CLEAR
Empowering staff to innovate care

NHS England

The National CLEAR Programme

CLEAR Focus Living Well 2024 – expression of interest pack

Supporting primary care networks to develop new models of care for CVD prevention

January 2024

33n

Welcome to the National CLEAR Programme

Introduction

Thank you for your interest in CLEAR Living Well 2024 – 14 transformation projects designed to support primary care networks (PCNs) across England with the continued focus on the prevention of cardiovascular disease (CVD).

Commissioned by NHS England (NHSE), we are inviting PCNs to submit an expression of interest (EOI) to take part in a five-month project to develop a new model of care to improve the quality and life expectancy of people with long term conditions at risk of CVD. It is open to 14 PCNS, two from each of the NHSE regions. We are now taking EOI for the second phase of the project, with the remaining places open to PCNs in the Midlands, East of England and South East.

The opportunity is part of ongoing nationwide work focused on the key NHS Long Term Plan ambitions and the national CVD programme. It will be based on preventative new models of care and workforce that were developed with frontline staff in three PCNs in Cheshire and Merseyside as part of CLEAR Living Well 2023 (further information can be found on page four).

The 14 successful PCNs will be supported to roll out one of the new models, through a series of workshops and one to one sessions, adapting it to meet the needs of the local population and workforce.

This document explains the CLEAR approach and how the programme can support your PCN to enhance your CVD prevention, proactively caring for patients at risk of developing CVD and other related long term conditions. This document is split into two parts:

- Part 1 provides further information on the opportunity and timescales.
- Part 2 gives some background to the National CLEAR Programme.

I look forward to receiving your expression of interest and working with you to optimise the health of your populations supporting them to live longer healthier lives.

Dr Alex Monkhouse
Director of Delivery, National CLEAR Programme and Director, 33n

> “After 20 years of working in cardiology, I feel prevention is critical to improving people’s quality of life and reducing their chances of having heart attacks, strokes, and angina.”
>
> Julie Bowen, Clinical Cardiology Nurse Specialist, Wirral Community Health and Care NHS Foundation Trust

Opportunity and national context

Our latest CLEAR Living Well 2024 Programme commissioned by NHS England offers 14 PCNs, two from each NHSE region, the opportunity to develop and prepare a high-level business case for an evidenced-based new model of care to enhance CVD prevention within their local populations.

The 14 sites will be selected through an expression of interest process (more information on page eight) with the programme split into two phases, phase one with six PCNs from January to May 2024, followed by phase two from May to September 2024.

Based on recommended models from the CLEAR Living Well 2023 (see page four), the PCNs will be supported by the national CLEAR programme to refine one of the new models to align it with their local populations and workforces.

The five-month project will comprise three regional workshops and a series of one-to-one meetings when PCNs will be assisted to build a business case for the new model of care. Through the workshops, the PCNs will be guided through the CLEAR approach including clinical engagement and data analysis to identify patients at risk of developing CVD and other related long-term conditions.

The work is part of the NHS Long Term Plan which highlighted CVD prevention as a clinical priority. It emphasised that CVD was the single biggest condition where lives can be saved and made a commitment to provide extra rehabilitation support for the prevention and management of disease to enable people to live longer more fulfilling lives.

The project will support PCNs to:

- Develop a systematic approach to CVD care and enhance the design of local CVD services
- Navigate primary care data to identify patients who are at risk of developing CVD and other related long-term conditions to align the new model of care with their local population
- Consider the system partners to work with to deliver CVD care in an inclusive and effective manner
- Maximise Additional Roles Reimbursement Scheme (ARRS) roles ensuring they align with patient and workforce needs.

The work will include workforce modelling, scenario modelling with projected impacts and a readiness assessment to implement the model of care – laying the foundations and ensuring the right approach is taken for both patients and staff.

CLEAR Living Well 2023

This latest programme is aimed at spreading the learning from the CLEAR Living Well 2023 programme which was driven by frontline staff from three primary care networks (PCNs) and the voluntary sector within Cheshire and Merseyside ICS.

The CVD Prevention team in the Clinical Policy Unit of NHSE commissioned the national CLEAR programme to support the PCNs to develop new models of care and workforce to proactively care for patients at risk of developing the disease and other related long term conditions. The PCNs involved were East Warrington, Central and West Warrington, and Healthier South Wirral PCNs. They were supported to identify patients at risk of developing CVD through data analysis and clinical engagement with organisations across the system. An initial pilot project was also carried out with Hyde PCN. The challenges, recommendations and forecast impact of the projects are outlined below.

