Hypertension Community of Practice Session

House Keeping

We appreciate that this event is being held over the lunch period so if you want to temporarily switch off your camera whilst listening to the presentations, then please feel free to do so.

Please ask any questions either at the end of the presentation or through the chat facility. If we don't manage to answer all questions in the session, we will follow these up after the event and circulate information to the group.

We want this to be an interactive session so we welcome comments, observations etc either in the chat or after the presentation.

To encourage open discussion, we will not be recording this event.

If you cannot see the chat or if you have any issues with the session, please email karen.verrill@ahsn-nenc.org.uk

Tackling Hypertension for better CVD outcomes

Dr Raj Bethapudi
GP Partner, trainer, appraiser
Co-chair, NENC ICS CVD Network
Clinical champion, AHSN NENC

NHS England and NHS Improvement

Cardiovascular Disease Prevention – A National and Local Priority

One death every 3 minutes	100,000 hospital admissions - heart attack	38,000 stroke deaths each year	£19 billion	Driver of inequalities
27% all UK deaths due to CVD	1 admission every 5 minutes	Stroke: leading cause of disability	Overall annual CVD costs the UK economy	CVD drives health inequalities: accounting for 1/4 life expectancy gap

But CVD is highly preventable…

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COVID-19: Impact on Care and Outcomes in Long-Term Conditions

Urgent Challenge – LTC Recovery

1. Pandemic resulted in dramatic change in primary care: reduced face to face access and high clinical demand (COVID surges and vaccination)
2. Disruption of routine, proactive care in high impact conditions such as CVD, hypertension, diabetes, COPD, asthma
3. Risk of deterioration/exacerbation in these conditions driving further waves of demand for urgent care and increasing premature mortality and morbidity

Opportunity

1. Restore *and transform* proactive care for people with long term conditions
2. Optimise clinical management to address historical under treatment
3. Optimise support for patient education, self management and lifestyle change

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UCLPartners Proactive Care Framework for Hypertension

Healthcare Assistants/Health & Wellbeing Coaches and other trained staff

Gather information e.g.	Up to date bloods, BP, weight, smoking status, run QRISK score
Self management e.g.	Education (blood pressure, CVD risk), self care (eg BP measurement), signpost resources
Behaviour change e.g.	Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol

Stratification & Prioritisation

Priority One	Priority Two	Priority Three	Priority Four
BP >180/120	BP160/100 or >140/90 if BAME plus comorbidities No BP record in 18 months	BP >140/90	BP <140/90 under age 80 years OR BP <150/90 aged 80 years and over

Prescribing Clinician

Optimise blood pressure and CVD risk reduction

1. Review: blood results, risk scores & symptoms
2. Check adherence and adverse effects
3. Review complications and co-morbidities
4. Initiate or optimise blood pressure medication
5. CVD risk – optimise lipid management and other risk factors

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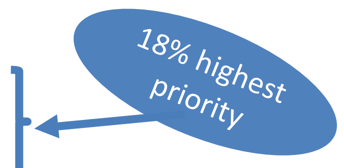
Stratification: improving outcomes and increasing capacity

- Stratification 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

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%



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Size of the Prize – North East and North Cumbria
BP Optimisation to Prevent Heart Attacks and Strokes at Scale

% patients with blood pressure treated to target

QOF 19/20
73.0%

COVID-19 Disruption

91,634 Thousands fewer patients with BP treated to target or BP not recorded

Risk: up to **1,370 extra heart attacks and strokes** in 3 years

54.6%
QOF 20/21

QOF Recovery
73.0%

74% 4,870 additional patients

77% 19,803 additional patients

80% 34,735 additional patients

Ambition 1	Ambition 2	Ambition 3
Potential cardiovascular events prevented in 3 years[1] And estimated savings		
29 heart attacks	**119** heart attacks	**208** heart attacks
Up to **£0.2 million[2]** saved	Up to **£0.9 million[2]** saved	Up to **£1.6 million[2]** saved
44 strokes	**177** strokes	**311** strokes
Up to **£0.6 million[3]** saved	Up to **£2.5 million[3]** saved	Up to **£4.3 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.

What can practices do?

