Hertfordshire and West Essex Integrated Care System

NHS
Hertfordshire and West Essex
Integrated Care Board

# Hypertension data pack

# Potters Bar PCN

## Improving hypertension detection and management

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# Introduction

## Purpose of this pack

- Hypertension is a key priority in Hertfordshire and West Essex ICS
- This data pack aims to support your Practice and PCN to improve performance on hypertension
- It provides data for your Practice and PCN on:
  - Hypertension prevalence
  - Prevalence of likely uncoded hypertension cases
  - Treatment to threshold
- The pack also provides links to useful hypertension resources and tools.

## Contents

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# Hypertension in HWE ICB

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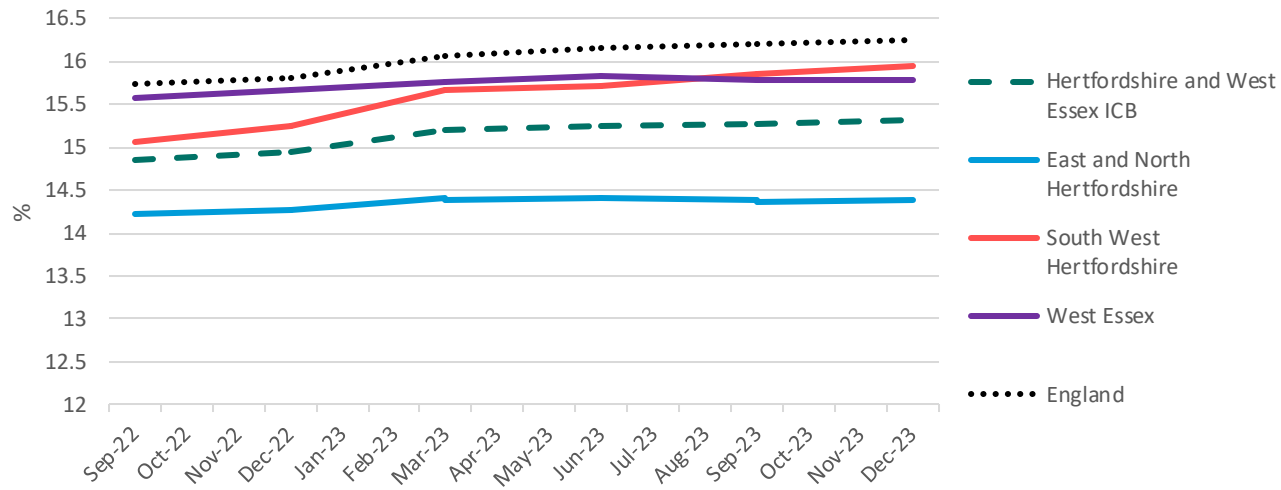
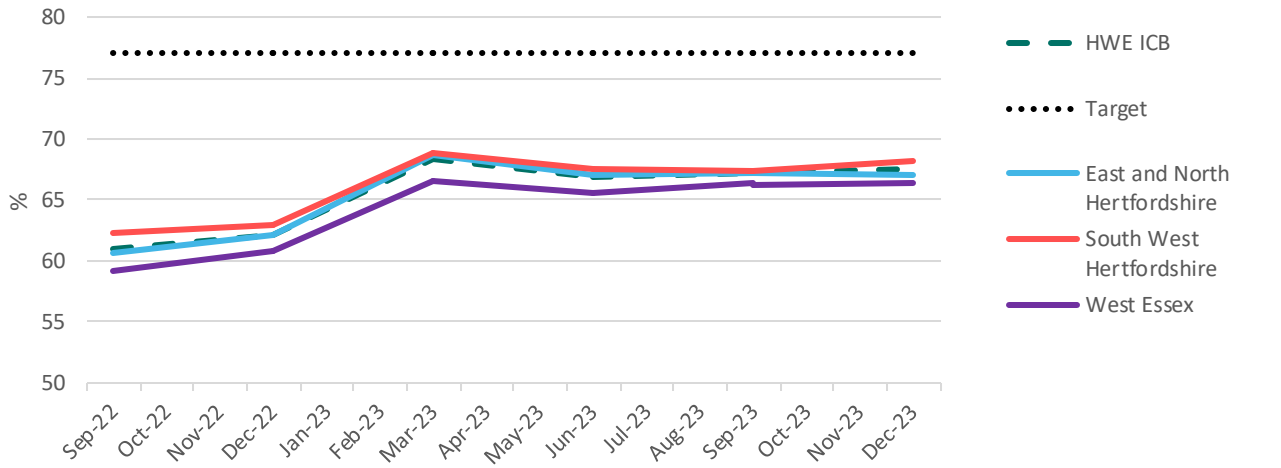
# Current hypertension performance in HWE ICB

- HWE ICB hypertension prevalence is lower than national average (15.31% vs 16.25%. Source: CVD Prevent December 2023)
- Prevalence increasing but only in line with national rate – our goal is to close the gap
- Prevalence is increasing most in SWH and least in ENH
- % coverage of 5-yearly blood pressure readings in over 45s has not returned to pre-pandemic levels
- Treatment to threshold improving, and we are approaching national target of 77%

GP-recorded hypertension prevalence in over 18s by Place area (Source: CVD Prevent)
**NOTE: Y axis starts at 12%**




