Somerset Hypertension Resource Pack

A practical guide to improving the management of hypertensive patients

May 2024

Executive Summary

This pack is designed to help practice and primary care network (PCN) teams in the vital work of diagnosing hypertension and managing it optimally to improve patient care. It also explains how you can help in the fight to prevent cardiovascular disease and reduce health inequalities across Somerset. It has been produced collaboratively by Dr Marie-Joelle West at Health Innovation South West with input from colleagues in Somerset including Dr Solomon Lebese, GP, and Peter Fee, PCN Lead Clinical Pharmacist.

It describes:

- The rationale for focusing on hypertension
- The national policy context aligned to practice contractual requirements
- Available search and risk stratification tools, implementation resources and data sources
- Best practice and learning from the local area
- The NHS blood pressure check service in community pharmacy
- Patient resources

And finally provides a comprehensive list of resources to help you in your work.

We really hope you find this pack useful. If you find time for nothing else, please look at the list of resources on page 15 and click through to some of the resources available. We would particularly highlight the UCL Partners resources, which comprise a set of high-quality learning modules, videos, and practical tools.

This pack will be regularly updated with the next version due in September 2024. Feedback from primary care teams to improve these resources for the future is welcome. Please send any feedback to somicb.generalpractice@nhs.net

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1. Why is the management of high blood pressure such an important priority?

Cardiovascular deaths constitute a quarter of all deaths in the UK and high blood pressure is the largest single known risk factor for cardiovascular disease and related disabilities. Many of your patients will have high blood pressure without knowing about it. Many will be known to have high blood pressure (hypertension) but may not be receiving optimum treatment. Cardiovascular deaths are a leading contributor to health inequalities in mortality rates between those in the most and least deprived populations. People living in the most deprived areas are 30% more likely to have hypertension[*].

Each Integrated Care System (ICS) has a population health priority. In Somerset we have chosen hypertension, because it has a good evidence base for intervention, and lives can be saved quickly. While we are focusing particularly on hypertension, we are not asking you to ignore other cardiovascular (CVD) risks and multi-morbidity. It is also important to take a personalised care approach to hypertension, having conversations with patients about what matters to them. The whole practice and PCN team have a role to play, whether clinical or non-clinical.

The Size of the Prize for high blood pressure (*Figure 1*) was developed using ICS level data collected before and one year after the start of the Covid pandemic, to demonstrate the potential for preventing cardiovascular events and costs savings (the data available from UCLPartners is shown 6 months in the past). Updated versions will be shared with practices via TeamNet.

This diagram shows how by getting back to the level of hypertensive management pre-Covid, and then gradually increasing it, we will save lives and prevent avoidable strokes and heart attacks.

As well as being good medical care, improvements in hypertensive care also allow practices to demonstrate how they are meeting the requirements of the New Funding Framework contract, successor to PCIS- the primary care improvement scheme.

[*] https://www.gov.uk/government/publications/health-matters-preventing-cardiovascular-disease/health-matters-preventing-cardiovascular-disease

