Academic Health Science Network
North East and North Cumbria

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

UCLPartners Proactive Care Frameworks: Optimising use of the wider workforce

Aiysha Saleemi – Pharmacist Advisor- UCLPartners

Please post comments and questions in the chat during the presentation

Presentation objectives

- Outline of UCLPartners Proactive Care Frameworks
- The wider workforce
- Case studies
- Competency based workforce model
- Recommended training
- Resources

UCLPartners Proactive Care Frameworks

UCLPartners has developed a series of frameworks for local adaptation to support proactive management of long-term conditions in post-COVID primary care.

- Led by a clinical team of GPs and pharmacists.
- Supported by patient and public insight.
- Working with local clinicians and training hubs to adapt and deliver.

Core principles:

1. Virtual where appropriate and face to face when needed.
2. Mobilising and supporting the wider workforce to optimise clinical care and holistic care
3. Step change in support for self-management.
4. Digital innovation including apps for self-management and technology for remote monitoring.




Hypertension: stratification and management

ARRS[$] roles/ other appropriately trained staff

Stratification & Prioritisation

Prescribing Clinician

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 (e.g. BP measurement), sign post self care resources
Behaviour change e.g.	Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol

Priority One	**Priority Two**	**Priority Three**	**Priority Four**
BP >180/120mmHg***	2a. BP >160/100mmHg*** 2b. BP >140/90mmHg*** if BAME AND CV risk factors or co-morbidities** 2c. No BP reading in last 18 months	3a. BP >140/90mmHg*** if BAME OR CV risk factors or comorbidities** 3b. BP >140/90mmHg*** or >150/90mmHg*** if ≥ 80 years	4a. BP <140/90mmHg*** under age 80 years 4b. BP <150/90mmHg*** aged ≥ 80 years

Optimise anti-hypertensive therapy 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

*QRISK 3 score is recommended to assess CV risk for patients with Severe Mental Illness, Rheumatoid Arthritis , Systemic Lupus Erythematosus, those taking antipsychotics or oral steroids; [$]ARRS = Additional Role Reimbursement Scheme

** / *** see next slide

High Blood Pressure Stratification and Management – Notes

- ** Co-morbidities / risk factors

- Established CVD (prior stroke/TIA, heart disease, peripheral arterial disease)
- Diabetes
- CKD 3 or more
- Obesity with BMI > 35

- ***Clinic vs Home BP readings

Clinic BP reading	Equivalent Home BP
BP = 180/120mmHg	BP = 170/115mmHg
BP = 160/100mmHg	BP = 150/95mmHg
BP = 150/90mmHg	BP = 145/85mmHg
BP = 140/90mmHg	BP = 135/85mmHg

Wider Workforce to Support Proactive Care

The wider workforce consists of:

- Healthcare assistants
- Health and Wellbeing Coaches
- Pharmacy Technicians
- Social Prescribing Link Workers
- Care Coordinators
- Nursing Associates

As well as…

- Physician Associates
- Clinical Pharmacists
- First Contact Physiotherapists
- Dieticians
- Podiatrists
- Occupational therapists
- Mental Health Practitioners

Why Utilise the Wider Workforce

- Utilising a wider workforce is part of the 2019 NHS Long Term Plan.
- Assigning specific tasks to other members of the primary care team ensures GPs can focus on providing high quality clinical care.
- With appropriate training, these roles will have more time to provide:
  - Personalised care
  - Support education/self-management/behaviour change
  - Address patients' wider concerns, signposting to relevant clinical staff where necessary.

Tasks

- Members of the wider workforce are integral in ensuring high quality care for patients.

- Supporting education, self-management and behaviour change

- Examples of tasks include:
  - Running searches
  - Carrying out proactive care consultations
  - Discussing lifestyle and behaviour change
  - Explaining inhaler technique and how to use BP machines
  - Signposting to more information
  - Listening to patients concerns and referring to the clinical team where necessary

Case study: A GP and Health and Wellbeing coach perspective Newham, East London

Join Dr Vaishali Ashar and Darshana Lathigra from Stratford PCN as they share their experiences of using the Frameworks.

Proactive Care Frameworks: A GP and Health and Wellbeing Coach Perspective - YouTube

North Havering – example

- Utilised Additional Role Reimbursement Scheme (ARRS) roles to support with implementation.