Hypertension: treatment to recommended age specific thresholds (all ages) (Source: CVD Prevent)
**NOTE: Y axis starts at 50%**

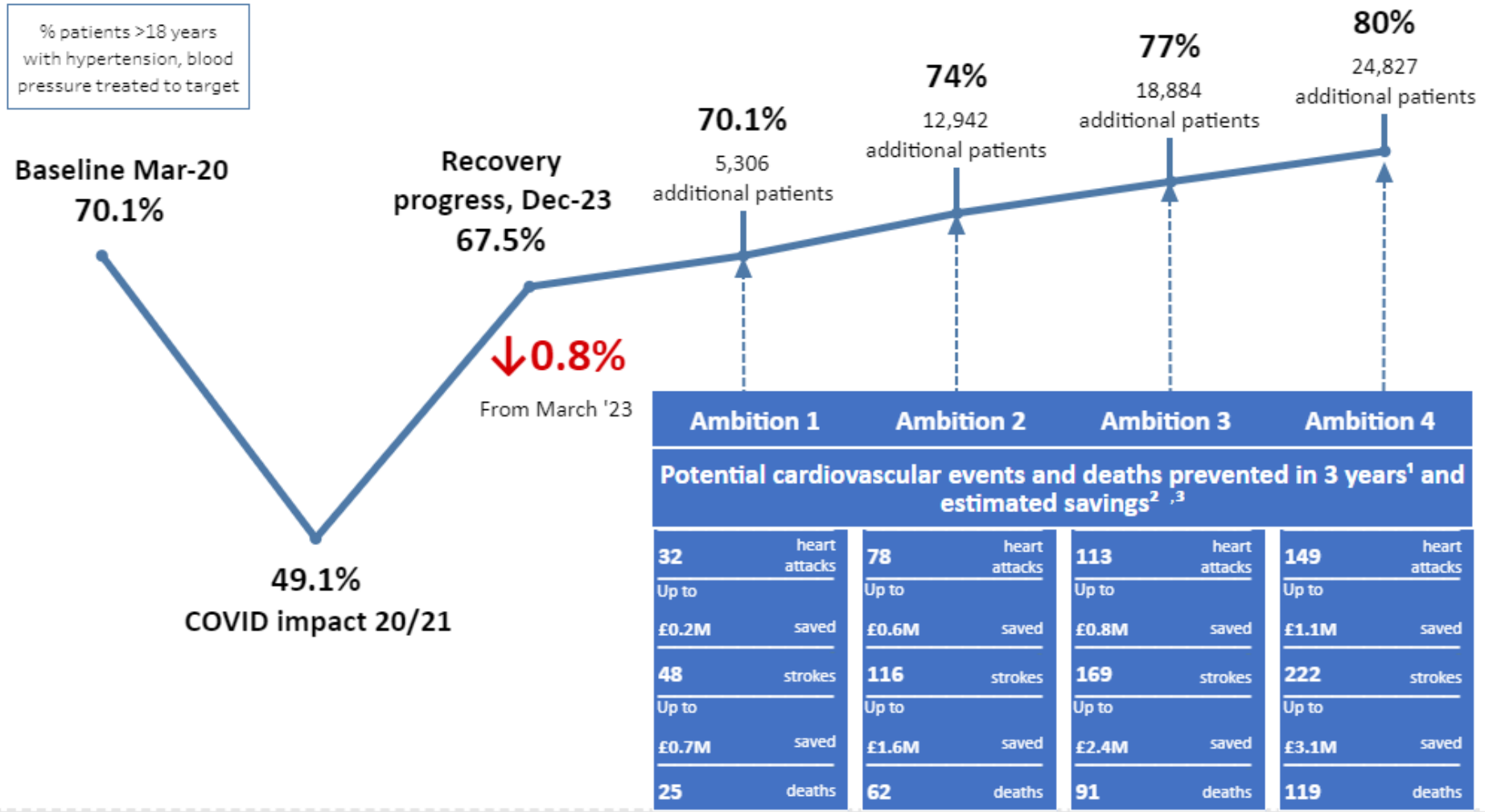


# Local opportunity

- This graph shows the improvement in health outcomes (stroke and myocardial infarction) that can be achieved through better hypertension management.
- It can be found at [Size of the Prize for high blood pressure (uclpartners.com)]

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

UCLPartners Health Innovation




| Ambition 1 | Ambition 2 | Ambition 3 | Ambition 4 |
|---|---|---|---|
| Potential cardiovascular events and deaths prevented in 3 years[1] and estimated savings[2,3] | | | |
| 32 heart attacks | 78 heart attacks | 113 heart attacks | 149 heart attacks |
| Up to £0.2M saved | Up to £0.6M saved | Up to £0.8M saved | Up to £1.1M saved |
| 48 strokes | 116 strokes | 169 strokes | 222 strokes |
| Up to £0.7M saved | Up to £1.6M saved | Up to £2.4M saved | Up to £3.1M saved |
| 25 deaths | 62 deaths | 91 deaths | 119 deaths |


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: CVDPrevent. Briefing note: CVDPrevent online methodology annex v1 December 2022
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.