Region
All

Select ICB here:
Somerset

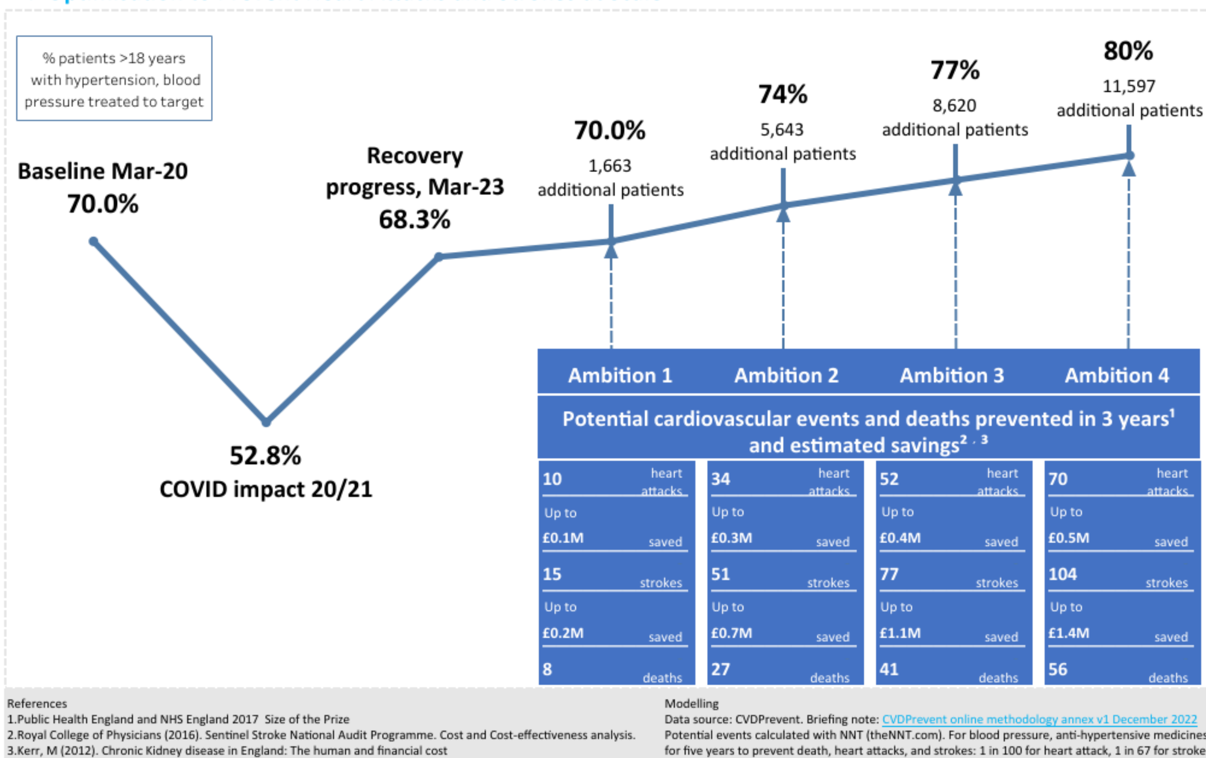


Figure 1: Size of the Prize for Somerset ICS showing the number of preventable cardiovascular events and estimated savings in 3 years' time; last updated 24 Aug 2023

So, to be clear, we are asking practice and PCN colleagues to:

- Talk about hypertension, at practice and PCN level.
- Commit to taking some action.
- Use the resources available to identify patients who may have undiagnosed hypertension, initiate care for newly diagnosed patients, and optimise care for patients already diagnosed.
- The result should be that we move towards the ambition of 77% of patients treated in accordance with NICE guidance, which will save lives and prevent heart attacks and strokes.

2. Hypertension Agenda for Primary Care

The agenda for hypertension management is guided by the NHS 10-Year Long Term Plan and incentivised through QOF payments and the PCN DES. It requires collaboration with a system-wide approach to improving hypertension diagnosis and management In addition, hypertension case finding and management, and lipid management are a clinical focus area in the national health inequalities programme CORE20PLUS5.

The financial incentives are summarised below to support practices meet their contractual requirements:

- QOF- Although HYP-001 (disease register) is income protected, the treatment indicators HYP-008 and 009 are not. This resource pack will support practices to maximise QOF performance and therefore funding.
- New Funding Framework- the new local GP contract designed by the ICB, requires practices to take a quality improvement approach to improving hypertension management. Using this resource pack will support practices in doing so.
- PCN DES- although the CVD specification has been merged into an overall requirement to provide co-ordinated person-centred care that improves population health, using this resource pack will allow PCNs to demonstrate how they are meeting the requirements of the DES.

2.1 The NHS 10 Year Plan

The ambitions for the management of hypertension in the NHS 10-year plan are:

- Detection: 80% of the expected number of people with hypertension will be diagnosed by 2029
- Treatment: 80% of the total number of people diagnosed with hypertension will be treated to target as per NICE guidelines NG136 by 2029. *The treatment target for hypertension is below 140/90 in people aged under 80, and below 150/90 in people aged 80 and over (*relating to clinic readings).

The NICE guidance is summarised in a 2 page infographic here.

2.2 NHS National Objectives 2024/25

The national priorities relevant to the CVD agenda are:

- Increase percentage of patients with hypertension treated to NICE guidance to 80% by March 2025, an increase on the 77% target in 23/24.

- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%.
- Continue to address health inequalities and deliver on the Core20PLUS5 approach.

2.3 Core20PLUS5

Core20PLUS5 *(Figure 2)* is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. CVD is one of the biggest contributors to the life expectancy gap between the most and least deprived population groups. Hypertension case-finding and optimisation and optimal lipid management is one of the 5 focus clinical areas in the Core20PLUS5 approach.

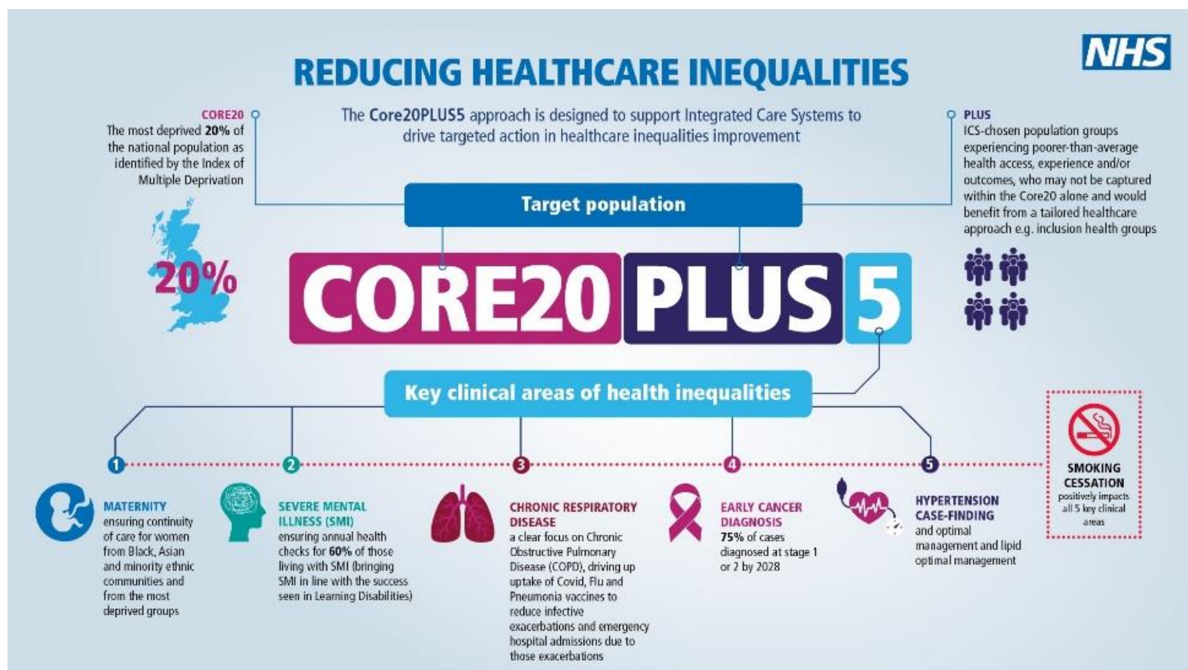


Figure 2: The Core20PLUS5 approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

2.4 Core20PLUS5 - Somerset System Target Population Cohort

At a system level in Somerset, the priority target population cohort includes the CORE20 (20% most deprived nationally, as defined by the Index of Multiple Deprivation (IMD) and the Somerset System Plus cohort which includes:

- Individuals, families, and communities experiencing rural and coastal deprivation.

- Individuals, families, and communities adversely affected by differential exposure to the wider determinants of health – for example, homeless persons, vulnerable migrants and/or those experiencing domestic abuse.
- Persons with severe mental illness and learning disability and people with autism.

3. Best practice, resources and support available

3.1 South West Population Health Fact Finder

A new interactive reference tool for Hypertension Case Finding & Management is freely available via the FutureNHS Collaboration Platform. It contains resources and links to programme drivers, targets, available data tools, interventions, case studies, and more. This includes learning and guidance material for staff working with hypertension for the first time. You need to create an account and sign in, but this is simple to do.

3.2 Regional campaign and toolkit

The National Know Your Numbers campaign aimed at encouraging over 40's to get their blood pressure checked at a community pharmacy, at home, or in other community settings. The national webpage also links to our local 'Take the Pressure Off' webpage.