- Example - Hypertension Framework

Group	Workforce identified to manage patients
1	GPs, clinical pharmacists and support from secondary care CVD consultant when needed
2a, 2b, 2c	Clinical pharmacists working across the PCN
3 and 4	Health and well-being coaches (HWC), social prescribers and care coordinators.
All groups	Offer lifestyle interventions via the ARRS roles e.g • Care coordinators and HWC offered wider lifestyle interventions (e.g. referral to obesity and smoking cessation resources.) • Care coordinators contacted every patient to ensure a recent blood pressure measurement was recorded – either undertaken at home, in community pharmacy or by coming into the surgery. They then directed the patient to the right clinician depending on need.

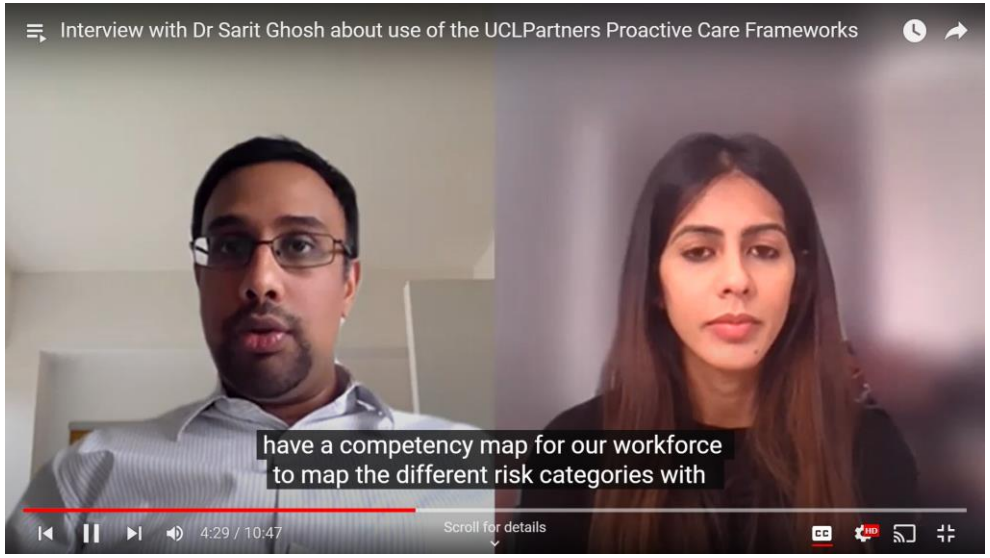
Case study: Enfield Unity Primary Care Network Optimising the Wider Workforce

Join Dr Nausheen Hameed from UCLPartners as she interviews Dr Sarit Ghosh, GP and Clinical Director Enfield Unity Primary Care Network sharing his experiences of using the Frameworks.

Interview with Dr Sarit Ghosh about use of the UCLPartners Proactive Care Frameworks

10 minutes

Workforce specific content between 4:00-6:00 minutes



Case studies – improving care and releasing capacity

- In Haringey, the UCLPartners hypertension framework was implemented in 5 practices. Over 3 months, they demonstrated a 41% reduction in patients in the highest risk group and 13% reduction in the second highest risk group because of treatment optimisation.
- Havering North PCN achieved 28% reduction in hypertension priority group 1 and 1,000 additional people had BP controlled to target.
- BHR Pharmacist led AF project - using UCLP stratification to review around 1,000 patients with atrial fibrillation. 314 patients commenced on anticoagulants, modelled to prevent 12 strokes across BHR every 18 months. 400 patients with AF and CVD commenced on statins for secondary prevention of CVD.
- Surrey heartlands ICS combined the UCLPartners Proactive Care stratification with BP @home and achieved improved blood pressure in 8,800 patients
- Lakeside PCN (180,000 patients): by adopting the UCLPartners stratification and prioritisation, they released sufficient nursing time to perform 650 additional smears.

