Eastern AHSN

National Blood Pressure Optimisation Programme:

An implementation Guide (Hertfordshire & West Essex)

Part of The AHSN Network

Office for Life Sciences

NHS

Purpose

This guide aims to provide information to support implementation of a population health management approach to blood pressure management within primary care in the East of England.

It is intended for ICS CVD Prevention Boards

Content

This guide will provide useful information including:

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 SystmOne

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
1.Health inequalities: prioritised uptake of Proactive Care @home framework in PCNs with highest levels of inequalities	• Challenges in defining this metric. • Approaches and methods for data collection are locally determined
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.	• It is important to define what implementation means. • Framework for defining level of engagement developed in line with QART spread categories requires clear definitions and criteria
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 <140/90	• The challenge is in deciding what our ambition should be because QOF 20-21 achievement is low compared with previous years • There will be challenges regularly collecting this data due to the frequency and timing of when QOF data is published.
4.Hypertension case finding metric to mirror that in the PCN DES to be published	• Challenges regarding data availability for this metric and the suspension of the metrics up to April 2022. • Too complex to achieve any hard target within the scope of the programme (12 Months)

Example of Impact

Example of impact

Optimising blood pressure in the highest risk patients in the London borough of Lambeth would prevent up to **71 heart attacks** and/or **106 strokes**, in the population of 446,000, over five years.

