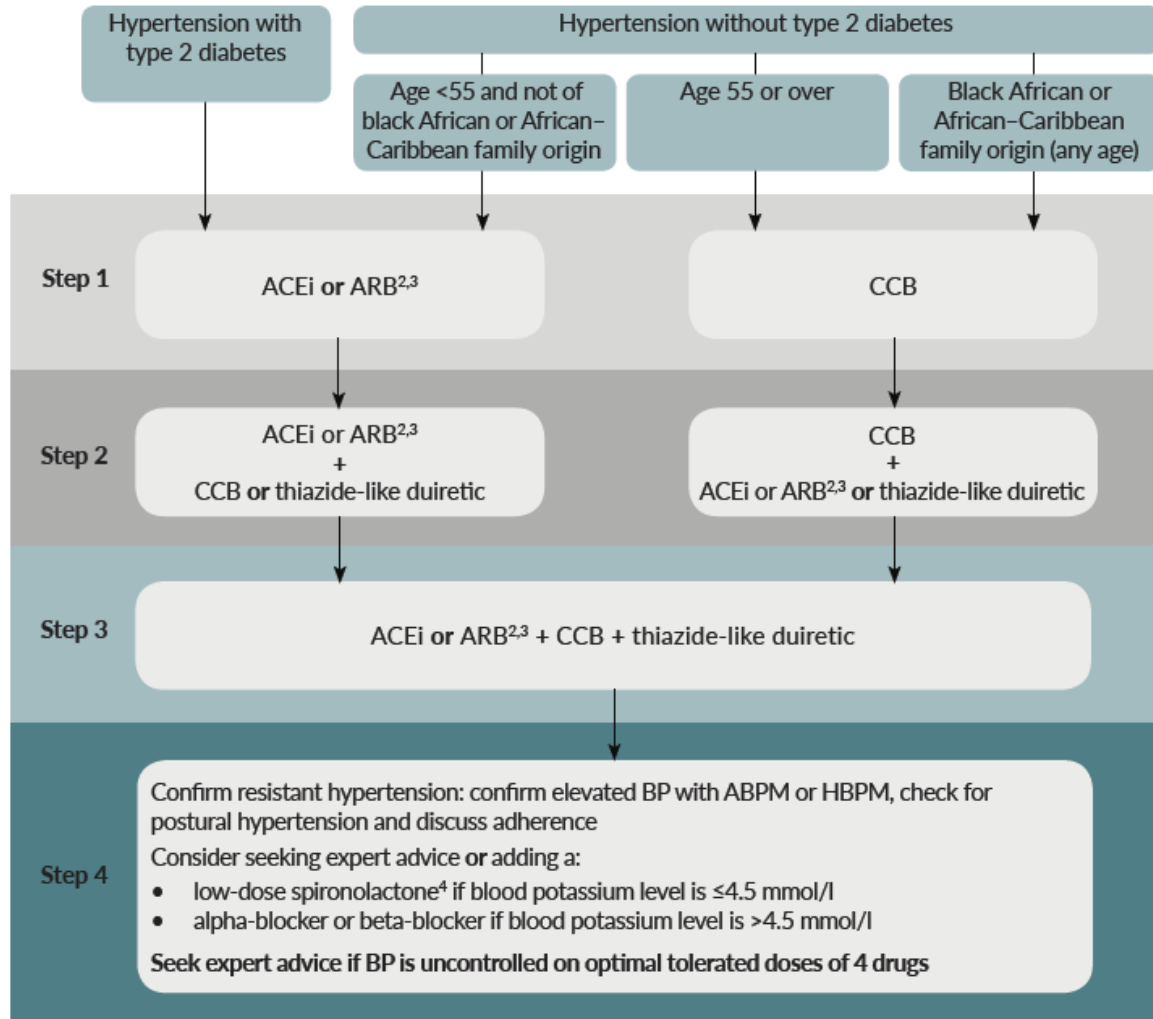
- Patients **with** AF:
 - Submit 2 BP readings each morning and evening over 4 days. Calculate the average systolic and diastolic values.

