The AHSN Network

NHS

Blood Pressure Optimisation Programme

Impact Report

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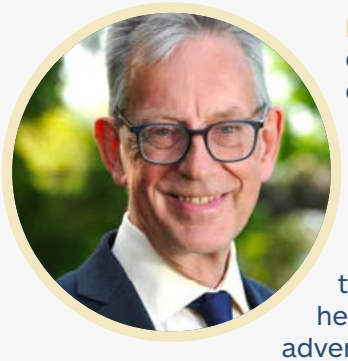
> ***"If we transform care to optimise blood pressure and lipid management at scale, we will prevent huge numbers of heart attacks and stroke"***
>
> Dr Matt Kearney

Foreword: Programme ambitions

An AHSN Network collective focus: cardiovascular disease prevention



Professor Gary Ford
Chair of the AHSN Network and Chief Executive of Oxford AHSN

The AHSN Network has an extensive history in working to tackle the major cardiovascular risk conditions that if untreated can lead to heart attacks, strokes and other adverse cardiovascular events. Since 2015, all 15 AHSNs have supported work on the detection and anticoagulation of atrial fibrillation (AF) leading to the avoidance of over 11,000 strokes.

Subsequently we have coordinated work improving lipid lowering management and improving the detection of familial hypercholesterolemia (FH). People are now receiving more intensive cholesterol lowering therapy including innovative drugs in some cases, to reduce their risk of developing heart attacks or stroke.

However, the pandemic had an adverse impact on the detection and management of cardiovascular disease (CVD) risk factors including hypertension. In June 2022, nearly 2 million fewer people with hypertension were recorded as being treated to target compared with the previous year (Quality and Outcomes Framework 20/21). This is why NHS England commissioned the AHSN Network to deliver this new national Blood Pressure Optimisation (BPO) programme building on our CVD portfolio of work to tackle this pressing health need.

> **"I extend my congratulations and thanks to all my colleagues from across the Network"**

It demonstrates our collective impact in delivering on our ambition to transform as many lives as possible through the rapid uptake of high value innovations. I extend my congratulations and thanks to all my colleagues from across the Network for their unwavering commitment to ensuring more patients benefit faster from innovation and service improvements that we support the health system to adopt.

Gary Ford

Professor Gary Ford
Chair of the AHSN Network and Chief Executive of Oxford AHSN

In June 2022, nearly **2 million fewer people** with hypertension were recorded as being treated to target compared with the previous year.

Foreword: Programme ambitions

Doing things differently to transform management of high blood pressure

Dr Matt Kearney
GP and Executive Clinical Director, Cardiovascular Health, UCLPartners

I am delighted to welcome you to this report showcasing the collective impact the AHSN Network has had in delivering the national Blood Pressure Optimisation (BPO) programme over the last 12 months.

Cardiovascular disease (CVD) causes a quarter of all deaths in the UK and is a major driver of health inequalities. In addition to lifestyle risk factors, leading causes of CVD are high blood pressure and high cholesterol. However, evidence shows that there are high levels of under diagnosis and suboptimal treatment in these conditions **(The Kings Fund)**.