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# Characteristics of people with undiagnosed hypertension in HWE ICB

## Non-modifiable risk factors

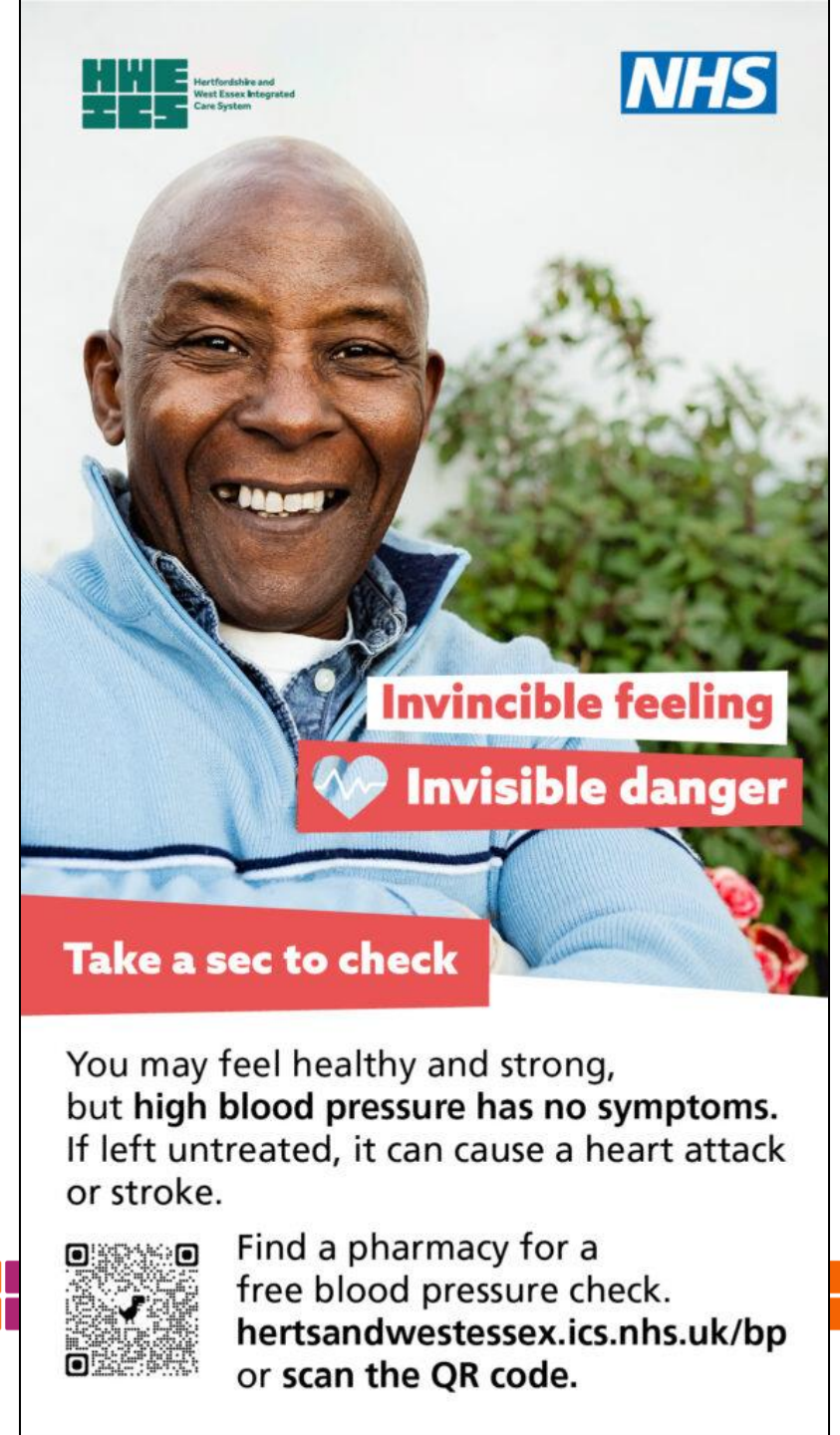
- Men more likely than women
- Aged 50+
- Black/Black British or Asian/Asian British ethnicity

## Modifiable risk factors

- Diet
- Smoking
- Alcohol consumption
- Weight

## Health beliefs and attitudes

- Those with undiagnosed hypertension more likely to **self-report** being in good or excellent health → challenge for services to encourage people to check their blood pressure if they feel well



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# Your PCN and Practice data