Support for implementation

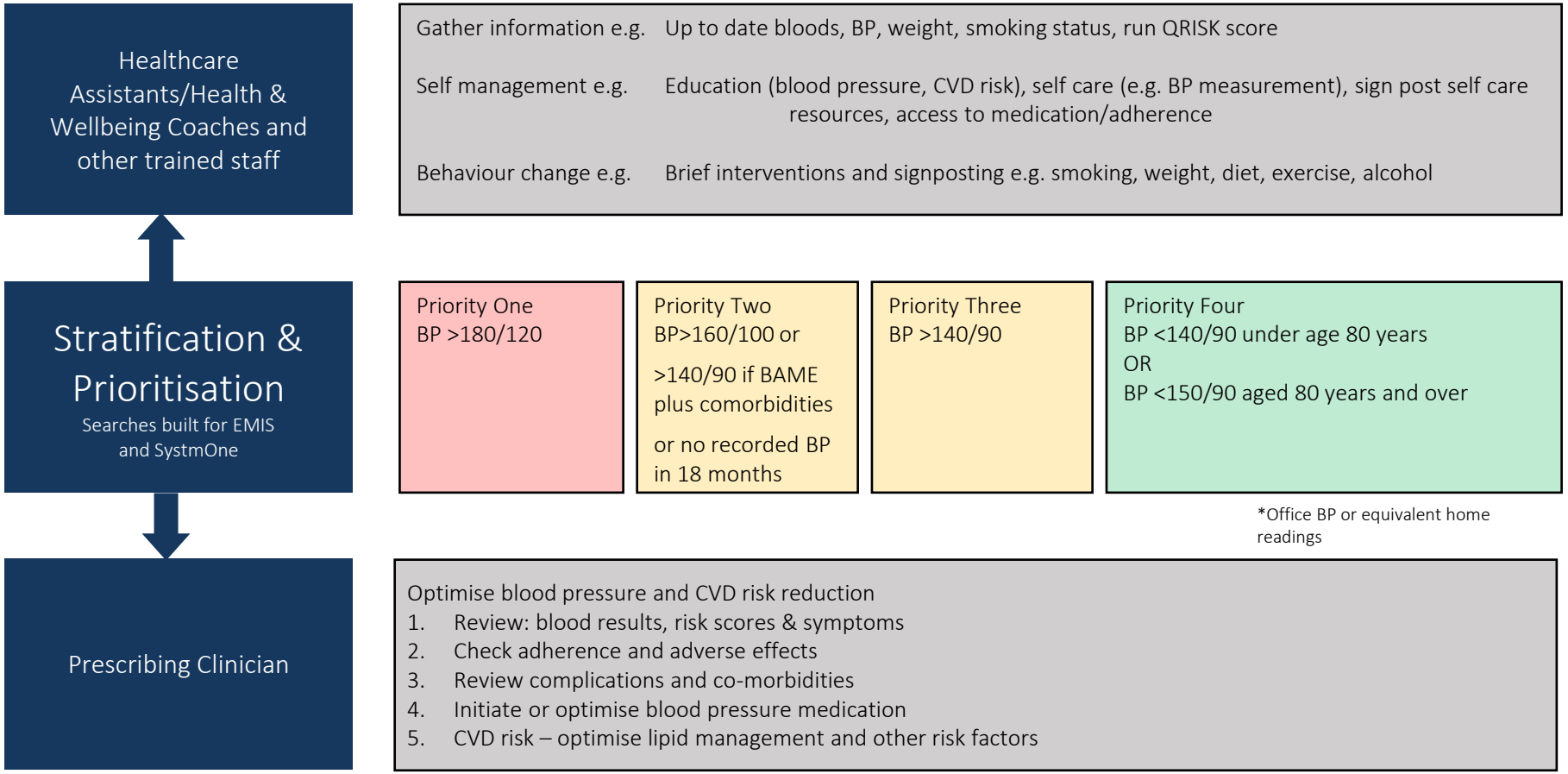
Role of AHSNs

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

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

Borough level searches

Total Population: ~446,000
Hypertension: 40,155

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

18% highest priority

52% low priority

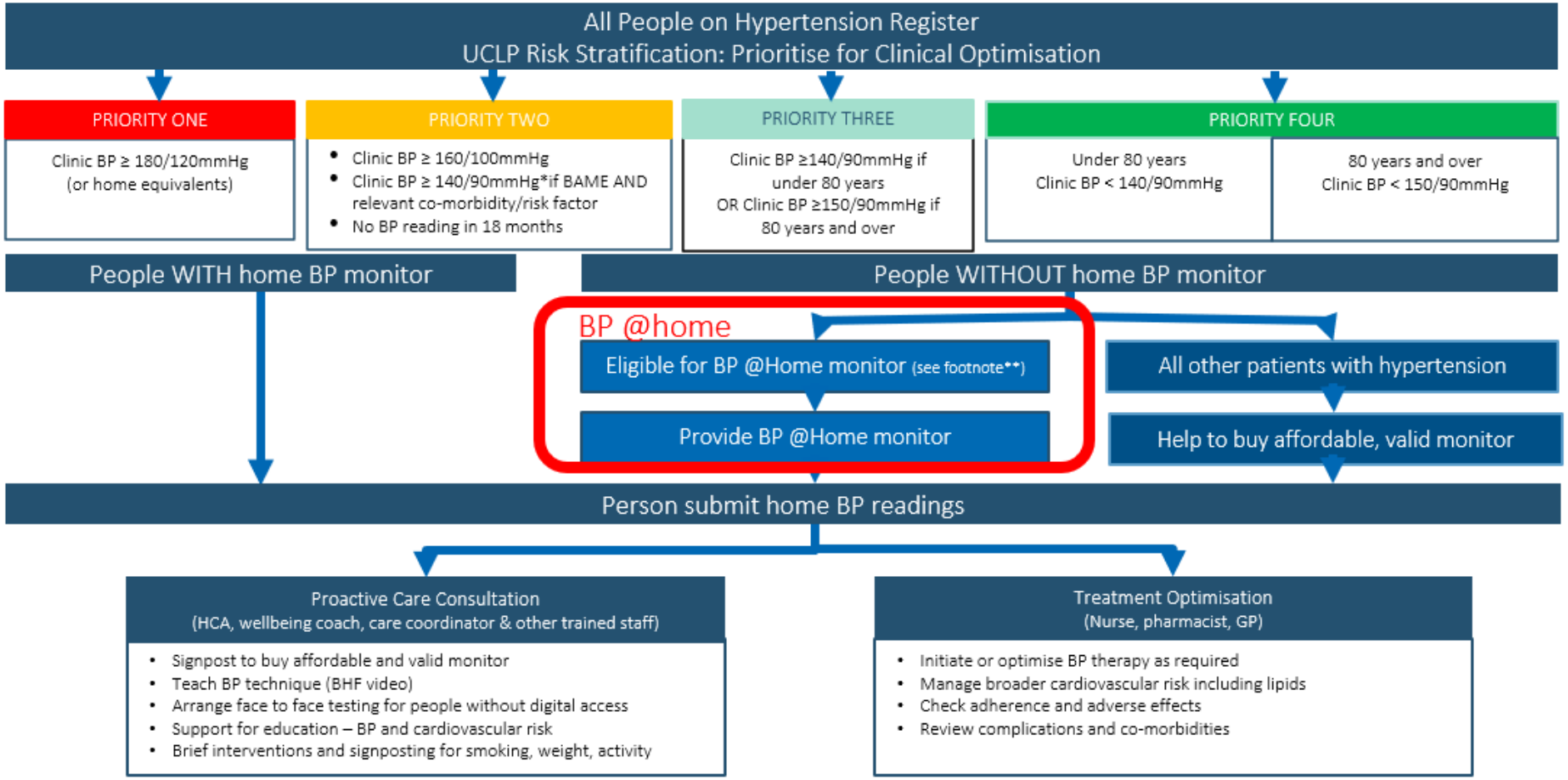
Links to other programmes

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

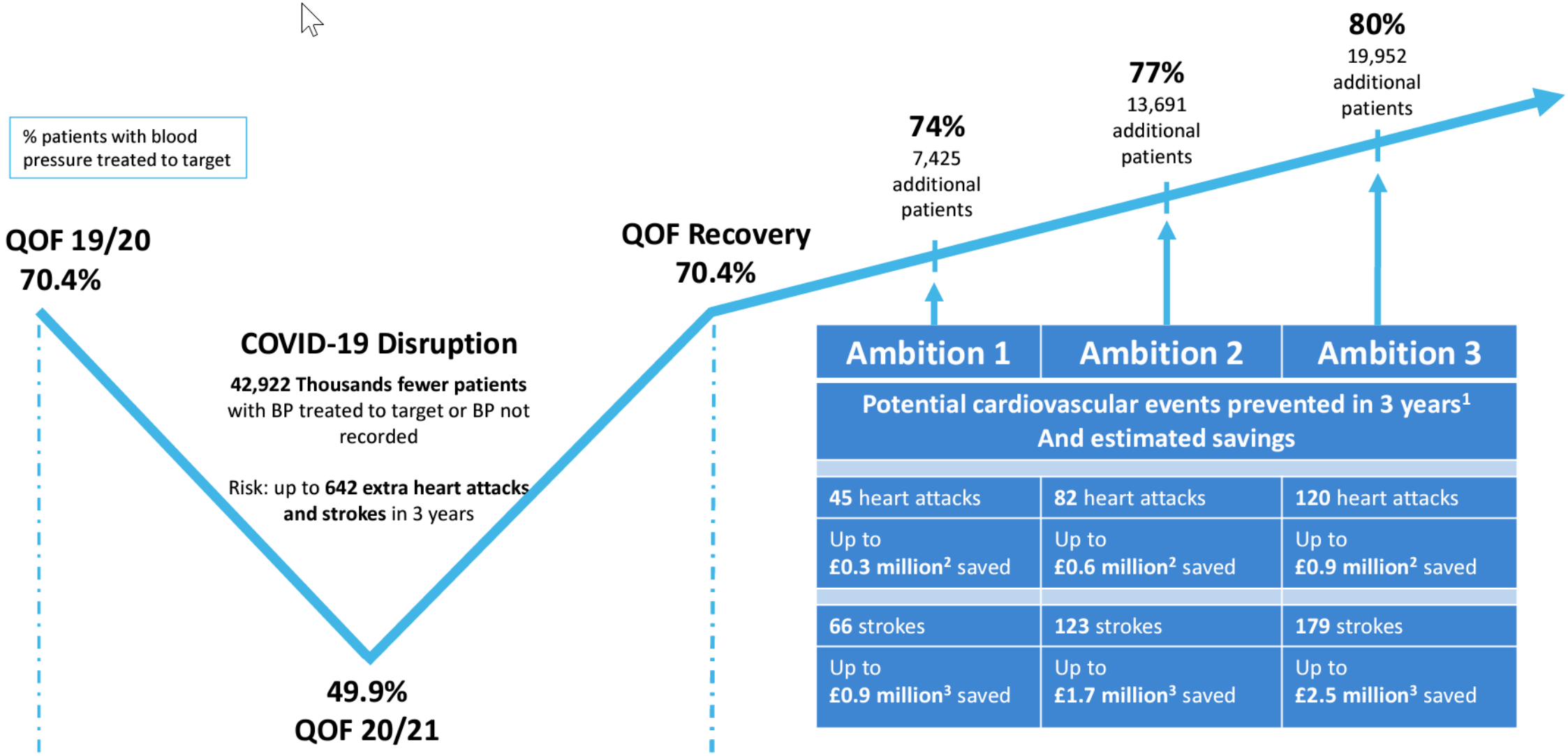
AHSN resources

Resources to support the implementation are available on NHS Futures

Local Priorities

Size of the Prize – Hertfordshire and West Essex
BP Optimisation to Prevent Heart Attacks and Strokes at Scale

UCLPartners



Ambition 1	Ambition 2	Ambition 3
Potential cardiovascular events prevented in 3 years[1] And estimated savings		
45 heart attacks	**82** heart attacks	**120** heart attacks
Up to **£0.3 million[2]** saved	Up to **£0.6 million[2]** saved	Up to **£0.9 million[2]** saved
66 strokes	**123** strokes	**179** strokes
Up to **£0.9 million[3]** saved	Up to **£1.7 million[3]** saved	Up to **£2.5 million[3]** saved

References