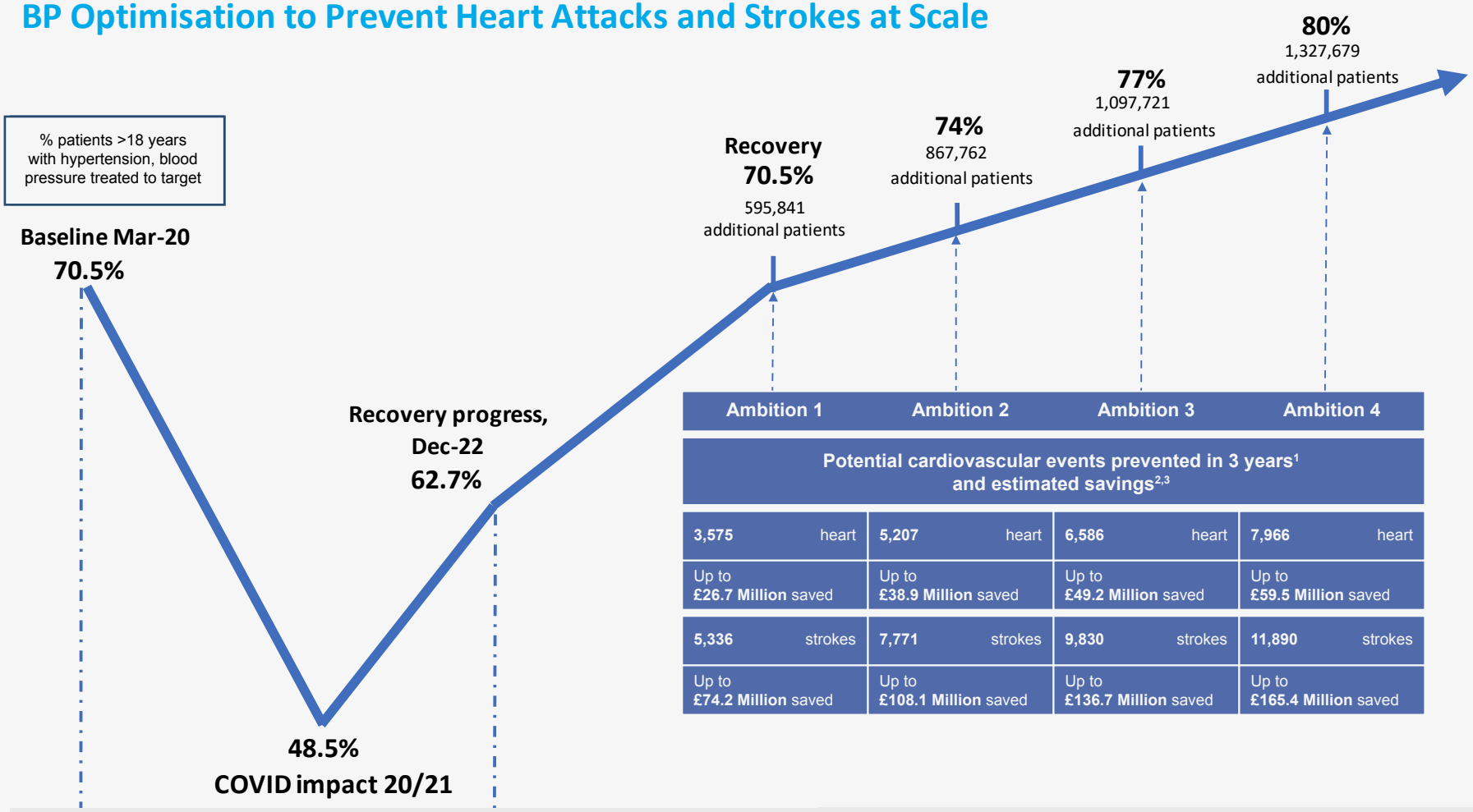
There is also clear evidence that optimising treatment for blood pressure and cholesterol can prevent cardiovascular events: one heart attack is prevented over five years for every 100 patients with high blood pressure treated with antihypertensives and one stroke for every 67 patients. And for every 100 patients with pre-existing CVD who are treated with a statin, 10 heart attacks or strokes will be prevented. UCLPartners' **Size of the Prize** analysis highlights the number of heart attacks and strokes that would be prevented across England if BPO rates recovered to pre-pandemic levels or achieved ambition levels beyond this.

> **"One heart attack is prevented for every 100 patients with high blood pressure treated with antihypertensives and one stroke for every 67 patients."**

However, it is critical to acknowledge that improving the management of the high-risk conditions like blood pressure and cholesterol is a 'wicked issue' that has progressed little over several decades. Optimising treatment in these conditions is difficult in real-world primary care where most people are asymptomatic and where multimorbidity, complexity and time pressure are commonplace in GP consultations. Reversing the historical challenge of under diagnosis and under treatment requires transformation. NHS England (NHSX) commissioned the AHSN Network to deliver a national BPO programme to address this challenge by supporting primary care to do things differently at scale.

There is also clear evidence that **optimising treatment for blood pressure** and cholesterol can prevent cardiovascular events

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



Ambition 1	Ambition 2	Ambition 3	Ambition 4
Potential cardiovascular events prevented in 3 years[1] and estimated savings[2,3]			
3,575 heart	**5,207** heart	**6,586** heart	**7,966** heart
Up to **£26.7 Million** saved	Up to **£38.9 Million** saved	Up to **£49.2 Million** saved	Up to **£59.5 Million** saved
5,336 strokes	**7,771** strokes	**9,830** strokes	**11,890** strokes
Up to **£74.2 Million** saved	Up to **£108.1 Million** saved	Up to **£136.7 Million** saved	Up to **£165.4 Million** 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: CVDPrevent. Briefing note: CVDPrevent online methodology annex v1 December 2022

Potential events calculated with NNT (theNNT.com). For blood pressure, anti-hypertensive medicines for five years to prevent death, heart attacks, and strokes: 1 in 100 for heart attack, 1 in 67 for stroke.

Fig 1.

To achieve this, the programme included a number of core elements:

Primary objective to implement the **UCLPartners Proactive Care Frameworks to optimise clinical care and self care in hypertension**

Secondary objective to support case finding initiatives

All with an explicit focus on tackling health inequalities

UCLPartners has provided national coordination and leadership of the BPO programme supporting all fifteen AHSNs to engage with all ICSs to deliver the programme objectives.

This coordination has included:

1) **Learning:** Facilitated-learning workshops
2) **Resources:** Development of implementation resources for the AHSN delivery teams and their primary care colleagues focused on the how and why of transformation
3) **Connections:** mentorship and nurturing of peer connections
4) **Clinical leadership:** to support programme delivery and regional engagement

Transformation in health care takes time. And in a period of unprecedented demand in primary care, with the pandemic backlog, prolonged 'winter' pressures, ongoing development of Primary Care Networks and system restructuring around Integrated Care Boards (ICBs), it is encouraging to see such progress over the last 12 months. AHSNs have made great strides in engaging primary care networks to adopt the UCLPartners Proactive Care Frameworks and begin to stratify their populations in order to optimise blood pressure and lipid management.

