

# National Blood Pressure Optimisation Programme: An implementation Guide (Cambridgeshire and Peterborough)





# Purpose

This guide aims to provide information to support implementation of a population health management approach to blood pressure management within primary care and it is intended for the Cambridgeshire and Peterborough ICS.

# Content

This guide will provide useful information including:

1. [Blood Pressure Optimisation Programme: Aims and objectives](#)
2. [Proactive care frameworks](#)
3. [Metrics: Challenges to be addressed](#)
4. [Example of impact](#)
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# **National Blood Pressure Optimisation Programme**

# Aim of programme



To ensure patients with hypertension are appropriately monitored and their blood pressure and broader cardiovascular risk are optimised to prevent heart attacks, strokes and dementia.

# Overview

## Aim

Academic Health Science Networks (AHSNs) to support local systems to ensure people with hypertension are appropriately monitored and have their blood pressure and broader cardiovascular risk optimised to prevent heart attacks, strokes, and dementia at scale.

## Objectives

1. Support PCNs to implement the [UCLPartners Proactive Care Framework for hypertension](#) to optimise clinical care and self-management of people with hypertension. **You can watch a presentation about the Proactive framework [here](#)**
2. Support PCNs to increase detection of people through case finding interventions.
3. Support ICSs to reduce health inequalities by targeting 20% most deprived populations and other local priority groups (Core20PLUS5).



# **Proactive care frameworks**

# Proactive care frameworks

The frameworks focus on how to do things differently at scale

- They **stratify** patients at highest risk to enable practices to prioritise clinical activity
- They **deploy** the wider workforce to reduce the workload for GPs
- They **improve** personalised care



# Core principles

- ❑ Virtual when appropriate and face to face when needed
- ❑ Mobilising and supporting the wider workforce (including pharmacists, HCAs, other clinical and non-clinical staff)
- ❑ Step change in support for self-management
- ❑ Digital innovation including apps for self-management and technology for remote monitoring

# Proactive Care Framework for Hypertension

- 1. Developed to support primary care teams to manage patients with hypertension**
- 2. Focuses on the HOW of doing things differently**
- 3. Takes a Population Health Management Approach**
- 4. Incorporates the following:**
  - Risk stratification
  - Prioritisation
  - Optimisation
  - Self-management
  - Clinical management
  - Personalised care for the whole person

## **The framework consists of six components**

1. Comprehensive stratification tools built for EMIS and SystemOne
2. Pathways that prioritise patients for follow up, support remote delivery of care, and identify what elements of LTC care can be delivered by staff such as Health Care Assistants and link workers.
3. Scripts and protocols to guide Health Care Assistants and others in consultations.
4. Training for staff to deliver education, self-management support and brief interventions. Training includes health coaching and motivational interviewing.
5. Digital and other resources that support remote care and self-care.
6. Project management and support for local clinical leadership



# **Metrics: Challenges to be addressed**

# Metrics: Challenges to be addressed

Metric	Challenges
<p>1. Health inequalities: prioritised uptake of Proactive Care @home framework in PCNs with highest levels of inequalities</p>	<ul style="list-style-type: none"> <li>Challenges in defining this metric.</li> <li>Approaches and methods for data collection are locally determined</li> </ul>
<p>2. 50% of primary care networks in England implementing Proactive Care Frameworks that include support for remote management, self-management and treatment optimisation in hypertension and including lipid optimisation as a core element of hypertension management.</p>	<ul style="list-style-type: none"> <li>It is important to define what implementation means.</li> <li>Framework for defining level of engagement developed in line with QART spread categories requires clear definitions and criteria</li> </ul>
<p>3. Blood Pressure Optimisation Rates: In those PCNs adopting Proactive Care Frameworks, increase by 5% (QOF 2020-21 baseline plus 5%) patients under 80 years with hypertension with BP controlled to &lt;140/90</p>	<ul style="list-style-type: none"> <li>The challenge is in deciding what our ambition should be because QOF 20-21 achievement is low compared with previous years</li> <li>There will be challenges regularly collecting this data due to the frequency and timing of when QOF data is published.</li> </ul>
<p>4. Hypertension case finding metric to mirror that in the PCN DES to be published</p>	<ul style="list-style-type: none"> <li>Challenges regarding data availability for this metric and the suspension of the metrics up to April 2022.</li> <li>Too complex to achieve any hard target within the scope of the programme (12 Months)</li> </ul>



# **Example of Impact**



## Example of impact

Optimising blood pressure in the highest risk patients in the Cambridgeshire & Peterborough would prevent up to **86 heart attacks** and/or **128 strokes**, over three years.