- Please refer to UCLP hypertension pathway for detailed guidance:
https://s31836.pcdn.co/wp-content/uploads/Hypertension-Framework_UCLPartners-LTCs-April-2021-v2.0.pdf

Home Blood Pressure Monitoring Pathway



Choice of antihypertensive drug¹, monitoring treatment and BP targets



Use clinical judgement for people with frailty or multimorbidity

Offer lifestyle advice and continue to offer it periodically

Monitoring treatment

Use clinic BP to monitor treatment.

Measure standing and sitting BP in people with:

- type 2 diabetes or
- symptoms of postural hypotension or
- aged 80 and over.

Advise people who want to self-monitor to use HBPM. Provide training and advice.

Consider ABPM or HBPM, in addition to clinic BP, for people with white-coat effect or masked hypertension.

BP targets

Reduce and maintain BP to the following targets:

Age <80 years:

- Clinic BP <140/90 mmHg
- ABPM/HBPM <135/85 mmHg

Age ≥80 years:

- Clinic BP <150/90 mmHg
- ABPM/HBPM <145/85 mmHg

Postural hypotension:

- Base target on standing BP

Frailty or multimorbidity:

- Use clinical judgement

¹For women considering pregnancy or who are pregnant or breastfeeding, see NICE's guideline on [hypertension in pregnancy](#). For people with chronic kidney disease, see NICE's guideline on [chronic kidney disease](#). For people with heart failure, see NICE's guideline on [chronic heart failure](#)

²See MHRA drug safety updates on [ACE inhibitors and angiotensin-II receptor antagonists: not for use in pregnancy](#), which states 'Use in women who are planning pregnancy should be avoided unless absolutely necessary, in which case the potential risks and benefits should be discussed', [ACE inhibitors and angiotensin II receptor antagonists: use during breastfeeding](#) and [clarification: ACE inhibitors and angiotensin II receptor antagonists](#). See also NICE's guideline on [hypertension in pregnancy](#).

³Consider an ARB, in preference to an ACE inhibitor in adults of African and Caribbean family origin.

⁴At the time of publication (August 2019), not all preparations of spironolactone have a UK marketing authorisation for this indication.

Abbreviations: ABPM, ambulatory blood pressure monitoring; ACEi, ACE inhibitor; ARB, angiotensin-II receptor blocker; BP, blood pressure; CCB, calcium-channel blocker; HBPM, home blood pressure monitoring.



This visual summary builds on and updates previous work on treatment [published by the BIHS](#) (formerly BHS)