By March 2023, **a total of 607 PCNs** (just under half of all PCNs in England) were recorded as utilising the frameworks. This is good progress in laying foundations, but it is only a start. To continue the spread and adoption of this innovation and to embed it as routine will require continued focus and support from ICBs to help primary care deliver on the **Size of the Prize** – if we transform care to optimise blood pressure and lipid management at scale, we will prevent huge numbers of heart attacks and strokes. But this will only be achieved by supporting primary care to do things differently at scale.

A total of **607 PCNs** were recorded as utilising the frameworks

Matt Kearney

Dr Matt Kearney
GP and Executive Clinical Director, Cardiovascular Health, UCLPartners

Section 1

Emerging evidence of Impact

“The BPO programme has allowed systems to focus on this area and provide a solid framework to support them to optimise patients.”

BPO lead

Section 1: Emerging evidence of impact

Doing things differently to transform management of high blood pressure

The national Blood Pressure Optimisation (BPO) programme was operational for 12 months. Programme activity by the AHSNs commenced at the start of April 2022 with an early focus on engaging and building relationships with primary care colleagues. This report covers the national Blood Pressure Optimisation (BPO) programme activity for the 12 month period April 2022 – March 2023. Programme activity by the AHSNs commenced at the start of April 2022 with an early focus on engaging and building relationships with primary care colleagues.

The UCLPartners Proactive Care Frameworks include:

- **Search tools to stratify, prioritise and optimise the management of blood pressure and cholesterol in people with hypertension**
- **Resources to support the wider primary care workforce in delivering structured support for education, self-management and behaviour change**

UCLPartners

> *"I've learnt that persistence is key."*
>
> BPO Lead

Programme activity by the AHSNs commenced at the **start of April 2022**

Section 1: Emerging evidence of impact

Implementing the UCLPartners Proactive Care Frameworks as a tool for transformation

Running search tools is easy but transformation takes time

The search and stratification tool, a core part of the UCLPartners Proactive Care Frameworks, has been designed to be relatively easy for a PCN to access and run. However, the pathway to treatment optimisation requires multiple steps and considerations, including:

- The search tools need to be run and patient cohorts identified for prioritisation
- New pathways need to be developed that use pharmacists or nurses to optimise care
- Patients need to have a clinical review to assess and change or titrate treatment – this may require several appointments
- Staff such as health care assistants need to offer structured support for education, self-management and behaviour change – and these staff may require additional support and training
- And if hard-pressed teams across a PCN are to deliver this transformation, they need structured implementation support to make it happen

> ***"The BPO programme has allowed systems to focus on this area and provide a solid framework to support them to optimise patients."***
>
> BPO lead

Transformation in primary care is complex and takes time but is essential if improvement is to be sustained. During the year the AHSNs have used a variety of tools and approaches to build on the early engagement activities and embed the programme locally.

Approaches taken included meeting clinical and operational leaders, setting out the case for change and articulating the support offer, joining regional meetings as well as approaching practices and PCNs directly. **Different AHSN approaches can be viewed here.**

CVD prevention is a national priority and high blood pressure has a huge population impact: both factors have helped generate engagement with new stakeholders across primary care.

> ***"Engagement and implementation takes time, it's so hard to quantify quick wins at this stage as we are still realising benefits."***
>
> BPO lead

Feedback from both AHSN BPO managers and primary care colleagues has been positive as to the value the UCLPartners Proactive Care Frameworks offer:

> *"All very useful, straightforward, fail-safe system that definitely has a positive impact on patient care and clinical outcomes.*
>
> *Achieving hypertension targets for patients is a huge task, especially with such large populations of hypertensive patients. Using the Proactive Care Framework and tailoring it for our needs has helped us improve the quality of care given to hypertensive patients and provided a structured approach to care. We have already seen a massive improvement in hypertensive control."*

Mr Nasar Aslam
Pharmacist Independent Prescriber, Broadway Health Centre, West Birmingham CCG Vaccination Lead

> *"The Frameworks speak for themselves- they enable primary care to do things differently by providing the 'how's' and the 'what's' we know need to change. They are useful tools that support practices to adopt more efficient ways to delivering high quality personalised and proactive patient care."*

Jess Lucas
Long Term Condition Programme Manager, Leicester, Leicestershire and Rutland Integrated Care Board

> *"The greatest achievement for me has been widespread engagement and the making of hypertension as an ICS priority"*
>
> BPO lead

Section 1: Emerging evidence of impact

Adoption and Spread of the UCLPartners Proactive Care Frameworks

Uptake data shows the programme has been well received by primary care colleagues and implementation of the approach has steadily increased during the year. There are now 607 PCNs recorded as implementing the Frameworks.

The graph on the right shows the adoption trend over the year. In each quarter, greater numbers of PCNs have moved from knowledge and interest into implementation and adoption. In addition, the UCLPartners search and stratification tools have been downloaded more than 16,500 times as well as being made available to several thousand practices via Ardens (Clinical Decision Support Tool for SystmOne & EMIS Web).

This indicates that the Hypertension Framework may be in substantial use across the country outside of the BPO programme. It is feasible that many practices/ PCNs not recognised as adopters have nevertheless prioritised BP optimisation.