- Introducing a hypertension champion within your practice
- Communications and messaging to patients
- Encouraging the use of BP monitors at home
- Supporting patient self-management
- Investment in training and leadership
- Support from other primary care services
- PCN/QOF action plan with simple an meaningful data, available to all staff

Thank you for listening

Register your interest for next– Learn and Share session

https://www.eventbrite.com/cc/blood-pressure-monitoring-community-of-practice-1490379

Clinical Digital Resource Collaborative

Join our Journey

CDRC Supporting Clinical Decisions

Ben Mole

Project Support Officer AHSN NENC and CDRC

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CDRC Supporting Clinical Decisions

About CDRC

CDRC develops patient-centric clinical resources for use in the clinical systems, SystmOne and EMIS

Who?

The Clinical Digital Resource Collaborative (CDRC), founded in 2018, is a collaboration between the **AHSN NENC**, **NECS**, **CBC Health Ltd** and **Cumbria PRIMIS Informatics**, with key strategic relationships with GP Federations and CCGs.

What?

A NENC regional NHS owned digital resource with national reach, that enables clinicians and clinical organisations to deliver gold-standard patient care efficiently.

How?

CDRC's identification and management resources put the clinician in control of patient care, improving patient outcomes and allow clinicians to provide the appropriate care at the right time.

Our Vision and Mission

CDRC Supporting Clinical Decisions

Vision

To become a regional central hub of free to use clinical resources.

Mission

Prevent clinical teams across the country having to reinvent the wheel via the creation of a central repository of ICP, ICS & National Resources, with regional adaption where required.

The Team

Dr Gareth Forbes
Co-Founder

Dr Jonathan Harness
Co-Founder and Chair

Billie Moyle
Primary Care Data Quality Lead (NECS)

Kathryn Muckles
Primary Care Data Quality Specialist (NECS)

I-Lin Hall
CDRC position -CDRC Delivery Insight (NECS)

Professor Julia Newton
Medical Director AHSN

Jody Nichols
Implementation Lead (AHSN)

Dr Tom Zamoyski
GP Clinical Lead (AHSN)

Dr Andrew Richardson
GP – EMIS Resource Development Lead (AHSN)

Michelle Waugh
Project Support Officer (AHSN)

Ben
Project Support Officer (AHSN/CDRC)

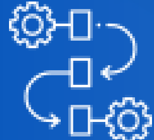
CDRC Resource Overview

Clinical/ Population Reporting

Data Entry Templates

Letters / Referral Forms

Patient Status Alerts



Protocols

Patient Recalls

Questionnaires

Hazard Reviewed Resources

Key Resources Provided by CDRC

CDRC Supporting Clinical Decisions

Clinical Reports / Patient Searches

Searches that support the identification of patients with undiagnosed or misdiagnosed conditions, patients who may benefit from interventions and optimisation of treatment.

Data Entry Templates

Detailed, intuitive templates, covering a range of clinical areas that allow for the accurate review, assessment and coding of patient data.

Patient Status Alerts / Icons

Alerts and Icons that alert you to situations relating to the patients that may require special attention.

Referral Forms

Regional Referral forms that pre-populate with relevant patient information from their clinical record.

Who are these resources for?

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Healthcare Professionals managing individual patients in practice.

Healthcare Professionals working as a clinical lead within their organisation – looking after particular cohorts of patients.

PCN, CCG, Federations, ICP, ICS level for population-based interventions

Admin roles within teams e.g., LTC management organisations.

Benefits of using CDRC

Improved quality and safety for patients, clinicians and the NHS

- *by identifying patients who are undiagnosed, misdiagnosed or coded incorrectly.*

Improved time / cost savings

- *by utilising pre-designed, validated resources (templates, searches, protocols, alerts).*

Flexible implementation

- *Clinical teams can choose to use only the resources which are important to them.*

Safe and compliant data sharing

Improved performance management

- *Via the use of 'dashboard' suites of searches/reports which provide real-time data on many aspects of clinical perf*

Opportunity to increase practice income

Resource Development Process

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External / Internal work organised with Jira
Jira Software
Jira Service Desk

Training materials / guides

Comms created and distributed via Social Media/Mailing List/Website

Fortnightly operation 'Huddle'

- Prioritise backlog
- Identify problems/bottlenecks

Testing of resources

Feedback requested and incorporated into resources

Steering Group Meeting
Update to key partners and Strategic/Risk management discussions

