Health Innovation
North East and North Cumbria

NHS
North East and North Cumbria

Blood Pressure Optimisation – Back to Basics

Tuesday, 10th December, 2024, 13:00-14:00, Online

House Keeping

- Please ensure your microphone and video are turned off during the session. This is to help with the quality of the call.
- If you need to take a break, please feel free to drop off the call at any time and re-join.
- Live captions are available if required. To turn on click on the 3 dots on your toolbar and select ‘Turn on Live Captioning’.
- This event will be recorded, and photographs may be taken.
- Please ask any questions you have through the chat facility. We will try to address questions during the event, but if we don’t manage to do this we will follow up after the event.
- Speaker presentations and recording will be circulated following the event.

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The Health Innovation Network – who are we?

In October 2023, Health Innovation North East and North Cumbria (HI NENC) changed its name from the Academic Health Science Network.

The new name reflects the organisation's key role to continue to support the development and spread of innovation across the region's health service.

But while our name has changed, our vision remains the same: to improve health outcomes, reduce inequalities, and boost the regional economy. Working alongside partners across the system, we will continue to accelerate health innovation in the region, and beyond.

Established in 2013 by NHS England we are one of 15 Health Innovations.

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In the North East and North Cumbria, CVD causes:

690 deaths a month

1 in 5 deaths (in some areas of the region)

CVD Prevention Portfolio programme

HI NENC is delivering a Cardiovascular Disease Prevention Portfolio programme with a focus on:

- Hypertension
- Chronic Kidney Disease
- Familial Hypercholesterolaemia
- Lipid Optimisation and Management in Secondary Prevention

Why do we do it?

Better health outcomes - Our vision is to reduce the risk of CVD and lower the incidence of related events, thereby improving population health by reducing morbidity and mortality. We aim to deliver programmes that address multiple health conditions, helping people live longer, healthier lives.

System partners working together - This vision will be realised through collaboration with regional partners, facilitating the development of tools, pathways, and services that can be scaled and adopted both within our region and beyond.

Economic growth benefits - We aim to drive a positive financial impact by enhancing service efficiencies, fostering partnerships with industry, and supporting the adoption of innovative solutions across the NHS.

Reducing health inequalities - We are committed to working with health organisations, community leaders, and local populations to ensure our initiatives support the reduction of health inequalities, helping to create fairer access to healthcare and prevent the widening of existing disparities.

Tracy Marshall
High blood pressure (Hypertension) – an overview

*'High blood pressure is the leading cause of preventable death worldwide'**

*'Through treating high blood pressure with antihypertensives, one heart attack for every 100 patients and one stroke for every 67 patients is prevented.'***

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**The global epidemiology of hypertension. Nat Rev Nephrol.2020 Apr;(4):223-237*
***Health Innovation Network Impact Report 2023/24*

www.healthinnovationnenc.org.uk

High blood pressure – what are the risks?

High blood pressure (hypertension) is one of the most important risk factors for Cardiovascular Disease (CVD) and is very common, especially in older adults.

If blood pressure is too high, it can damage blood vessels.

There are usually no symptoms, so people may not realise they have it.

High blood pressure can lead to serious problems like heart attacks or strokes.

Lifestyle changes and blood pressure medicines can help people stay healthy.

Things that increase someone's chance of having high blood pressure:

- Age – you're more likely to get high blood pressure as people get older
- Having close relatives with high blood pressure
- Ethnicity – higher risk ethnicities include Black African, Black Caribbean and South Asian.
- An unhealthy diet – especially a diet that's high in salt
- Being overweight
- Smoking
- Drinking too much alcohol
- Feeling stressed over a long period

‘Know your numbers’

Current NHS guidance states:

Aged **under 80 years** of age, blood pressure is considered high if the reading is either:

- **140/90** or higher when checked by a healthcare professional
- **135/85** or higher when checked at home

Aged 80 or over, blood pressure is considered high if the reading is either:

- **150/90** or higher when checked by a healthcare professional
- **145/85** or higher when checked at home

However…… An ideal blood pressure reading is under 120/80

What can you do?

Find hypertension: Use searches, such as CDRC, to identify patients who are not treated to target.

Do: take accurate measurements and provide patients with self-management information, including know your numbers.

Take a MECC* approach to hypertension - Offer all patients with CVD, CKD and diabetes a blood pressure check annually.

Follow hypertension annual review guidance - including taking a urine sample and HbA1c test.

BP & Chronic Kidney Disease

There are usually no symptoms of kidney disease in the early stages.

Chronic Kidney Disease is commonly caused by other conditions that put strain on the kidneys, such as hypertension, a risk factor for cardiovascular disease.

We are looking for practices to participate in the campaign, ***"Are You Taking The Pee?"*** to co-design materials to remind staff to take urine for uACR (a key CKD test). This will take 1.25hrs for a couple of staff members. There is a prize draw! Interested?

Contact Karen Verrill karen.verrill@healthinnovationnenc.org.uk

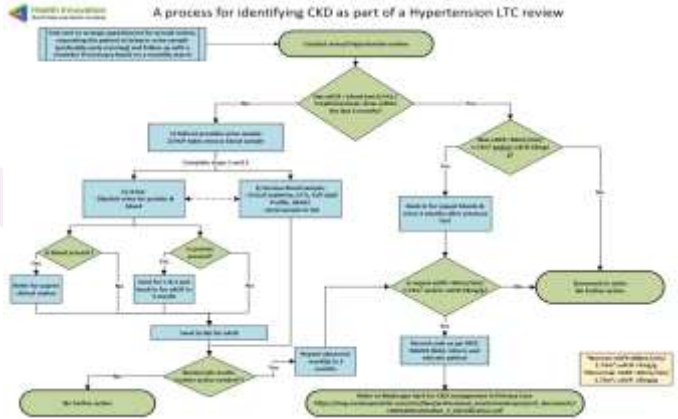
BP & Chronic Kidney Disease: coming soon……

Make every contact count - take a comorbid approach to CKD

Offer annual testing to all adults with CVD, hypertension and diabetes. This should comprise of

- a blood test to measure eGFR
- AND a urine test to detect uACR.

Both tests are required to accurately detect kidney damage (NICE recommendation)



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facts.cvd

www.healthinnovationnenc.org.uk

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NENC ICB Long Term Conditions
The CVD Workstream

Jack Lyon – Project Delivery Lead – CVD

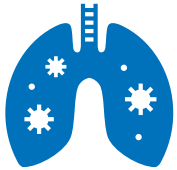
Long Term Conditions

The all-age programme will support the delivery of related priorities within the NENC ICB clinical conditions strategic plan and national priorities.

Core Workstreams:

CVD
(CVD Prevention, Lipids, Non-Specialised Cardiac)

Diabetes



Respiratory

*Other workstreams will exist or task and finish groups

NENC ICB Clinical Conditions Strategic Plan
Cardiovascular Health Recommendations

The cardiovascular health recommendations were developed in collaboration with the long term conditions & physical health clinical networks.

Prevention

- We will **proactively manage risk factors** within primary care such as atrial fibrillation, hypertension, hyperlipidemia, stroke, diabetes and chronic kidney disease management.