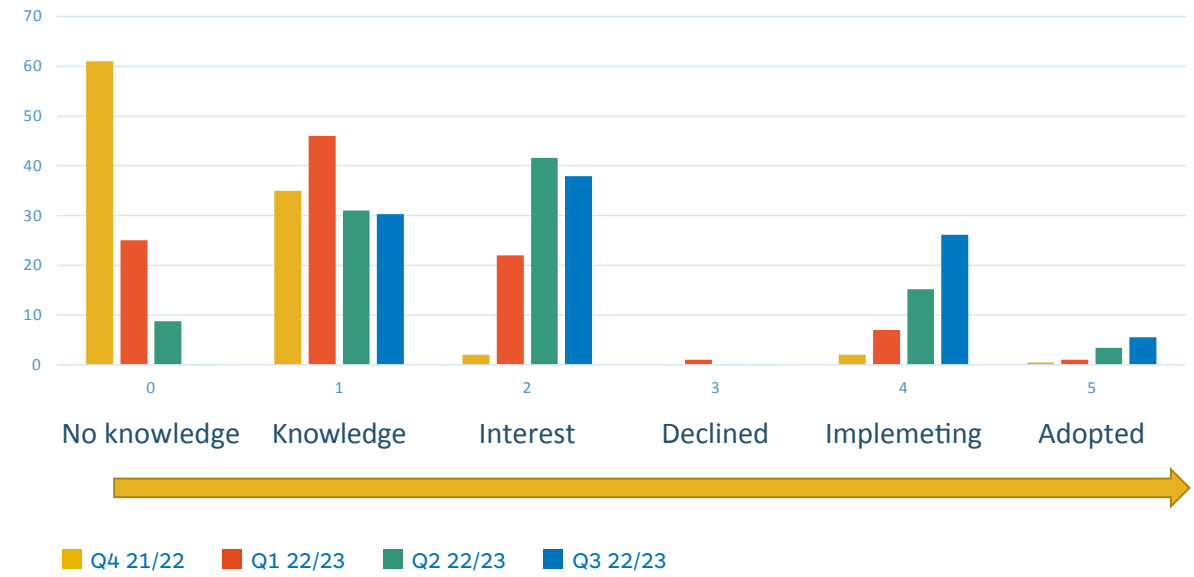


Fig 2.

Search and stratification tools have been downloaded more than 16,500 times

Adoption of the BPO programme in PCNs

Map shows the increase in PCNs adopting the UCLPartners Proactive Care Framework [or similar approach] for hypertension as represented by orange dots.

Q4 21/22 | **Q1 22/23** | **Q2 22/23** | **Q3 22/23** | **Q4 22/23**

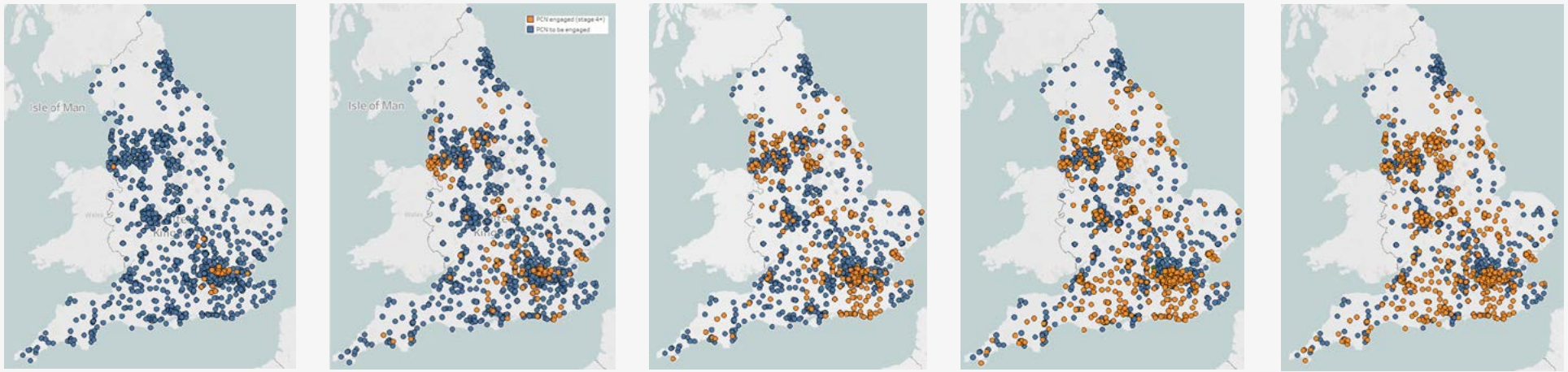


Fig 3.

Orange circles = PCNs implementing
Blue circles = PCNs yet to implement

Section 1: Emerging evidence of impact

How has the BPO programme impacted blood pressure optimisation rates?

BPO rates increased between March 22 and Sept 22 by 2.7%

The BPO programme was primarily focused on building a foundation to enable transformation; gradually recruiting PCNs, supporting teams and revising clinical pathways. It was not expected that this would lead to significant change in BPO rates nationally in this timeframe. However, across England overall, BPO rates increased between March 2022 and December 2022 by 2.7% (CVDPrevent). Several factors, other than the BPO programme, may have influenced this including:

- **The focus on post-COVID recovery**
- **QOF targets**
- **Local improvement programmes focused on blood pressure**

However, there are encouraging early signs of the programme's potential impact.