**Support for implementation**

# Role of AHSNs

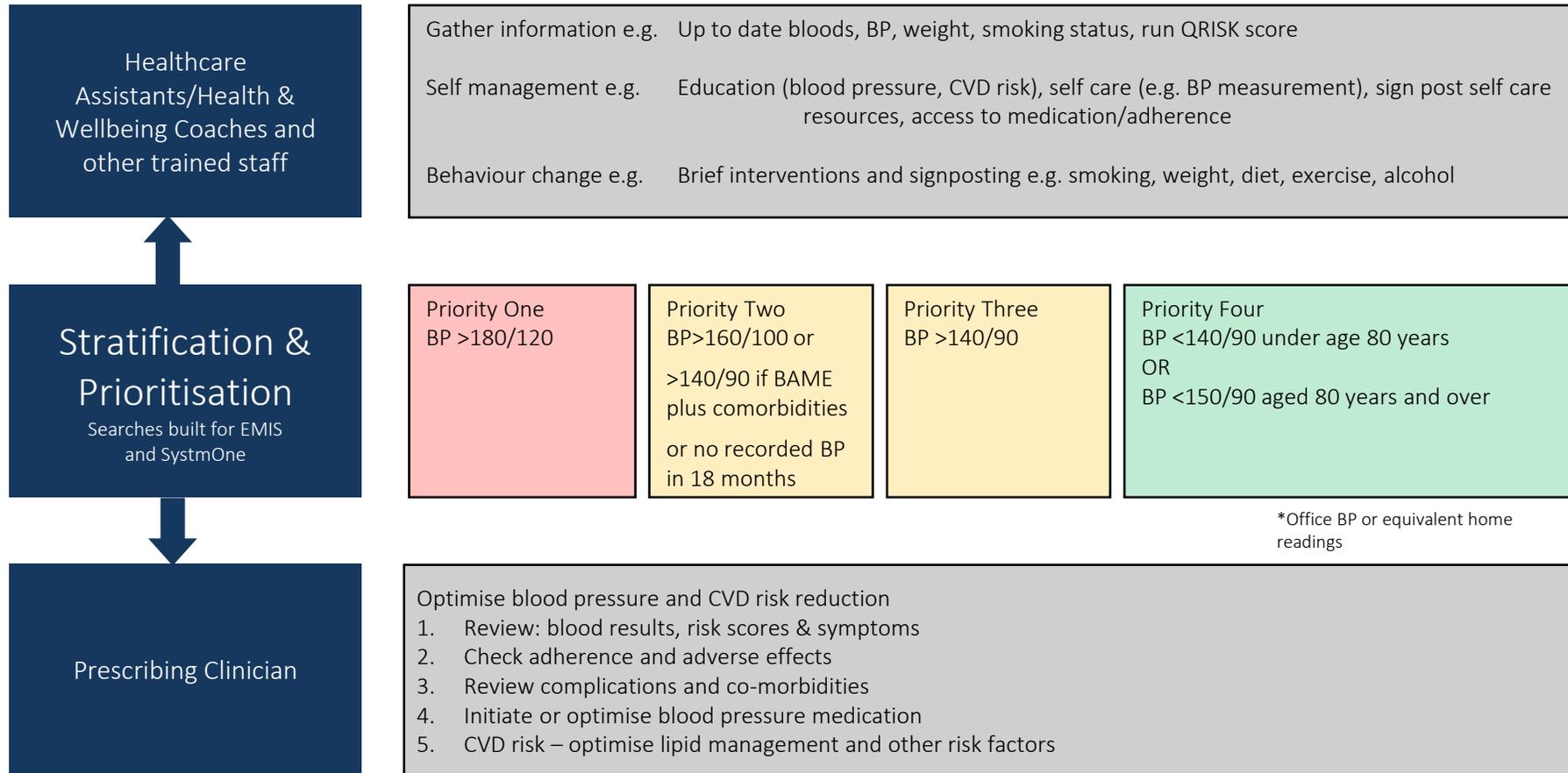
## Support primary care to:

- **Risk stratify** all people with hypertension
- **Prioritise** those at highest risk
- **Optimise** blood pressure, cholesterol and broader cardiovascular risk management
- **Systematically support** education, self-management and behaviour change
- **Case-find** people with undiagnosed hypertension
- **Develop plan** to scale implementation of hypertension Proactive Care Framework



# **Hypertension framework: stratification & management**

# Hypertension Framework: stratification and management



## Example modelling (Lambeth borough)

Hypertension example

- Informs workflow and workforce planning
- Helps GPs meet QOF and other targets
- Shift between priority groups over time shows clinical impact

### Borough level searches

Total Population: ~446,000

Hypertension: 40,155

Optimisation of BP in priority groups 1, 2a and 2b will prevent up to 71 heart attacks and/or 106 strokes in 5 years in this population of 446,000

Priority Group	Definition	No. of patients	%
<b>PRIORITY 1</b>	Clinic BP $\geq$ 180/120mmHg	541	1%
<b>PRIORITY 2a</b>	Clinic BP $\geq$ 160/100mmHg	2,756	7%
<b>PRIORITY 2b</b>	Clinic BP $\geq$ 140/90mmHg and BAME + additional CV risk factor	3,827	10%
<b>Priority 2c</b>	No BP reading in last 18 months	5,902	15%
<b>Priority 3a</b>	Clinic BP $\geq$ 140/90mmHgBP if BAME or CVD, CKD, diabetes	3,818	10%
<b>Priority 3b</b>	BP $\geq$ 140/90mmHg - all other patients	2,347	6%
<b>Priority 4a</b>	BP < 140/90mmHg (under 80 years)	18,013	45%
<b>Priority 4b</b>	BP < 150/90mmHg (80 years and over)	2,951	7%