Engagement Group Meeting
Marketing / Stakeholder Engagement specialists supporting team to build an appropriate strategy

Liaising/Collaboration with key partners/networks on

NECS (North of England Care Support)

- Hazard Review

contact-CDRC@ahsn-nenc.org.uk

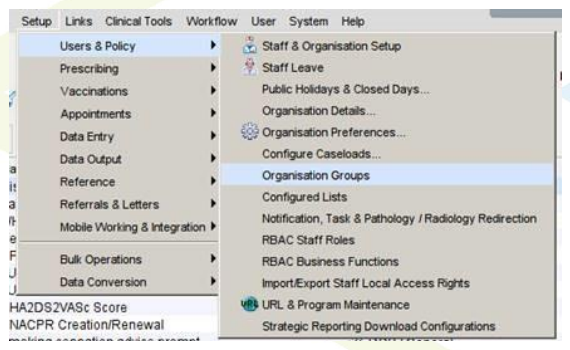
How to Access CDRC Resources

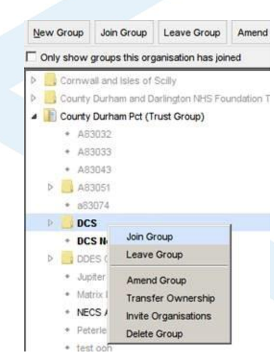
CDRC Supporting Clinical Decisions

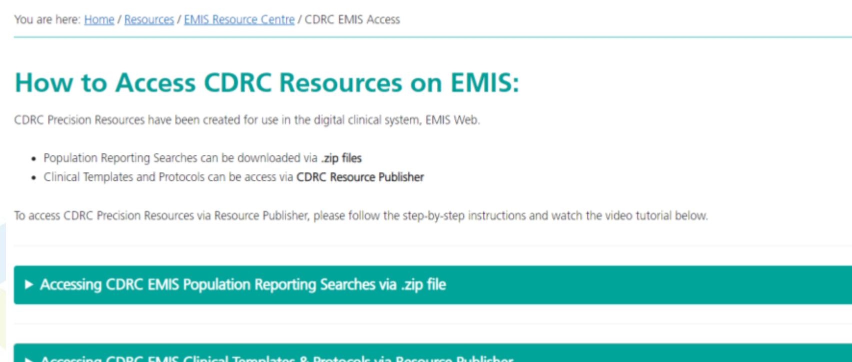
Depending on your clinical system the method to access CDRC resources will differ.

SystmOne:

EMIS:







Joining the group does not give any access to any of your organisation's data (patient or otherwise) to any other organisation.

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Dr. Gareth Forbes

Co-Founder CDRC

BP/Hypertension Resource Demonstration

IIF Performance

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Hypertension

20.00%
19.00%
18.00%
17.00%
16.00%
15.00%
14.00%
13.00%
12.00%
11.00%
10.00%

2005 2007 2009 2011 2013 2015 2017 2019 2021

Derwentside · Durham & CLS · NHS England

Hypertension Performance

CDRC Supporting Clinical Decisions

Indicator	Count	%
BP 1 SCREENING - BP CHECKING IN PEOPLE WITHOUT HIGH RISK CONDITIONS --------------------------------------...	0	0.0 %
BP 1 Screening - Patients over 45 without a condition requiring annual BP check	1386	22.8 %
BP 1.1 Screening - Patients over 45 without a condition requiring annual BP check with BP check in last 5 years	1134	81.8 %
BP 2 CASEFINDING - PEOPLE WITH RAISED BP WHO ARE NOT ON THE HYPERTENSION REGISTER ---------...	0	0.0 %
BP 2 Casefinding - Patients whose last BP is raised but not on hypertension register	317	5.2 %
BP 3 MONITORING - BP CHECKING IN PEOPLE WITH HIGH RISK CONDITIONS --...	0	0.0 %
BP 3 Monitoring - Patients who need annual BP	1546	25.5 %
BP 3.1 Monitoring - Patients who need annual BP with BP in the last year	1450	93.8 %
BP 4 CONTROL - BP MANAGEMENT FOR LTCs WHICH NEED BP CONTROL ---...	0	0.0 %
BP 4 Control - Patients who need BP control (CKD, T1DM, HT)	1319	21.7 %
BP 4.1 Control - Patients who need BP control with BP recorded in the last year	1247	94.5 %
BP 4.2 Control - NICE target - Achieved	1094	82.9 %
BP 4.21 Control - NICE target <130/80 - on target	17	39.5 %
BP 4.23 Control - NICE target <135/85 - on target	6	100.0 %
BP 4.25 Control - NICE target <140/90 - on target	974	83.9 %
BP 4.26 Control - NICE target <150/90 - on target	97	88.2 %
BP 4.3 Control - Conditions needing BP control - personal target set	559	42.3 %
BP 4.31 Control - Personal Target set and achieved	426	73.8 %
BP 4.32 Control - Personal Target is LOWER than NICE target	93	16.1 %
BP 4.33 Control - Personal Target is HIGHER than NICE target	3	0.5 %