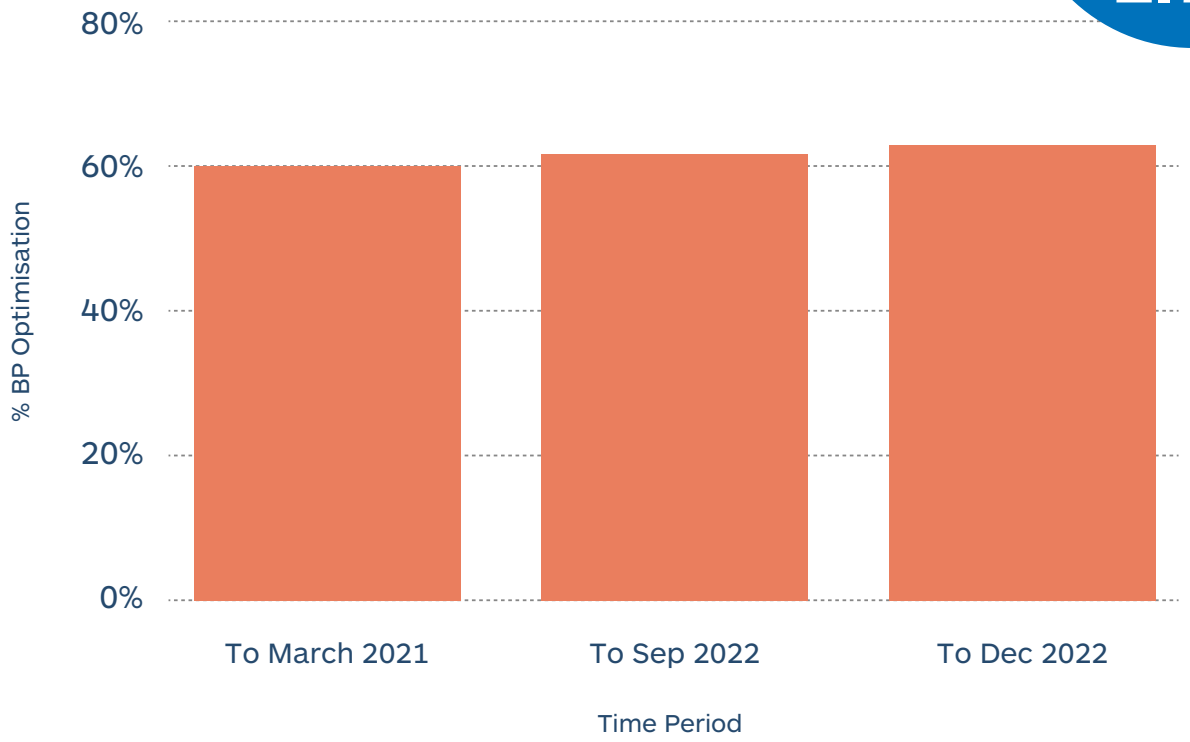


Fig 4.
Proportion of patients with BP optimised to appropriate age-related threshold. March 2022 to December 2022. CVDPrevent data, NHS England.

In the first 9 months of the programme, practices identified as adopters and receiving implementation support from their AHSNs achieved an 0.4% greater improvement in BP optimisation rates compared to all other practices.

