

# National Blood Pressure Optimisation Programme Implementation Booklet



# Purpose

This guide aims to provide information to support implementation of a population health management approach to blood pressure management within primary care and is intended for Primary Care Networks and practices.

# Content

This guide will provide useful information including:

1. [Blood Pressure Optimisation Programme: Aims and objectives](#)
2. [Proactive care frameworks](#)
3. [Risk stratification & Search Tool Demos](#)
4. [Size of the Prize: East of England](#)
5. [Patient video](#)
6. [Resources](#)
7. [Top Tips for implementation](#)
8. [Links to other programmes](#)
9. [Frequently asked questions](#)
10. [Resource links](#)
11. [Contacts](#)



# **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

## AHSN Role

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/practices to implement the **UCLPartners Proactive Care Framework for hypertension** to optimise clinical care and self-management of people with hypertension.
2. Support PCNs/practices to increase the detection of people through case-finding interventions.
3. Support primary care to reduce health inequalities by targeting 20% of most deprived populations and other local priority groups (Core20PLUS5).



# **Proactive Care Frameworks**

## Proactive care frameworks

UCLPartners has developed a series of [frameworks](#) for **local adaptation** to support proactive **management of long-term conditions in primary care**. The frameworks:

- stratify patients at the highest risk,
- deploy the wider workforce to reduce the workload for GP's, and
- improve personalised care

The **core principles** focus on:

- Virtual where appropriate, face to face where needed
- Mobilising and supporting the wider workforce (e.g. pharmacists, HCA's, and others) to optimise clinical care, support patient education and lifestyle change
- Step change in support for self-management
- Digital innovation including apps for self-management and technology for remote monitoring



## The framework consists of six components

Comprehensive stratification tools built for EMIS and SystemOne

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.

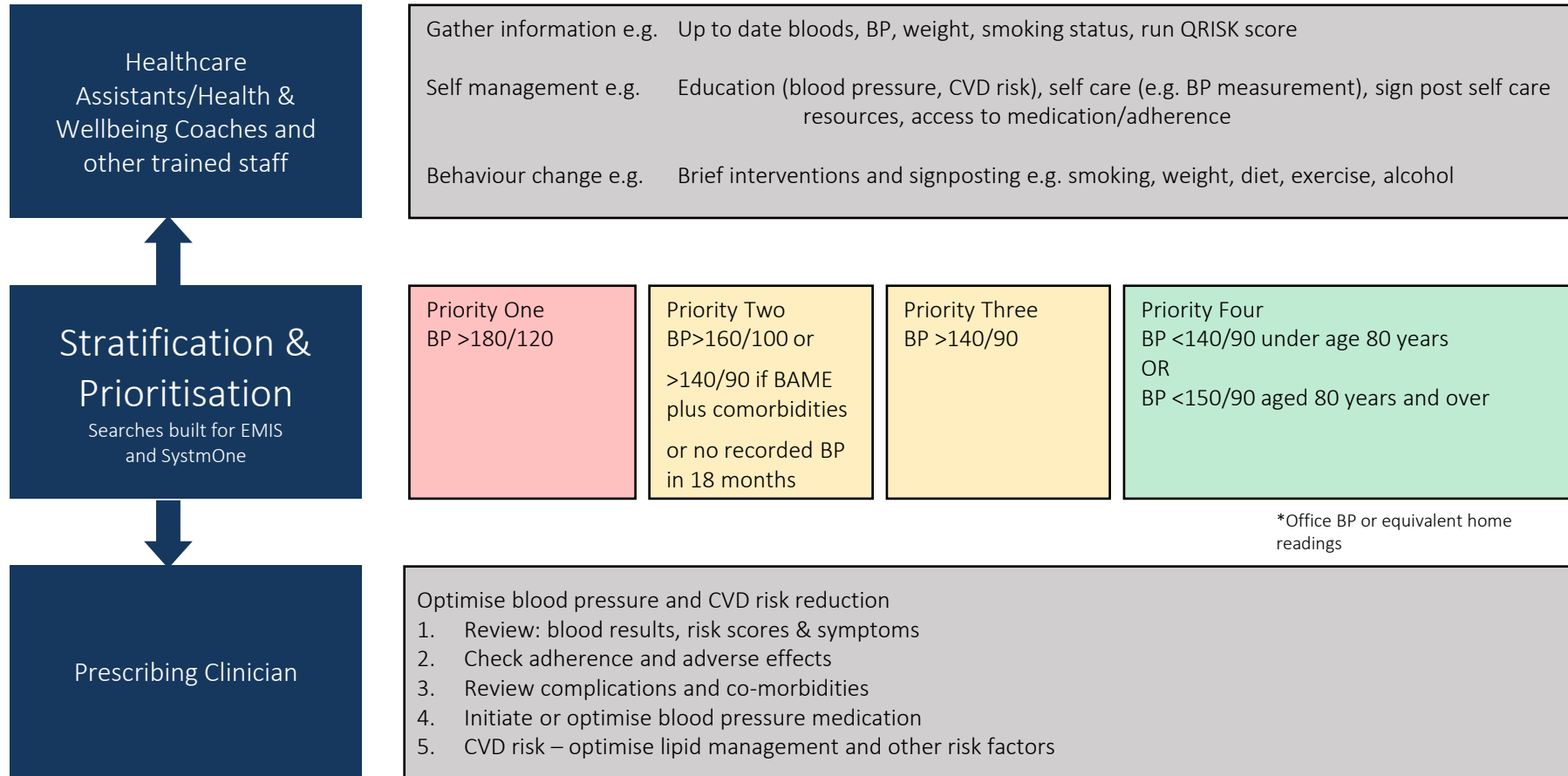
Scripts and protocols to guide Health Care Assistants and others in consultations.