Case finding and diagnostics

- We will proactively **case find** for hypertension, atrial fibrillation, diabetes, hyperlipidemia, chronic kidney disease, stroke and heart failure and deliver **access to timely diagnostics and effective treatment,** addressing unwarranted variation, ensuring capacity for diagnostic and treatment services.

Treatment

- We will commission and deliver high quality nationally agreed **models of care.**

Rehabilitation

- We will ensure **secondary prevention/optimisation is embedded** in our care pathways and at each contact point to target atrial fibrillation, hypertension, stroke, hyperlipidemia, diabetes and CKD management.

CVD National Priorities

CVD PREVENTION
NHSE Planning metric 2024/25: • Increase the percentage of patients with hypertension treated according to NICE guidance to 80% by March 2025. • Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025. • Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people.
NON-SPECALIST CARDIAC
NHSE Planning Metric: • Cardiac Rehabilitation: 85% of acute coronary syndrome and 33% of heart failure eligible patients to start cardiac rehabilitation by 2029. • Diagnostics: Increase the percentage of patients receiving a diagnostic test within six weeks in line with the March 2025 ambition of 95%. • Heart Failure: Improve early detection, diagnosis, and treatment.

The ICB is working on developing CVD action plan that aligns with the NENC ICB clinical conditions strategic plan and national priorities.

Some of the recent pieces of Work on Blood Pressure…

Blood Pressure Kiosk Project

Improving access to blood pressure checks through the placement of blood pressure kiosks in community centres.

- 6 community centres across NENC are hosting the blood pressure kiosks. Each centre also has 30 home blood pressure monitors to loan to kiosk users when appropriate.
- The areas targeted were based on the relevant data.
- 82 blood pressure champions have been trained to support the use of the kiosks, advise on results and appropriate signposting.

Comms, Engagement and Education

Know your Numbers

Targeted Social Media

Case study for GP Practice/PCN Engagement Work

Learning Academy

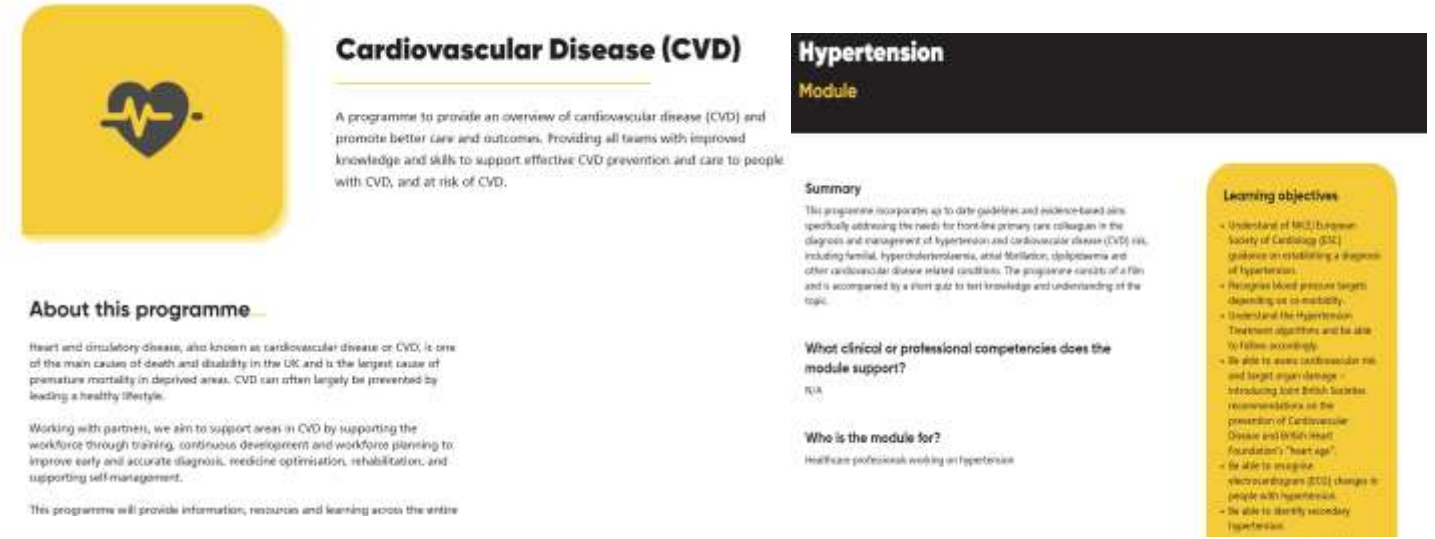
MECC Gateway

2.	You have the power! ❤ A simple blood pressure check can make a big difference. Whether at your GP or local pharmacy, take that first step to keep your heart strong. Don't wait—know your numbers today! https://www.nhs.uk/health-assessment-tools/check-your-blood-pressure-reading #HeartHealth #KnowYourNumbers	
3.	**Blood pressure check due? Don't wait until it's too late!** People over 40 should get their blood pressure tested at least once every 5 years. Get tested at: • Your GP surgery • Your local pharmacy • At home • At an NHS Health Check appointment Find out more at: https://www.nhs.uk/conditions/blood-pressure-test/	David Webb Blood Pressure Video

The NENC ICB Learning Academy

https://academy.boost.org.uk/programmes

The Learning Academy offers a wide range of courses, seminars, and events, all designed to support our collective commitment to delivering the highest standards of care to the population we serve.



Cardiovascular Disease (CVD)

A programme to provide an overview of cardiovascular disease (CVD) and promote better care and outcomes. Providing all teams with improved knowledge and skills to support effective CVD prevention and care to people with CVD, and at risk of CVD.

About this programme

Heart and circulatory disease, also known as cardiovascular disease or CVD, is one of the main causes of death and disability in the UK and is the largest cause of premature mortality in deprived areas. CVD can often largely be prevented by leading a healthy lifestyle.

Working with partners, we aim to support areas in CVD by supporting the workforce through training, continuous development and workforce planning to improve early and accurate diagnosis, medicine optimisation, rehabilitation, and supporting self-management.

This programme will provide information, resources and learning across the entire

Hypertension

Module

Summary

This programme incorporates up to date guidelines and evidence-based aims specifically addressing the needs for front-line primary care colleagues in the diagnosis and management of hypertension and cardiovascular disease (CVD) risk, including familial, hypercholesterolaemia, atrial fibrillation, dyslipidaemia and other cardiovascular disease related conditions. The programme consists of a film and is accompanied by a short quiz to test knowledge and understanding of the topic.

What clinical or professional competencies does the module support?

N/A

Who is the module for?