IIF Performance

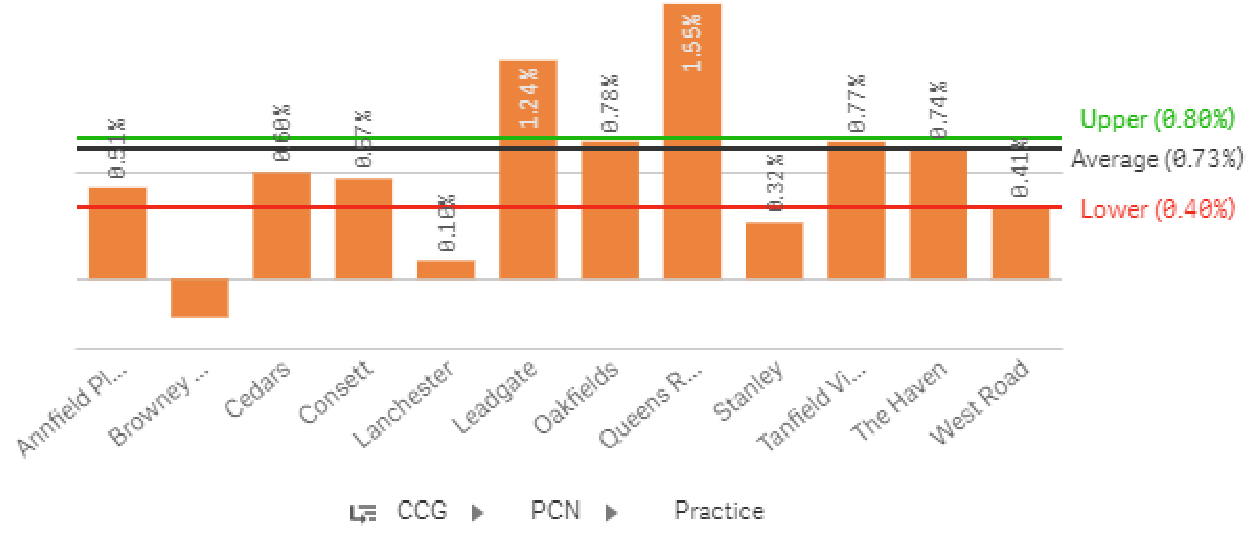
CVD-01

Percentage of patients aged 18 or over with an elevated blood pressure reading (≥140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or

48.2%
26.2%
49.6%
48.4%
52.4%
64.8%
58.2%
53.2%
43.4%
44.6%
64.0%
34.8%
Upper (50.0%)
Average (48.2%)
Lower (25.0%)
Annfield Pl...
Browney ...
Cedars
Consett
Lanchester
Leadgate
Oakfields
Queens R...
Stanley
Tanfield Vi...
The Haven
West Road

