CVDACTION implementation: Wandsworth GP Federation

Name: Wandsworth GP Federation
Structure: 3 PCNs, 13 GP practices, 150,000 patients
Approach: PCN level Clinical Pharmacist clinics, supported by dedicated GP leads and administrators. Holistic follow-up appointments provided via social prescribers and/or health and wellbeing coaches.
Specific focus: hypertension, lipids, health inequalities
Technical implementation: Wandsworth Federation's Business Intelligence team hosted CVDACTION locally on their servers using PowerBI and populated the dashboard using data extracted from each practice's EMIS system, using pre-existing data sharing agreements.
Key operational support and oversight:

- CVDACTION delivery team
- SWL ICB - Programme Manager Health Improvement
- Wandsworth Federation - Clinical Director, Business Manager, Programme Manager

Context

Spotlight on the Alton Estate in Roehampton:
The Alton Estate, one of the UK's largest council estates, is home to over 13,000 residents and faces significant transport and healthcare access challenges. Residents rely on buses for transport, with no nearby train connections, limiting access to healthier food options, leisure facilities, and broader community resources compared their more affluent neighbours in areas like Barnes, Putney, and Kingston. This contrast has amplified health inequalities among the estate's population.

At the heart of the estate are three GP practices that have a central role in the community's health care. To combat significant health disparities, a Community Health Champion scheme has been established, engaging local residents as trusted health advocates. This initiative has proven particularly effective in reaching patients who traditionally disengage from healthcare services. In partnership with these Community Health Champions, Dr Farwa Hasan, Joint Clinical Director of the West Wandsworth Primary Care Network, saw the opportunity forCVDACTION to address cardiovascular disease (CVD) health inequalities for her patients and those of neighbouring PCNs in the Federation.

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Implementation journey

CVDACTION was implemented across three PCNs within the Wandsworth Federation: Battersea PCN, PRIME PCN and West Wandsworth PCN - covering approximately 150,000 patients with a higher proportion of CORE20plus5 patients than the wider Federation. The wider catchment area of these PCNs sees a more diverse range of demographics, for example less than 2 miles down the road is from Roehampton is Putney, which is regarded as a more affluent area. It is also important to note that the closure of Hammersmith Bridge also disproportionately affected Roehampton by reducing the level of transport infrastructure in the surrounding area.

Motivation for adopting CVDACTION:

The Wandsworth GP Federation described the key motivator for taking part as being able to access CVDACTION, because it would allow them to target health inequalities within an area of high deprivation. This was facilitated centrally by Dr Hasan and Jai Voralia, a Business Manager who provided operational support. They undertook local engagement and vision sharing with every practice – making sure to secure both clinical and operational buy in through conversations with Clinical Directors, Practice Managers and the wider teams - to enable the adoption and implementation across the Federation's footprint. CVDACTION's adoption offered both financial incentives, by helping to meet QOF and IIF targets and a means to make early, preventive interventions.

Setting up and accessing CVDACTION:

In each practice, CVDACTION searches and dashboards were set up with analytical support provided by the GP Federation's in-house Business Intelligence (BI) team, with the dashboard hosted on their PowerBI platform.

Each practice appointed a Clinical Lead and an Administrator to oversee CVDACTION access and to manage patient lists based on priority needs, enabling population management at a practice level.

Dr Hasan said:

"I got my hands on the dashboard and was totally blown away … Clinically speaking, the dashboard will be a massive game changer and totally unlike any other tools currently available."

Engaging patients and the community:

The Federation's success as a CVDACTION demonstrator site was described as a source of pride for both staff and patients. When onboarding patients to the programme, staff made sure to emphasise the proactive nature of the appointment and how they had specially been selected to take part. As a result, the team believed it impacted both engagement and adherence to medications prescribed. Patients had a sense of pride in being contacted for an appointment which they otherwise might not have received - contrasting with the historical model of solely inviting patients for an annual appointment.

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Implementation journey cont.