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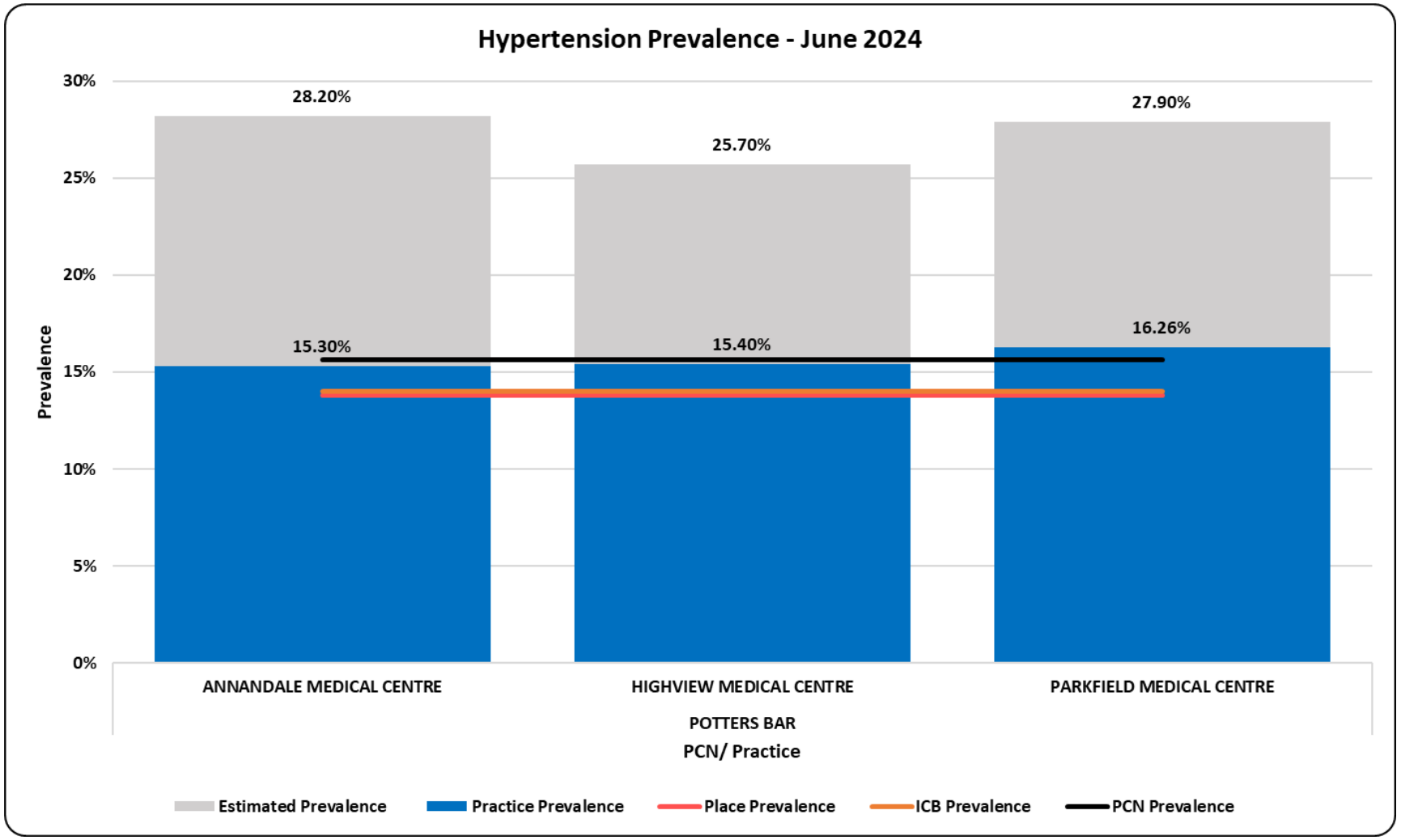
# 1. Hypertension prevalence

https://app.ardensmanager.com/




- Hypertension prevalence in Potters Bar PCN is 15.7%, which is above the ICB average.
- There remains a significant gap between the observed (QOF) prevalence and the estimated prevalence based on modelling
- **All Practices** should use the Ardens Manager case finder to review likely miscoded cases https://app.ardensmanager.com/
- We also recommend that practices undertake proactive case finding to increase hypertension prevalence
- See the tools and resources section for further support

Source: Ardens Manager, QOF 22-23, Fingertips, and NHS Digital.

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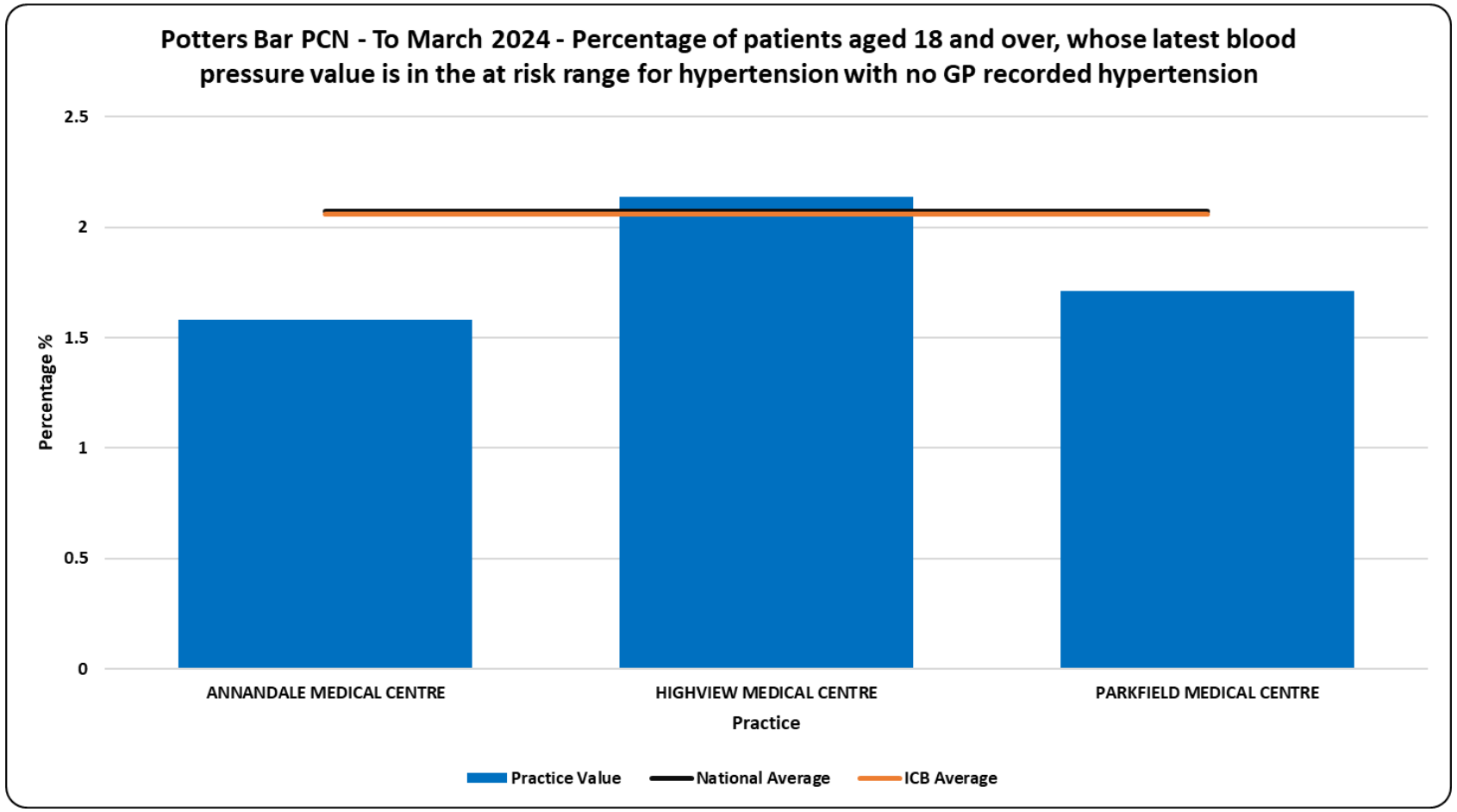
# 2. Uncoded hypertension




