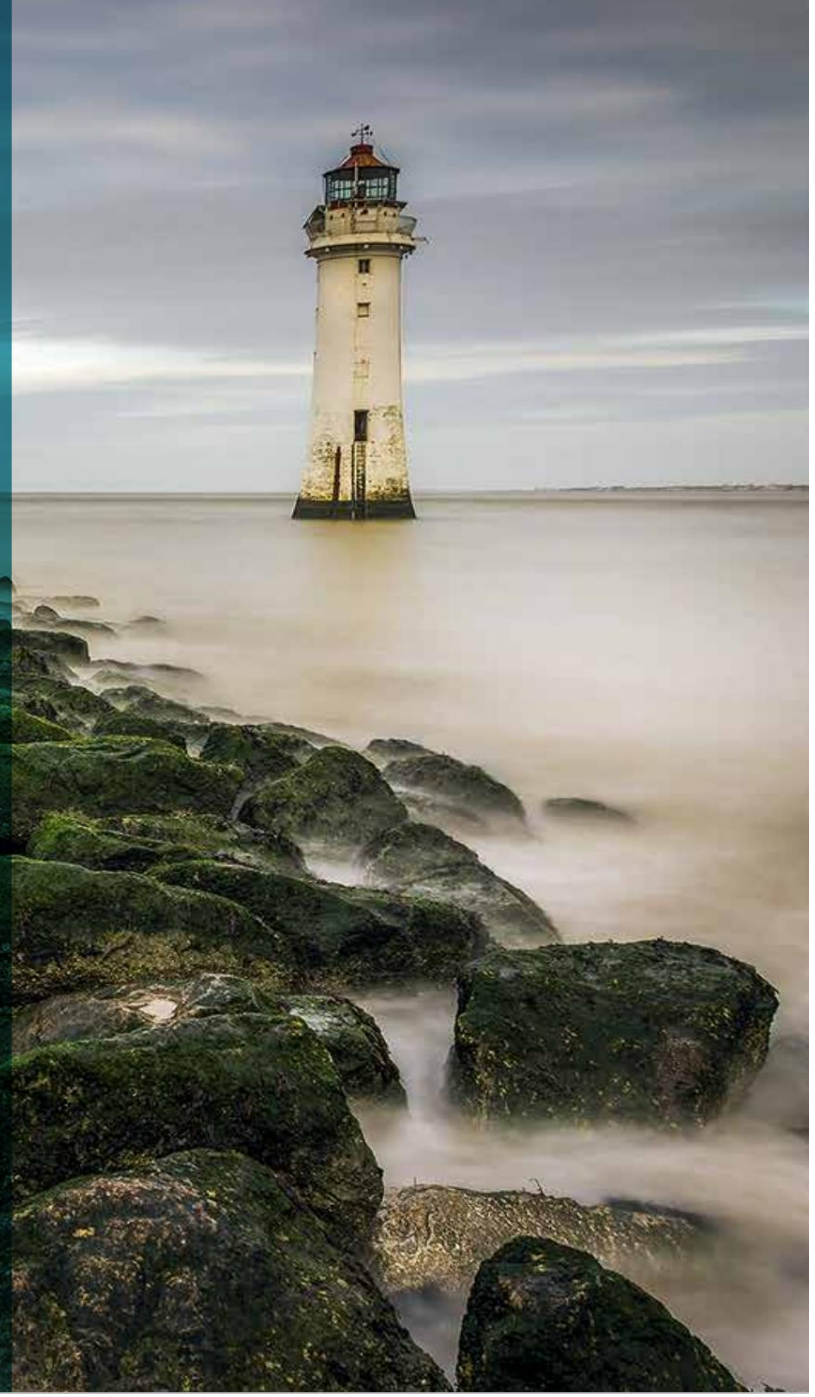
# Wirral Health and Wellbeing Strategy 2022-2027

Starting Well. Living Well. Ageing Well.



**Priority 2:**
**Strengthen health and care action to address differences in health outcomes**

## CVD PREVENTION

Rebecca Mellor
Public Health Principal

Keep Wirral Well

# P2 Implementation Plan

## Implementation of a CORE20Plus5 delivery plan, with initial focus on CVD

**Short to medium term actions:**

- Develop a set of actions following the CVD Prevention workshop (held in September).
- Secure ongoing funding for Housebound Hypertension and BP@Home projects
- Evaluate the community health check pilot
- Explore options for closer integration of various 'Health check' programmes across Wirral
- Improve access and sharing of data/intelligence across partners to measure performance and outcomes relating to CVD
- Action plans to be developed across key Core20Pplus5 Health & Care inequality areas