Hyde

With high levels of deprivation, obesity and smoking, there was an increased CVD risk within the PCN's population and life expectancy was lower than the national average. Take-up of NHS Health Checks was half pre-pandemic levels. Patients with two or more CVD lifestyle risk factors had 5.5 more consultations per year on average than the general adult population. After analysing data from 57,000 patients and 1.5 million appointments, the project team recommended that the identification of patients with CVD risk factors could be enhanced by increasing the uptake of NHS Health Checks - optimising IT systems and improving booking and screening access, especially for younger patients. Other recommendations included increasing hypertension reviews - remotely for medium and low risk patients, and face-to-face reviews in practices and pharmacies for those at high risk. A new CVD personalised care team would help patients change their behaviour and better manage their own health. Taking a systematic approach to the identification, monitoring and management of patients at risk of CVD was forecast to improve significantly both people's life expectancy and quality of life. Up to 19 strokes and heart attacks a year could be avoided saving the NHS around £350,000 with a wider return on investment of £1.6million. The avoidance of disease could release around 15,000 consultations a year.

East Warrington

The PCN was facing a number of challenges with CVD rates above the national average and many people living in areas of significant deprivation. The COVID-19 pandemic had led to a reduction in the detection of high blood pressure and the take up of services encouraging people to manage their own health was low. The project recommended a new multi-disciplinary CVD prevention team to improve the screening and the management of patients with high blood pressure. This included an 'in reach' community worker to raise awareness among hard-to-reach groups. A social prescriber could help patients address the wider determinants of health. The forecast impact of the recommendations was an increase in GP capacity, improved CVD prevention and outcomes, reduced healthcare costs and better patient care, safety and access. Over three years, six heart attacks and four strokes could be prevented and 184 more patients from deprived areas could be diagnosed each year. Savings of up to £247k could be generated through extra quality and outcomes framework payments, a 6,000 reduction in annual GP appointments and reduced prescription costs. Heart attack and stroke prevention could generate wider system savings of almost £100k.

CLEAR Living Well 2023

Central and West Warrington

Within their local population, the PCN had high levels of deprivation and CVD. Take-up of NHS Health Checks was low, and clinicians were keen to establish clear pathways for prevention and management of the disease. After analysing eight years of data involving 72,000 patients, 1.2 million appointments and 5.4 million consultations, the project team made a series of recommendations including a new PCN-wide health check hub with a multi-disciplinary team. Staff trained in the prevention and management of CVD would increase the number of NHS Health Checks to meet the 75% national target . They would provide health checks in the community, reaching people in deprived areas and ethnic minority groups. Each PCN practice would have a CVD champion acting as a link to prevention services and work with the third sector to provide blood pressure checks. Patient outcomes could improve, and health inequalities be reduced by increased access, targeted care and strengthened workforce capability. A reduction in CVD could generate potential annual productivity savings for the PCN of up to £1.25 million through the release of an estimated 30,000 primary care appointments a year and direct remuneration to the PCN with increased activity. The system could see a prevention of up to 463 A&E attendances, reduced use of medications and a reduction in stroke and myocardial infarction of up to 24 cases, saving the wider system around 550K per annum.

Healthier South Wirral

The PCN needed better, more targeted ways of identifying patients at risk of CVD and to bring screening for atrial fibrillation and high cholesterol in line with blood pressure screening. Heart attacks and strokes had increased in recent years but take-up of NHS Health Checks by patients with CVD risk factors was low. The project analysed data from an eight-year period. Recommendations included a dedicated CVD team from the existing workforce with health coaches running satellite clinics, prevention and lifestyle advice, and a care-coordinator identifying at risk patients and referring to community clinics. The forecast impactwas a more proactive, preventative approach to CVD screening and diagnosis and a healthier population. Improved screening and treatment for patients with high blood pressure is projected to prevent four heart attacks and five strokes over three years.
Improved management of patients with hypertension could prevent three strokes, heart attacks and deaths over five years. It is forecast that GP appointments could reduce by 1,184 a year, saving £49,728. The prevention of heart attacks and strokes could generate forecast savings to the NHS of £99,998 over three years.