CCG ▶ PCN ▶ Practice

IIF Performance



Academic Health

CDRC Hypertension Searches

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Search	Count	%
? Hypertension/BP 1.1 Screening Priority 1 - Consider repeat BP Last BP >=170/105 #	18	0.3 %
? Hypertension/BP 1.1 Screening Priority 1.1 - Consider repeat BP Last BP >=170/105 - harder to reach patients	7	0.1 %
? Hypertension/BP 1.2 Screening Priority 2 - Consider repeat BP Last BP >=160/100 #	34	0.6 %
? Hypertension/BP 1.2 Screening Priority 2.1 - Consider repeat BP Last BP >=160/100 - harder to reach patients	13	0.2 %
? Hypertension/BP 1.3 Screening Priority 3 - Consider repeat BP Last BP >=150/90 #	166	2.7 %
? Hypertension/BP 1.3 Screening Priority 3.1 - Consider repeat BP Last BP >=150/90 - harder to reach patients	28	0.5 %
? Hypertension/BP 1.4 Screening Priority 4 - Consider repeat BP Last BP >=140/90 #	276	4.5 %
? Hypertension/BP 1.4 Screening Priority 4.1 - Consider repeat BP Last BP >=140/90 - harder to reach patients	40	0.7 %
? Hypertension/BP 1.5 Screening - Other Groups 1.1 BAME - Consider repeat BP Last BP >=140/90	4	0.1 %
? Hypertension/BP 1.5 Screening - Other Groups 1.2 Core20Plus5 - Consider repeat BP Last BP >=140/90	83	1.4 %
? Hypertension/BP 1.5 Screening - Other Groups 1.3 Hard to reach - Consider repeat BP Last BP >=140/90	40	0.7 %
? Hypertension/BP 1.5 Screening - Other Groups 1.4 Hardest to reach - Consider repeat BP Last BP >=140/90	20	0.3 %
? Hypertension/BP 2.1 Casefinding - Potential Hypertension indicator but no HT code (run every 3-12 months)	4	0.1 %
? Hypertension/BP 2.2 Casefinding - Medication that might be for HT but no HT (run every 3-12 months)	10	0.2 %
? Hypertension/BP 2.3 Casefinding - ABPM>=135/85 and not appropriately coded (run monthly)	1	0.0 %
? Hypertension/BP 3.00 Management is suboptimal - All patients	262	4.3 %
? Hypertension/BP 3.01 Management is suboptimal - Hard to reach	99	1.6 %
? Hypertension/BP 3.1 Management Priority 1 - Highest potential for intervention - multiple issues	0	0.0 %
? Hypertension/BP 3.2 Management Priority 2 - High potential for intervention - multiple issues	13	0.2 %
? Hypertension/BP 3.31 Management Priority 3a - Consider treatment intensification - Highest priority	15	0.2 %
? Hypertension/BP 3.32 Management Priority 3b - Consider poor concordance	30	0.5 %
? Hypertension/BP 3.33 Management Priority 3c - No BP check for 18M	37	0.6 %
? Hypertension/BP 3.41 Management Priority 4a - Consider treatment intensification - Higher priority	18	0.3 %
? Hypertension/BP 3.43 Management Priority 4c - No BP check for 15M	14	0.2 %
? Hypertension/BP 3.51 Management Priority 5 - Consider treatment intensification - Lower priority	147	2.4 %
? Hypertension/BP 3.51 Management Priority 5.1 - Consider treatment intensification - Lower priority - Hard to reach	42	0.7 %
? Hypertension/BP 3.6 Management Priority 6 - Consider setting personal target	761	57.5 %

Hypertension Screening

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Search	Count	%
? Hypertension/BP 1.1 Screening Priority 1 - Consider repeat BP Last BP >=170/105 #	18	0.3 %
? Hypertension/BP 1.1 Screening Priority 1.1 - Consider repeat BP Last BP >=170/105 - harder to reach patients	7	0.1 %
? Hypertension/BP 1.2 Screening Priority 2 - Consider repeat BP Last BP >=160/100 #	34	0.6 %
? Hypertension/BP 1.2 Screening Priority 2.1 - Consider repeat BP Last BP >=160/100 - harder to reach patients	13	0.2 %
? Hypertension/BP 1.3 Screening Priority 3 - Consider repeat BP Last BP >=150/90 #	166	2.7 %
? Hypertension/BP 1.3 Screening Priority 3.1 - Consider repeat BP Last BP >=150/90 - harder to reach patients	28	0.5 %
? Hypertension/BP 1.4 Screening Priority 4 - Consider repeat BP Last BP >=140/90 #	276	4.5 %
? Hypertension/BP 1.4 Screening Priority 4.1 - Consider repeat BP Last BP >=140/90 - harder to reach patients	40	0.7 %
? Hypertension/BP 1.5 Screening - Other Groups 1.1 BAME - Consider repeat BP Last BP >=140/90	4	0.1 %
? Hypertension/BP 1.5 Screening - Other Groups 1.2 Core20Plus5 - Consider repeat BP Last BP >=140/90	83	1.4 %
? Hypertension/BP 1.5 Screening - Other Groups 1.3 Hard to reach - Consider repeat BP Last BP >=140/90	40	0.7 %
? Hypertension/BP 1.5 Screening - Other Groups 1.4 Hardest to reach - Consider repeat BP Last BP >=140/90	20	0.3 %