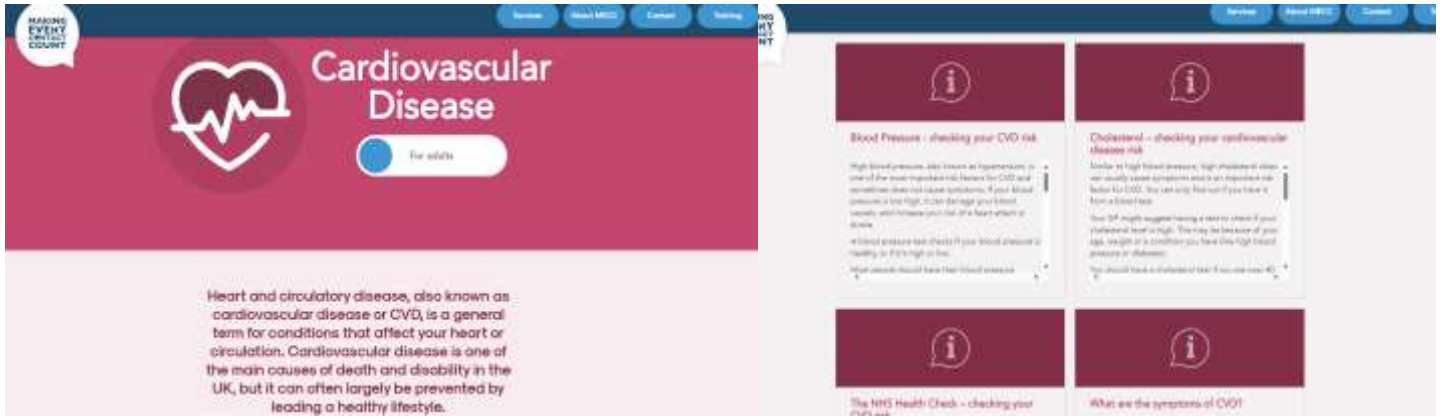
Healthcare professionals working on hypertension

Learning objectives

- Understand of NICE/European Society of Cardiology (ESC) guidance on establishing a diagnosis of hypertension.
- Recognise blood pressure targets depending on co-morbidity.
- Understand the Hypertension Treatment algorithms and be able to follow accordingly.
- Be able to assess cardiovascular risk and target organ damage - introducing Joint British Societies recommendations on the prevention of Cardiovascular Disease and British Heart Foundation's "heart age".
- Be able to recognise electrocardiogram (ECG) changes in people with hypertension.
- Be able to identify secondary hypertension.

MECC Gateway – CVD Tile

https://www.meccgateway.co.uk/nenc/services/Cardiovascular%20Disease



Regional Hypertension Data

Hypertension Prevalence

(per 100,000 population)

	Estimated Prevalence	Actual Prevalence	Gap/Hidden Prevalence
North East North Cumbria	27.3	21.4	5.9%
County Durham	27.7%	23%	4.7%
Gateshead	27.0%	21.9%	5.1%
Newcastle	21.4%	14.9%	6.5%
North Cumbria	29.5%	22.0%	7.5%
North Tyneside	27.9%	21.4%	6.5%
Northumberland	30.7%	23.5%	7.2%
South Tyneside	28.0%	20.6%	7.4%
Sunderland	27.5%	22.9%	4.6%
Tees Valley	27.0%	21.5%	5.5%

Estimated Prevalence – recorded high blood pressure with no prescribed medication or self-reported drug treatment – *Health Survey for England*

Actual Prevalence – hypertension diagnosis documented on primary care record – *GP Clinical Systems*

CVD PREVENT

CVDPREVENT is a national primary care audit that automatically extracts routinely held GP data. This data tool provides open access to the data, with clear, actionable insights for those tasked with improving cardiovascular health in England. Key features of CVDPREVENT include:

- Access to CVD data at a National, ICS, PCN and individual practice levels to enable teams to understand the performance of their services and potential improvement opportunities.
- New data published every quarter, see the data publications dates here: **Home | CVDPREVENT**

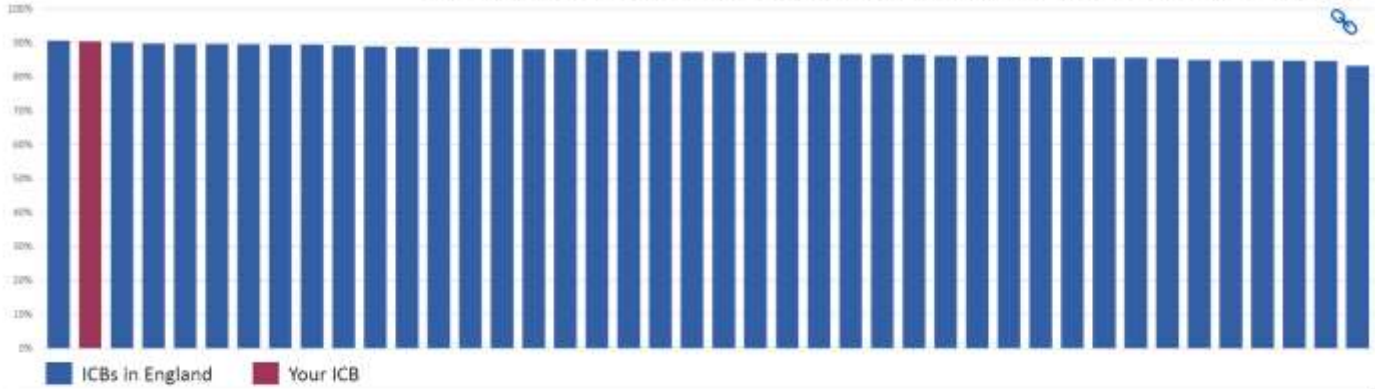
Data shown in the following slides is extracted from GP Systems June 2024, new data will be published in the new year

CVDPREVENT

Hypertension – blood pressure monitoring

CVDP004HYP: Patients with GP recorded hypertension, with a record of a blood pressure reading in the preceding 12 months.

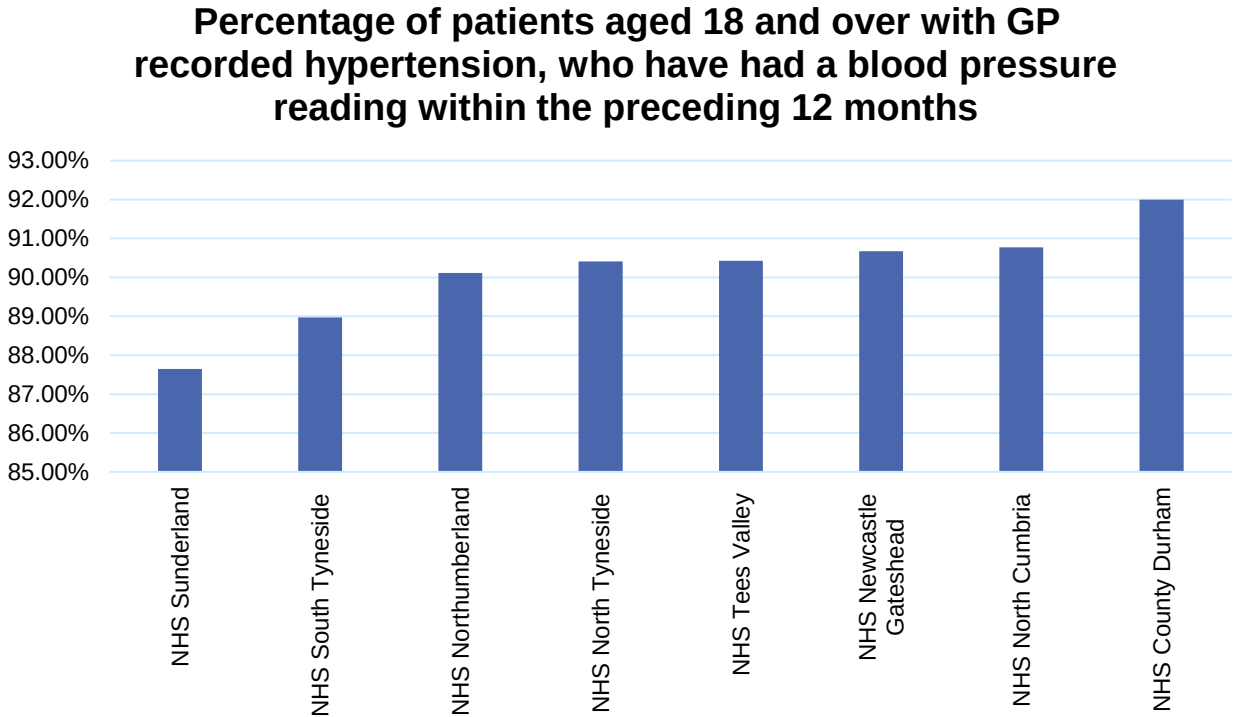
Click on the link icon in the top right corner to view this chart on the CVDPREVENT Data & Improvement Tool