Participation in the CLEAR project

Each phase of the programme will last five months, the schedule includes an onboarding webinar in January (for both phases), weekly catchups and three workshops – these will be a mixture of face-to-face and virtual.

Participating PCNs - with at least one GP as the clinical lead - will need to commit to attending all the above meetings and workshops with the national project team.

Following selection, an initial meeting will take place with each successful PCN to go through the project plan and select the new model of care to be developed which will be taken forward to the design phase.

Preparation for the workshops

A few hours will need to be set aside to prepare and gather information for the three workshops. Further guidance will be sent out on the data requirements needed once the 14 PCNs have been selected, this information will include:

- Summary data on patients at risk of CVD e.g. cohort size, service use and demographics
- Current pathways for the prevention and management of patients at risk of CVD
- Stakeholders identified to inform clinical engagement and attend workshop 1 (virtual)
- Perceived challenges on screening and treatment for the cohort
- Details of the current workforce

The project's outputs will include a final presentation on the PCN's specific high-level business case, implementation roadmap and communication plan.

A timetable for both phases of the project is on page seven.

Programme timelines

Phase one			
Activity	Format	Dates	Detail
Onboarding webinar	Virtual	2-5 Jan	Further information on the project and guidance to 1:1 meetings and workshops.
Initial one-to-one meetings with PCNs	Virtual	8-22 Jan	Meetings with clinical and data leads to assess readiness, discuss models of care, aims and expectations.
Workshop one	Virtual / in-person	5-19 Feb	Discussion on the new model of care. Stakeholder engagement and initial review of PCN data
Workshop two	Virtual / in-person	4-18 Mar	Refinements to new models of care, pathway and workforce re-design.
Workshop three	Virtual / in-person	1-15 Apr	Operationalisation, key steps to implementation and impact.
Final one-to-one meetings with PCNs	Virtual	29 Apr-13 May	Presentation of outputs, feedback and evaluation plan.
Phase two			
Activity	Format	Dates	Outline
Initial one-to-one meetings with PCNs	Virtual	13 May-3 Jun	Meetings with clinical and data leads to assess readiness, discuss models of care, aims and expectations.
Workshop one	Virtual / in-person	10 Jun-1 Jul	Discussion on the new model of care. Stakeholder engagement and initial review of PCN data
Workshop two	Virtual / in-person	8-29 Jul	Refinements to new models of care, pathway and workforce re-design.
Workshop three	Virtual / in-person	5-26 Aug	Operationalisation, key steps to implementation and impact.
Final one-to-one meetings with PCNs	Virtual	2-23 Sept	Presentation of outputs, feedback and evaluation plan.

Expression of interest process

Deadline for EOIs

The first phase of the project is underway and we are now taking EOI for the second phase of the project, with the remaining places open to PCNs in the **Midlands, East of England** and **South East.** The second phase is due to commence in May 2024.

The deadline for expressions of interest for the second phase is **5pm on Friday 16 February 2024**.

Please send your completed form by email to the CLEAR project team: projectsupport@33n.co.uk

Confirmation of successful PCNs will be made on **Friday 1 March 2024.**

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Part 2: An introduction to CLEAR

January 2024

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Introducing the National CLEAR Programme

What is CLEAR?

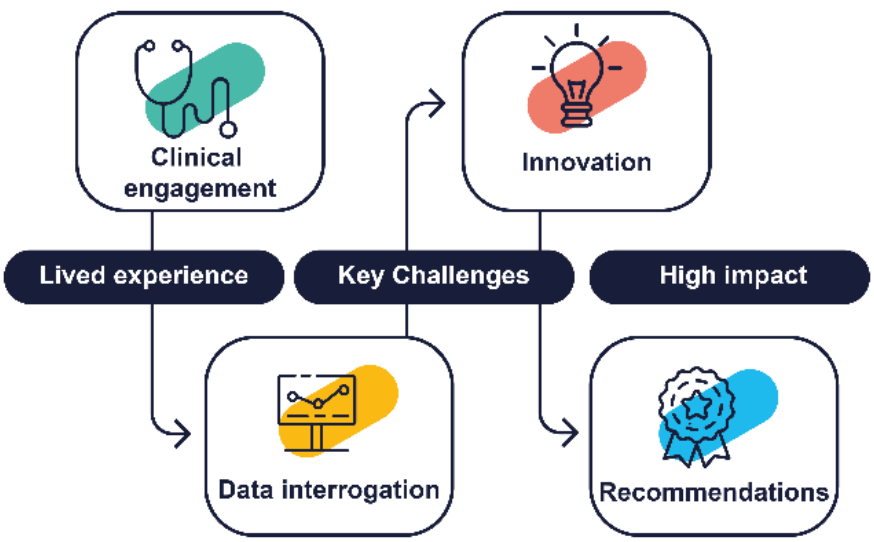
The national Clinically Led workforcE and Activity Redesign (CLEAR) programme supports organisations across primary and secondary care in transformation, data analysis and workforce redesign to improve the quality, safety and efficiency of services and deliver sustainable change. Since launching in 2019, the programme has completed more than 50 projects across key NHS priority areas with productivity gains of more than £20m.