Last BP High Searches

~10% of the population. Subdivided into manageable chunks to prioritise:

- Level of BP
- Hard to reach patients
- BAME
- Core20Plus
- QoF or IIF maximisation potential

Tools to reach these patients

- Patient flags
- Optional popups
- Accurx or communication annexe messaging
- Integration with community pharmacy hypertension scheme

Academic Health

Hypertension Casefinding

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? Hypertension/BP 2.1 Casefinding - Potential Hypertension indicator but no HT code (run every 3-12 months)	4	0.1 %
? Hypertension/BP 2.2 Casefinding - Medication that might be for HT but no HT (run every 3-12 months)	10	0.2 %
? Hypertension/BP 2.3 Casefinding - ABPM>=135/85 and not appropriately coded (run monthly)	1	0.0 %

Missed Coding Searches

- Drug to diagnosis (~1.5%)
- Raised home blood pressure but no hypertension diagnosis (~1.0%)
- Non QoF code suggesting hypertension (~1.5%)

Hypertension Management

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? Hypertension/BP 3.00 Management is suboptimal - All patients	262	4.3 %
? Hypertension/BP 3.01 Management is suboptimal - Hard to reach	99	1.6 %
? Hypertension/BP 3.1 Management Priority 1 - Highest potential for intervention - multiple issues	0	0.0 %
? Hypertension/BP 3.2 Management Priority 2 - High potential for intervention - multiple issues	13	0.2 %
? Hypertension/BP 3.31 Management Priority 3a - Consider treatment intensification - Highest priority	15	0.2 %
? Hypertension/BP 3.32 Management Priority 3b - Consider poor concordance	30	0.5 %
? Hypertension/BP 3.33 Management Priority 3c - No BP check for 18M	37	0.6 %
? Hypertension/BP 3.41 Management Priority 4a - Consider treatment intensification - Higher priority	18	0.3 %
? Hypertension/BP 3.43 Management Priority 4c - No BP check for 15M	14	0.2 %
? Hypertension/BP 3.51 Management Priority 5 - Consider treatment intensification - Lower priority	147	2.4 %
? Hypertension/BP 3.51 Management Priority 5.1 - Consider treatment intensification - Lower priority - Hard to reach	42	0.7 %
? Hypertension/BP 3.6 Management Priority 6 - Consider setting personal target	761	57.5 %

BP Management System

- Integrates all conditions needing BP management (hypertension, CKD, type 1 diabetes)
- Looks at **BP monitoring; medication concordance** and **BP control**

- Patients divided into manageable chunks to prioritise, e.g.:
  - Intervention potential
  - Hard to reach patients
  - QoF
- Allows customised BP targets and takes palliative care/significant frailty into account
- Minimises false positives
- Can support creation of local incentive schemes

Hypertension Template

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Hypertension CDRC

Hypertension | Investigation/Referral | Coding / Casefinding | Exceptions | QoF Ruleset | Resources

Hypertension

NICE Hypertension Summary | NICE Hypertension Guidance

Coding

BP Targets

BP Graph

BP

Estimated NICE Target - none | Estimated NICE Target - none

No QoF Target | No QoF Target | No QoF BP Target

Target Systolic BP NOT RECORDED | Target Diastolic BP NOT RECORDED

Date	Systolic	Date	Diastolic
19 Jun 2019	O/E - Systolic ... 150...	19 Jun 2019	O/E - Diastolic ...60 ... QOF
15 Oct 2019	O/E - Systolic ... 140...	15 Oct 2019	O/E - Diastolic ...90 ... QOF
11 Nov 2019	O/E - Systolic ... 110...	11 Nov 2019	O/E - Diastolic ...90 ... QOF
11 Nov 2019	O/E - Systolic ... 180...	11 Nov 2019	O/E - Diastolic ...90 ... QOF
19 Jun 2020	O/E - Systolic ... 80 ...	19 Jun 2020	O/E - Diastolic ...40 ... QOF
10 Mar 2022	O/E - Systolic ... 150...	10 Mar 2022	O/E - Diastolic ...90 ... QOF