1. Public Health England and NHS England 2017 Size of the Prize
2. Royal College of Physicians (2016). Sentinel Stroke National Audit Programme. Cost and Cost-effectiveness analysis.
3. 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 on deprivation and hypertension

The GP Practice highlighted in red requires attention.

CCG	PCN	GP PRACTICE	Hypertension QOF Recorded Prevelance %	Hypertension patients managed to NICE target %
HERTS VALLEYS	ATTENBOROUGH & TUDOR PCN	ATTENBOROUGH SURGERY	60.5	74.7
EAST AND NORTH HERTFORDSHIRE	HATFIELD PCN	BURVILL HOUSE SURGERY	62.3	67.6
EAST AND NORTH HERTFORDSHIRE	HATFIELD PCN	LISTER HOUSE SURGERY	66	64.2
EAST AND NORTH HERTFORDSHIRE	HATFIELD PCN	POTTERELLS MEDICAL CENTRE	53.3	75.2
EAST AND NORTH HERTFORDSHIRE	HATFIELD PCN	WRAFTON HOUSE SURGERY	77.5	74.3
EAST AND NORTH HERTFORDSHIRE	HERTFORD AND RURALS PCN	CASTLEGATE SURGERY	54.2	72.2
EAST AND NORTH HERTFORDSHIRE	HERTFORD AND RURALS PCN	CHURCH STREET SURGERY	60.9	81.4
EAST AND NORTH HERTFORDSHIRE	HERTFORD AND RURALS PCN	HANSCOMBE HOUSE SURGERY	64.3	66
EAST AND NORTH HERTFORDSHIRE	HERTFORD AND RURALS PCN	WALLACE HOUSE	66.6	73.2
EAST AND NORTH HERTFORDSHIRE	HERTFORD AND RURALS PCN	WATTON PLACE CLINIC	76.9	73.2