Your ICB achievement benchmarked against all other ICBs in England

- NHS North East and North Cumbria Integrated Care Board achievement (June 2024) = **90%**
- **51,650 people** aged 18 and over with GP recorded hypertension did not have a recent blood pressure reading within the preceding 12 months

Blood Pressure Monitoring



HYPERTENSION MONITORING

CVDP004HYP: Patients with GP recorded hypertension, with a record of a blood pressure reading in the preceding 12 months.

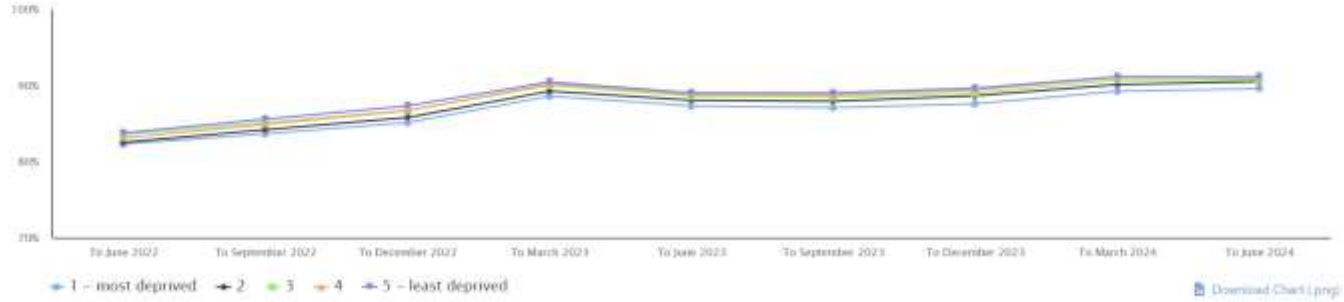
Data Extract | Metadata

All Persons Time Series | **Inequalities Marker Time Series** | System Level Comparison | Area Breakdown

Inequalities Marker Time Series: NHS North East and North Cumbria Integrated Care Board

Chart | Table

Age group | **Deprivation quintile** | Ethnicity | Sex | Learning Disability | Mental Health



Download Chart (.png)

HYPERTENSION MONITORING

CVDP004HYP: Patients with GP recorded hypertension, with a record of a blood pressure reading in the preceding 12 months.

Data Extract | Metadata

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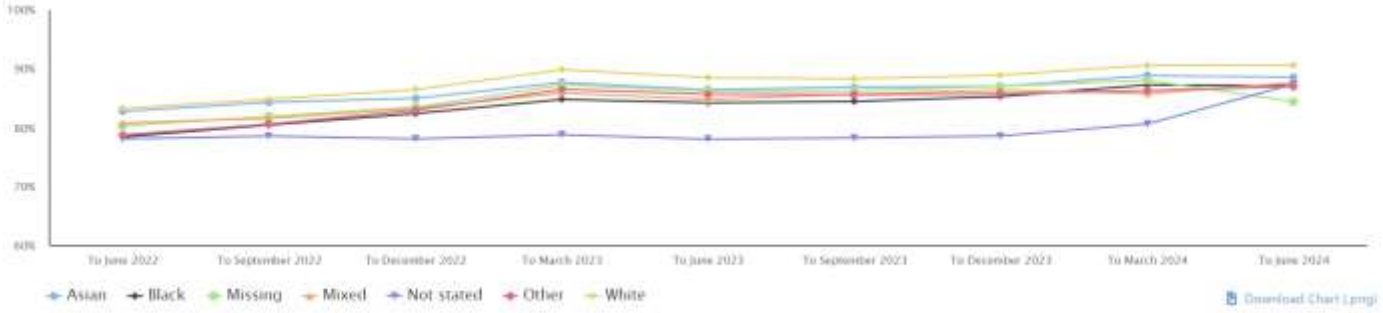
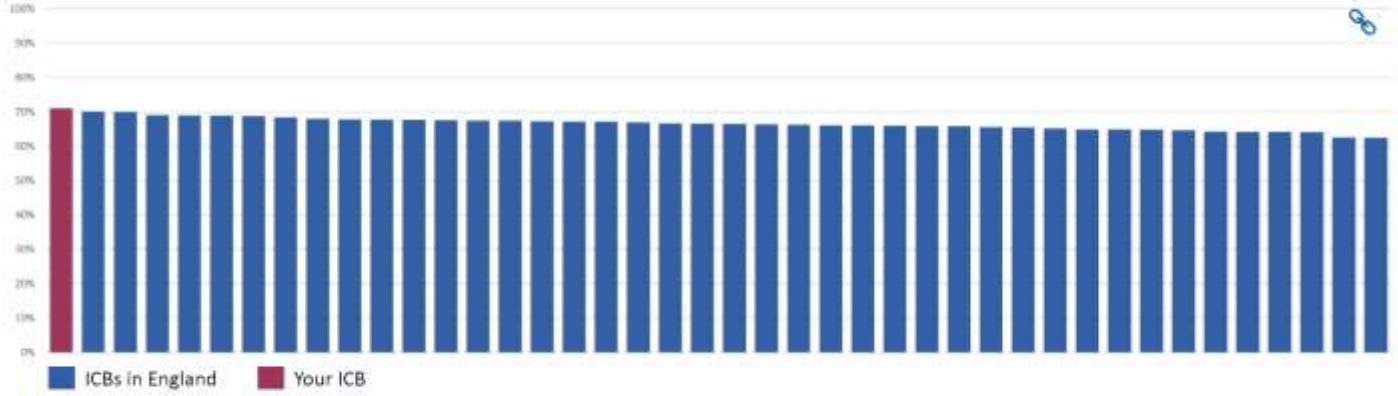


Download Chart (.png)

Hypertension – treatment to target

CVDP007HYP: Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.