Training for staff to deliver education, self-management support and brief interventions. Training includes health coaching and motivational interviewing.

Digital and other resources that support remote care and self-care.

Project management and support for local leadership.

# 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



# **Risk Stratification & Search Tools Demo**

# Risk Stratification & Search Tool Demos



UCLPartners demonstration videos which provide details of how to run searches and take you through these tools in action – we will use asthma and COPD as examples. Use these in conjunction with the search guide.

- **Access search and stratification tools [here](#)**

EMIS

SystemOne



### EMIS Hypertension search tools

- Download the [EMIS Hypertension search tools](#)
- Download the [Hypertension](#) search description

### SystemOne Hypertension search tools

- Download the [SystemOne Hypertension](#) search tools
- Download the [Hypertension](#) search description

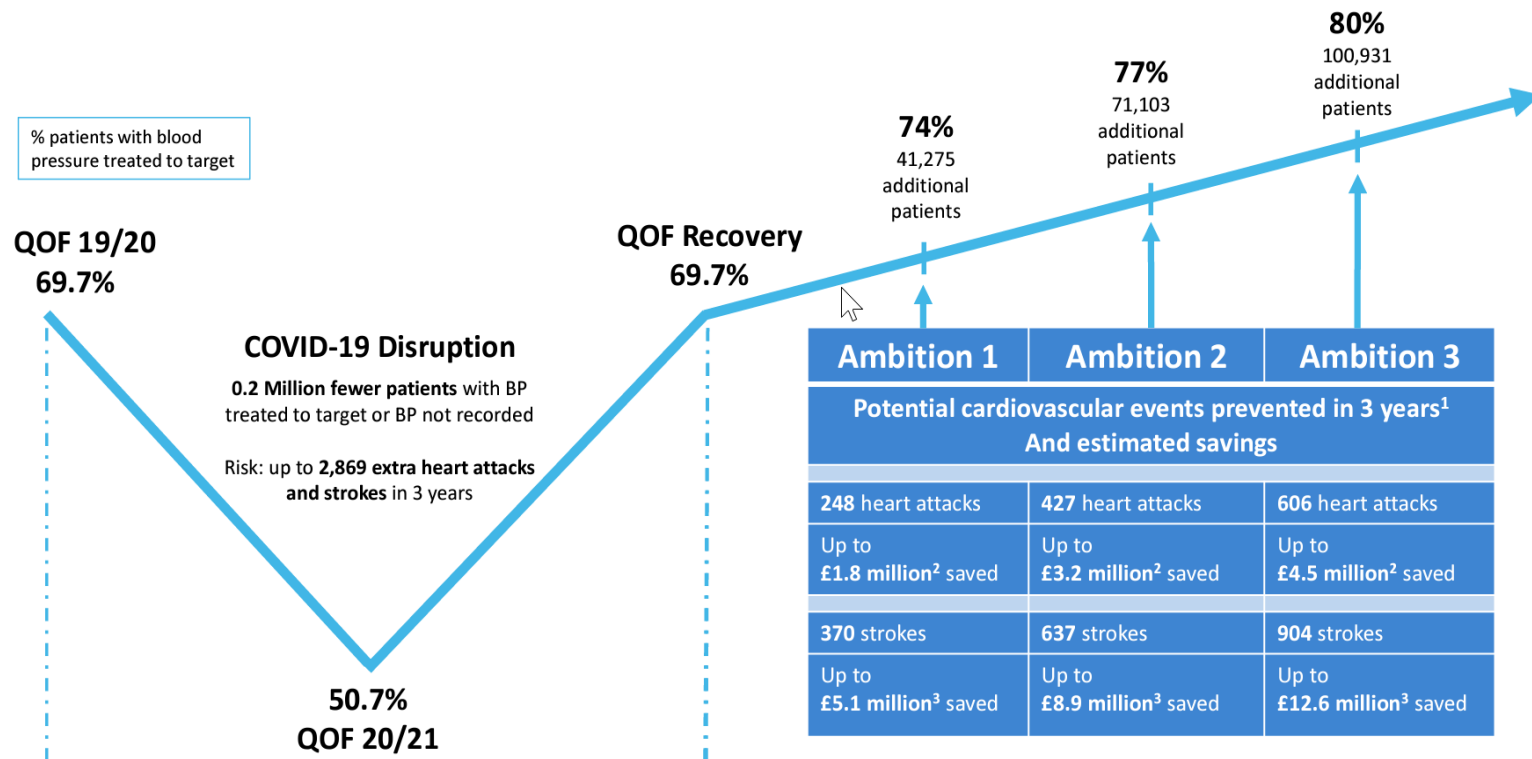


# **Size of the Prize**

# Size of the Prize East of England

In this [4 minute video Dr Matt Kearney](#) gives an overview about the programme and a new resource that helps to articulate the opportunities of the programme - the Size of the Prize, [ICB specific data is available here](#) on the UCLPartners website.