Supporting new ways of working:

The PCN introduced new procedures to improve the patient journey and promote shared decision making. They created pre-written AccuRX (a service that provides text messages to patients) scripts with embedded links to easily share information and blood pressure diaries with patient. They also introduced a new standardised consulting template to help guide the clinical team through the appropriate questions to ensure treatment decisions were made with the patient. They made adjustments for patients who were flagged as living within the more deprived IMD quintiles on the dashboard e.g. additional attempts were made when trying to contact the patients over a longer time period rather than the standard three attempts, as it understood that there are a number of factors that prevent people from engaging with care in a traditional way. Also, a longer appointment time of 20 minutes was made available, particularly important when English was not the first language of the patient. Once an appointment has been made with an individual, they receive a medical intervention first with a clinician and then wider lifestyle support with a health and wellbeing coach or with a social prescriber. A clinical member of the team speaks Urdu which enables effective appointments where Urdu is the primary language.

Optimising use of the wider workforce:

Use of the wider team was critical to implementing CVDACTION. For example, in the West Wandsworth PCN, a dedicated administrator co-ordinated appointments, scheduled clinics and sent invites to patients. The clinical team was brought together with staff who had a pre-existing interest and expertise in motivational interviewing so that these skills could be fully utilised in interactions with patients. The team also included wider ARRS (Additional Roles and Reimbursement Scheme) roles, like Health and Wellbeing coaches, who worked alongside Community Health Champions, based within the Roehampton Estate, to understand the barriers faced by patients in accessing preventative healthcare. A Prescribing Clinical Pharmacist from the PCN delivered the clinics, with support and oversight from a clinical lead. The use of the wider team in implementing CVDACTION and supporting patients in CVD prevention has influenced the Federation's approach to recruiting ARRS staff in the future to reflect these enhanced roles.

Impacts

Improvement in treatment:

Quantitative data was available for a 6-month period. Despite the short time frame, which also included the set-up phase for the project, significant improvement was seen in blood pressure and cholesterol management.

- Blood pressure optimisation: in 1,659 patients, blood pressure improved enough to move them to a lower hypertension stage. Of these, 1412 patients were newly treated to target.
- Cholesterol optimisation: 127 patients with established CVD were newly started on statins.

These two interventions alone can be expected to prevent 28 heart attacks and strokes in the next 5 years just in this population.

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Impacts cont.

Patient feedback was positive:

With support from their local Health Innovation Network, HIN South London, the team undertook some patient engagement to seek feedback on their services. Through a survey in the waiting room of the GP Practices, and a further focus group they were able to capture key insights from patients. Overall Patient experience was very favourable. High proportions of those who responded the survey would recommend the clinic to others and happy with the length of time of the appointments. All respondents said the clinic staff treated them with dignity and respect, and they felt listened too and were given information that was easy to understand. Also, the dedicated support with management of medications via discussion with a healthcare professional and follow up written information was welcomed, as this supported the understanding of the medication itself and any side-effects that may arise with prolonged used.

Targeting health inequalities:

The PCN specifically used CVDACTION to address health inequalities. Using the demographics filter in the dashboard, they started with those patients living within the most deprived IMD quintiles and worked their way down from most deprived to least deprived.

The comprehensive nature of the CVDACTION searches and stratification allowed practices to identify more patients at risk of CVD than previously recognised. This was in addition to increasing awareness of social inequalities that contribute to poorer CVD outcomes, for example language barriers, domestic abuse and night shift working leading to lack of access to community pharmacies to collect medicines.

The CVDACTION dashboard highlights risk factors across different demographics e.g. age, ethnicity, gender, deprivation, serious mental illness and learning difficulties. This detailed view brought additional focus on who was at highest risk and where inequalities existed within specific cohorts that may not have been fully recognised before; for example, women in their 40s whose hypertension had been under treated for a number of years.

As described above, the team specifically focused on improving their ability to reach and engage patients in more disadvantaged communities with multiple attempts at contact, longer appointments and more holistic patient focused consultation styles.

Additional information

Who to contact:

Dr Farwa Hassan – Clinical Director, West Wandsworth PCN (farwa.hasan@nhs.net)

Resources:

- CVDACTION - Making prevention happen
- UCLPartners Proactive Care Frameworks

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