18% highest priority

52% low priority



Links to other programmes

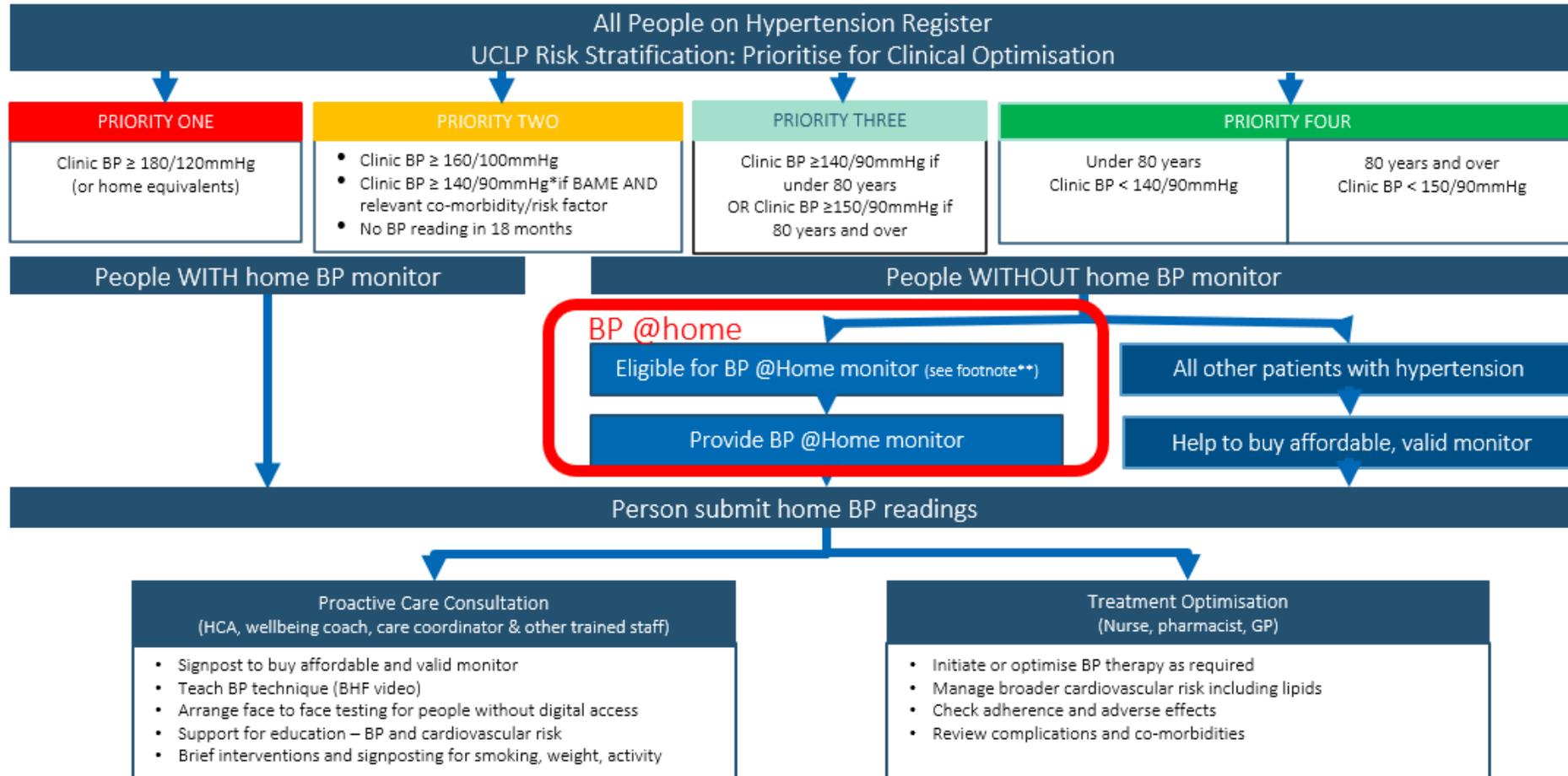
# Links to other programmes

- The national blood pressure optimisation programme:
  - **Supports** the implementation of UCLPartners Proactive Care Framework for Hypertension
  - **Builds** on BP @Home



# Link to BP@home

## BP @Home: supporting remote monitoring



\*\*BP @Home eligibility: UCLP stratification plus demographic, socio-economic and clinical factors



# AHSN resources

# AHSN resources

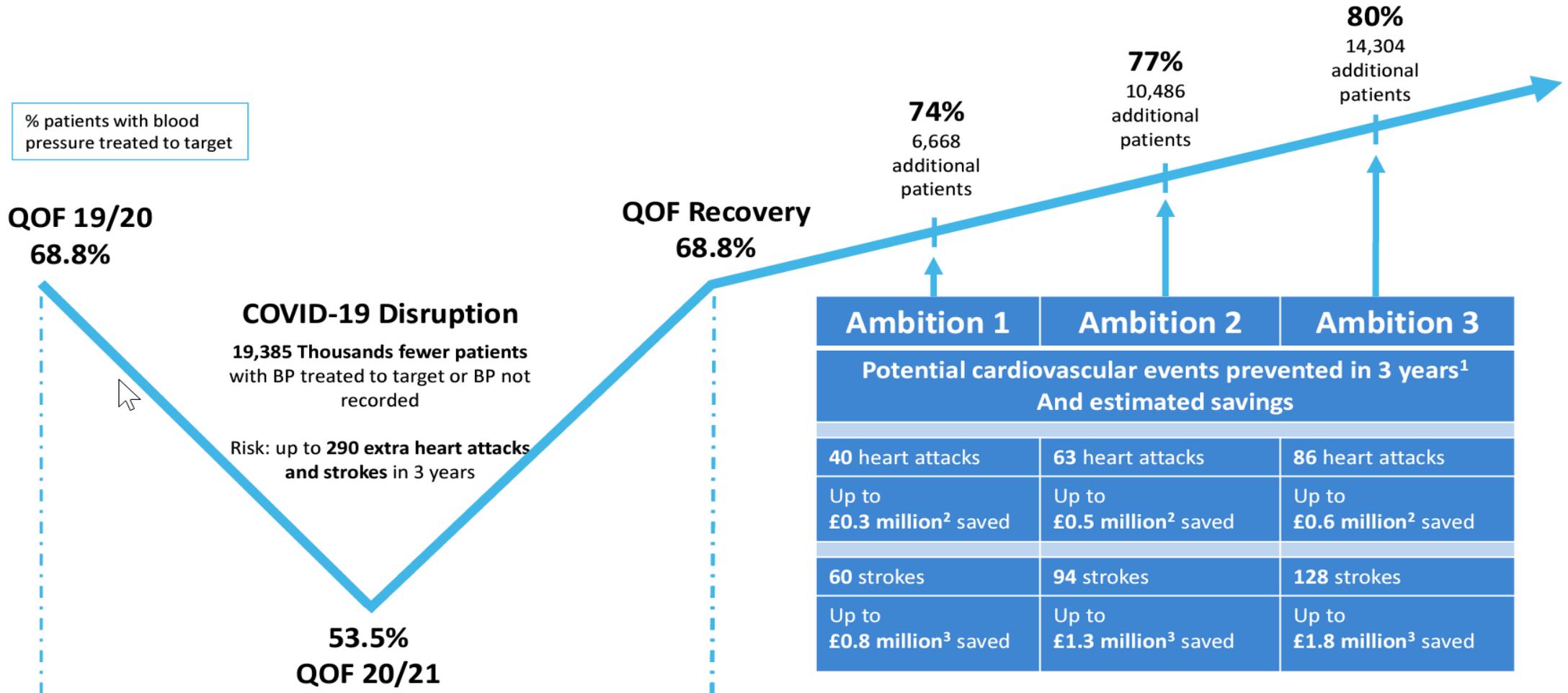
Resources to support the implementation are available on [NHS Futures](#)