Management of Broader Cardiovascular Risk in AF: Cholesterol

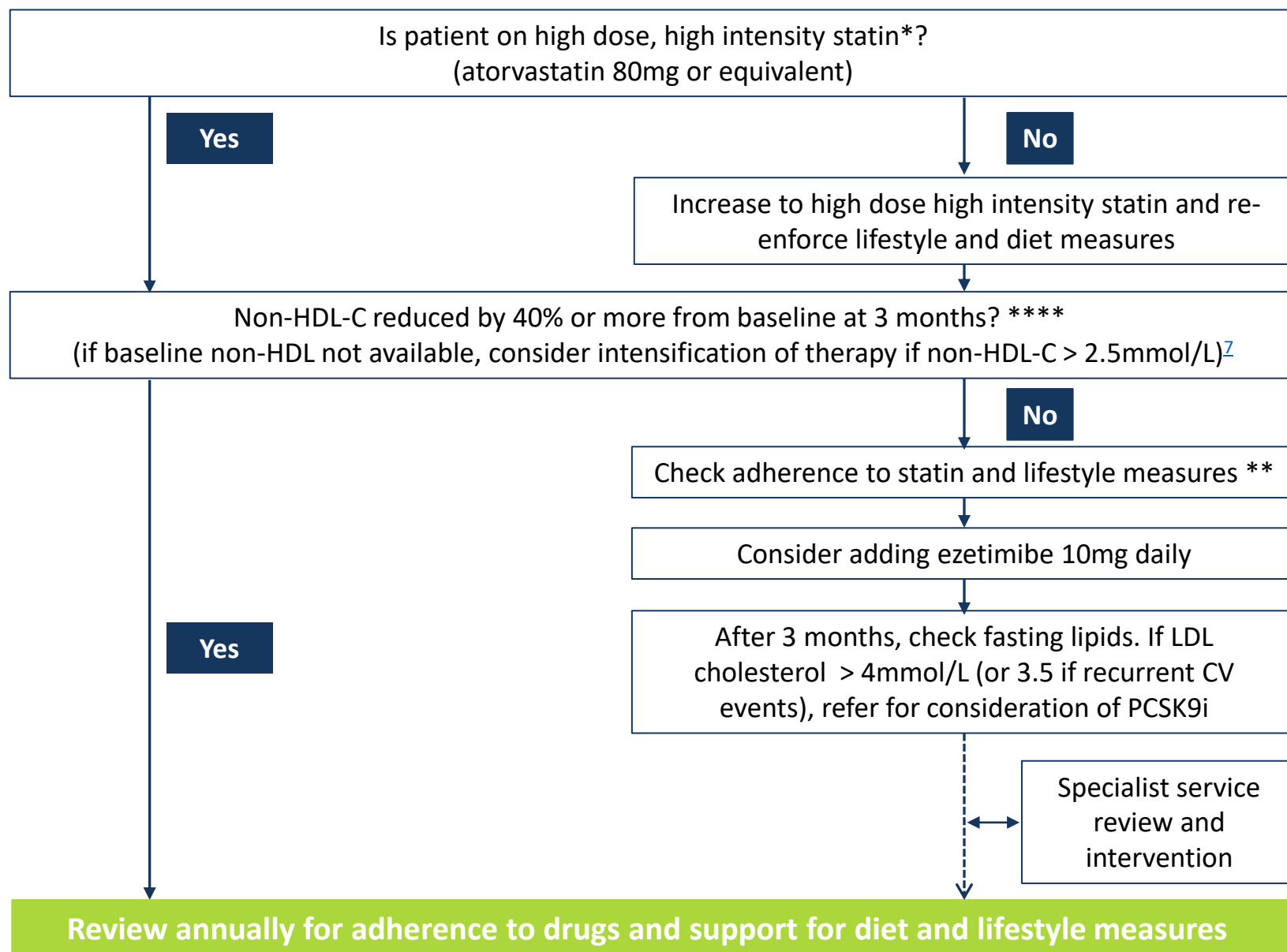
Managing High Cholesterol and Cardiovascular Risk in People with Atrial Fibrillation

The following slides will help clinicians manage the broader cardiovascular risk in people with AF:

- **Pre-existing cardiovascular disease**
 - Optimise lifestyle
 - Use of high intensity statins at maximal appropriate dose
- **No pre-existing cardiovascular disease**
 - Optimise lifestyle and lipid lowering therapy as primary prevention in people with:
 - QRisk >10% in ten years
 - CKD 3-5
 - Type 1 Diabetes for >10 years or over age 40
- **All patients:**
 - Responding to possible statin intolerance
 - Managing muscle symptoms and abnormal LFTs in people taking statins
- **Please refer to UCLP lipid pathway for detailed guidance:**

https://s31836.pcdn.co/wp-content/uploads/Lipids-and-FH-Framework_UCLPartners-LTCs-April-2021-v4.1.pdf

Optimisation of Lipid Management in People with AF and CVD – Secondary Prevention



Optimal High Intensity Statin for secondary prevention
 (High intensity statins are substantially more effective at preventing cardiovascular events than low/medium intensity statins)