| Practice | Percentage & No. of Patients in Cohort |
|---|---|
| ANNANDALE MEDICAL CENTRE | 1.58%, or 100 patients |
| HIGHVIEW MEDICAL CENTRE | 2.14%, or 170 patients |
| PARKFIELD MEDICAL CENTRE | 1.71%, or 185 patients |

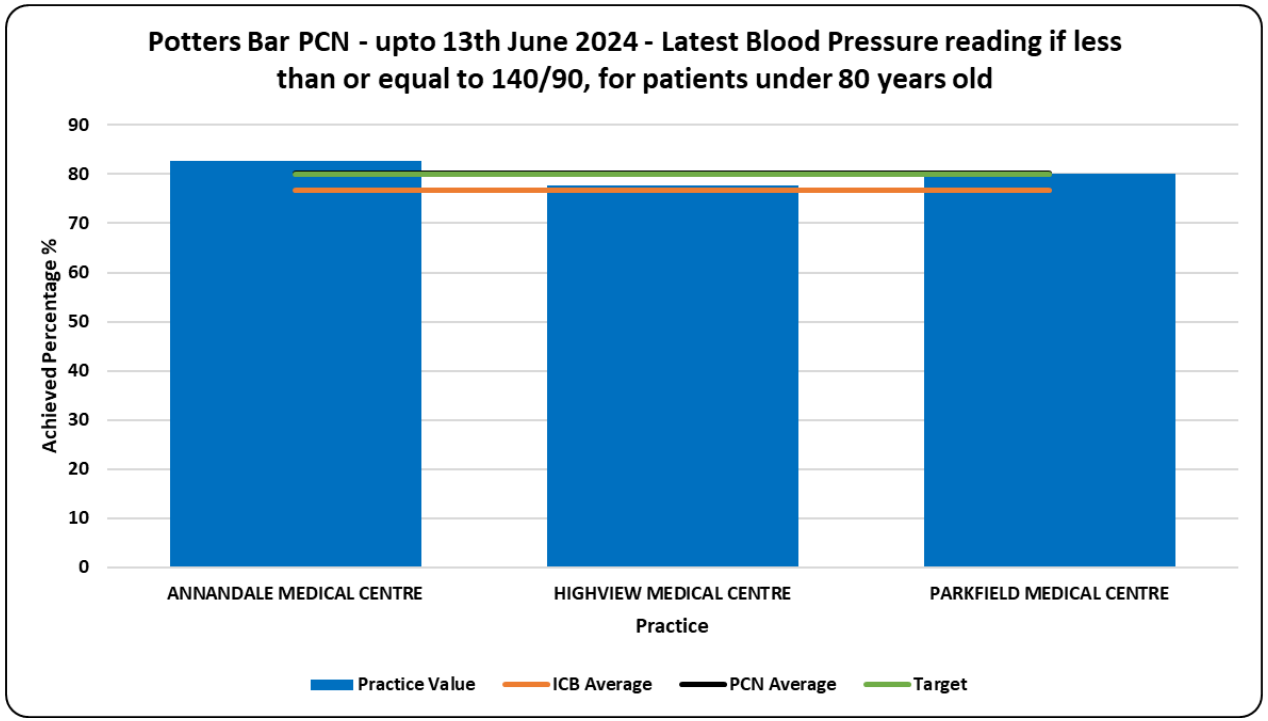
Source: CVD Prevent, NHS Digital.

