YORKSHIRE & HUMBER
ACADEMIC HEALTH SCIENCE NETWORK

National Blood Pressure Optimisation Programme

April 2022 to
March 2023

Part of
The AHSN Network

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Cardiovascular Disease: the impact

CVD is a leading cause of premature mortality & morbidity in UK

In the UK 27% of all deaths are due to CVD – that's one death every 3 minutes

More than 100,000 hospital admissions in the UK are due to heart attacks – that's one admission every 5 minutes

Stroke is the fourth biggest killer in the UK causing 36,000 deaths each year

Healthcare costs relating to CVD are estimated at £9 billion Overall CVD costs the UK economy ~£19 billion each year

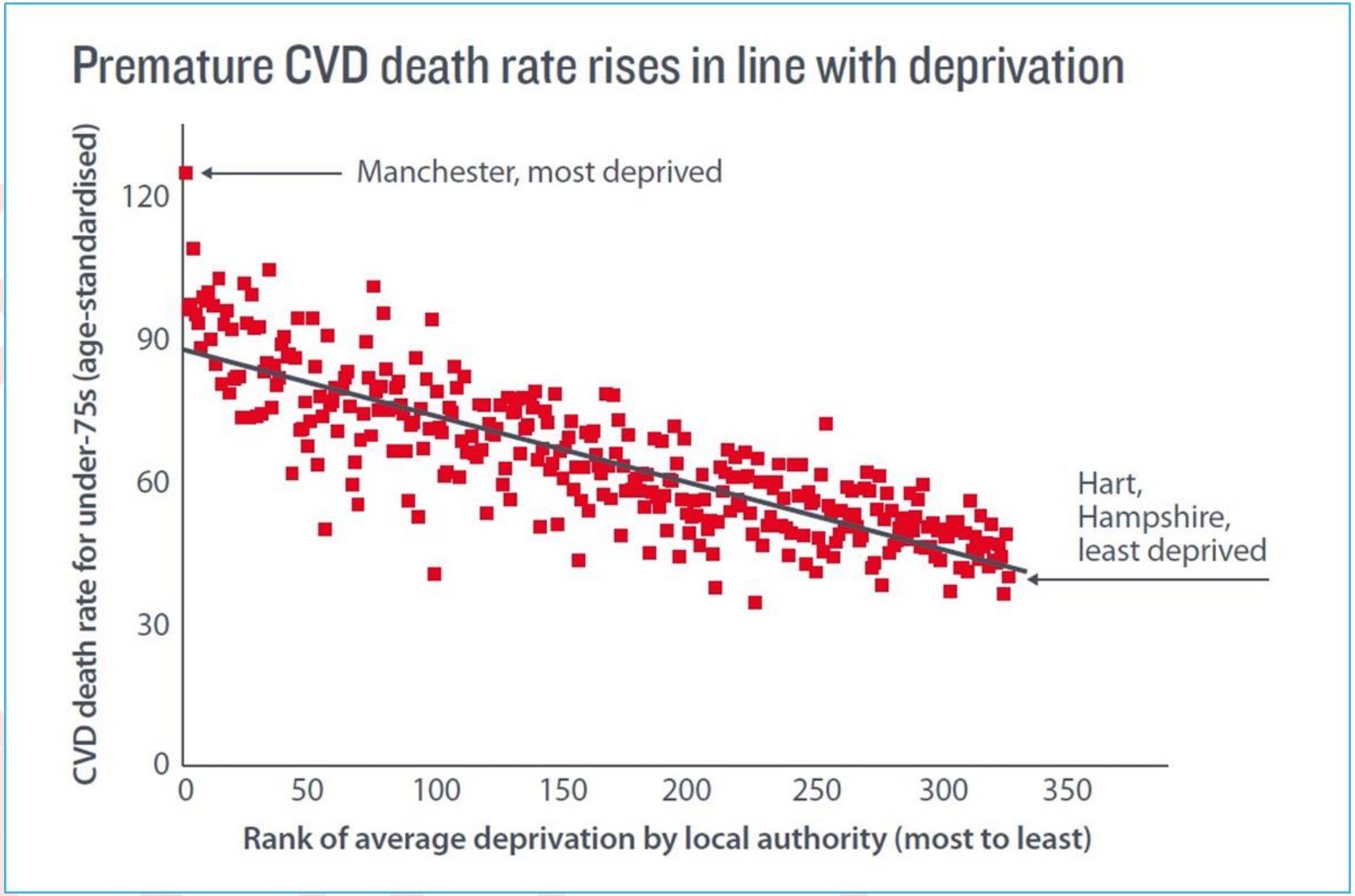
Hypertension, Lipid Management and CVD

- Hypertension and high cholesterol are **leading risk factors** for CVD
- They are **highly modifiable** – treatment substantially lowers the risk of CVD
- Despite this, both are **underdiagnosed and undertreated**