**Impact evidenced by:**

- Increased identification of hypertension in most at-risk groups
- Increase in people from most at-risk groups having Healthchecks
- Case studies from Wirral residents evidencing greater awareness of blood pressure

**Longer-term actions:**

- Integration with programmes of support that deal with underlying reasons behind levels of preventable hypertension and other long terms conditions that are largely preventable (e.g. type 2 diabetes, obesity) in the community.
- Local delivery of the national 'Major Conditions Strategy' (CVD is one of six major conditions groups).
- Implementation of the new 'WorkWell' Partnership Programme, with local systems providing support to disabled people and people with health conditions who want help to start, stay or succeed in work

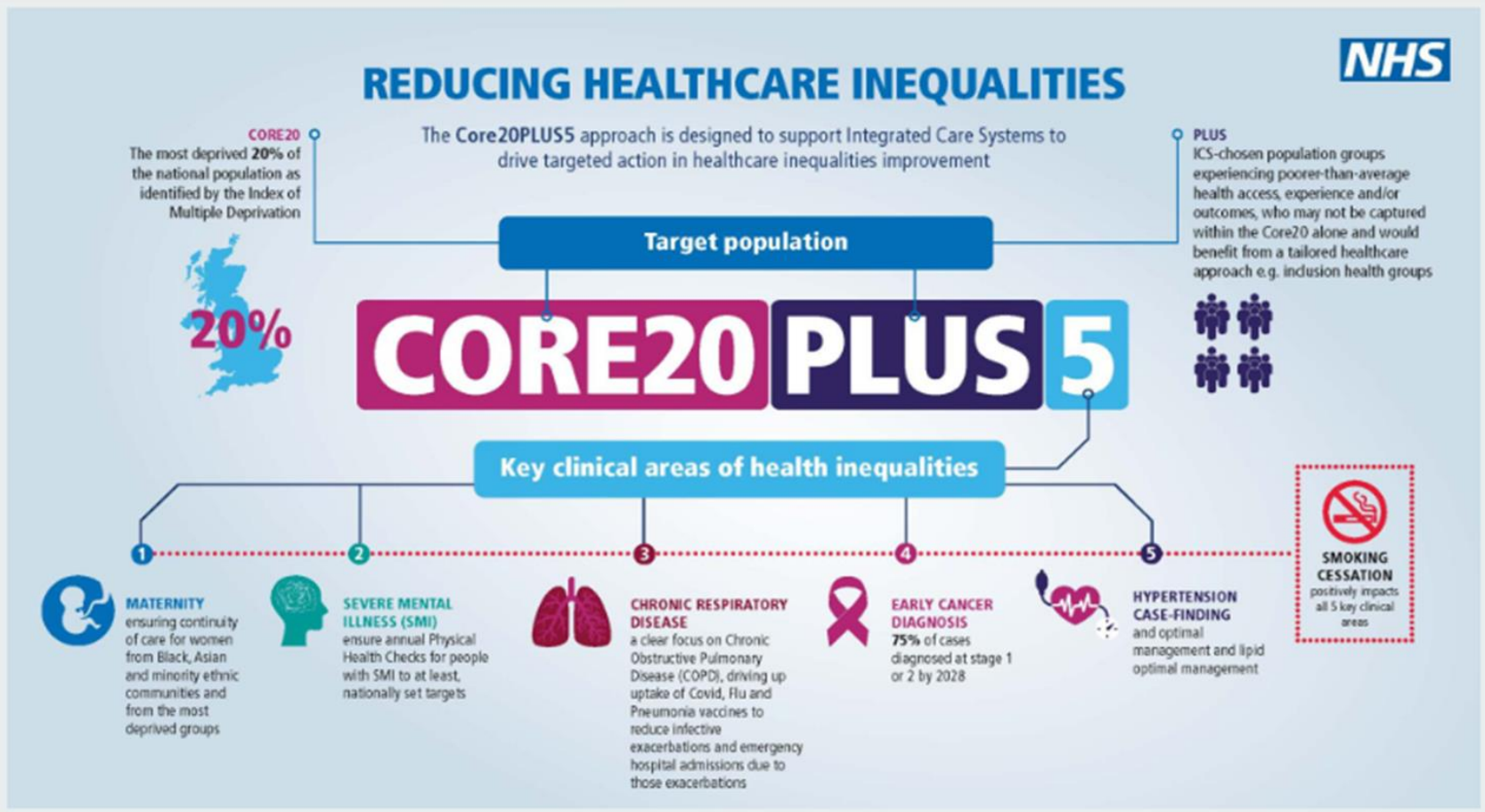
**Impact evidenced by:**

- Decrease in heart attacks and strokes amongst Wirral residents
- Decrease in inequality gap for heart attacks and strokes
- Decrease in obesity related diseases

**Overseen by:**

- Wirral Place-based Partnership Board
- COREPlus25 Group
- CVD Working Group.