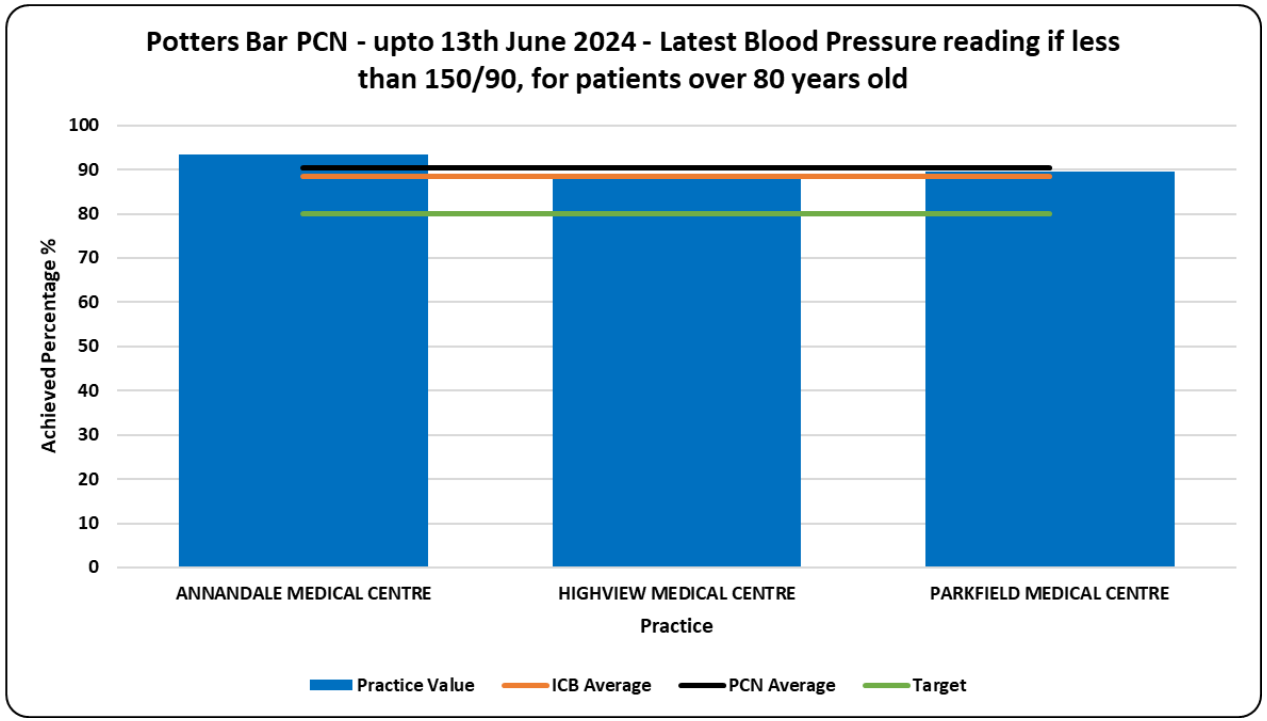
These data show the proportion of patients aged 18 or over who are likely to have hypertension but are not currently code as hypertensive (lower values better, suggesting fewer uncoded patients).

Reviewing and correcting coding for these patients can be a 'quick win' to ensure patients are receiving proper management and to increase prevalence.

You can use Ardens Manager to run targeted searches for cases that are likely to be hypertension but are currently miscoded – https://app.ardensmanager.com/me

# 3. Treatment to threshold




These graphs show the proportion of patients with diagnosed hypertension whose blood pressure is within recommended thresholds (treatment to threshold).

In your PCN treatment to threshold is 80.2% for those under 80, and 90.4% for those over 80.

This is above the ICB average, and meets the national target of 80% for those under 80.

You can use the UCL Partners risk stratification tools in Ardens manager to support prioritisation of those above threshold– https://app.ardensmanager.com/me

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Source: Ardens Manager, NHS Digital.

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# Support and resources

1. Enhanced Commissioning Framework
2. Working with Community Pharmacy
3. Identifying miscoded patients
4. Risk stratification and targeting
5. Raising patient awareness
6. Webinars and training
7. Local case studies
8. Checklist of ideas for action

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# 1. Enhanced Commissioning Framework

Consider making hypertension a priority for disease detection in your Enhanced Commissioning Framework submission

ECF Disease Detection Plans to be submitted by 30 June 2024.

**Reducing Variation in disease prevalence**

**Appendix 4 – Disease Detection Practice Plan**

| Practice details | |
|---|---|
| Practice name | |
| Primary Care Network | |
| Name and Title of person/people completing the template | |
| Will the practice work with other practices (PCN/locality/other) | |
| If yes, which practices will work | |

| REVIEW OF 23/24 PLAN | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Please confirm the area of focus in 23/24 | Asthma | COPD | on-diabetic hyperglycaem | Diabetes | AF | Heart failur | Dementia | hronic Kidney diseas | Other |
| | | | | | | | | | |
| | If other, please provide details: | | | | | | | | |
| Review of 23/24 Plan - including summary of outcome versus ambition e.g. how many new diagnoses? | | | | | | | | | |

| Identifying local opportunities 24/25 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Have you reviewed data on disease prevalence within the practice? | The ICB has PCN PHM packs which can be accessed via the ICB website Primary Care Network packs - Hertfordshire and West Essex Integrated Care System | | | | | | | | Link here |
| Which diseases have been identified as areas where there is opportunity to improve detection? | Asthma | COPD | on-diabetic hyperglycaem | Diabetes | AF | Heart failur | Dementia | hronic Kidney diseas | Other |
| | | | | | | | | | |
| | If other, please provide details:<br>*Please note that practices receive funding to improve disease detection through other routes (e.g. other sections of the ECF or national contracts) and will not be eligible for this component of the ECF.* | | | | | | | | |
| Are there any target groups within the local population where disease detection is lower than expected? (e.g. people from higher levels of deprivation, people from minority ethnic groups) | *Please list any demographic groups that the practice has identified as a priority and how these have been identified. Please provide any detail on actions that will support targeting this/these group(s).* | | | | | | | | |