The background of the slide is a dark blue color with a faint, light blue network diagram. The diagram consists of several interconnected circles of varying sizes, representing nodes in a network, with thin lines connecting them. The nodes are distributed across the slide, with a larger cluster in the top center and smaller clusters in the bottom left and bottom right corners.

# Local Priorities

# Size of the Prize – Cambridgeshire and Peterborough BP Optimisation to Prevent Heart Attacks and Strokes at Scale



**References**

- Public Health England and NHS England 2017 Size of the Prize
- Royal College of Physicians (2016). Sentinel Stroke National Audit Programme. Cost and Cost-effectiveness analysis.
- Kerr, M (2012). Chronic Kidney disease in England: The human and financial cost

**Modelling**

Data source: NCVIN 2021. Briefing note: QOF 2020/21 Management of hypertension – HYPALL metric (HYP003 + HYP007). Potential events calculated with NNT (theNNT.com). For blood pressure, anti-hypertensive medicines for five years to prevent death, heart attacks, and strokes: 1 in 100 for heart attack, 1 in 67 for stroke.

# Data for deprivation and hypertension

\* Priority PCNs highlighted in green and priority practices highlighted in orange

PCN	GP PRACTICE		
OCTAGON WISBECH PCN	CLARKSON SURGERY	69.7	66.2
FENLAND PCN	CORNERSTONE PRACTICE	78.1	58.2
CAMBRIDGE CITY PCN	EAST BARNWELL HEALTH CENTRE	63.5	65.3
GRANTA PCN	GRANTA MEDICAL PRACTICES	59	66.8
ST NEOTS PCN	LAKESIDE HEALTHCARE ST NEOTS	72.1	67.3
OCTAGON WISBECH PCN	NORTH BRINK PRACTICE	76.1	61
SOUTH PETERBOROUGH PCN	OLD FLETTON SURGERY	61.1	61.1
OCTAGON WISBECH PCN	PARSON DROVE SURGERY	65.2	60
OCTAGON WISBECH PCN	TRINITY SURGERY	66.4	78.9
WOODLANDS	CHERRY HINTON MEDICAL CENTRE	63.4	61.9
A1 NETWORK PCN	ALCONBURY SURGERY	62.2	79.4
MERIDIAN PCN	BOURNE SURGERY	61.2	81.1
A1 NETWORK PCN	BUCKDEN SURGERY	63.9	69.2
ELY SOUTH PCN	BURWELL SURGERY	56.9	73.1
ST IVES PCN	CHURCH STREET SURGERY	82	75
MERIDIAN PCN	COMBERTON SURGERY	65.3	73.1
CAMBRIDGE NORTH VILLAGES PCN	COTTENHAM SURGERY	63.9	76.8
ST IVES PCN	CROMWELL PLACE SURGERY	62.9	70
SOUTH FENLAND PCN	FENLAND GROUP PRACTICE	75.1	56.1
CAMBRIDGE NORTH VILLAGES PCN	FIRS HOUSE SURGERY	66.2	73.3
SOUTH FENLAND PCN	GEORGE CLARE SURGERY	69.2	72.1
ST NEOTS PCN	GREAT STAUGHTON SURGERY	59.8	66.8