Watch this 90-second animation for a quick guide to CLEAR

Originally developed in partnership with Health Education England and now commissioned by NHS England, regions and systems, the CLEAR programme places clinicians at the heart of healthcare decision making and innovation.

The programme is hosted by East Lancashire Hospitals NHS Trust and delivered by the trust and 33n - a team of NHS clinicians, educational specialists and data analysts united in their passion to improve services, address workforce challenges and enhance patient care.

Our goal is to provide solutions to the changing needs of the healthcare system, support the sustained recovery of services, encourage staff retention and shape services for the future. The CLEAR methodology is outlined below – for this programme, as new models have already been defined, the first two stages clinical engagement and data interrogation will take place during the workshops followed by refinement of the new models of care and a business case developed.



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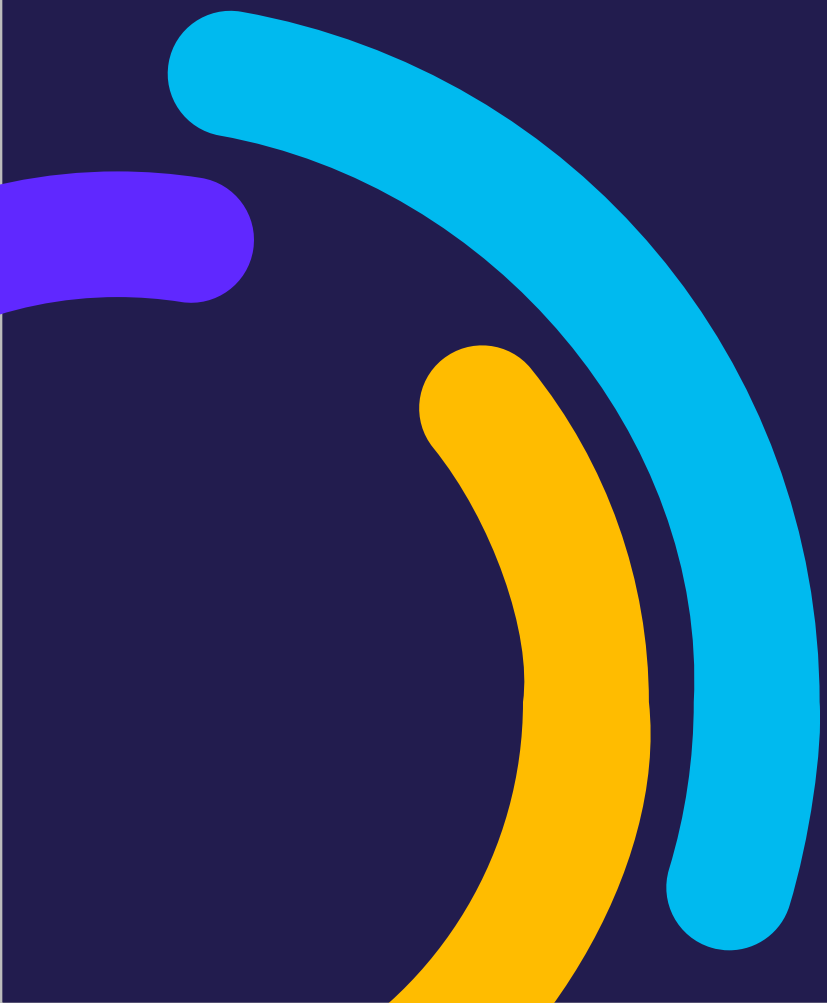

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