3.3 Regional and National Examples of good practice

Many PCNs and practices have successfully optimised BP management. These include:

- Blood pressure optimisation at Okehampton Medical Centre
- Community-based BP checks across the country: Report from the British Heart Foundation
- Case studies from around England: Blood Pressure Optimisation Impact Report

These targets require a community wide approach to BP detection and management working in collaboration with NHS Somerset, Public Health teams, Community Pharmacy and Health Innovation South West. The support available can be tailored to individual needs of the PCN or GP practice and includes:

- Accessing and understanding relevant data and evidence.

- Facilitating access to digital tools, data dashboards and emerging innovative technologies.
- Supporting Health Coaches and Care Co-ordinators to develop skills, knowledge, and confidence in working with patients on hypertension.
- Linking up with relevant service providers (e.g. pharmacies) and other PCNs and practices, who have successfully implemented BP management.
- Providing advice on accessing the free UCL Partners tools.
- Providing SOPs for PCN hubs and advice on design of clinical process.

If you would like to request help, please contact somicb.generalpractice@nhs.net

3.4 A risk stratification approach to hypertension management

As recommended by the Royal College of GPs Long Term Conditions Recovery Guidance, a series of Proactive Care Frameworks for the management of long term conditions as been developed by UCLPartners for primary care including on hypertension.

Benefits of a risk stratification approach to hypertension management:

- Stratification informs workflow and workforce planning by prioritising and optimising clinical care.
- GP workload can be reduced by utilising the wider workforce to manage different priority groups.
- A shift between priority groups demonstrates clinical impact and helps GPs to meet QOF and other targets.
- Prioritisation improves the personalised care offer for patients.

3.5 The UCLP Proactive Framework

The free resources are available by registering via the UCLP Framework website and include:

- Search & stratification tools for EMIS *(see priority categories in Figure 3).*
- Implementation guidance and resources for clinicians focussing on the HOW *(see example in Figure 3).*
- Case studies and video clips from clinicians.
- Protocols for Health Care Assistants (HCA) and similar roles.
- Digital resources for staff and patients.

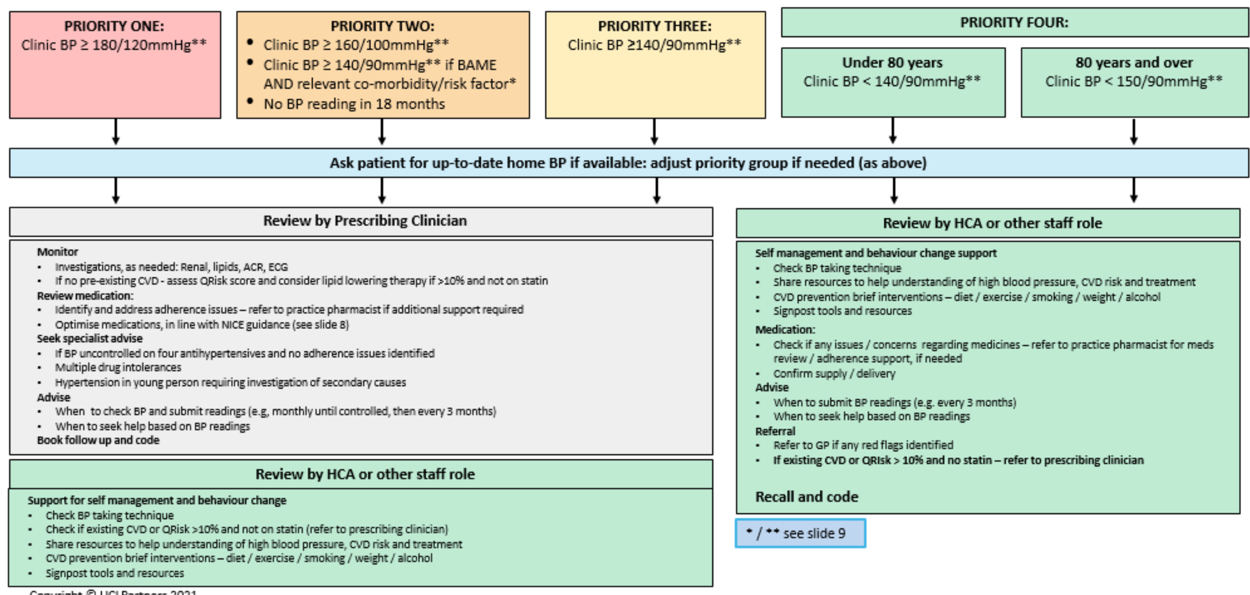


Figure 3: Workflow following blood pressure stratification.