## Size of the Prize – East of England 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

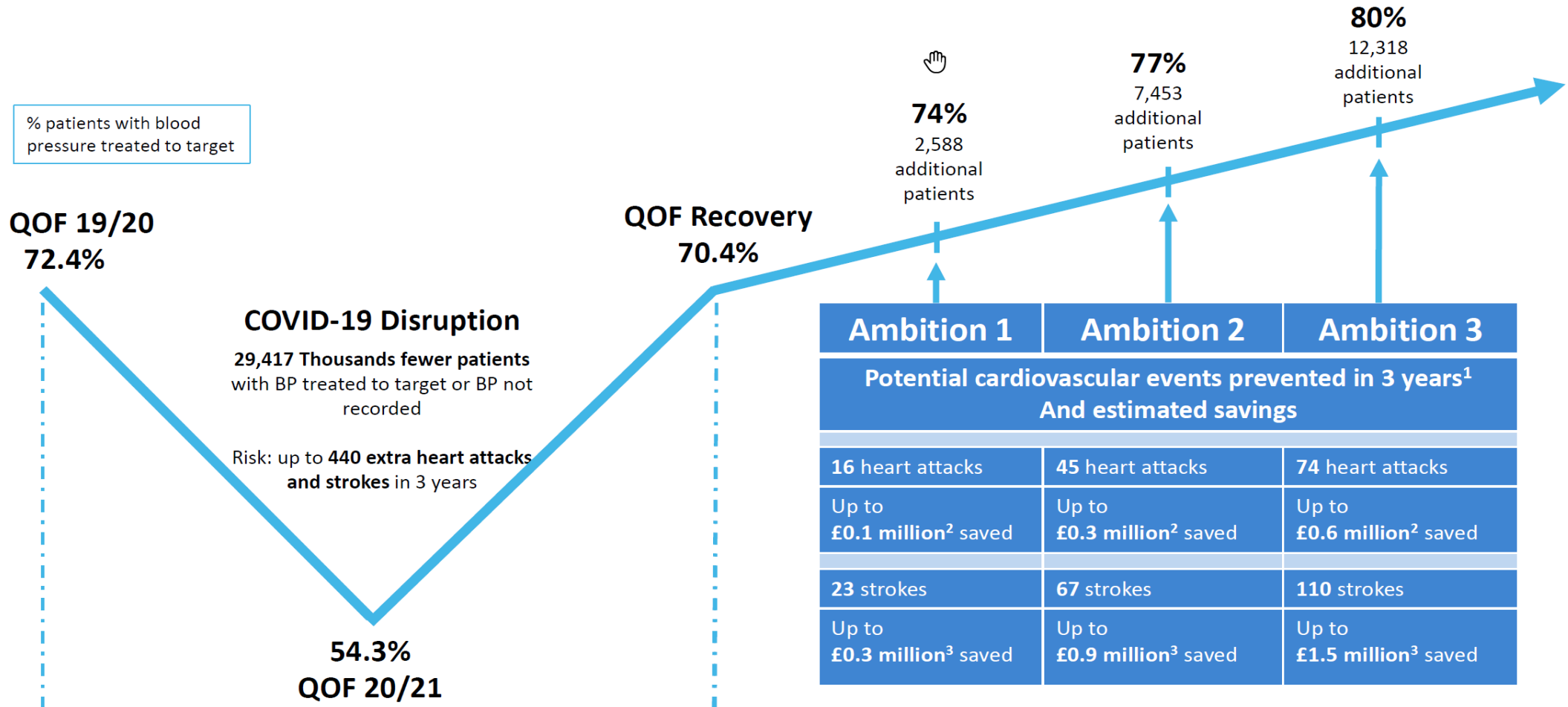
### Modelling

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.

[Link to contents](#)



# Size of the Prize – Suffolk and North East Essex 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

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# Patient Video

## Patient video



*This video was created with funding from NHSX. The video is also available in Punjabi, Bengali, Urdu, Somali, Gujarati, Polish, Sylheti, Arabic, Farsi, Kurdish Sorani, Romanian, Chinese, Tamil and Turkish, [click here to view the full playlist](#).*



# Resources

# Proactive Care Framework implementation workbook

- [The workbook modules](#) aim to help you understand the key concepts behind the frameworks, what they are and how to successfully implement them.
- The **workbooks** contain **free resources** to share with your teams, including video case studies, recommendations for implementation and QI tools and templates.

Workbook contents:

- Module 1: What are the proactive care frameworks
- Module 2: Team roles
- Module 3: Risk stratification
- Module 4: Taking a QI approach



# **Top Tips for implementation**

# Top Tips for Implementation

1. Find the right **clinical or operational lead** within your PCN/Practice to **champion** this work.
2. Consider thinking about how the Proactive Care Frameworks can help to **deliver local or national initiatives** (i.e. BP @Home, Quality Outcomes Framework, Locally Commissioned Services, Direct Enhanced Service, Impact Investment Fund) leading to more efficient ways of working.
3. Ensure that both **staff and patients** have been **informed** about the **proactive care frameworks** and any changes to the usual long term condition reviews (e.g. reviews by healthcare assistants, social prescribers etc).
4. Ensure a **workforce mapping** exercise has been conducted to **review the skill sets** of your current workforce and that all members are working to their maximum competencies.



**Links to other programmes**





## Links to other programmes

The national blood pressure optimisation programme:

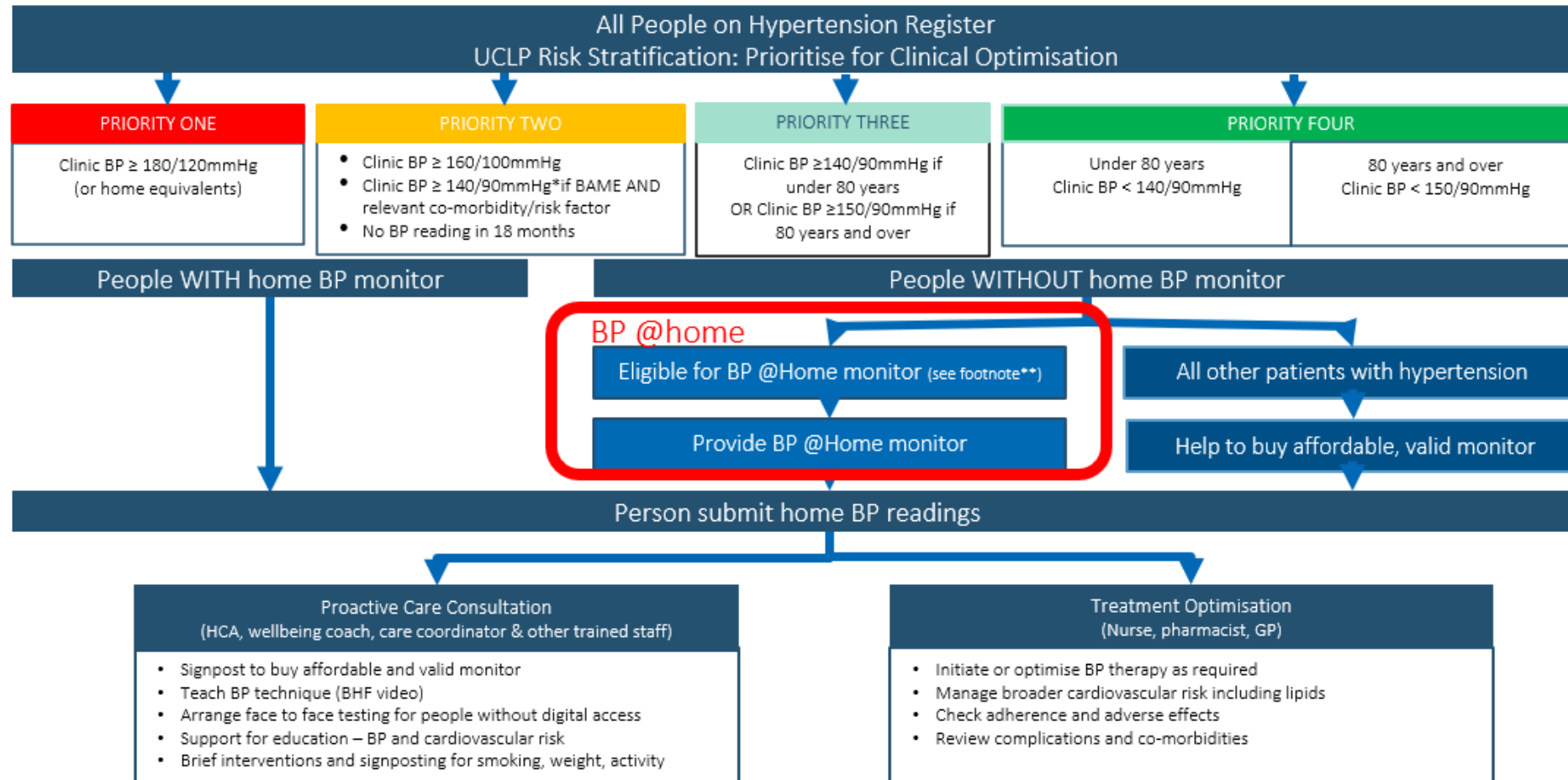
**Supports** the implementation of UCLPartners Proactive Care Framework for Hypertension

**Builds** on BP @Home

[Link to contents](#)

# Link to BP@home

## BP @Home: supporting remote monitoring



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



# **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**



# Resource Links

# BP Optimisation – Resource Links

Name	Origin	Purpose	Object
<b>Hypertension Framework</b>	UCLPartners	Overview	<a href="#">Link</a>
<b>Search and risk stratification tools</b>	UCLPartners	Search and Stratification tools, free of charge	Register <a href="#">here</a> to download resources
<b>Clips and Protocols</b>	UCLPartners	How to run searches	<a href="#">Link</a>
<b>Workbook implementation modules 1-4</b>	UCLPartners	<ol style="list-style-type: none"> <li>1. Understand context</li> <li>2. Identify workforce</li> <li>3. Risk stratification</li> <li>4. Using Quality Improvement</li> </ol>	Register <a href="#">here</a> to download resources
<b>Digital resources for hypertension</b>	UCLPartners	Monitor, Management, Wellbeing	<a href="#">Link</a>
<b>Suggested essential training and education support for delivery</b>	UCLPartners	Training for Healthcare assistants, nursing assistants, social prescribers, Pharmacists, nurses, physician associates and others	<a href="#">Link</a>



# Contacts

*Eastern* **AHSN** 

[cvdteam@eahsn.org](mailto:cvdteam@eahsn.org)

[Eastern AHSN CVD webpage](#)



@EasternAHSN



Eastern AHSN



@EasternAHSN

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Life Sciences

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