Competency Based Model

Job titles

- Health and Wellbeing Coach
- Care Co-Ordinator
- Pharmacist
- Social Prescriber

Competencies

- Skills
- Knowledge
- Behaviours

Workforce groups involved in implementing the Frameworks – from evaluation trial sites

Workforce group	Practice 1	Practice 2	Practice 3	Practice 4
GP	X	X	X	X
Practice nurse	X	X	X	X
Advanced nurse practitioner	X		X	X
Nursing assistant/associate	X	X		
Clinical pharmacist	X	X	X	X
Healthcare assistant	X	X	X	X
Social prescribing link worker	X			
Care coordinator or health and wellbeing coach	X		X	
Administrative roles	X	X	X	X
Other	Community pharmacist		IT consultant	

CIHR 2021

Recommended training required for implementing the Proactive Care Frameworks

Five step summary of recommended training for all staff to implement Proactive Care Frameworks

1. Local practice
2. Consultation
3. Condition specific
4. Support for lifestyle change
5. Digital tools

Condition specific information for HCAs, social prescribers, nursing assistants and other appropriately trained staff UCLPartners

Conditions	Clinical	Related parameters	Available Resources
Blood Pressure Digital resources	• Understanding of hypertension and what the BP numbers mean • Understanding of cardiovascular risk and how to reduce it • BP checks – how to take an accurate BP • Explaining • Explaining readings • Lifestyle a • Checking • Red flags	Pulse • How to check rate and rhythm? (see AF) QRisk • What does it mean and how to calculate it? (see cholesterol)	• What is high blood pressure? https://www.bhf.org.uk/informationsupport/risk-factors/high-blood-pressure#Heading1 • Blood Pressure: What do the numbers mean? http://www.bloodpressureuk.org/your-blood-pressure/understanding-your-blood-pressure/what-do-the-numbers-mean/ • Cardiovascular risk assessment:

Additional condition specific information for pharmacists, physician associates, nurses and others contacting medium risk patients UCLPartners

Conditions	Clinical	Available Resources
Hypertension Digital resources	Information in slide 6 plus: • Medication adherence • Treatment titration • Common medication side-effects and how to manage these • Pulse check • QRisk score	• Hypertension in adults: diagnosis and management NICE guideline [NG136] https://www.nice.org.uk/guidance/ng136 • NICE Guidance CG76: Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence https://www.nice.org.uk/guidance/cg76 • PCCS Academy: Module 3: Hypertension https://pccsuk.org/academy/en/page/hypertension • CPPE clinical pharmacy support on hypertension https://www.cppe.ac.uk/gateway/hyper • Pharmaceutical Journal Article on 'Hypertension: management' https://pharmaceutical-journal.com/article/ld/hypertension-management • QRisk 2 calculator https://www.qrisk.org/2017/ or QRISK®3-2018 risk calculator https://qrisk.org/three/ • BP UK - How to measure your blood pressure at home http://www.bloodpressureuk.org/your-blood-pressure/how-to-lower-your-blood-pressure/monitoring-your-blood-pressure-at-home/how-to-measure-your-blood-pressure-at-home/ • BHF - How to check your pulse https://www.bhf.org.uk/informationsupport/tests/checking-your-pulse • NHS England - Shared decision making https://www.england.nhs.uk/shared-decision-making/

Competency

Supporting self-management

COMPETENCY	WORKFORCE					LEARNING RESOURCES
	1	2	3	4	5	
Recommend blood pressure monitors						Blood pressure monitors – British Heart Foundation
Demonstrate use of blood pressure monitor						Managing BP at home Manage your blood pressure at home - British Heart Foundation (bhf.org.uk)
Check patient use of blood pressure monitor						As above
Explain when and how to submit blood pressure readings						Agree locally
Explain when to act on blood pressure readings						See red flags on multimorbidity protocol here (page 10).

'Utilising an integrated team means that the patients are benefitting from a multidisciplinary approach to their care. One of the legacy pieces from this work will be multi-disciplinary team meetings for the Physician Associates to feed back into.'

Physicians Associate, North-West London.

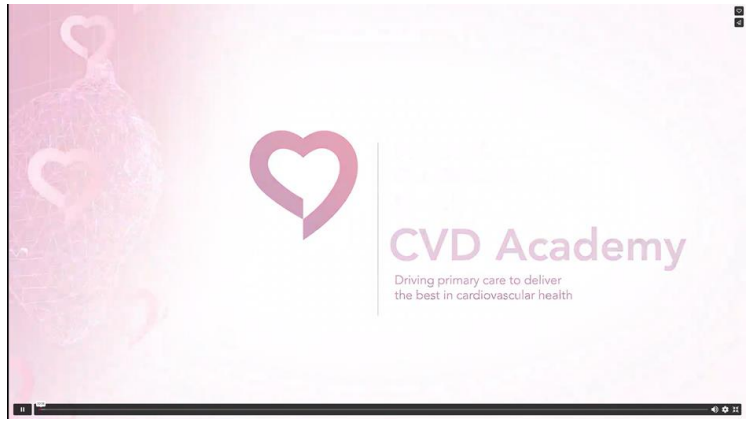
"…the right patient sees the right clinician, … frees up time for the more experienced physicians to see the more complex patients, and it also allows us to decide who to focus on first."