4. Resources for patient self-management

There is a wide range of information for patients and support for self-management

- A guide about how to manage your blood pressure from Heart UK.
- A guide about High Blood Pressure from the Stroke Association.
- Home monitoring resource hub from Blood Pressure UK..
- NHS Diabetes Prevention Programme: the Healthier You programme, a nine-month, evidence-based lifestyle change programme.
- NHS Digital Weight Management programme: supports adults living with obesity who also have a diagnosis of diabetes, hypertension, or both.
- Library loans of home blood pressure monitors – free loan from libraries in Somerset.
- NHS Type 2 Diabetes Path to Remission Programme: Supports adults who have developed type 2 diabetes within the last 6 years.
- Slimming World on Referral: Adults who have not previously tried Slimming World can receive a free 12-week introductory course on referral from their GP.
  Somerset Activity & Sports Partnership - Health Coaching Service
  SASP health coaches and active lifestyle services support patients with long term conditions to be more active and take control of their own health.

5. Data for improvement

5.1 QOF dashboards

https://www.nhspathways.org/nhspathways/members/QOF/index.aspx?qofgroup=HYP (see below) allows you to see how your practice, and other practices, perform against the measures; and to find out the prevalence of disease, and the percentage of all patients who have the condition.

5.2 CVD Prevent

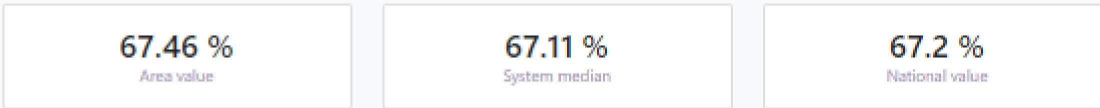
The Cardiovascular Disease Prevention Audit (CVDPREVENT) is a national primary care audit that automatically extracts routinely held GP data and is up-dated every quarter allowing on-going review of progress to targets throughout the year This tool is extremely user friendly and provides data at practice and PCN level allowing practices to compare their performance with their peers. Data is broken down by age, sex, ethnicity, and deprivation status so that that practices can readily identify areas of inequality of provision.

Figure 4 below shows an example of the types of comparative data that is available through CVD Prevent.

CVDP007HYP: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold. Proportion %

Quality Improvement | Data Extract | Metadata

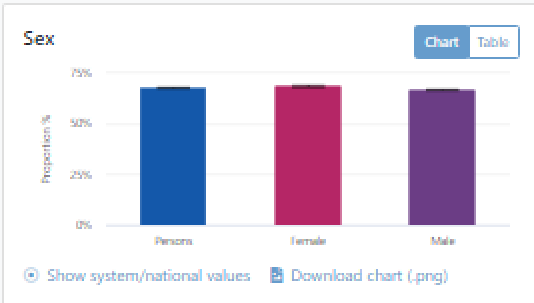
All Persons Data

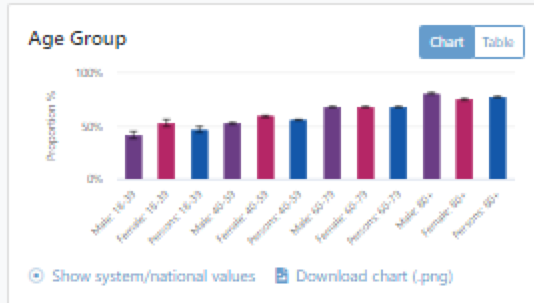


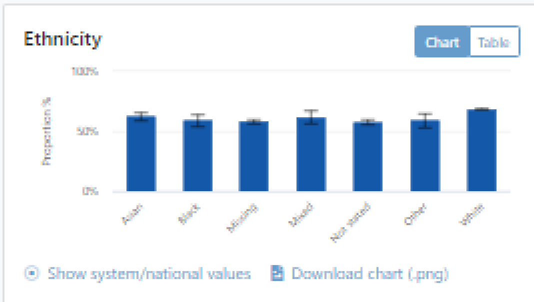
Inequalities Markers | Area Comparison | Learning Disabilities | Data Extract (.csv)

System median | National value

Markers showing national values but no area values means that the area value has been suppressed for disclosure control due to small count.