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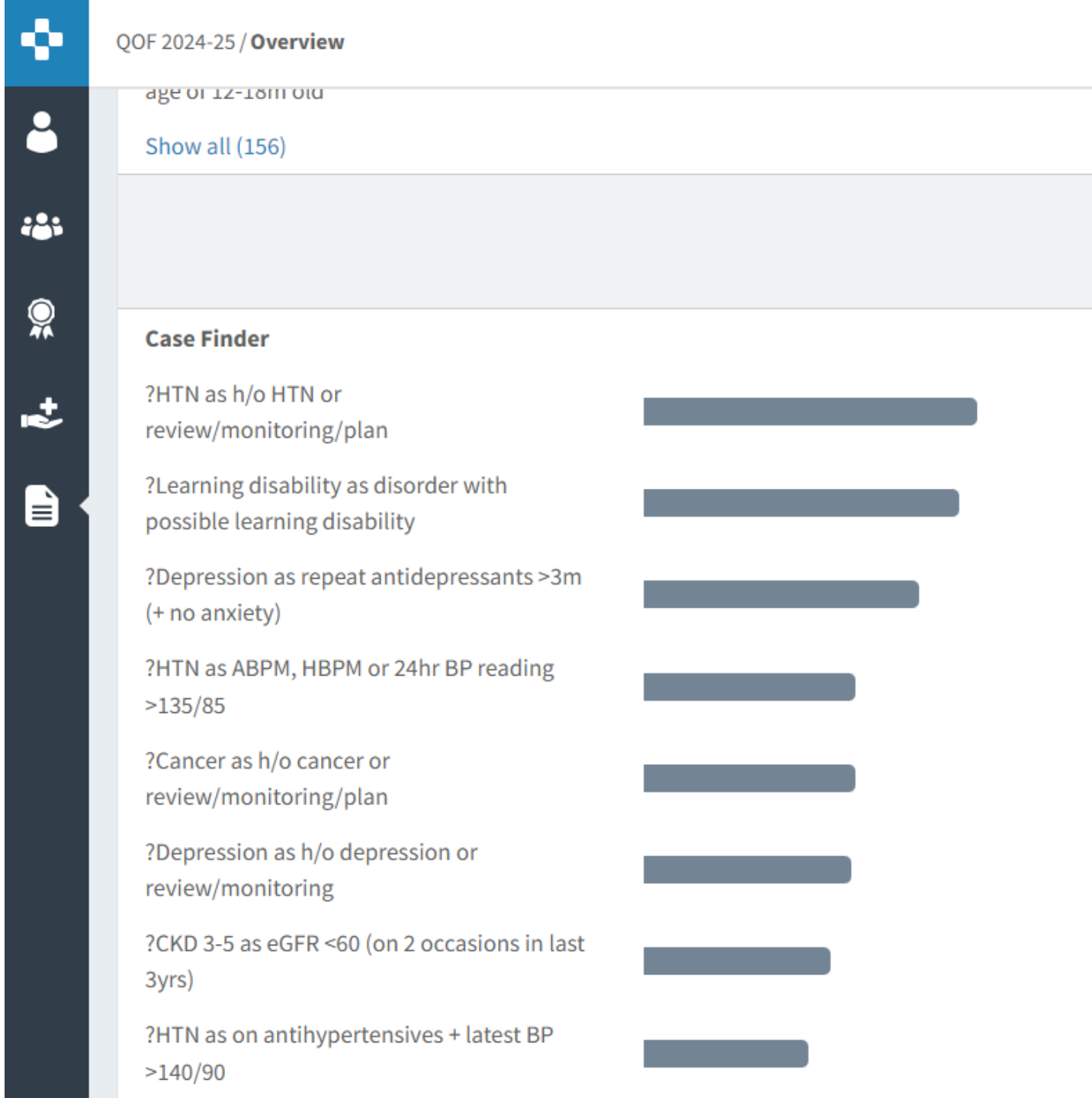
# 2. Identifying miscoded patients

- You can use the QOF Case Finder clinical reports on Ardens Manager to identify patients who may have not had a hypertension diagnosis coded correctly
- They can be accessed at Ardens Manager https://app.ardensmanager.com/ via Contracts > QOF 2024-25 > Case finder
- There are five case finder reports related to hypertension:
    - ?HTN as h/o HTN or review/monitoring/plan
    - ?HTN as ABPM, HBPM or 24hr BP reading >135/85
    - ?HTN as on antihypertensives + latest BP >140/90
    - ?HTN as resolved but on antihypertensives



