CLEAR
Empowering staff to innovate care

CLEAR Living Well 2023

East Warrington Primary Care Network

Improving patient outcomes and reducing health inequalities through the prevention and better management of high blood pressure

AT A GLANCE

CLEAR CHALLENGE

A need for better detection and management of high blood pressure, low take-up of health checks, and poor communication across primary care

KEY CHANGES

New CVD team, volunteer CVD ambassadors, improved home and practice-based blood pressure monitoring and better use of technology

FORECAST BENEFITS

Heart attacks and strokes avoided, health inequalities reduced, patient care improved with savings of up to £347,000 for the PCN and wider system

THE CHALLENGE

The population of East Warrington Primary Care Network had high rates of cardiovascular disease (CVD) with many living in areas of significant deprivation.

COVID-19 had led to a reduction in the detection and treatment of high blood pressure. Take up of lifestyle services to encourage people to manage their own health was low and limited resources were hindering efforts to improve CVD prevention and treatment.

There was a need to address health inequalities and improve access to services, particularly among hard to reach groups. Processes for managing CVD patients could be improved and there was some duplication of work across the PCN.

WHAT THEY DID

The project team gathered the views of a wide range of staff, interviewing 30 people involved in CVD prevention and management.

This insight was combined with data from the three practices' clinical health records for the period from January 2015 to December 2022. Key themes were identified that were impacting CVD prevention locally.

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CLEAR RECOMMENDATIONS

A new CVD prevention team could be created from the existing staff to improve the screening and management of patients with high blood pressure. The focus of the multi-disciplinary team would be on lifestyle advice and patient empowerment, requiring minimal GP input. The team could include a social prescriber and health and wellbeing coach who would help patients address the wider determinants of their health.

A community worker could be appointed to raise awareness of CVD among hard to reach groups and support volunteer ambassadors who would be trained to encourage others to self-manage their health. Blood pressure monitors could be offered to patients in their homes and placed at surgeries using lockers to enable them to be accessible out of hours.

Evening and weekend appointments could be increased as well as the use of technology - for example text messaging to improve engagement with patients.

> The recommendations could lead to an additional 184 patients from deprived areas being diagnosed with CVD each year with £300,000 savings to the PCN and wider health system

FORECAST IMPACT

The new model of care would increase general practice capacity, improve CVD prevention and outcomes, reduce overall healthcare costs and lead to better patient care and access.

Over three years, the recommendations could lead to six heart attacks and four strokes being prevented and an additional 184 patients from deprived areas being diagnosed with CVD each year.

PCN productivity savings of more than £260,000 could be generated from a 6,000 reduction in annual GP appointments, reduced prescription costs and extra Quality and Outcomes Framework payments. It's projected that heart attack and stroke prevention could generate wider system savings of almost £100,000 every three years. Increasing staff skills could also improve morale, recruitment and retention.