Click on the link icon in the top right corner to view this chart on the CVDPREVENT Data & Improvement Tool



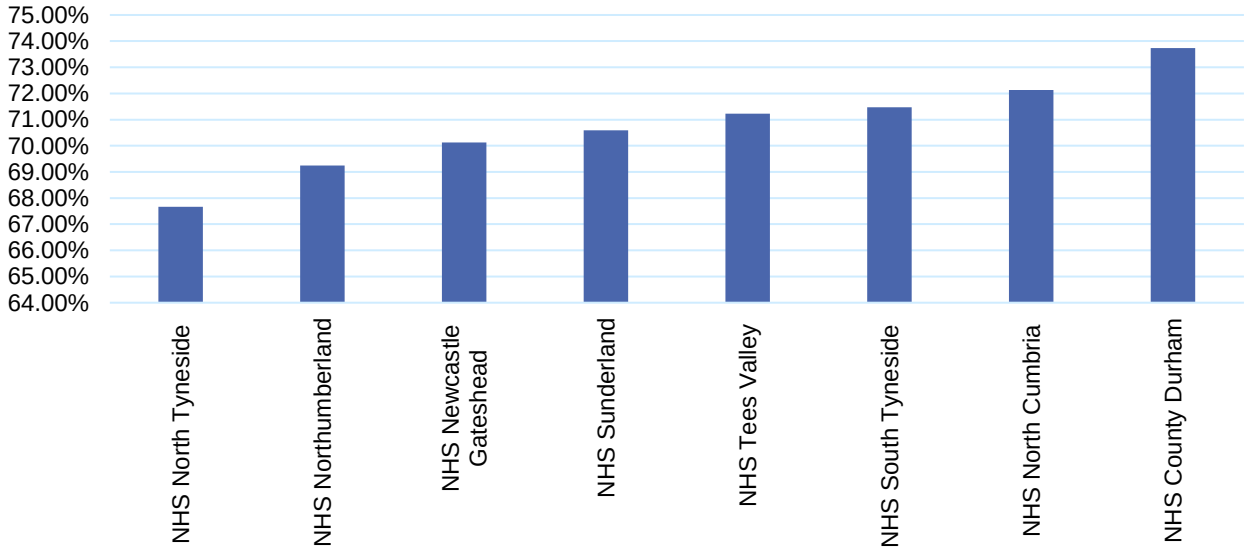
Your ICB achievement benchmarked against all other ICBs in England

- NHS North East and North Cumbria Integrated Care Board achievement (June 2024) = **71% (national ambition 80%*)**
- In your ICB at least **47,895 people** with known hypertension need to be treated to meet the national ambition

*NHS Priorities and Operational Planning Guidance 2024/25

Hypertension Treatment to Target

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



HYPERTENSION MANAGEMENT

CVDP007HYP: Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.

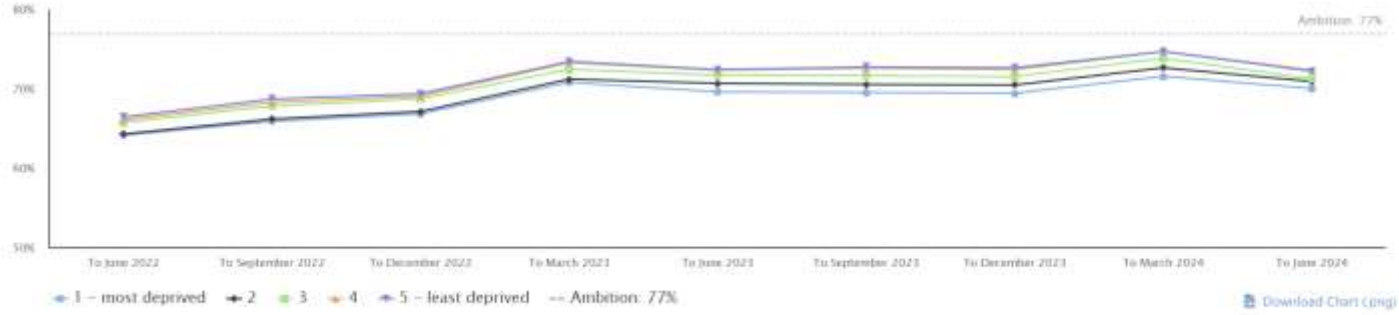
Data Extract | Metadata

All Persons Time Series | **Inequalities Marker Time Series** | System Level Comparison | Area Breakdown

Inequalities Marker Time Series: NHS North East and North Cumbria Integrated Care Board

Chart | Table

Age group | **Deprivation quintile** | Ethnicity | Sex | Learning Disability | Mental Health



Download Chart (.png)

HYPERTENSION MANAGEMENT

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Data Extract | Metadata

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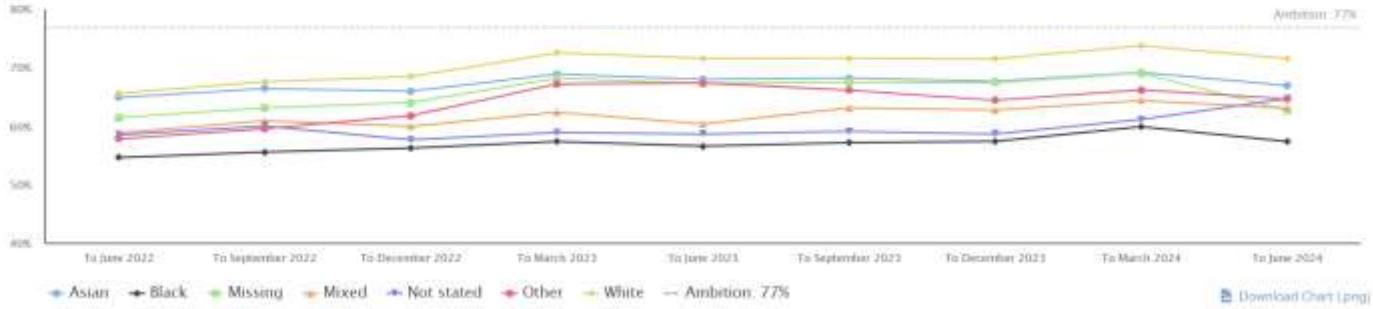

Download Chart (.png)

CVDPREVENT ICB Quality Improvement Packs

Purpose of this pack

To provide ICBs with data and practical actions to improve achievement in single risk factors, reduce variation between practices, and facilitate peer support within the system.

This quality improvement pack will cover:

1. Hypertension monitoring
2. Hypertension treatment to target
3. Prescriptions of lipid lowering therapies in patients at risk of cardiovascular disease (CVD)
4. Lipid treatment to target in patients with CVD

Time for Action

Across NHS North East and North Cumbria Integrated Care Board at the end of June 2024

51,650 people with hypertension did not have a recent blood pressure reading

155,705 people with hypertension were not treated to the appropriate blood pressure threshold

64,705 people at a high risk of CVD* did not have a current prescription for lipid lowering therapy

Using the UCLPartners Size of the Prize resources, it's estimated that treating an additional 47,065 hypertensive patients to threshold in NHS North East and North Cumbria Integrated Care Board would prevent **287 heart attacks** and **429 strokes**, saving **250 lives** and **£6.1M**.