# Tackling inequalities in health and care service access, experience and outcome




**Plus Groups in Wirral:**

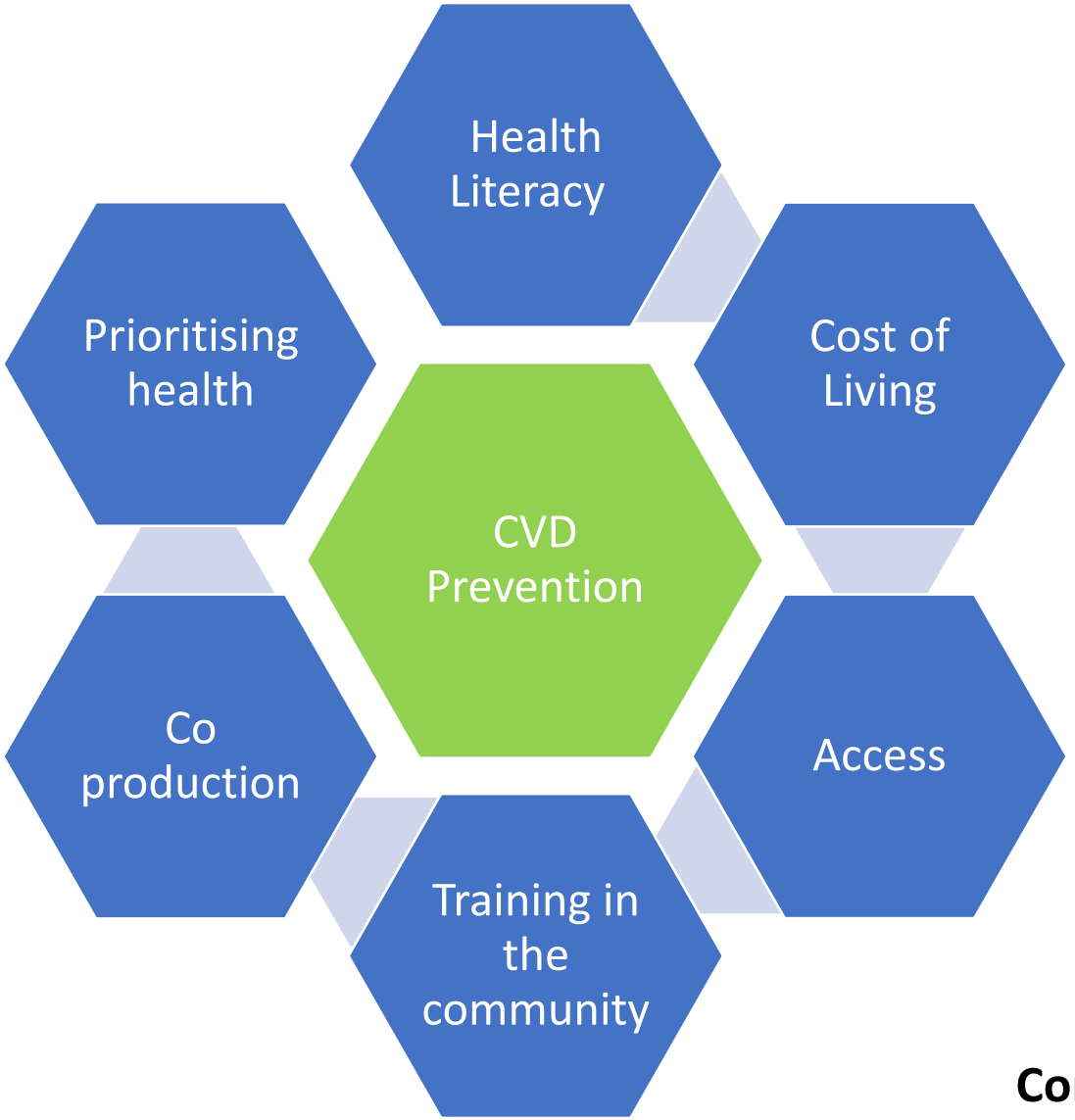
- Ethnic minority communities
- Those who misuse substances
- People with multi morbidities
- People with Learning disabilities

# Vision and scope of CVD Prevention ('Game Changer')

To **reduce the number of preventable heart attacks and strokes** through improvement activity focused specifically on the 'ABC' conditions, targeting the communities and individuals in greatest need (Core20Plus..).