Hypertension Register

End Organ Damage

No current record of hypertension

Core Data

Patient Resources

16 Sep 2021 Body mass index - observation (22K..) 39.84 Kg/m² QOF

19 Jun 2019 GPPAQ physical activity index: active (XaPPE) QOF

Ex smoker (BUT current passive smoker)

Alcohol intake 3 Units/Week 19 Jun 2019

BP Treatment

BP Exceptions

On max tol Rx

NO clear record of current antihypertensive treatment

Scripts + BPs

Medication Timeline

Lipids

Latest QRISK >10% and not on treatment

Not on lipid lowering therapy

QRISK2 cardiovascular disease 10 year risk score 38.72 % 19 Jun 2019

!! CONSIDER LIPID LOWERING !!

Hypertension Review

Hypertension Review/ Monitoring Check Not Done

<Previous

Show recordings from other templates

Show empty recordings

Event Details | Information | Print | Suspend | Ok | Cancel | Show Incomplete Fields

Hypertension Template

CDRC Supporting Clinical Decisions

Hypertension CDRC

Hypertension | Investigation/Referral | Coding / Casefinding | Exceptions | QoF Ruleset | Resources

Hypertension Codes

Problem Summary

If there is stage 1 hypertension (Clinic 140/90-159/99, Home 135/85-149/94) and no evidence of end organ damage, use this code:

Stage 1 HT without evidence of end organ damage

Stage 1 HT without evidence of end organ damage

If the patient does not have stage 1 hypertension, or has now moved to stage 2 hypertension or developed end organ damage, use any of these codes:

Hypertension

Hypertension codes QOF

Hypertension resolved

Hypertension

Hypertension codes QOF

Hypertension resolved

Casefinding Information

BP Casefinding - Last BP raised

Hypertension QoF Codes

Hypertension Codes (non QoF)

Stage 1 HT without evidence of end organ damage

Date | Che... | ...

No previous values

Show recordings from other templates

Show empty recordings

Event Details | Information | Print | Suspend | Ok | Cancel | Show Incomplete Fields

Academic Science Network
North East and North Cumbria

ahsn-nenc.org.uk

@AHSN_NENC

Hypertension Visualisation

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Coming soon!

125 / 60 mmHg

03 02 23 O/E - Systolic BP reading

Date	Systolic	Date	Diastolic
09 11 22	160 mmHg	09 11 22	70 mmHg
11 11 22	138 mmHg	11 11 22	78 mmHg
09 12 22	144 mmHg	09 12 22	80 mmHg
09 12 22	140 mmHg	09 12 22	85 mmHg
09 12 22	160 mmHg	09 12 22	82 mmHg
03 02 23	125 mmHg	03 02 23	60 mmHg

Personal BP Target	Estimated NICE Target	QoF Target
< 150 mm Hg / < 90 mm Hg	140 / 90	150 / 90
10 05 21		
10 05 21		

Record Target

Date	Medication
13 02 23	Felodipine 10mg modified-release tablets
16 01 23	Felodipine 10mg modified-release tablets

Show BPs with Medication

Hypertension with T2DM | Hypertension without T2DM

	Age <55 and not of black African or African-Caribbean origin	Age 55 or over	Black African or African-Caribbean origin (any age)
Step 1	ACEi or A2RB	CCB	
Step 2	ACEi or A2RB + CCB or thiazide like diuretic	CCB + ACEi or A2RB **OR** thiazide like diuretic	

Visualisation Tool

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Lipid Dashboard

Lipids Dashboard

Secondary Prevention

Proportion with established ASCVD

6%

Lipid Lowering Treatment: 92%

Concordance: 96%

Lipids in last 12m: 89%

Has Lipid Target (on LLT): 87%

Lipid Target Achieved: 67%

Treatment Potency

V High	High	Mod	Low	None
36%	42%	9%	5%	8%

Secondary Prevention Quality Improvement Tools

Primary Prevention

Proportion with clear indication for primary prevention

19%

Lipid Lowering Treatment

Lipid Lowering Concordance

Lipids in last 12 months

Has Lipid Target (on LLT)

Lipid Target Achieved

Questions and Discussion