Quality improvement in CVD prevention

Top tips to implement change for quality improvement

- **CVD clinical leadership** in ICBs and practices is key to facilitating continuous data-led quality improvement
- **Educational outreach** meetings provide protected and facilitated time to take a data- led approach. Outputs can range from simple actions to transformational change
- **Learning from local improvers** can highlight actions that could be relevant to your local context
- **Engagement with health innovation networks** and other relevant stakeholders is a crucial component of improvement and translating evidence into practice
- **Think equity-focused quality improvement** and prioritise reviews in people who are known to experience healthcare inequalities

Hypertension – treatment to target

Key actions to improve

1) **SEARCH** your GP clinical system for hypertensive patients whose last BP is above the age-appropriate treatment threshold.
   - Patients may show as 'not treated to target' because their last BP reading was more than 12 months ago (see CVDPREVHYP indicator). To rectify, follow the steps outlined in slide 6.
2) **REVIEW** patients
   - Risk-stratify and prioritise patients with BPs further from target, according to CVD risk, and where there are known healthcare inequalities in BP management (e.g., working age males, black or mixed ethnicity)
   - Explore population health management tools that may be available within your ICB. Other pre-written electronic searches & tools (some free to NHS users) are also available to help with risk stratification and prioritisation
   - Consider utilising practice Additional Roles Reimbursement Scheme (ARRS) pharmacy workforce or other appropriately trained staff to gather information (up to date bloods, BP, weight, smoking status, lun QRISK score), to encourage behaviour change and signpost to other information or services
3) **OPTIMISE** anti-hypertensive therapy and CVD risk reduction in line with NICE guidance
   - Review blood results, risk scores and symptoms
   - Review complications and co-morbidities
   - Assess CVD risk – optimise lipid management and other risk factors
   - Encourage self management and care of hypertension through patient education
   - Explore medicines taking behaviour and any barriers to adherence, including adverse effects
   - Initiate or optimise blood pressure medication; many people will require more than one antihypertensive
4) **ENSURE** call and recall for BP checks, at least annually

Northumbria Healthcare
NHS Foundation Trust

Reducing Cardiovascular Disease: Finding and treating hypertension

Catherine Tucker

Senior Clinical Pharmacist Lipid clinic NTGH

The national picture

Atrial Fibrillation (AF)

Atrial fibrillation is one of the most common forms of abnormal heart rhythm (arrhythmia) and a major cause of stroke.

- Nearly **1.4 million people** in England have been diagnosed with atrial fibrillation.
- It is estimated that there are at least 230,000 people aged over 65 with undiagnosed (or silent) atrial fibrillation in England.

Around **50%** of heart attacks and strokes are associated with high blood pressure in England

High Blood Pressure

- High blood pressure is the leading modifiable risk factor for heart and circulatory disease in England.
- An estimated **30 per cent of adults** in England have high blood pressure and most are not receiving effective treatment.
- Around 9.4 million people in England are on a GP hypertension register.

Linked conditions

- Adults with diabetes are **2-3 times** more likely to develop CVD, and are **nearly twice as likely** to die from heart disease or stroke as those without diabetes
- In England, **one third** of adults with diabetes die from a heart or circulatory disease

High Blood Cholesterol

- High blood cholesterol is a significant risk factor for developing heart and circulatory diseases – it's estimated that more than **two in five (43 per cent) of adults** in England have cholesterol levels above national guidelines (above 5mmol/L).
- In England around two thirds of NHS Health Check participants (age 40 to 74) have high cholesterol.
- More than six million adults in England are taking lipid-lowering drugs such as statins.

https://www.bhf.org.uk/-/media/files/for-professionals/research/heart-statistics/bhf-cvd-statistics-uk-factsheet.pdf

Every 6 minutes someone in England is admitted to hospital due to a heart attack

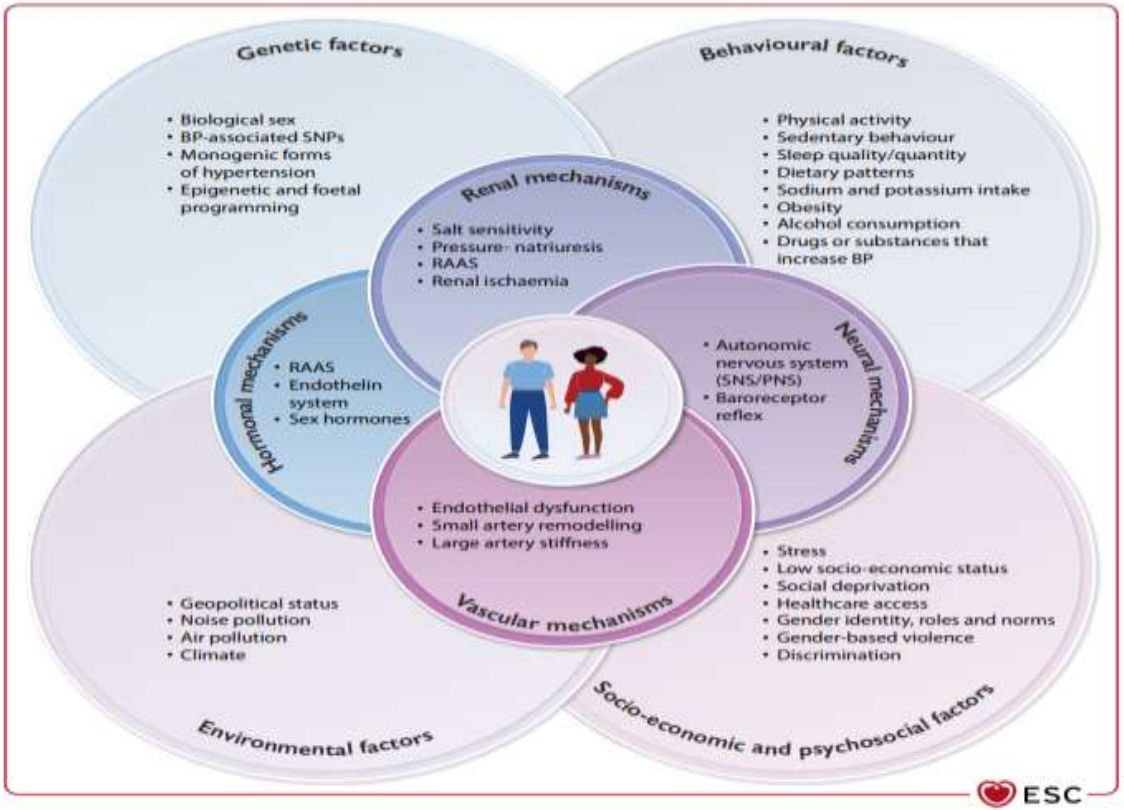

Figure 1 Pathophysiology of elevated blood pressure and hypertension. BP, blood pressure; PNS, parasympathetic nervous system; RAAS, renin-angiotensin-aldosterone system; SNP, single-nucleotide polymorphism; SNS, sympathetic nervous system. Complex interplay between genes, environmental, and behavioural factors, organs, physiological systems, and neurohumoral processes contribute to BP regulation. Dysfunction of these processes leads to hypertension. The contribution of these factors to elevated BP and hypertension may differ among males and females.