What **different approaches we can take to implement earlier detection opportunities and better management of CVD (heart attacks and strokes) with a focus on our most vulnerable residents**.

# What is needed to make the biggest impact




**Core20Plus5 - CVD Workshop**
**20th September 2024**

# NHS Prevention Pledge

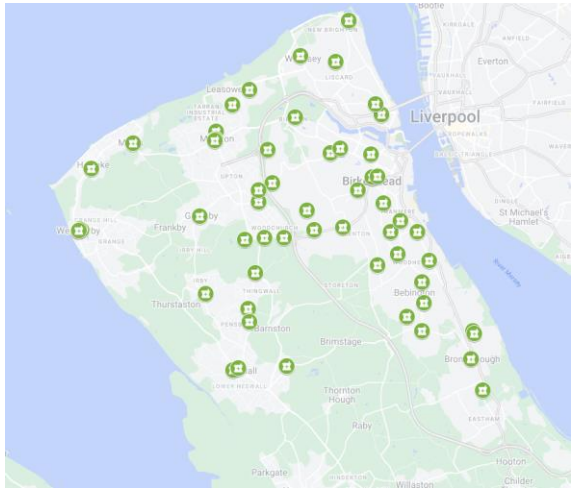

- Disease prevention approach
- Supporting NHS organisations to become anchor institutions
- 14 pledge commitments
- Synergies with Core20Plus5


# Housebound hypertension project ‘BP at Home’

- **67%** of patients have a BP reading that is treated to target. This is a significant increase from the starting point in January 2022.
- **63%** of the 39,000 hypertensive patients who have never submitted a home BP reading meet their BP target.
- The introduction of Digital BP Messaging has had a significant positive effect on finding new cases of hypertension who are now being effectively managed.
- Further expanded to include non –housebound frail residents

# NHS community pharmacy hypertension case-finding advanced service

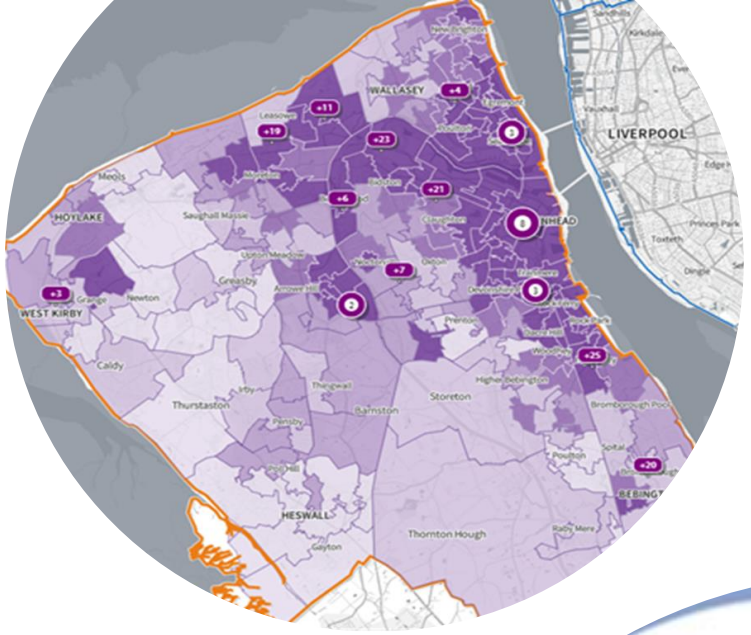
- **Identify people aged 40 or older** –with high blood pressure (who have previously not had a confirmed diagnosis of hypertension), and to refer them to general practice to confirm diagnosis and for appropriate management.
- **Undertake ad hoc clinic and ambulatory blood pressure measurements for adults of any age**. These requests can be in relation to people either with or without a diagnosis of hypertension.
- Promote healthy behaviours to patients.




Since the start in 2022, Wirral community pharmacies have conducted 8,523 consultations.

Of these **2,194** were found to have blood pressure above the norm, with 1907 having had no previous diagnosis or treatment for the condition.