CHIR Evaluation, GP site one

Training opportunities

National opportunities

- Hypertension - elearning for healthcare (e-lfh.org.uk)
- Primary Care Cardiovascular Society CVD Academy (Module 3) Hypertension https://pccsuk.org/academy/en/page/hypertension



Resources to support new way of working

- Implementation workbook - approx. 60 mins to work through each module https://uclpartners.com/uclpartners-proactive-care-framework-implementation-workbook/
  - Module 1 – What are the Frameworks, outlines the context in which they were created, the benefits and the principles underpinning the approach.
  - Module 2 – Team Roles, focuses on the clinical prioritisation and systematic use of the wider workforce to help teams to optimise patient care, safely manage workflow, free up GP capacity and increase job satisfaction for staff.
  - Module 3- Risk stratification – an introduction to what risk stratification is and how to utilise the UCLPartners risk stratification searches
  - Module 4- Taking a QI approach – a set of simple quality improvement activities with examples , for people with a basic understanding of QI
- Suggested essential training and education support for delivery of the frameworks https://s42140.pcdn.co/wp-content/uploads/Proactive-Care-Training-Resources-v3.0-Sept-2021.pdf
- Behavioural skills training
  - Communication skills https://www.youtube.com/watch?v=oDV7Is26Ayc&list=PLUQr-7EYOp6SVRL0zVCnqhlKw9ht290cl&index=3
  - Motivational training
    - Workshop 1: https://www.youtube.com/watch?v=ZmHlsci78vk (35 mins)
    - Workshop 2: https://www.youtube.com/watch?v=baElmtKJBxU (28 mins)
- Scripts for consultations – https://s42140.pcdn.co/wp-content/uploads/Protocol-for-CVD-Conditions-Version-2-June-2021-FINAL1-1.pdf

Next Steps

- Practice/PCN level
  - Consider the competencies/skill set you may require to implement the chosen Framework(s) and map that against the workforce that is currently available.
  - Training needs analysis.
  - Consider utilising staff members across practices within the same PCN to fill any identified gaps in required workforce.

- Personal
  - Complete form on UCLP website to access videos on health coaching techniques.
  - Read through the script and practice with colleagues.
  - Speak to a clinician in your practice about gathering information prior to consultations.

UCLPartners

Thank you

For more information please contact:

primarycare@uclpartners.com

www.uclpartners.com
@uclpartners

Academic Health Science Network
North East and North Cumbria

facts.cvd
Find Assess Correct Treat Sustain Cardiovascular Disease

The role of a Pharmacy Technician in Lipid Optimisation, for Secondary Prevention patients in Primary care

Tracy Marshall, Programme Manager, AHSN NENC and Pharmacy Technician

Pharmacy Technician workforce

*"Pharmacy Technicians are key members of the pharmacy and multidisciplinary team, engaging with patients and liaising with other healthcare professionals in both primary and secondary care, to support safe and effective use of medicines."**

facts.cvd
Find Assess Correct Treat Sustain Cardiovascular Disease

* Association of Pharmacy Technicians (APTUK)

How can Pharmacy Technicians support lipid optimisation?

- Run the searches
- Stratify and prioritise the patient list
- Triage and gather patient information
- Document finding in patients notes
- Based on findings and NEELI guidelines make recommendations for lipid optimisation
- Task appropriate clinicians
- Review and follow-up on recommendations made

facts.cvd
Find Assess Correct Treat Sustain Cardiovascular Disease

Triage

- Export the search on to a spreadsheet – used as a working document and regularly updated

- Check
  - Patient details
  - Lipid profile results (and any other relevant blood results)
  - Current and past treatments
  - Compliance
  - Allergies/intolerances
  - Latest BP and pulse readings

- Document in patient's medical record
  - Findings from above
  - Related CVD history
  - Treatment recommendations

- Task
  - Pharmacist / specialist nurse / relevant clinician

facts.cvd
Find Assess Correct Treat Sustain Cardiovascular Disease

Workforce

- Pharmacy technicians have a dedicated skill set and knowledge base. This enables them to triage the patient list and make recommendations on treatment options (following all appropriate guidelines) while also considering other medications and conditions.
- They provide the clinician with a detailed review of a patient's current situation/medical history/medications/blood results/BP and pulse readings etc.
- The clinician uses this information to make an informed decision regarding the patient's treatment options.
- This approach ensures the workforce are being used appropriately, and to the best of their ability and potential.