# Data for deprivation and hypertension

ELY SOUTH PCN	HADDENHAM SURGERY	59.3	78.3
MERIDIAN PCN	HARSTON SURGERY	57.4	75.6
A1 NETWORK PCN	KIMBOLTON MEDICAL CENTRE	73.3	73
CAMBRIDGE NORTH VILLAGES PCN	MAPLE SURGERY BAR HILL HEALTH CENTRE	69.6	62
FENLAND PCN	MERCHEFORD HOUSE	77.3	77.4
CAMBRIDGE NORTH VILLAGES PCN	MILTON SURGERY	58.3	75.7
ST IVES PCN	MOAT HOUSE SURGERY	63.8	74.1
ST NEOTS PCN	MONKFIELD MEDICAL PRACTICE	54.8	74.3
SOUTH PETERBOROUGH PCN	NEW QUEEN STREET SURGERY	72.8	64.4
CAMBRIDGE CITY PCN	NUFFIELD ROAD MEDICAL CENTRE	59.7	64.7
ST IVES PCN	OLD EXCHANGE SURGERY	78.4	74.1
MERIDIAN PCN	ORCHARD SURGERY,MELBOURN	63.1	71.4
SOUTH PETERBOROUGH PCN	OUNDLE	65.1	69.9
CAMBRIDGE NORTH VILLAGES PCN	OVER SURGERY	73.3	74.5
SOUTH FENLAND PCN	PRIORS FIELD SURGERY	69.9	68.3
FENLAND PCN	RAMSEY HEALTH CENTRE	67.8	70.3
ST IVES PCN	RIVERPORT MEDICAL PRACTICE	76.5	60.8
FENLAND PCN	RIVERSIDE PRACTICE	66.6	72.4
MERIDIAN PCN	ROYSIA SURGERY	71	65.9
ST IVES PCN	SPINNEY SURGERY	63.8	59.8
ST NEOTS PCN	ST NEOTS HEALTH CENTRE	58.4	63.8
ELY NORTH PCN	ST. GEORGE'S MEDICAL CENTRE	70.9	75
ELY SOUTH PCN	STAPLOE MEDICAL CENTRE	72.2	66.8
CAMBRIDGE NORTH VILLAGES PCN	SWAVESEY SURGERY	54.1	74.4
MERIDIAN PCN	THE HEALTH CENTRE PRACTICE	65.7	74.3
SOUTH PETERBOROUGH PCN	WANSFORD	79.4	71.8
CAMBRIDGE NORTH VILLAGES PCN	WATERBEACH SURGERY	66	60.7
A1 NETWORK PCN	WELLSIDE SURGERY	70.8	65.4
CAMBRIDGE NORTH VILLAGES PCN	WILLINGHAM MEDICAL PRACTICE	54.4	65.8
SOUTH PETERBOROUGH PCN	YAXLEY GROUP PRACTICE	73.5	73.9
CAMBRIDGE CITY PCN	YORK STREET MEDICAL PRACTICE	47.9	67.9

**Please tell us about the local priorities for C&P?**



# **Frequently asked questions**

# Frequently asked questions

- Please find frequently asked questions by following the [link](#)
- If you have a question that is not answered here, please email [primarycare@uclpartners.com](mailto:primarycare@uclpartners.com)



# Contacts



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[Eastern AHSN CVD webpage](#)

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