# Community Outreach




**Living Well Bus (Cheshire and Wirral Partnership Trust)**

- Roving / mobile service with **targeted approach** to geographical areas of lower take up
- Primary focus is **COVID-19 and flu vaccinations** plus addition offer of **full NHS Health Check**
- Onwards referral to other community support
- 1 day per week for Wirral (shared resource across C&M)

60 clinics held between 3rd April 2023 to 20th January 2024
**337 blood pressure checks** carried out
**81 (24%) referrals** to General Practice for further action

# NHS Community Health Checks

208 (55%) of those who had a Health Check were men

199 (53%) of people from ethnic communities had a Health Check

265 (70%) of Health Checks were on people in the most deprived areas

76 (20%) of Health Checks had a high cholesterol reading

85 (22%) of Health Checks had a high blood pressure reading

170 (45%) of Health Checks resulted in a moderate/high diabetes risk profile


HEALTH LITERACY APRIL 19th 2023
HYPERTENSION ≈ HIGH BLOOD PRESSURE
Send people...
JARGON FREE: FACTUAL INFORMATION
One Wirral CIC
ISSUES
No Information
When it is given it's too late... GIVE IT AT DIAGNOSIS
Always told NHS is UNDER PRESSURE So stops is going to the DOCTOR when there is an ISSUE
DIGITAL INCLUSION
Do Patients have access ? ? ? ? ?
GP Surgery
DIDN'T KNOW WHAT HYPERTENSION WAS NO INFO GIVEN !!
ONE SIZE DOES NOT FIT ALL
NOT GIVEN & had to buy own from chemist THEN
Only see GP when symptoms interupt our life style
People didn't know how to use blood pressure machines
What do the numbers mean ??
120 80
People didn't know what the numbers meant....or where to go or call if high G.P or A+E ??
No Time Slot
Given for TELEPHONE APPOINTMENTS
SOLUTIONS
Tailor Your info to me as an individual please
Ask me... "Can You tell me what we have just Spoken about"
Don't Speak AT me...let me ask Questions
Ask me if I understand what You said
EDUCATION SESSIONS
What is high blood pressure, what does it mean, what's the right thing to do, how do I manage it in my life, what is the right medication, how do I take my B.P.?
INFO 4 You
VIDEO
Www.self-help-hypertension...
PROVIDE MANY VARIED INFO RESOURSES ESPECIALLY VIDEOS
I am so very anxious all the time about it !
It's a worry... I do my B.P. every day !
I DO MINE TWICE A DAY !
SEE THE PERSON IN THEIR LIFE & NOT JUST A PATIENT