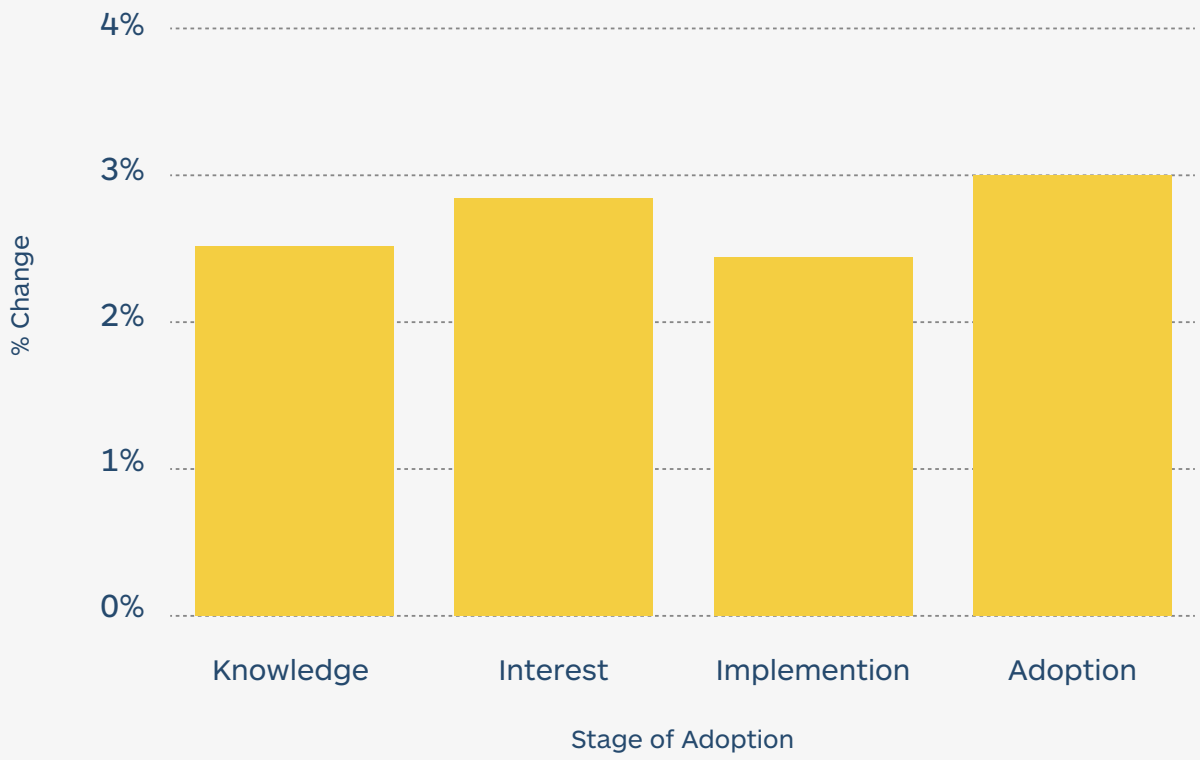


Fig 5. Proportion improvement in BP optimisation March 2022 to September 2022, by Stage of Adoption. CVDPrevent data, NHS England.

The UCLP search tool stratifies patients with hypertension into four Priority groups:

Group 1: Latest BP above 180/120 (or home equivalent)

Group 2: Latest BP above 160/110 or above 140/90 if BAME with cardiovascular co-morbidities

Group 3: Latest BP above 140/90 (or 150/90 if 80 plus years)

Group 4: Latest BP treated to target – below 140/90 (or 150/90 if 80 plus years)

There is a clear trend across the baseline performance quintiles with worst performing practices in March 2022 making greatest improvements by December 2022.

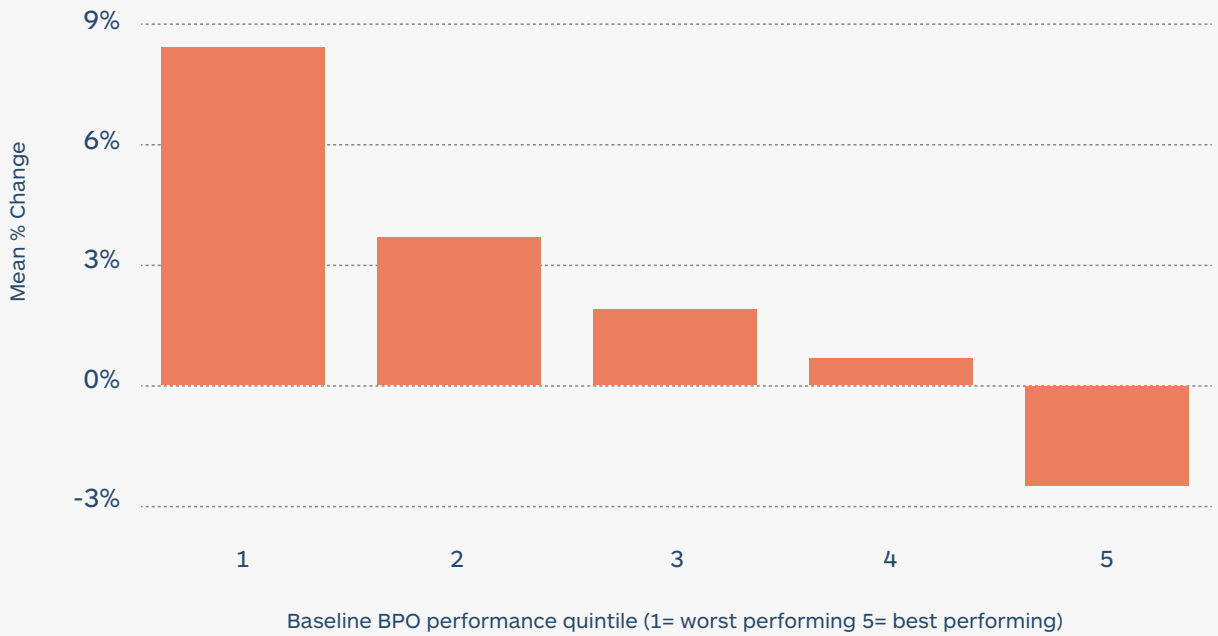


Fig 6. Proportion improvement in BP optimised March 2022 to December 2022, by baseline performance quintile.

CVDPrevent data, NHS England

Performance quintiles making greatest improvements by December 2022

In Leicester, Leicestershire and Rutland, 51% practices implemented the hypertension framework resulting in 8,231 additional patients treated to target

Healthy South Wirral PCN blood pressure project reduced priority group 1 by 50%

Havering North PCN implemented the hypertension framework leading to 8% reduction in priority group 1 and 1,000 additional patients treated to target

In multiple PCNs across south-east London, pharmacist led interventions resulted in substantial reductions in patient numbers in the high priority groups as blood pressure was optimised

Across Surrey Heartlands ICB, over 8,000 patients had their blood pressure control improved and more than 4,000 additional patients were treated to target

These examples illustrate significant impact in increasing the numbers of patients treated to target, together with a shift from high priority groups to lower Priority groups. Even with at-scale optimisation of blood pressure, it will take time to see a reduction of heart attacks and strokes.