# 3. Risk stratification and targeting

- UCL Partners has created a suite of materials to support practices to risk stratify their patients
- This enables work to be prioritised according to the highest risk patients
- The tools can be accessed here: [Search and risk stratification tools – UCLPartners]
- Ardens Manager have created searches to identify these groups. These can be accessed via: https://app.ardensmanager.com/

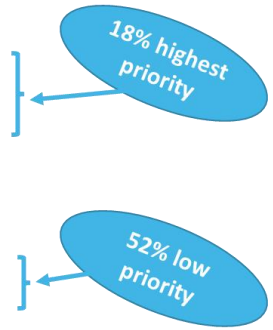
**Example search and stratification (London Borough)**

UCLPartners

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



# 4. Webinars to share good practice and approaches

The following webinars and training contain useful support on how to approach hypertension:

- **UCL Partners Proactive Care Framework for Hypertension** – delivered to HWE ICB August 2023

- How I achieved the QOF indicators in 6 months:. How to take general practice hypertension management from one of the lowest performing to the highest performing in the country – delivered to Eastern AHSN 20/09/2023 **Bitesize - How I achieved the QoF indicators in 6 months - hypertension on Vimeo**

- **Hypertension in primary care: transforming the prevention of cardiovascular disease** with Dr Matt Kearney, Dr Max Hickman, Dr John Ford and an excellent patient story from Godwin Daudu covering topics related to optimising hypertension management in primary care – recorded June 2023

- **East Anglian CV Seminar Series – Still the biggest killer** with Professor Ian Wilkinson provides an in-depth overview of hypertension diagnosis and management - recorded September 2021

# 5. Engaging with Community Pharmacy

Community pharmacies can support GP practices in the detection of HTN.

**What they offer**

- GP practices can refer any patient over 18 for a BP or an ABPM check at a community pharmacy that has registered to provide the advanced hypertension case finding service. Participating practices can be found here: Find a pharmacy that offers free blood pressure checks - NHS (www.nhs.uk)

**Referrals and pathways**

- The referral can be made using nhs.net email, Ardens template or via EMIS (EMIS is activated for Hertsmere and Dacorum only as a pilot) or GP practice sends a text message to a patient to attend a local pharmacy of their choice that is registered for the service. Results are emailed back to the GP
- The specification for the service, including the recommended care pathway is here Advanced service specification: NHS community pharmacy hypertension case-finding advanced service (NHS community pharmacy blood pressure check service) (england.nhs.uk)
- The updated HWE ICB hypertension pathway is here download (hweclinicalguidance.nhs.uk)

**Benefits**

- Enhance patient care, potential to reduce workload and improve efficiency and income by enabling GP Practices to:
  - Use CP readings for QOF/IIF/DNA
  - Refer to CP to support ABPM waiting lists/ABPM LES
  - Refer for routine BP checks (and so decrease number of appts for BP checks by HCAs)
  - Refer as part of BP follow-ups required in clinic or discharge letters from secondary care

# 6. Raising patient awareness


- The ICB has created a suite of resources to raise patient awareness of hypertension and where to get blood pressure checked
- All resources include a QR code that takes patients to a webpage of information about hypertension High blood pressure - Herts and West Essex ICS, including a postcode finder for participating community pharmacies, how to take BP at home and lifestyle changes
- Freely downloadable resources are here Campaign resources - Herts and West Essex ICS and include:
  - Posters
  - Digital screens
  - Social media animations
  - Screensavers
  - Email banners

- For hard copies of any materials please email hweicbenh.communications@nhs.net

# 7. Local case study – The Maples GP Practice, ENH – increase in hypertension detection

## Baseline position

- Hypertension detection at this Practice was below the ICB average (49.6% vs 50.8%)

## What the Practice did

- Close working with community pharmacy
- Sending out social media posts raising awareness of hypertension and how to send in readings (Facebook)
- Use of Accurx, including sending video from one of the GPs about importance of blood pressure checking
- Loaning home blood pressure monitors
- Practice nurses taking BP readings
- Reception blood pressure monitor
- Receptionists trained to support people to take readings

## Impact

- - Detection increased to 53.7% in March 2024 (Source: BI)
- -This is above PCN and ICB averages.

"It has taken a lot of work from everyone – a multi-faceted approach" (Practice Manager)

# 8. Checklist of actions on hypertension

1. **Review the NICE Guidance**: to re-familiarise yourself with treatment guidelines for HTN management
2. **Use shared decision-making with patients** to help address patient concerns and increase ownership of healthcare. Use the NICE hypertension shared decision aid.
3. **Use the shared learning database** to see examples of how services elsewhere have worked to improve their care and meet the guidelines
4. **Track your Practice's progress** by visiting the updated CVD PREVENT dashboard (updated quarterly, and viewable by region, ICB, PCN and practice) OR run your report and upload to Ardens Manager
5. **Refresh all practice GPs on the current treatment guidelines**
6. **Use the NICE baseline audit tool**
7. **Review records to** identify the cohort of patients documented BP over the target thresholds
8. **Create an action plan** to review identified patients at risk
9. **Review current call/recall procedures**
10. **Offer waiting room BP measurements**
11. **Work with local services** to create opportunities to measure BP in the community (e.g. Pharmacies)
12. **Use patient decision aids** to help patients understand the importance of medication
13. **Use motivational interviewing** to help patients manage their hypertension

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**Please contact your Primary Care Coordinator or Clinical Lead if you have further questions**

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