# John's story

John is mid 80's, living in Birkenhead, with moderate frailty

Bereaved, 2018

Insulin-dependent diabetic with multiple health issues

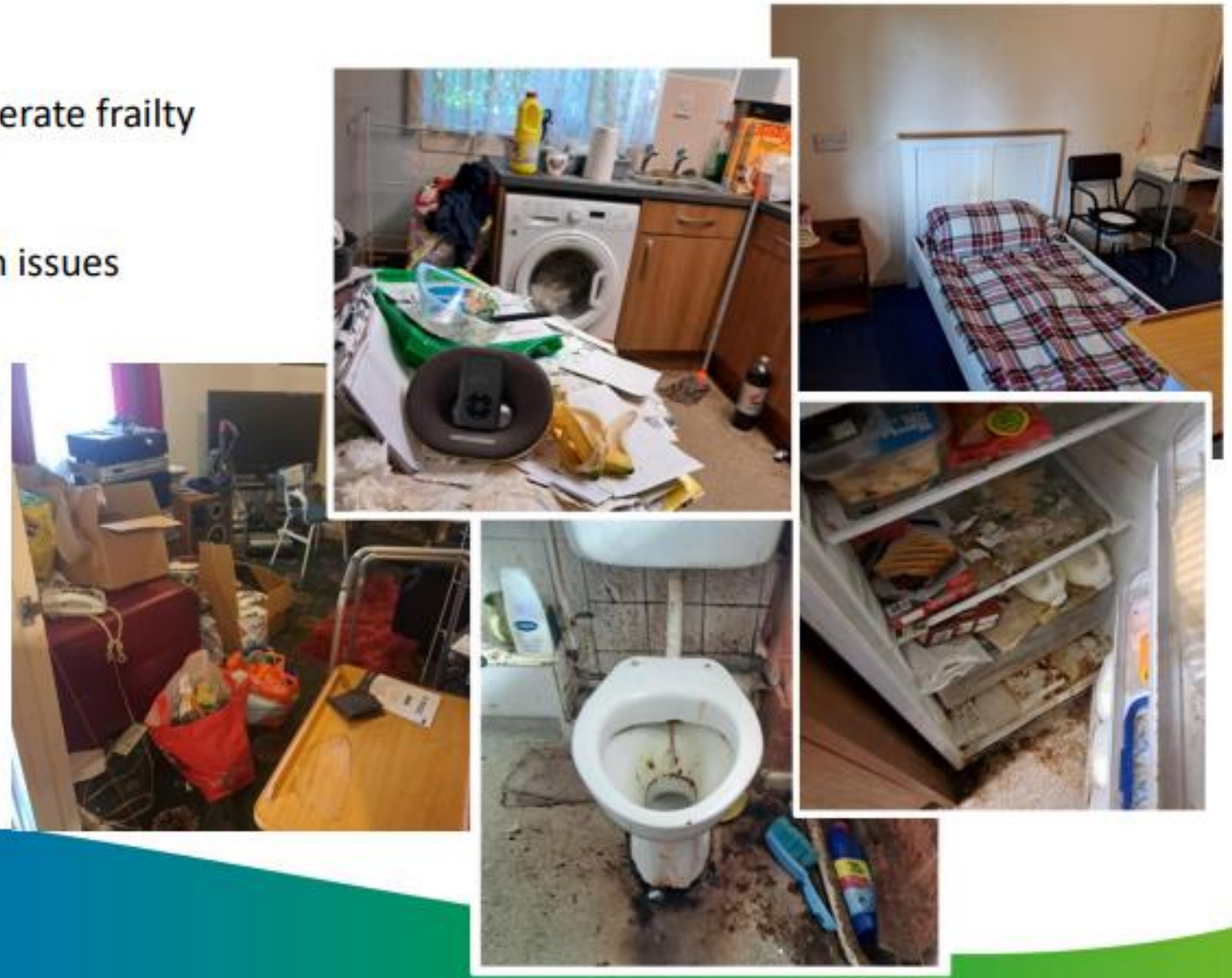
Living in filthy conditions

**At least nine health and care services involved** including GP, community nursing, domiciliary care, adult social care, housing association

GP surgery three doors way

One year of missed appointment reminders

**What mattered to John:**
**"getting back some control of my life"**



# Population Health Management (PHM): why frailty?

People with moderate & severe frailty = likely 3-4% of C&M population (70-90k)

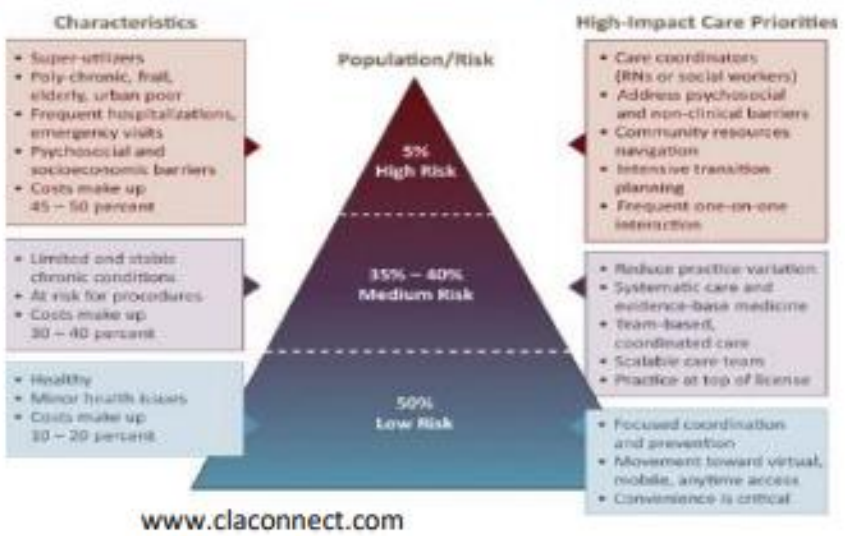
Hallmark = complexity and vulnerability, e.g. longest waits in A&E

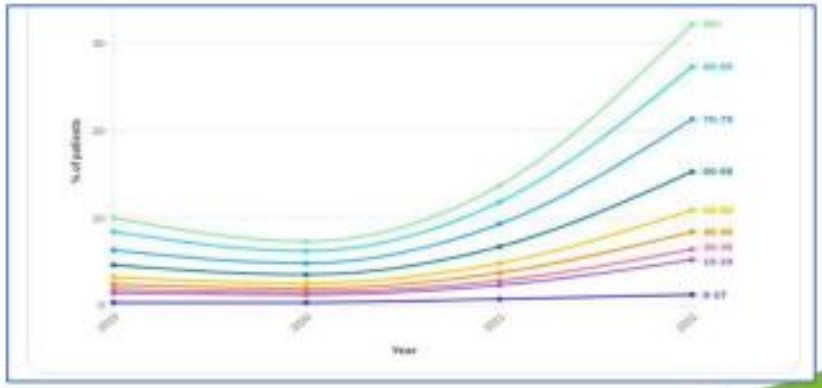
Already high contact with health and care services, often poorly coordinated