McEvoy J et al. European Heart Journal (2024) 45, 3912–4018 https://doi.org/10.1093/eurheartj/ehae178

Long term complications

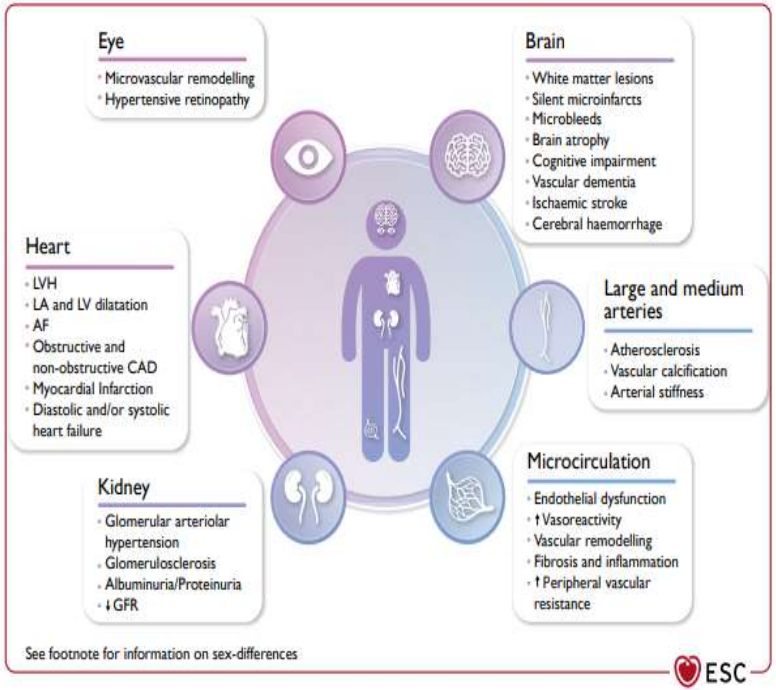

Figure 2 Persistently elevated blood pressure and hypertension lead to hypertension-mediated organ damage and cardiovascular disease. AF, atrial fibrillation; CAD, coronary artery disease; GFR, glomerular filtration rate; LA, left atrial; LV, left ventricular; LVH, left ventricular hypertrophy. See the supplementary data online for detailed information on sex differences.

McEvoy J et al. European Heart Journal (2024) 45, 3912–4018 https://doi.org/10.1093/eurheartj/ehae178

Around **50%** of heart attacks and strokes are associated with high blood pressure

NHS healthcare foundation Trust

- Why blood pressure checks?
- Improve
  - Access
  - Detection
  - Management
- Reduce risk of CVD
- Increase conversations about health & wellbeing

Clinical Digital Resource Collaborative

www.cdrc.nhs.uk

Northumbria Healthcare
NHS Foundation Trust

Casefinding

The following reports will help identify patients that may not have been appropriately coded

Report Name	Returns	Action
? HypertensionBP 2.1 Casefinding - Potential Hypertension indicator but no HT code	Patients with a code to suggest hypertension (e.g. hypertension annual review) without a QoF hypertension code	The QoF and Contracting template will help to identify the codes (see example below)
? HypertensionBP 2.2 Casefinding - Medication that might be for HT but no HT	Patients taking medication which might be for hypertension who don't have an obvious indication for this	
? HypertensionBP 2.3 Casefinding - ABPM>=135/85 and not appropriately coded	Patients with a home BP average reading >=135/85 (which defines hypertension) without a subsequent hypertension code	
? Drug to Diagnosis 094 - Betablocker without obvious indication		Also likely to detect other diagnoses such as hypertension, heart failure, SVT, CHD

Management

The following reports will help target patients for intervention. They have been arranged in such a way to facilitate prioritisation

Report Name	Returns	Intervention	Notes
? HypertensionBP 3.1 Management Priority 1 – Highest potential for intervention	Priority 1 patients Has all three of: - 3 months overdue BP check - Suspected poor concordance - BP is >20/10 over NICE or personal target	Review patient	
? HypertensionBP 3.2 Management Priority 2 – High potential for	Priority 2 patients Has two out of three of:	Review patient	Patients with stage 1 hypertension without end organ damage who

Blood pressure targets

www.cks.nice.org.uk/topics/hypertension/

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NICE CKS Hypertension- treatment pathway

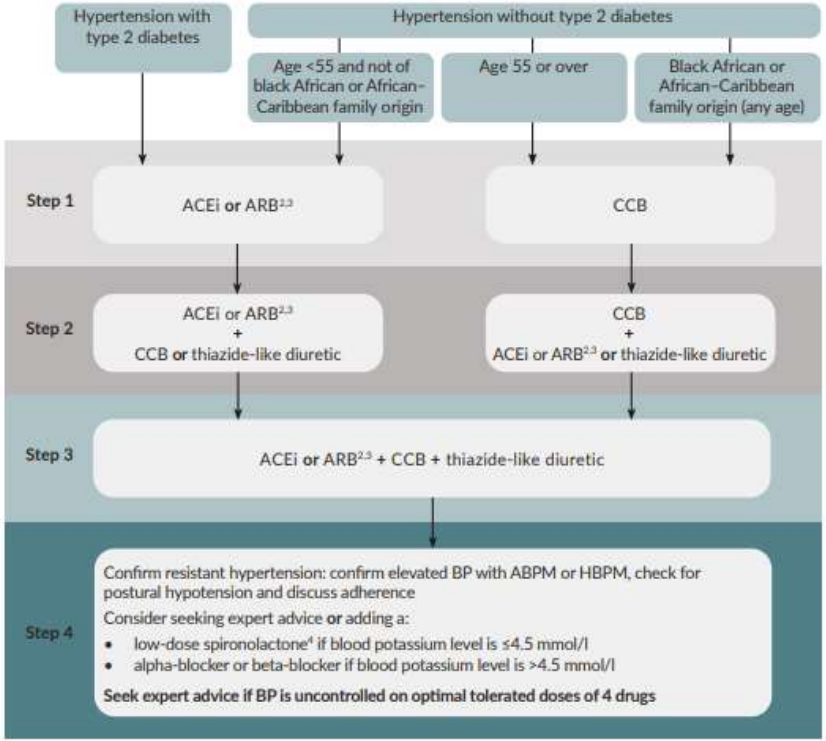
Clinic blood pressure versus Home Blood Pressure Monitoring

- <80y 140/90mmHg
- >80y 150/90mmHg
- CKD <130/80 mmHg

Treat to target, treatment pathway:

- What have you tried: titrate dose, add in next step
- If side effects try alternative

Choice of antihypertensive drug[1], monitoring treatment and BP targets



Monitoring treatment

Use clinic BP to monitor treatment.