However, there is well established and robust evidence that optimising blood pressure leads directly to a reduction in cardiovascular events.

Where practices and PCNs either:

- Record and maintain an increase in numbers of patients treated to target
- See a shift in patient numbers from higher to lower Priority groups

This is as a robust predictor of population health impact.

To understand more about the impact and work that has been undertaken, you can read all AHSN individual case studies **here**.

"Both, the collaboration with our national community pharmacy BP check services and connecting primary care staff through additional training and resources to champion patient self-management – have been key to the success of the BPO programme. It has been positive to see this build upon our already successful BP@Home service and ultimately optimise care for patients which is the foundation of our broader NHS England CVD strategy."

Tim Cullinan
Deputy Director,
Digital Care Models,
NHS England

Section 1: Emerging evidence of impact

A focus on tackling health inequalities

> ***"The Proactive Care Framework is a great tool for our PCN Health Inequalities Leads as they work on the CVDPrevention element of our Core20PLUS5 approach to tackling health inequalities."***
>
> Dr Bola Owolabi, National Director for Health Inequalities, NHS England

Core20PLUS5 recognises that **optimising management** of blood pressure offers a high impact opportunity for reducing health inequalities. High blood pressure is a leading cause of CVD, which is a major driver of health inequalities, accounting for around 20% of the life expectancy gap between the most deprived and affluent populations. Developed by Unity Insights and disseminated by UCLPartners, AHSNs were provided with data to identify practices serving the 20% most deprived populations and the 20% of practices with the lowest BP optimisation rates.

AHSNs reported the data helped them take a focussed approach to activities in some of their most deprived local communities and enabled constructive conversations with primary care colleagues about those populations that experience health inequalities.

During the year, each AHSN undertook a health inequality impact assessment to further understand the local population demographics and features that might affect how a BPO programme could be received in communities. The UCLPartners programme team offered public and patient engagement training sessions to support with community facilitation on behalf of all 15 AHSNs in partnership with Siân Rees, Director Community Involvement and Workforce Innovation, at Oxford AHSN plus the national lipids programme.

Many AHSNs offered bespoke support to PCNs to tackle inequalities.

For example: West of England AHSN case study can be found **here**.

CVD accounts for a fifth of the life expectancy gap between most deprived and most affluent

High blood pressure is a leading cause of CVD

Section 1: Emerging evidence of impact

Case finding

Case finding new diagnoses of hypertension was a secondary objective of the programme (as outlined in the beginning of this report). Substantial numbers of people with high blood pressure are undiagnosed and this is a focus of activity in many PCNs. The national support included briefing sessions with the national community pharmacy team and showcasing different approaches via the "A conversation with series..." – a virtual series set up by UCLPartners to share best practice.

All AHSNs have supported initiatives around case finding with several examples of direct support given to community case finding work.

For example:

- **Supporting PCNs with community-held engagement events**
- **Working with public health teams on BP and AF checks in local sports and leisure settings**

For example: Kent Surrey Sussex case study can be found **here** and

North East North Cumbria AHSN case study can be found **here**.

> ***"The positive impact of the BPO programme has been felt on wider complementary programmes. We have seen an increase in the local use of the community pharmacy BP checks service and it has supported PCNs identify patients with previously undiagnosed high blood pressure through case finding interventions."***

Dr Yeyenta Osasu
National Pharmacy Integration Lead, NHS England

All AHSNs have supported initiatives around case finding with **several examples of direct support** given to community case finding work.

Section 1: Emerging evidence of impact

Case studies from across the AHSN Network

To highlight the rich variety of BPO programme delivery across the country, case studies from each AHSN region have been collated. The case studies demonstrate how AHSNs have worked with their local system partners to deliver impactful projects, resulting in workforce and patient benefits.

Click on the AHSN logo to read their case study and follow up via the contact details contained in each for more information.

Section 2

How has the programme been received by key partners and frontline staff?

> ***"The programme has allowed systems to focus on BPO and provide a solid framework to support them to optimise patients."***
>
> BPO lead

Section 3: How has the programme been received by key partners including frontline staff?

Feedback received from stakeholders demonstrated how warmly the national BPO programme has been received. Primary care teams recognise the value of the UCLPartners Proactive Care Frameworks as a practical resource developed by primary care for primary care. System partners have welcomed the focused support that have brought hypertension management and case finding with a focus on reducing health inequalities into the fore. They have also embraced and adapted the programme as a key part of their CVD prevention strategies.

The feedback received can be themed into two key areas:

1) The BPO programme has been a driver for change:

The BPO programme has been a catalyst to bringing regional and national stakeholders to the table to focus on improving hypertension management. The AHSNs have harnessed the momentum of the 12-month programme to convene constructive conversations and facilitate partnership working that resulted in all 42 ICBs engaging in the programme and committing to the programme objectives.