Evidence base for what works: we know what good looks like

Great benefits for patients *plus* very positive system impact

**The PHM principles and model for people with frailty apply to any cohort who would benefit from proactive care planning**



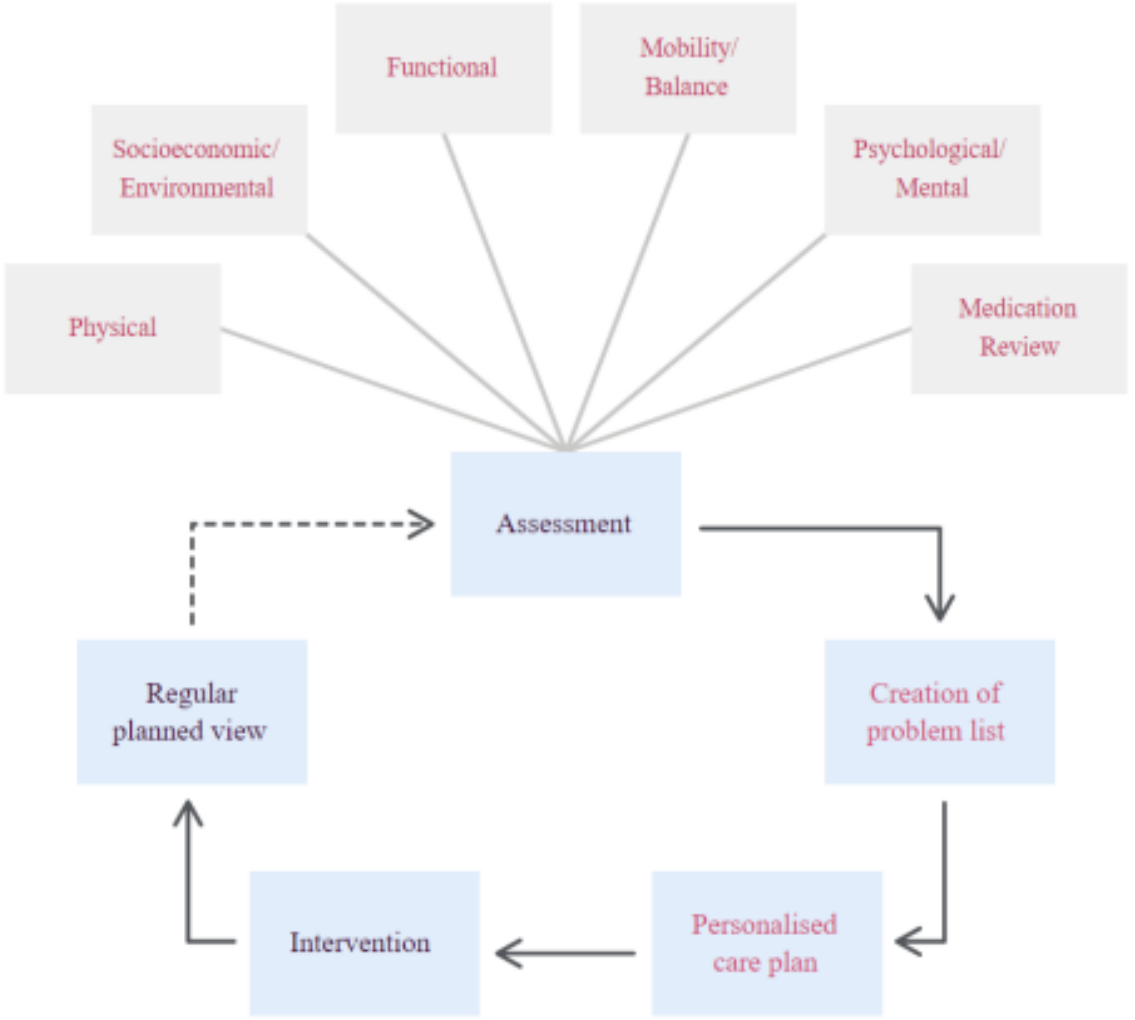
Proportion of patients waiting 12+hours by age, @RCEMpresident

# Comprehensive Geriatric Assessment

Evidence-based, holistic and person-centred assessment and care planning process.

Ensures people's needs and wishes are understood ("what matters to you?"), with nothing missed.

**Many parts of the CGA are already done in silo by different professionals.** This wastes time and opportunities for better coordinated care.