EAST AND NORTH HERTFORDSHIRE	HITCHIN AND WHITWELL PCN	BANCROFT MEDICAL CENTRE	56.1	77.5
EAST AND NORTH HERTFORDSHIRE	HITCHIN AND WHITWELL PCN	REGAL CHAMBERS SURGERY	67.1	62.8
EAST AND NORTH HERTFORDSHIRE	HITCHIN AND WHITWELL PCN	THE PORTMILL SURGERY	58.8	66.6
EAST AND NORTH HERTFORDSHIRE	HITCHIN AND WHITWELL PCN	WHITWELL SURGERY	76	77.3
EAST AND NORTH HERTFORDSHIRE	HODDESDON & BROXBOURNE PCN	AMWELL SURGERY	67.8	76.7
EAST AND NORTH HERTFORDSHIRE	HODDESDON & BROXBOURNE PCN	HAILEY VIEW SURGERY	67.4	80.1
EAST AND NORTH HERTFORDSHIRE	HODDESDON & BROXBOURNE PCN	HAILEYBURY COLLEGE	0	46.2
EAST AND NORTH HERTFORDSHIRE	HODDESDON & BROXBOURNE PCN	PARK LANE SURGERY	64.8	74.3
EAST AND NORTH HERTFORDSHIRE	HODDESDON & BROXBOURNE PCN	THE LIMES SURGERY	57.8	81
EAST AND NORTH HERTFORDSHIRE	ICKNIELD PCN	ASHWELL SURGERY	59.4	65.6
EAST AND NORTH HERTFORDSHIRE	ICKNIELD PCN	BIRCHWOOD SURGERY	72.2	70.4
EAST AND NORTH HERTFORDSHIRE	ICKNIELD PCN	THE BALDOCK SURGERY	66.5	74.9
EAST AND NORTH HERTFORDSHIRE	ICKNIELD PCN	THE GARDEN CITY SURGERY	61.4	58.7
EAST AND NORTH HERTFORDSHIRE	ICKNIELD PCN	THE NEVELLS ROAD SURGERY	60.3	67.2
EAST AND NORTH HERTFORDSHIRE	ICKNIELD PCN	THE SOLLERSHOTT SURGERY	67.8	63.1