Atorvastatin	80mg
Rosuvastatin	20mg

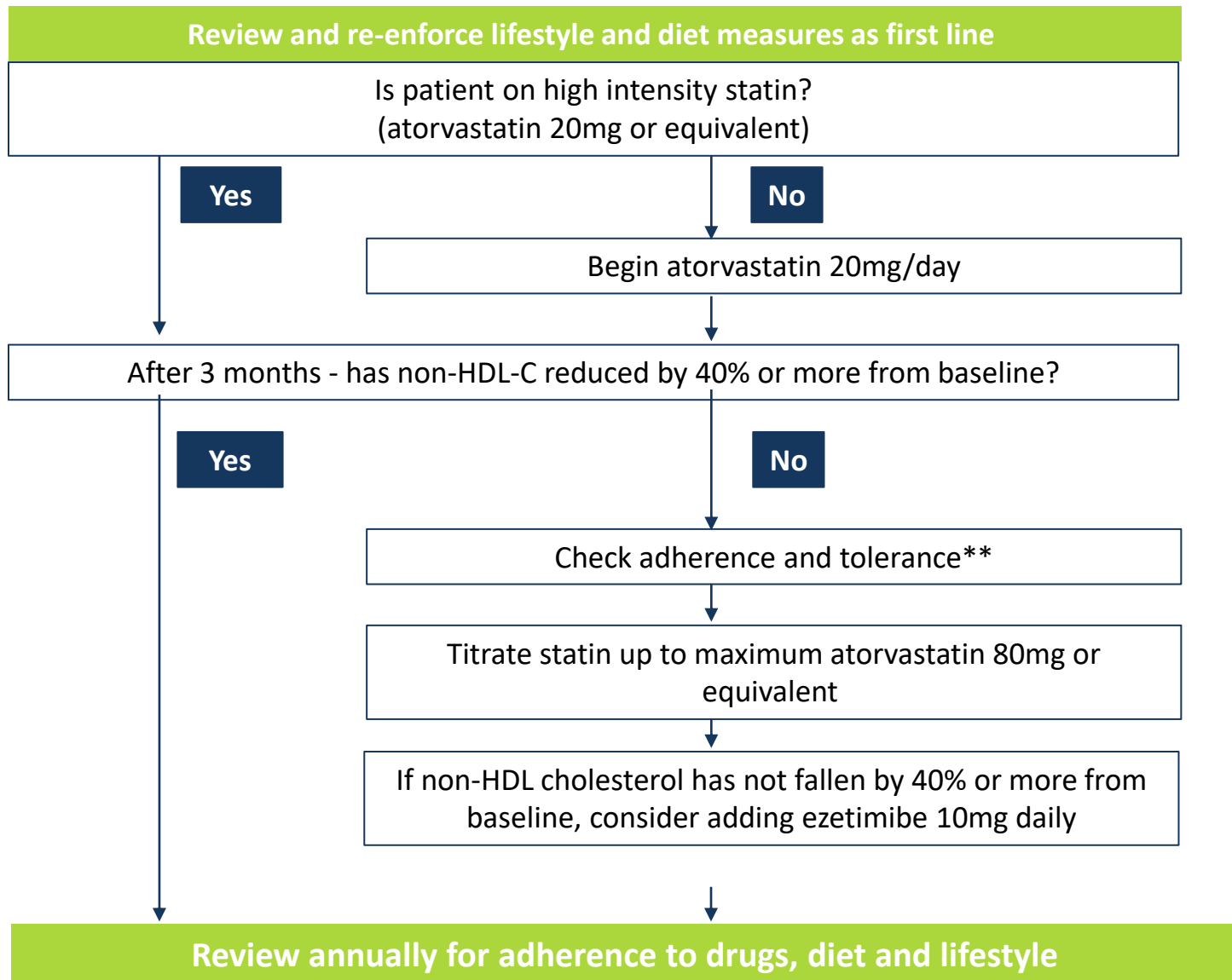
* Dose may be limited if:

- eGFR < 30ml/min
- Drug interactions
- Intolerance

** If statin not tolerated, follow [statin intolerance pathway](#) and consider ezetimibe 10mg daily +/- [bempedoic acid](#) 180mg daily

**** NICE Guidance recommends a 40% reduction in non-HDL cholesterol

Optimisation of Lipid Management in People with AF and High Cardiovascular Risk* – Primary Prevention



Optimal High Intensity statin for Primary Prevention
(High intensity statins are substantially more effective at preventing cardiovascular events than low/medium intensity statins)

Atorvastatin	20mg
Rosuvastatin	10mg

* High CVD risk

- QRisk >10% in ten years
- CKD 3-5
- Type 1 Diabetes for >10 years or over age 40

** If statin not tolerated, follow [statin intolerance pathway](#) and consider ezetimibe 10mg daily +/- [bempedoic acid](#) 180mg daily

Important considerations

- Most adverse events attributed to statins are no more common than placebo*
- Stopping statin therapy is associated with an increased risk of major CV events. It is important not to label patients as 'statin intolerant' without structured assessment
- If a person is not able to tolerate a high-intensity statin, aim to treat with the maximum tolerated dose
- A statin at any dose reduces CVD risk – consider annual review for patients not taking statins to review cardiovascular risk and interventions

A structured approach to reported adverse effects of statins

1. Stop for 4-6 weeks.
2. If symptoms persist, they are unlikely to be due to statin
3. Restart and consider lower initial dose
4. If symptoms recur, consider trial with alternative statin
5. If symptoms persist, consider ezetimibe +/- bempedoic acid