Hypertension & Lipid Management

- Around 30% of people with hypertension are **unaware they have it**
- Around 1/3 of those diagnosed with hypertension are not **treated to target**
- **Controlling cholesterol** is also important in preventing heart attacks in those with hypertension
- But most men aged over 55 and women 60 plus with hypertension are **not on statins**

CVD is also a major driver of health inequalities



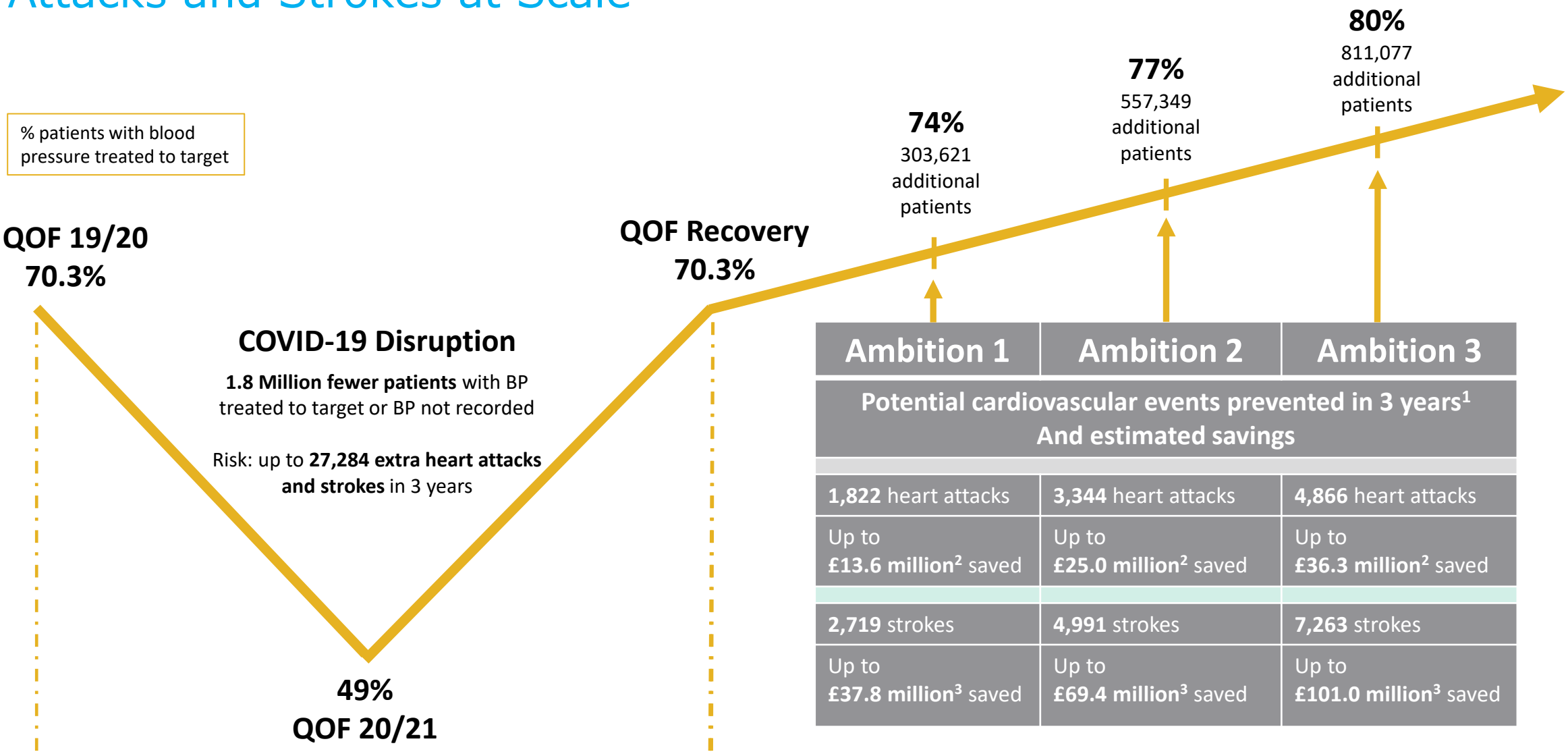
CVD accounts for a quarter of the life expectancy gap