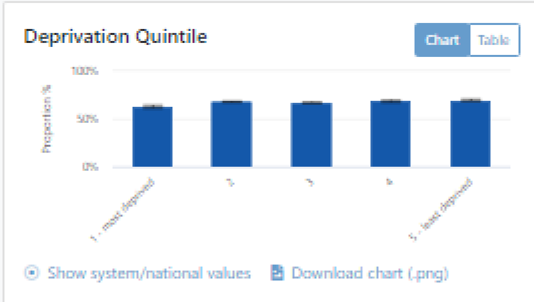


Figure 4: Data extract from CVD Prevent showing Hypertension indicator in December 2023 for Somerset.

5.3 SHAPE (Strategic Health Asset Planning and Evaluation)

SHAPE is a web enabled, evidence-based application linking national data sets, clinical analysis, deprivation indices, primary care, and demographic data with information on healthcare estates performance and facilities location. The application also includes a fully integrated Geographical Information System mapping tool and supports travel time analysis.

Access to the SHAPE Place Atlas is free to NHS professionals and Local Authority professionals with a role in Health or Social Care. Access to the application is by formal registration and licence agreement.

5.4 Eclipse

For patient risk/optimisation identification of unmet need patients/ co-morbidities and risk we would highly recommend practices to use Eclipse live searches https://www.eclipsesolutions.org/eclipselogin.aspx

Eclipse is a powerful tool, and we recommend that practices make full use of it. If you need further help to understand the capabilities of Eclipse in relation to hypertension, please ask your Medicines Management locality lead.

5.5 Prescribing and Medicines Management - NHS Somerset Integrated Care Board (ICB)

Practices and PCNs should be aware of and make use of the following resources:

Prescribing and Medicines Management - NHS Somerset ICB

Chapter 2.4 – Blood pressure conditions – Somerset Prescribing Formulary (nhssomerset.nhs.uk)

https://www.nice.org.uk/guidance/ng136/resources

6. The role of Community Pharmacy

6.1 The Hypertension case-finding service

This advanced service contract (similar to a GP enhanced service) will support the work that general practices and wider PCN teams will be undertaking on CVD prevention and management. To improve diagnosis of patients with hypertension, community pharmacies will work proactively with PCNs via the hypertension case finding service.

90 Pharmacies in Somerset have signed up so far, giving over 95% coverage. In public-facing communications, the service is termed the NHS Blood Pressure Check Service.

A community pharmacist will opportunistically measure the blood pressure of consenting adults who come into the pharmacy, by offering anyone a free blood pressure check who:

- is over the age of 40;
- has not previously been identified as having hypertension or a related condition; and
- has not had their blood pressure measured by a health professional within the previous six months.

At the end of a consultation, where readings indicate:

- **normal blood pressure**, the pharmacist will promote healthy behaviours.
- **high blood pressure**, the pharmacist will offer Ambulatory Blood Pressure Monitoring (ABPM) from the pharmacy and will also promote healthy behaviours.
- **very high blood pressure**, the pharmacist will urgently refer the patient to see their GP within 24 hours and the pharmacist will inform the patient's GP practice by NHS mail or via another locally agreed platform.
- **low blood pressure**, the pharmacist will provide appropriate advice and may also refer the patient to their GP if there are any concerns.

All blood pressure readings are sent to the general practice from the community pharmacy so records can be updated and appropriate action taken.

The service specification can be found here: NHS community pharmacy hypertension case-finding advanced service.

6.2 General Practice referrals to Community Pharmacy

In Somerset we commission the EMIS Local Services button for general practice to directly refer from EMIS into a pharmacy. This improves data governance, makes it easier to refer and receive referrals. If practices want to refer patients who have already been diagnosed with hypertension for blood pressure checks, then pharmacies should work with their practices to agree a local process by which this will work; there are no specific requirements set for this process and it could involve the practice and pharmacy agreeing that a specific list of patients can access the service or a cohort of patients could be specified.