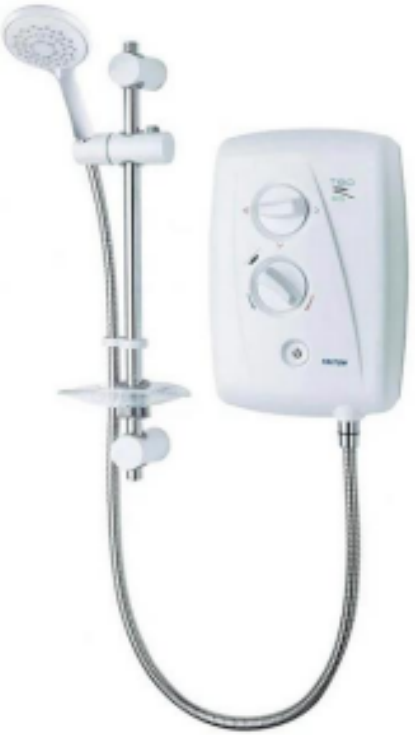

https://www.bgs.org.uk/resources/2-cga-in-primary-care-settings-the-elements-of-the-cga-process

# Harry and Joan's story

Harry and Joan live in north Wirral. They are in their 80's. Harry lives with moderate frailty.

Following Harry's discharge from Arrowe Park Hospital:

- Almost all info needed for CGA was available ***but*** much only in **non-searchable/non-coded fields and files**
- The most important information (**'what matters to you?'**) only known from a recent phone call with Age UK care coordinator



What mattered?

**"Being able to get into the shower" - Harry**

**"Getting help with dressing him in the morning" – Joan**

We need to be able to make **better use of existing information and coordinate care** more consistently.
And be clear about clinical ownership for holistic assessment and care planning.

# Population Health Management: what good looks like (for frailty)

RECOGNISE AND REFER

Frailty training & prompts (GP, DNs, UCR, IMC…)

Defined proactive and reactive pathways

GATHER INFORMATION

Bringing together existing information - common data fields and coding

ASSESSMENT AND CARE PLANNING

Consistent CGA & care plan templates, knowledge, skills,

Clinical ownership,

Coordination of Frailty MDT

SHARE PLANS

Information sharing protocols and flags

TRACK AND FOLLOW UP

Tracking people post-CGA,

Doing planned reviews,

Responding to changes

**PCN-level 'Care Traffic Control' -**
**Working with consistent principles, outcomes, tools, capacity and capability**

Compassion | Open | Trust

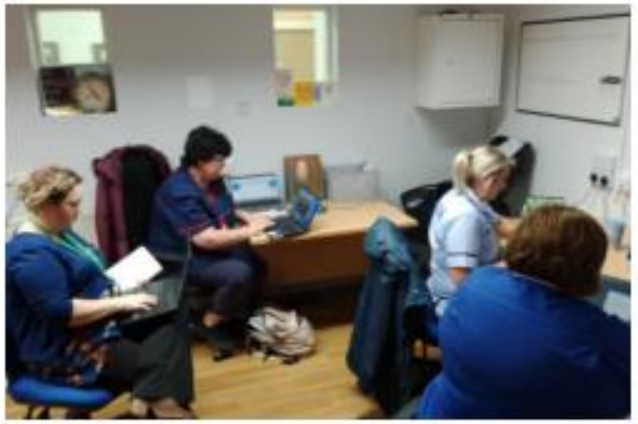
MORETON & MEOLS Primary Care Network

NHS Wirral Community Health and Care NHS Foundation Trust

# Test & Learn in progress: Moreton & Meols PCN

Feb-July 2024, **WCHC and Moreton & Meols PCN** are testing an **integrated frailty team** approach:

1. PCN **Paramedic** and **Pharmacist** and WCHC **Senior Matron**, **Nurse Practitioner for Older People** (NPOP) and **Early Intervention Assistant**
2. **Co-located team**
3. **Shared pathways** – referrals from practices, district nurses, prompts via discharges and use of risk stratification
4. **Shared CGA and care planning templates and patient record**
5. **PCN footprint 'care traffic control'**



# Postscript: John's story

A fall and hospital stay followed by time in Clatterbridge Intermediate Care Centre (CICC)

In this period, Nurse Practitioner for Older People worked with housing association and domiciliary care agency to clean the flat and replace the fridge

Referrals to social prescribers and other services

At CICC, John started to 'come out of himself' and before discharge was happily interacting with staff and other patients, looking forward to going home.

# Next Steps

- **Core20Plus5** will become a programme in the Wirral Health and Care Plan - CVD prevention delivery plan
- Develop **insight** into the experience of people living with different conditions
- Use **data** to address the differences in health outcomes and help us to understand our communities needs.
- **Identify what is happening across Primary Care** on CVD prevention