Hypertension Primary Care Drivers

Drivers

- Post-pandemic opportunity to restore and transform proactive care for long-term conditions
- Maximising opportunities for remote monitoring and self-management when appropriate
- Engaging a wider healthcare professional workforce in CVD prevention
- Welcomed by GPs & primary care teams for improving care, releasing GP capacity, meeting QOF, IIF and other targets

Size of the Prize – England BP Optimisation to Prevent Heart Attacks and Strokes at Scale



Ambition 1	Ambition 2	Ambition 3
Potential cardiovascular events prevented in 3 years[1] And estimated savings		
1,822 heart attacks	**3,344** heart attacks	**4,866** heart attacks
Up to **£13.6 million**[2] saved	Up to **£25.0 million**[2] saved	Up to **£36.3 million**[2] saved
2,719 strokes	**4,991** strokes	**7,263** strokes
Up to **£37.8 million**[3] saved	Up to **£69.4 million**[3] saved	Up to **£101.0 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.

National Blood Pressure Optimisation Programme

https://www.ahsnnetwork.com/blood-pressure-optimisation-programme

National Blood Pressure Optimisation Programme

Aim

To ensure people with hypertension are appropriately monitored and have their blood pressure and broader cardiovascular risk optimised to prevent heart attacks, strokes, and dementia at scale.

Objectives

- **To prioritise and optimise clinical care** using a structured approach to risk stratify patients using eg UCLPartners proactive care framework for hypertension
- **To reduce health inequalities** by targeting the 20% most deprived populations and other local priority groups (Core20PLUS5)
- To **increase detection of patients** through case finding interventions.

Framework for Hypertension Stratification and Management

UCLPartners

PRIORITY ONE:
Clinic BP ≥ 180/120mmHg**

PRIORITY TWO:
- Clinic BP ≥ 160/100mmHg**
- Clinic BP ≥ 140/90mmHg** if BAME AND relevant co-morbidity/risk factor*
- No BP reading in 18 months

PRIORITY THREE:
Clinic BP ≥140/90mmHg**

PRIORITY FOUR:

Under 80 years
Clinic BP < 140/90mmHg**

80 years and over
Clinic BP < 150/90mmHg**

Ask patient for up-to-date home BP if available: adjust priority group if needed (as above)

Review by Prescribing Clinician

Monitor
- Investigations, as needed: Renal, lipids, ACR, ECG
- If no pre-existing CVD - assess QRisk score and consider lipid lowering therapy if >10% and not on statin

Review medication:
- Identify and address adherence issues – refer to practice pharmacist if additional support required
- Optimise medications, in line with NICE guidance (see slide 8)

Seek specialist advice
- If BP uncontrolled on four antihypertensives and no adherence issues identified
- Multiple drug intolerances
- Hypertension in young person requiring investigation of secondary causes

Advise
- When to check BP and submit readings (e.g, monthly until controlled, then every 3 months)
- When to seek help based on BP readings

Book follow up and code

Review by HCA or other staff role

Support for self management and behaviour change
- Check BP taking technique
- Check if existing CVD or QRisk >10% and not on statin (refer to prescribing clinician)
- Share resources to help understanding of high blood pressure, CVD risk and treatment
- CVD prevention brief interventions – diet / exercise / smoking / weight / alcohol
- Signpost tools and resources