Closing the health inequalities gap

- This project supports the NHS long term plan, and will help to reduce the number of cardiovascular events in NENC
- *"Heart and circulatory disease…(CVD), causes a quarter of all deaths in the UK … and is the largest cause of premature mortality in deprived areas. This is the single biggest area where the NHS can save lives over the next 10 years."*
- (NHS Long Term Plan)
- *CVD ……is a major driver of health inequalities, accounting for a quarter of the life expectancy gap between deprived and affluent communities. The global burden of disease study, identified high blood pressure and high cholesterol as leading risk factors that drive mortality and morbidity from CVD. These risk factors are high impact but also highly modifiable*
- *(UCLPartners 24 February 2022 | Dr Matt Kearney)*

facts.cvd
Find Assess Correct Treat Sustain Cardiovascular Disease

Uniformity and ability to replicate

- We decided that to enable other pharmacy technicians to work in similar ways, in different geographical areas, we would develop a process map.
- Collecting consistent information and working in a comparable way will highlight any disparities and differences across the ICS
- We can learn from the differences, share, and implement any areas of good practice

facts.cvd
Find Assess Correct Treat Sustain Cardiovascular Disease

Academic Health Science Network
North East and North Cumbria

PHARMACY TECHNICIAN'S ROLE IN SECONDARY PREVENTION AND FH LIPID OPTIMISATION PROCESS MAP

Check list before you start:

- Insurance (if necessary)
- Portable DBS (if patient facing)
- Honorary contract (Third party confidentiality agreement if necessary)
- Introduction/Email from Practice Manager or clinical lead to staff prior to visit
- Be provided with a Smart card & ID and access to Windows, EMIS/S1
- ICE (for ordering & checking blood results)
- Agree a nominated Pharmacist and ways of working

CDRC SEARCHES RUN BY PHARMACY TECHNICIAN EITHER REMOTELY OR ON SITE. EXPORT TO SPREADSHEET (ATTACHED)

↓

TRIAGE PATIENT LIST USING SPREADSHEET, FILTER NON-HDL≥2.5, SORT HIGHEST TO LOWEST

↓

CHECK & DOCUMENT (ON THE SPREADSHEET) THE FOLLOWING:
- COMFIRM PATIENT NAME & EMIS/SI ID MATCH
- WHEN LAST LIPID PROFILE COMPLETED & RELATED RESULTS (E.g U&E, LFT, TFT)
- CURRENT LIPID TREATMENT & HISTORY
- ALLERGIES/INTOLERANCE
- COMPLIANCE

↓

DOCUMENT FINDINGS
ADD RELATED CVD HISTORY TO THE EMIS/S1 PATIENT CONSULTATION RECORDS:
E.g. ISCHEAMIC HEART DISEASE, PAD, LIPID DISORDER MONITORING CHECK.

↓

BASED ON FINDINGS AND NEELI GUIDELINES MAKE RECOMMENDATIONS FOR LIPID OPTIMISATION. DOCUMENT IN PATIENT'S RECORDS (E.g please consider patient for xxx)