For further support, contact Laura Picton, ICB Clinical Lead for Community Pharmacy via somicb.generalpractice@nhs.net

7. List of available resources with links

Name	Origin	Purpose	Object
Hypertension Framework	UCLPartners	Overview	Link
Search and risk stratification tools	UCLPartners	Search and Stratification tools, free of charge	Register here to download resources
Clips and protocols	UCLPartners	How to run the searches	Link
Workbook implementation modules 1-4	UCLPartners	Develop implementation model	Register here to download resources
Digital resources for hypertension	UCLPartners	Monitoring, Management, Wellbeing	Link
CVD Prevent	CVD Prevent	Interactive data tool	Link
Financial Incentives	UCLPartners	Details of QOF points, DES and IIF	See below
Size of the Prize Somerset	UCLPartners	Graphical representation of heart attack and stroke prevention	Link
Staffing example	UCLPartners	Workforce utilisation in primary care	Link
Protocol for remote consultations	UCLPartners	For HCAs and other staff	Link
Suggested training and education support	UCLPartners	Implementation support for wider workforce	Link
Case Studies	UCLPartners	Peer experiences and case studies	Link
A Practical Guide	British Hypertension Society	Implementing Home Blood Pressure Monitoring In Your Practice	Link
Hypertension case finding service	LPC	Training for Community Pharmacy	Link
Core20PLUS5	NHS England	Overview	Infographic
NHS Health Checks Service	Office for Health Improvement and Disparities (OHID)	Guidance for staff to promote health	Link
SW Hypertension Case Finding and Management	NHS England	Implementation resources	Link
Know Your Numbers	NHS England	Public campaign	Link
Take the Pressure Off	NHS Somerset	Local campaign	Link
Community based Blood Pressure Checks	British Heart Foundation	Report	Link
NICE Guidance NG136	NICE	NICE guidance	Link

Name	Origin	Purpose	Object
Long Term Conditions Recovery Guide	RCGP	Practical guide	Link
QOF Dashboard	NHS Pathways	QOF comparison tool	Link
SHAPE	DHSC	Analytical tool – population and geography	Link
Eclipse	Eclipse	Medication-based risk stratification	Link
Prescribing and Medicines Management	NHS Somerset	Medicines and prescribing resources	Link
Somerset Formulary- BP medication	NHS Somerset	Formulary – BP medication	Link
Manage Your Blood Pressure	Heart UK	Patient resource	Link
High Blood Pressure	Stroke Association	Patient Resource	Link
NHS Diabetes Prevention Programme	NHS England	Programme	Link
NHS Digital Weight Management Programme	NHS England	Programme	Link
Library loans of BP monitors	Somerset Council	Information on BP monitor loans from libraries	Link
SASP Health Coaches	SASP	Information on health coaching	Link

8. Glossary of commonly used terms

Case-finding- also called detection; finding people with high blood pressure who have not been diagnosed.

CORE20PLUS5 – a national programme to reduce health inequalities, for example the difference in life expectancy between the wealthiest and poorest people.

CVD- cardiovascular disease; disease of the heart and circulatory system

Detection – finding people with high blood pressure who didn't know they had it, and so are not diagnosed. Also called detection.

Hypertension- high blood pressure

Hypertensive- having high blood pressure, e.g. 'a hypertensive patient'

ICB- integrated care board; the body responsible for planning, funding and improving health care services for the people of Somerset.

NICE- the national institute for health and care excellence; the organisation that creates guidance on clinical care.

New Funding Framework- the new Somerset GP contract which requires practices to take a quality improvement approach to improving hypertension management.

PCN- primary care network; a group of GP surgeries working together in a local area

PCN DES- the primary care network directed enhanced service; the contract that practices hold as members of a PCN which determines funding and services

QOF- quality and outcomes framework- part of the GP contract that provides funding for practices if certain targets are achieved. It is an important part of practice income.

Risk stratification- sorting patients into different categories according to their level of risk, using data. This helps to identify patients who should be prioritised for care.

TeamNet- an information sharing system that all practices in Somerset can use.

Treatment optimisation- treating patients in accordance with NICE guidance.

UCLPartners – a health innovation organisation within the NHS