Review by HCA or other staff role

Self management and behaviour change support
- Check BP taking technique
- Share resources to help understanding of high blood pressure, CVD risk and treatment
- CVD prevention brief interventions – diet / exercise / smoking / weight / alcohol
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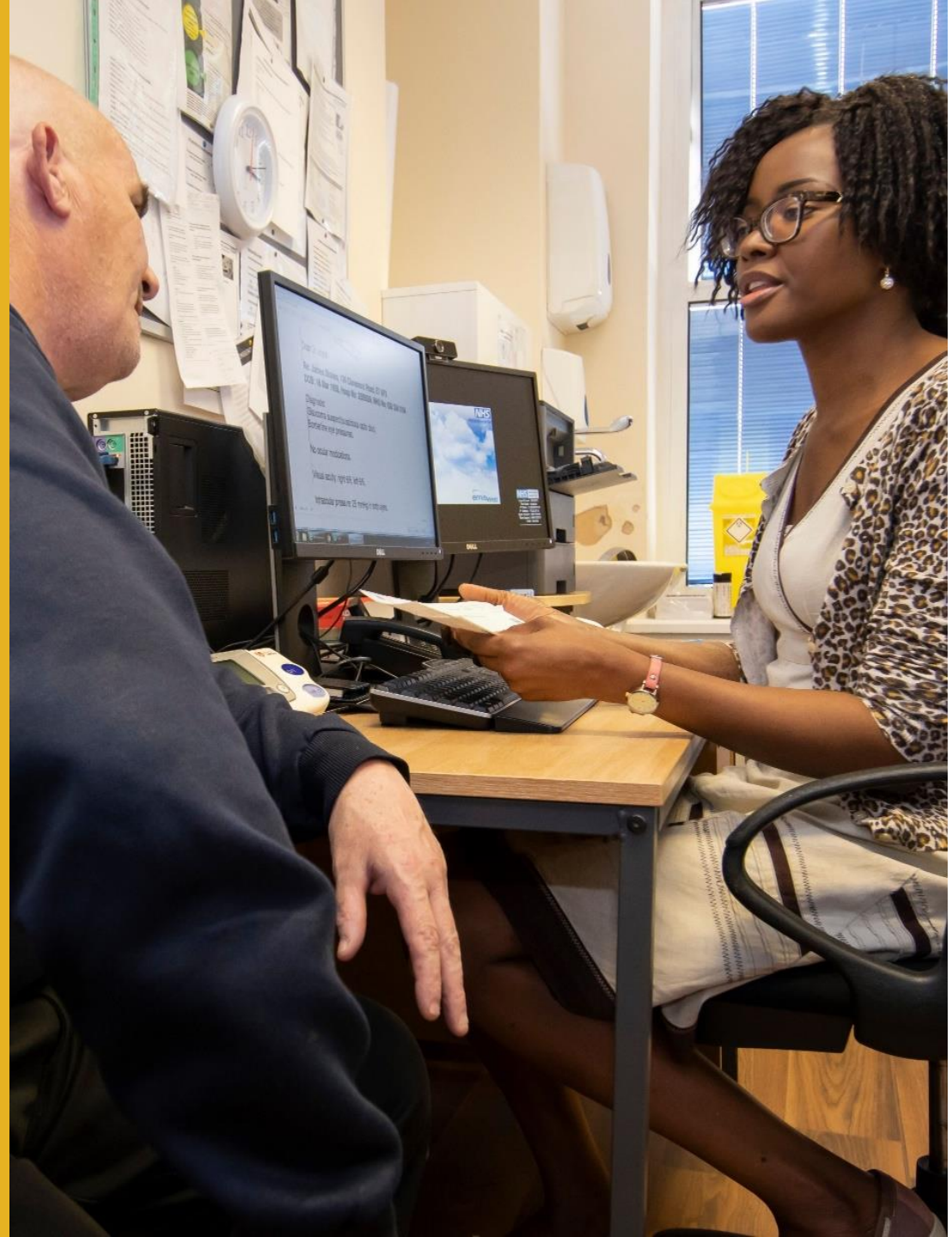
Medication:
- Check if any issues / concerns regarding medicines – refer to practice pharmacist for meds review / adherence support, if needed
- Confirm supply / delivery

Advise
- When to submit BP readings (e.g. every 3 months)
- When to seek help based on BP readings

Referral
- Refer to GP if any red flags identified
- **If existing CVD or QRIsk > 10% and no statin – refer to prescribing clinician**

Recall and code

* / ** see slide 9



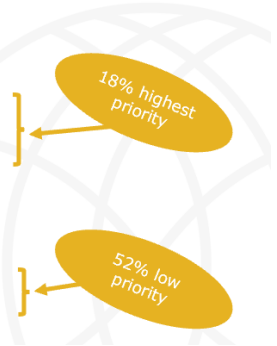
Example of impact

Optimising blood pressure in the highest risk patients in the London borough of Lambeth would prevent up to **71 heart attacks** and/or **106 strokes**, in the population of 446,000, over five years.

