CVDACTION implementation: Sutton Primary Care Networks

Name: Sutton Primary Care Networks CiC (SPCN)
Structure: 4 PCNS, 21 GP practices, 215,000 patients
Approach: Centralised hub clinic model staffed by ANPs, clinical pharmacists and supported by centralised admin function
Specific focus: hypertension, lipids, CKD, health inequalities
Technical implementation: Sutton's in-house data team hosted CVDACTION locally on their servers using PowerBI and populated the dashboard with data extracted from EMIS Enterprise, using pre-existing data sharing agreements with each participating practice.
Key operational support and oversight:

- CVDACTION delivery team
- SWL ICB - Programme Manager Health Improvement
- SPCN - Head of New Business, Clinical Director, Deputy Head of Patient Services

Context

Sutton Primary Care Networks (SPCN) brings together all GP practices around Sutton to share resources and improve patient care for their population of 215,000. SPCN has extensive experience of delivering CVD risk stratification at scale and has previously utilised UCLPartners Proactive Care Frameworks successfully.

The borough of Sutton has seen significant demographic changes, 43% of the population in 2021 identified as from Asian, Black, Mixed/Multiple and White non-British ethnic backgrounds, up from 27% in 2011. Additionally, there are areas of deprivation, particularly in central Sutton, which fall into the 20% most deprived regions in England.

In 2022, prevalence of hypertension, coronary heart disease (CHD) and stroke were higher in Sutton than the London average. South West London Integrated Care System (SWL ICS) data (February 2024) showed that of those patients diagnosed with hypertension, only 68% have met their blood pressure targets and people from Black ethnic groups, people aged under 40 and over 80, and those living in more deprived areas are least likely to meet their blood pressure target.

Jagdish Kumar, Head of New Business, and Dr Raza Toosy, Wallington Joint Clinical Director, saw CVDACTION as a major opportunity to address some of these inequalities by focusing on patients with the greatest need for improvement in their care.

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Implementation journey

Building on existing infrastructure to deliver a hub model:

- CVDACTION and the broader UCLPartners Proactive Care Frameworks are designed for adaptation, making it easy to integrate with local infrastructure and ways of working. Sutton has an advanced PCN structure in place, facilitating a borough-wide, single-service approach. They provide centralised clinical and administrative resources and established data sharing agreements with all practices in the geography.
- SPCNs built on this infrastructure to deploy CVDACTION through a centralised hub clinic model, staffed by advanced nursing practitioners (ANPs) and clinical pharmacists and supported by a centralised call-and-recall team.
- Centralised data, from all practices and PCNs, was extracted via EMIS Search and Reports and collated into the PowerBI dashboard template, which was hosted on local centralised servers. This meant that pre-existing access permissions could be used to view the necessary data.
- Once the high-risk patients were identified through the CVDACTION dashboard, the centralised call-and-recall team invited patients, on behalf of the practice, to a clinic located in one of their extended access hubs (one in each PCN).
- To ensure there was no overlap in work, early implementation face-to-face meetings helped establish boundaries and agreements between the central clinic and the practices. Together, agreeing which patients would be seen, referral back to practices and how communication would be shared etc. This effective communication and collaboration between practices also helped to navigate the cultural shift away from historical approaches to clinical reviews. These were previously based on month of birth or anniversary of previous review rather than by clinical need or risk. One of the 21 practices opted not to fully participate in the central optimisation programme, but they were willing to receive patient lists and provide care locally for their patients.

Taking a personalised approach:

SPCN saw the opportunity that CVDACTION provided to increase the personalisation of care for their patients. The admin teams developed scripts to help callers provide consistent detail about the service and reassure patients throughout their journey. These scripts were further developed based on questions asked by patients and feedback from the call-and-recall team. The team were given specific training by clinicians to help them understand and talk about CVD risk factors and associated conditions. This allowed them to be more confident in conversation with patients and provide more details where appropriate. It was received well by patients, a survey completed by 387 patients collecting call handler feedback produced very positive responses.

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Implementation journey cont.

Prioritising workforce development:

SPCN tailored the workforce approach to their individual patient pathways, using the wider primary care workforce and had a commitment from the start of the programme to invest in workforce training and development. Training for staff included:

- Motivational interviewing
- CVD clinical care guidelines
- Medication training
- Support for complex patients

They found that upskilling staff and providing clinical leadership was critical in overcoming competency gaps and promoting best practice. For future iterations, they have discussed formalising the development process further by building dedicated clinical oversight capacity into senior clinicians job descriptions.

Capturing the right data:

SPCN have a digital team which allowed them to apply strong governance and data management practices to their CVDACTION programme – monitoring activity and responding to gaps as they occurred. Using appropriate clinical codes, patients were 'tagged' once they had interacted with the service meaning their optimisation journey could be monitored and supported effectively. The SPCN team were also able to collect appointment analytics which informed the shaping of the service, meaning they and could follow up specifically with patients who did not attend their appointments to further explore any barriers to access.

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 184 patients, blood pressure improved enough to move them to a lower hypertension stage. Of these, 141 patients were newly treated to target.
- Cholesterol optimisation: 156 patients with established CVD were newly started on statins. This intervention alone can be expected to prevent 15 heart attacks and strokes in the next 5 years just in this population.

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Impacts cont.

Patient satisfaction:

Staff worked hard to help patients feel engaged with the service, including asking patients how they prefer to be supported to manage their conditions. The call-and-recall system provided personalised touchpoints, giving patients the opportunity to provide valuable feedback for the team. The team also undertook patient engagement and involvement activities in parallel with the clinical work, supported by South London Health Innovation Network, which provided insights into how patients would respond to specific personalised approaches to care. Also, patient feedback showed they valued an appointment length of 30 minutes which created space for them to ask questions and understand more about their condition/s and how best to manage them.

Feedback on the service has been collated throughout, and more than two thirds of patients felt their experience was either good or very good. Many patients appreciated being given time to discuss their medications and see staff taking a holistic approach to their care.

Enabling holistic care:

The SPCN team found that CVDACTION also enabled a holistic approach to proactive care for their patients. For example, one unexpected outcome was that a large number of patients were referred from the CVDACTION consultation to wider services such as social prescribers, mental health practitioner, health coaches, diabetes prevention team and weight management team.

Refining processes:

An added benefit of the CVDACTION Programme was that SPCN was able to test and refine their data processes, aiming to better understand patient engagement. A key takeaway was that there are opportunities to refine their procedures around data loading and processing, e.g. introducing automation. They also noted that the efforts they put into workforce upskilling and team building led to better collaboration across the organisation. SPCN intend to continue to innovate at a larger scale, improving automation, and refining data processes will also be key next steps.

Additional information

Who to contact:

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Resources:

- CVDACTION - Making prevention happen
- UCLPartners Proactive Care Frameworks

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