Measure standing and sitting BP in people with:

- type 2 diabetes **or**
- symptoms of postural hypotension **or**
- aged 80 and over.

Advise people who want to self-monitor to use HBPM. Provide training and advice.

Consider ABPM or HBPM, in addition to clinic BP, for people with white-coat effect or masked hypertension.

BP targets

Reduce and maintain BP to the following targets:

Age <80 years:

- Clinic BP <140/90 mmHg
- ABPM/HBPM <135/85 mmHg

Age ≥80 years:

- Clinic BP <150/90 mmHg
- ABPM/HBPM <145/85 mmHg

Postural hypotension:

- Base target on standing BP

Frailty or multimorbidity:

- Use clinical judgement

[1] For women considering pregnancy or who are pregnant or breastfeeding, see NICE's guideline on hypertension in pregnancy. For people with chronic kidney disease, see NICE's guideline on chronic kidney disease. For people with heart failure, see NICE's guideline on chronic heart failure.

[2] See MHRA drug safety updates on ACE inhibitors and angiotensin-II receptor antagonists: not for use in pregnancy, which states 'Use in women who are planning pregnancy should be avoided unless absolutely necessary, in which case the potential risks and benefits should be discussed', ACE inhibitors and angiotensin II receptor antagonists: use during breastfeeding and clarification: ACE inhibitors and angiotensin II receptor antagonists. See also NICE's guideline on hypertension in pregnancy.

[3] Consider an ARB, in preference to an ACE inhibitor in adults of African and Caribbean family origin.

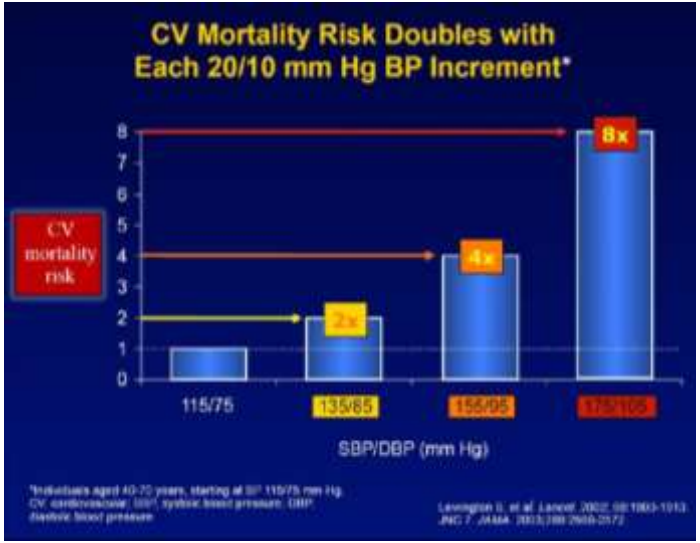
[4] At the time of publication (August 2019), not all preparations of spironolactone have a UK marketing authorisation for this indication.

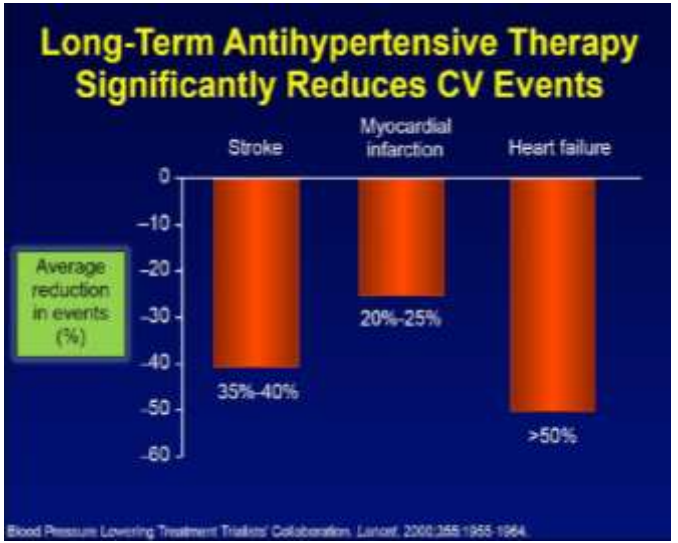
Abbreviations: ABPM, ambulatory blood pressure monitoring; ACEi, ACE inhibitor; ARB, angiotensin-II receptor blocker; BP, blood pressure; CCB, calcium-channel blocker; HBPM, home blood pressure monitoring.

BIHS British and Irish Hypertension Society

This visual summary builds on and updates previous work on treatment published by the BIHS (formerly BHS)

Reducing BP, reduces CVD events





Key Messages

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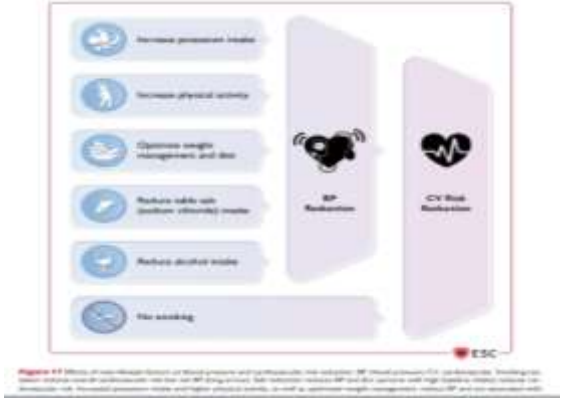
- Identify high BP
  - BP checks
  - Digital searches (CDRC) and IT system support to prioritise higher risk CVD patients
- Treat high BP
- Optimise medications
- Make Every Contact Count
  - Lifestyle / medication adherence
- Communication of CVD messages across multiple sectors and professionals



Public Health England: Tackling high blood pressure 2018
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/672554/Tackling_high_blood_pressure_an_update.pdf

Resources

NHS
Northumbria Healthcare
NHS Foundation Trust

British Heart Foundation

HEART UK
THE CHOLESTEROL CHARITY

CPPE
CENTRE FOR PHARMACY POSTGRADUATE EDUCATION

i2i
INSPIRING GREATNESS
EMPOWERING EVERYONE

Specialist Pharmacy Service

ROYAL PHARMACEUTICAL SOCIETY

Genomics Education Programme

Health Innovation
North East and North Cumbria

Next steps

How do you monitor?

We would love to hear the methods you use to monitor your hypertension patients.

This will help us to identify if any PCNs / practices require support in this area, or identify areas of good practice to share

Please follow this link or scan the QR code to complete a short questionnaire

Many thanks

How can HI NENC support?

Dedicated blood pressure optimisation page on the HI NENC website with numerous resources

HI NENC will support Primary Care Networks (PCNs) to identify underdiagnosed hypertension, ensuring patient treatment is optimised to NICE recommendations to reduce the number of CVD events.

Remote monitoring resources

Remote monitoring for primary care clinicians

Two practices developed pathways for hypertension, taking different approaches and using different systems:

Increasing uptake of annual Hypertension reviews SOP (Saville practice)

Blood Pressure Remote Monitoring using BP@HOME SOP (St Albans)

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