CLEAR
Empowering staff to innovate care

CLEAR Living Well 2023

Central and West Warrington PCN

Improving the prevention and management of cardiovascular disease through targeted support and community outreach

AT A GLANCE

CLEAR CHALLENGE

High levels of deprivation and CVD, low take up of NHS Health Checks and a need for clear structured CVD pathways

KEY CHANGES

New NHS Health Check Hub reaching out to community settings, enhanced pre-diabetes reviews and proactive assessments for patients considered obese

FORECAST BENEFITS

Better patient outcomes, reduced health inequalities, more than 460 ED attendances prevented and annual productivity savings for the PCN of £1.2m

THE CHALLENGE

There were high levels of deprivation and cardiovascular disease (CVD) in the primary care network (PCN) population - with people having higher than average CVD risk factors, with obesity the largest cohort. However, take-up of NHS Health Checks - a key predictor of CVD - was low at 26%.

PCN clinicians were keen to establish clear structured pathways for the prevention and management of the disease. There was an opportunity to improve communication and engagement within and between the PCN workforce, third party providers and community services to enhance patient care.

WHAT THEY DID

Clinicians from the PCN supported by the National CLEAR team sought the views of staff involved in CVD prevention and management through interviews and focus group, engaging 25 colleagues.

Seven years of data was analysed relating to more than 72,800 patients registered between 2015 and 2022. This consisted of 1.25m appointments and 5.5m consultations. The insights and data were combined to identify key themes impacting CVD prevention locally.

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CLEAR RECOMMENDATIONS

A PCN NHS Health Check Hub could be created, staffed by a dedicated multi-disciplinary team and optimising the Additional Roles Reimbursement Scheme (ARRS). Staff trained in CVD prevention and management would increase the number of checks in line with the ambitions of the NHS Long Term Plan. This team would also provide health checks in community settings to reach patients in more deprived areas. and ethnic minority groups. Another key recommendation was for enhanced pre-diabetes reviews to be carried out by the team, giving the opportunity to conduct a mini health check at the same time.

A CVD champion could be nominated at each practice who would link with prevention services and work with Warrington Voluntary Action to plan visits to community groups. All patients with a body mass index (BMI) of over 30 could be recalled every two years to assess their risk of CVD and encourage healthier lifestyles. Other recommendations included improving text communication with patients to enable them to book appointments digitally.

> More targeted measures could improve health outcomes with a reduction of 24 strokes and heart attacks and more than 460 A&E attendances prevented annually with PCN productivity savings of £945,000 a year

FORECAST IMPACT

Patient outcomes would improve and health inequalities be reduced by increased access and more targeted prevention measures – particularly through the NHS Health Check Hub. Strengthened workforce capability on CVD prevention would also reduce pressure on GPs.

There would be increased life expectancy and quality of life with an annual reduction of 24 strokes and heart attacks and more 460 A&E attendances prevented, saving the system up to £268,788 over three years. For the PCN a reduction in CVD could generate annual productivity savings of up to £1.2m, which would offset the £77,000 cost of the new model of care, through the release of around 30,000 primary care consultations a year and increased revenue from additional activity.