**(Collins et al systematic review, Lancet 2016)*

Digital Resources

Living with Atrial Fibrillation

British Heart Foundation - <https://www.bhf.org.uk/information-support/heart-matters-magazine/medical/living-with-atrial-fibrillation>
<https://www.bhf.org.uk/information-support/conditions/atrial-fibrillation>
[Managing blood pressure at home](#)

Starting anticoagulation

Starting anticoagulation with Jack - <https://vimeo.com/206257430>
Don't wait to anticoagulate - <http://www.dontwaittoanticoagulate.com/>

Educational video resources for patients created by UCLPartners - <https://uclpartners.com/work/anti-coagulation-videos/>

Patient organisations

The AF Association has information for patients - <https://www.heartrhythmalliance.org/afa/uk/patient-resources>
Anticoagulation UK - <https://www.anticoagulationuk.org/provision/anticoagulants>

Diet

Providing information and recipes for easy ways to eat better from the [‘One You’](#) website
[NHS advice on lowering cholesterol levels & what is cholesterol and how do I lower it?](#)

Smoking cessation

[NHS support](#), stop smoking aids, tools and practical tips

Alcohol

[Heart UK alcohol guidance](#) & [NHS Drink Less guidance](#)

Exercise

[iPrescribe app](#) offers a tailored exercise plan by creating a 12-week exercise plan based on health information entered by the user
[Getting active around the home](#): tips, advice and guidance on how to keep or get active in and around the home from Sport England
[Dance to health](#): Online dance programme especially tailored to people over 55 years old

Digital Resources to Support Clinical Management: Atrial Fibrillation

Video resources (*What is anticoagulation; I am on a DOAC; Starting a DOAC; Anticoagulation in VT; Anticoagulation in atrial fibrillation; Switching from warfarin to a DOAC*) created by UCLPartners <https://uclpartners.com/work/anti-coagulation-videos/>

Cockcroft-Gault Equation <https://www.mdcalc.com/creatinine-clearance-cockcroft-gault-equation>

RCGP Module

The Royal College of General Practitioners has now launched a new e-module to help healthcare professionals not only learn about Atrial Fibrillation, but also about the current national guidelines to clinical practice. <https://elearning.rcgp.org.uk/course/info.php?id=262>

Locally commissioned digital tools:

AF Toolkit – www.aftoolkit.co.uk

UCLP Proactive Care resources to address additional CVD and respiratory conditions can be accessed [here](#)

Implementation Support

Proactive Care Frameworks: Implementation & Support Package

Implementation Support is critical to enable sustainable and consistent spread.

UCLPartners has developed a support package covering the following components:

Search and stratify

Comprehensive search tools for EMIS and SystmOne to stratify patients

- Pre-recorded webinar as to how to use the searches
- Online Q&A to troubleshoot challenges with delivery of the search tools

Workforce training and support

Training tailored to each staff grouping (e.g. HCA/ pharmacist etc) and level of experience

- **Delivery:** Protocols and scripts provided/ training on how to use these underpinned with motivational interviewing/ health coaching training to enable adult-to-adult conversations
- **Practical support:** e.g. correct inhaler technique; correct BP technique, Very Brief Advice for smoking cessation, physical activity etc
- **Digital implementation support:** how to get patients set up with appropriate digital
- **Education sessions** on conditions
- **Communities of Practice**

Digital support tools

Digital resources to support remote management and self-management in each condition

Implementation toolkits available where required, e.g. MyCOPD

Support available from UCLP's commercial and innovation team for implementation

Thank you

For more information please contact:

primarycare@uclpartners.com

www.uclpartners.com
[@uclpartners](#)

Version tracker

Version	Edition	Changes Made	Date amended	Review due
2	2.0	<ul style="list-style-type: none">Incorporated hypertension and cholesterol management content for patients with multi-morbidity		
2	2.1	<ul style="list-style-type: none">Amended version control table to include dates and removed date from first slide	June 2021	December 2021
3	3.0	<ul style="list-style-type: none">Removed slide on resources for remote diagnostics and monitoringAmended information on cholesterol managementRemoved statistics on statins and statin intensity tableAdded ORBIT bleeding risk toolAdded option of bempedoic acid	August 2021	February 2022