Data on deprivation and hypertension

PCN	GP PRACTICE	Hypertension QOF Recorded Prevelance %	Hypertension patients managed to NICE target %
LEA VALLEY HEALTH PCN	CROMWELL MEDICAL CENTRE	74.4	58.7
LEA VALLEY HEALTH PCN	CUFFLEY AND GOFFS OAK MEDICAL PRACTICE	72	68.1
LEA VALLEY HEALTH PCN	HIGH STREET SURGERY	78.6	79.4
LEA VALLEY HEALTH PCN	STANHOPE SURGERY	73.3	69.5
LEA VALLEY HEALTH PCN	STOCKWELL LODGE MED.CTR.	65.4	72
LEA VALLEY HEALTH PCN	THE MAPLES	62.7	71.3
LEA VALLEY HEALTH PCN	WARDEN LODGE MEDICAL PRACTICE	69.2	48.4
STEVENAGE SOUTH PCN	BEDWELL MEDICAL CENTRE	74.4	65.8
STEVENAGE SOUTH PCN	KING GEORGE SURGERY	70.2	62.6
STEVENAGE SOUTH PCN	KNEBWORTH & MARYMEAD PRACTICE	69.7	72.9
STEVENAGE SOUTH PCN	SHEPHALL HEALTH CENTRE	63.6	73.3
STORT VALLEY & VILLAGES PCN	CENTRAL SURGERY	68.7	75.9
STORT VALLEY & VILLAGES PCN	CHURCH STREET PARTNERSHIP	58.4	63.1
STORT VALLEY & VILLAGES PCN	MUCH HADHAM HEALTH CENTRE	70.8	71.9
STORT VALLEY & VILLAGES PCN	PARSONAGE SURGERY	66.1	73.5
STORT VALLEY & VILLAGES PCN	SOUTH STREET SURGERY	65.6	77.4
WARE AND RURALS PCN	DOLPHIN HOUSE SURGERY	64.5	81.2
WARE AND RURALS PCN	ORCHARD SURGERY	85.7	66.7
WARE AND RURALS PCN	PUCKERIDGE & STANDON SURGERY	66.4	68.5
WARE AND RURALS PCN	THE MEDICAL CENTRE BUNTINGFORD	64.6	69.8
WELWYN GARDEN CITY A PCN	HALL GROVE GROUP PRACTICE	65	80.8
WELWYN GARDEN CITY A PCN	SPRING HOUSE HEALTH	66.9	68.9
WELWYN GARDEN CITY A PCN	THE GARDEN CITY PRACTICE	56.9	68.8
WELWYN GARDEN CITY AND VILLAGES PCN	BRIDGE COTTAGE SURGERY	63	64.9
WELWYN GARDEN CITY AND VILLAGES PCN	PEARTREE LANE SURGERY	67.2	61.4

Please tell us about the local priorities for Herts & West Essex?

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

Contacts

Eastern AHSN

cvdteam@eahsn.org

[Eastern AHSN CVD webpage]

@EasternAHSN

Eastern AHSN

@EasternAHSN

Part of The AHSN Network

Office for Life Sciences

NHS