↓

TASK/ASSIGN TO PCN, PRACTICE PHARMACIST OR SPECIALIST NURSE TO REVIEW & ACTION

↓

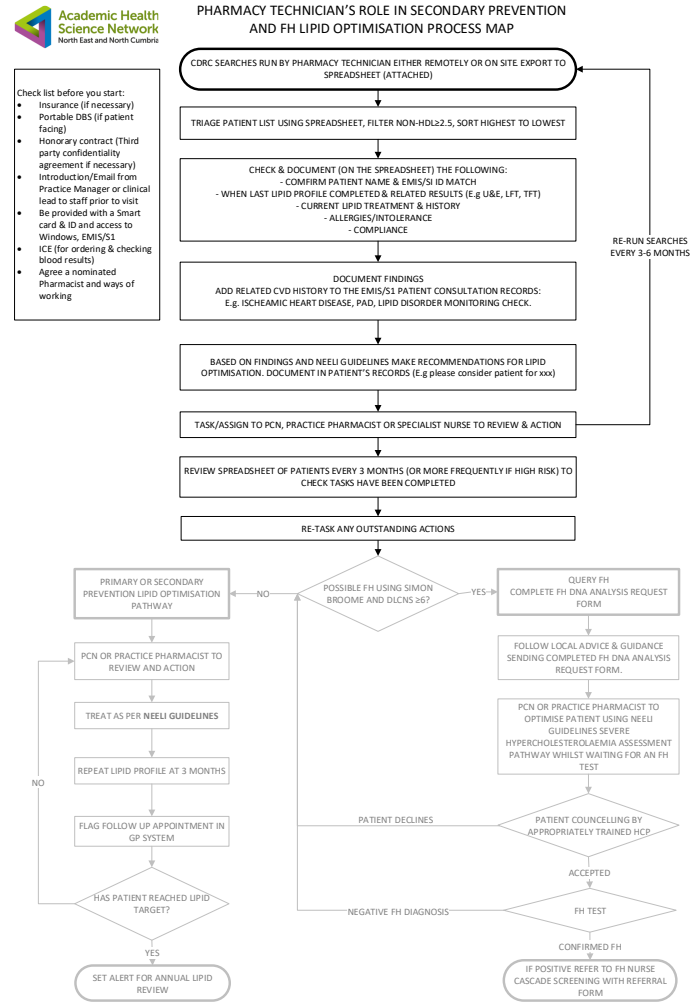
REVIEW SPREADSHEET OF PATIENTS EVERY 3 MONTHS (OR MORE FREQUENTLY IF HIGH RISK) TO CHECK TASKS HAVE BEEN COMPLETED

↓

RE-TASK ANY OUTSTANDING ACTIONS

RE-RUN SEARCHES EVERY 3-6 MONTHS

facts.cvd
Find Assess Correct Treat Sustain Cardiovascular Disease



Resources

In addition to the process map, we wanted to provide current and useful resources all in one place.

As well as guidance already established, the following tools were developed:

- Refined searches
- Protocols for primary and secondary CVD prevention*
- Guidance for running and exporting searches
- Data collection/review tools

* With thanks to Village Green Surgery, Wallsend, pharmacy team and the CDRC team esp. Ben Mole, for help and support with the searches

facts.cvd
Find Assess Correct Treat Sustain Cardiovascular Disease

Academic Health Science Network
North East and North Cumbria

Appendix of Resources

Example of Primary and Secondary CVD prevention, lipid management protocols (Village Green Surgery)**

CDRC guide to importing searches into EMIS

Step by step guide to run and export the CDRC searches on EMIS

Example of a spreadsheet used to sort and prioritise patients requiring lipid optimisation

SOP Primary Care FH & Lipid Optimisation Programme

Lipid Optimisation for Secondary Prevention Handbook

NEELI Guidelines

Educational Resource document

**With special permission from Village Green Surgery, Wallsend: Rachel Bird, Senior Clinical Pharmacist & Barry Todd, Pharmacist Practitioner.

Developed by:

Tracy Marshall – Programme Manager and Pharmacy Technician – AHSN NENC tracy.marshall@ahsn-nenc.org.uk

Mark Harris - Programme Manager – AHSN NENC

Current workforce

- 1 technician working 1 or 2 days in North of Tyne
- 2 technicians working 1 day each in South of Tyne
- 1 technician working 3 days in North Cumbria

- Support from CVD team, practice pharmacists, specialist nurses and CDRC team

facts.cvd
Find Assess Correct Treat Sustain Cardiovascular Disease

Lessons learned

- Pharmacy Technicians are playing a really important role in lipid management and highlighting other areas for concern. Making better use of the pharmacy technician workforce, enables clinicians to spend time on tasks better suited for their skills e.g. clinics, prescribing, patient reviews etc.

- Right person, right time, right role!

facts.cvd
Find Assess Correct Treat Sustain Cardiovascular Disease

Thank you

?

tracy.marshall@ahsn-nenc.org.uk

facts.cvd
Find Assess Correct Treat Sustain Cardiovascular Disease