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%

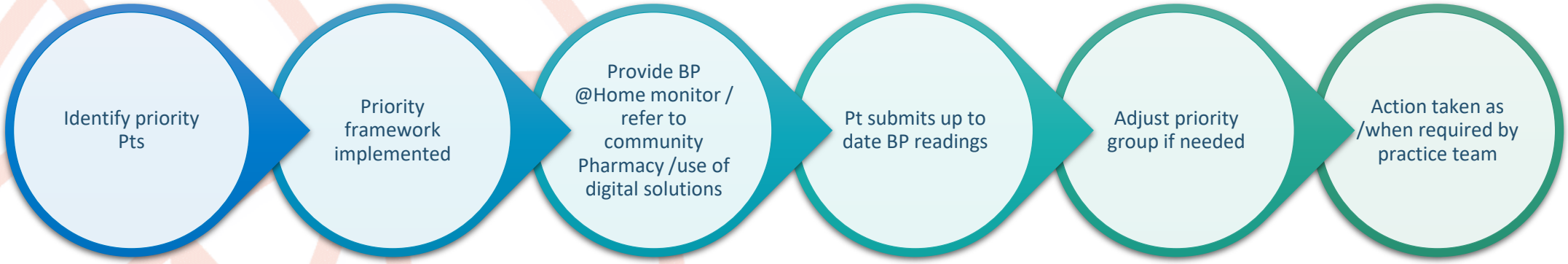


The link between BPO and BP@Home

BP @Home

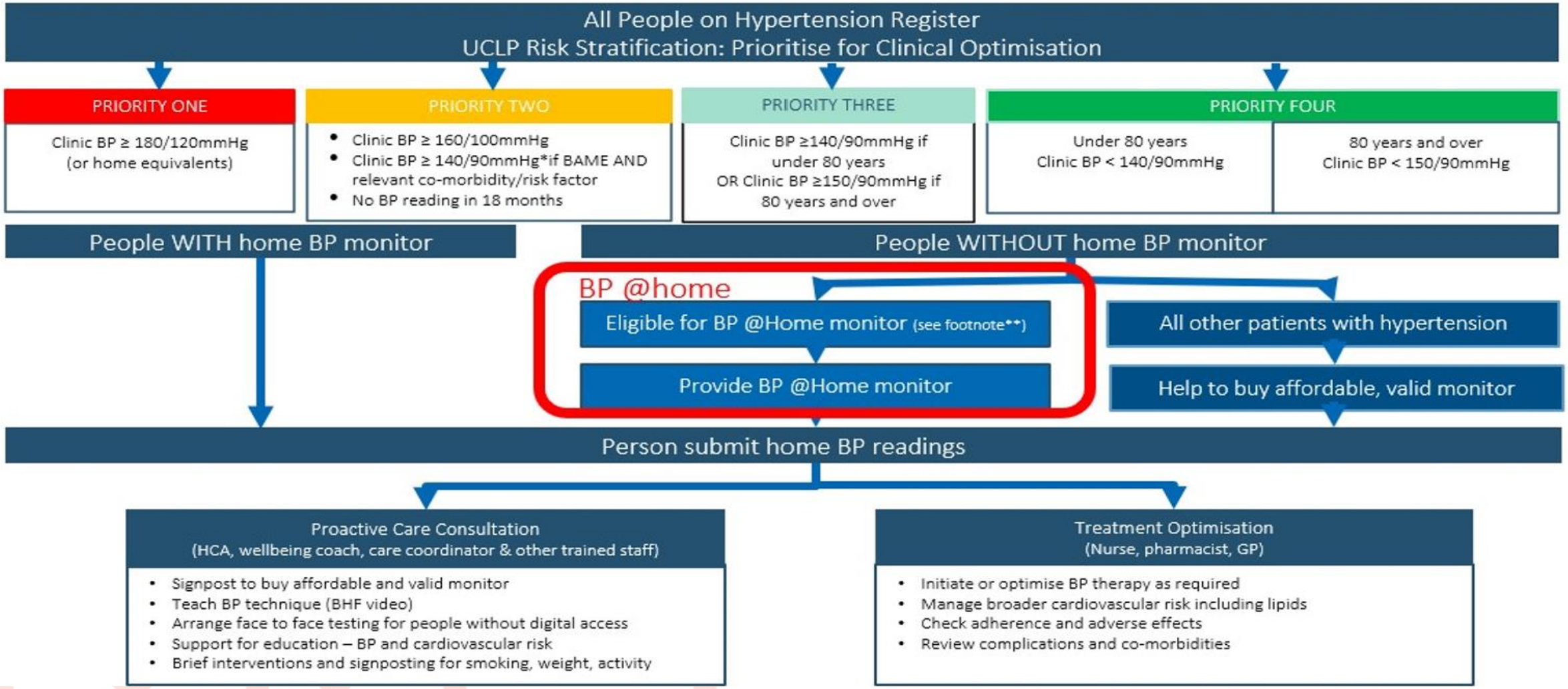
Provide BP @Home monitor → Pt submits home BP readings → Action taken as /when required from the practice team

BPO (Builds on BP @Home)



Link to BP @Home

BP @Home: supporting remote monitoring



Support for implementation

Role of the AHSNs

To support Primary Care to:

- **Risk stratify** all people with hypertension
- **Prioritise** those at highest risk
- **Optimise** blood pressure, cholesterol and broader cardiovascular risk management
- **Systematically support** education, self-management and behaviour change
- **Case-find** people with undiagnosed hypertension
- **Develop plan** to scale implementation of hypertension Proactive Care Framework

AHSN resources

Resources to support the implementation are available on NHS Futures and https://uclpartners.com/proactive-care/

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