> ***"The national BPO programme has been key in supporting South West London ICB in identifying and targeting areas where health inequalities are most prevalent and have the greatest opportunity for improvements for those with CVD."***

Alex Lang
Head of Transformation, Long Term Conditions, South West London ICB

> ***"Increasing the detection and management of risk factors for cardiovascular disease is key to improving healthy life expectancy and reducing avoidable death and disability.***
>
> ***The national blood pressure optimisation programme, delivered by the AHSN Network, provides primary care teams with the tools and frameworks to support them to deliver targeted interventions that can benefit those at highest risk of CVD."***

Helen Williams
National Speciality Advisor for CVD Prevention, NHS England

> *At the British Heart Foundation, we know hypertension is associated with approximately 50% of heart attacks and strokes. It is fantastic to see the national BPO programme have a clear focus on the management of hypertension – helping people to live better, longer lives.*

Will King
Health and Care Lead, British Heart Foundation

> *The BPO programme has supported the ICBs, encouraging vascular review processes and improving lifestyle advice, and optimising workforce capacity.*

BPO lead

Laura Semple
Director of National Programmes, AHSN Network

The UCLPartners Proactive Care Frameworks are designed to be adapted locally which meant the AHSNs were able to quickly develop localised offers for their regions that created opportunities for collaboration and partnership working.

Hear from Laura Semple, Director of National Programmes, AHSN Network as she outlines how the BPO programme has linked with the Lipid Management and Familial Hypercholesterolemia national programme to create a launch pad for ongoing CVD prevention innovation.

> *This framework has allowed for further discussion around newer treatments available within national guidelines.*

Primary care colleague

2) The Proactive Care Frameworks enable primary care to improve BP management when demand is high and resources are limited and provides workforce development opportunities:

A key element of the UCLPartners Proactive Care Frameworks is that they enable primary care teams to stratify their patients, understand who needs optimisation, to prioritise safely and to manage capacity.

Patients have benefited from the implementation of the UCLPartners Proactive Care Frameworks due to the optimal use of the primary care workforce meaning the right person sees the right patient at the right time. In addition, the systematic nature of the UCLPartners Proactive Care Frameworks leads to a better understanding of patient needs and quality of the care provided.

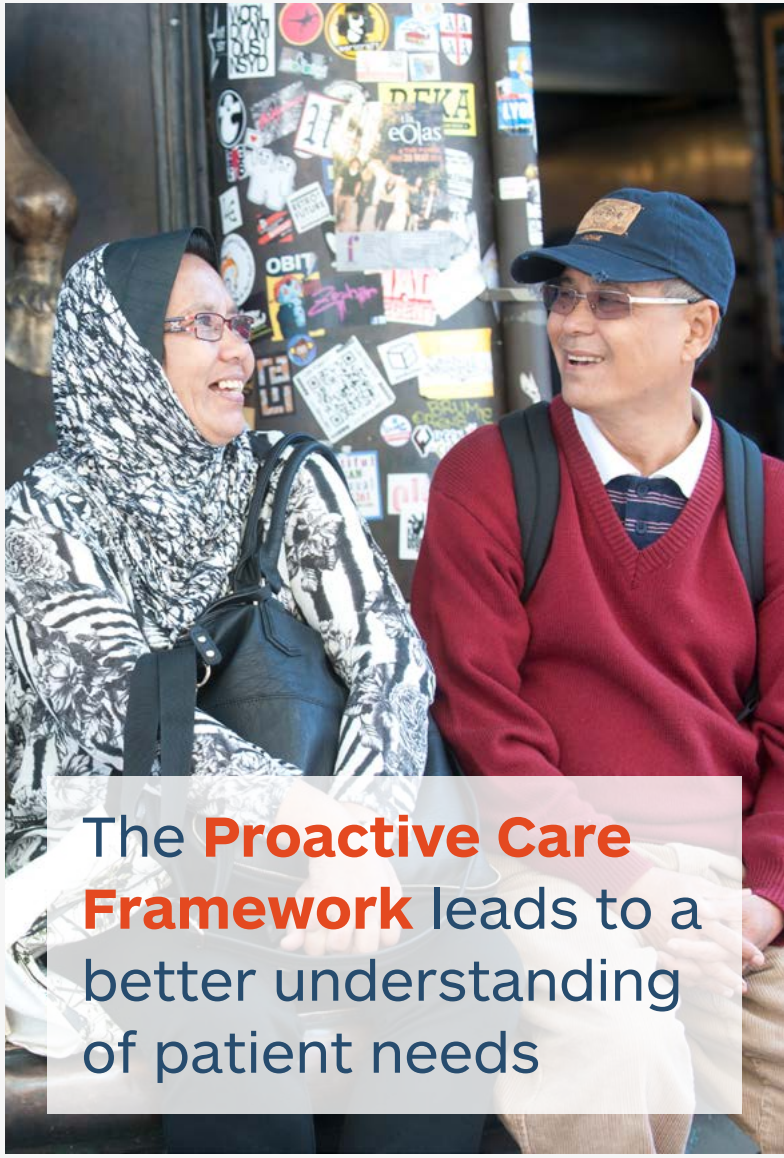
> ***"[The Proactive Care Framework] ...Has made the list of over 1,000 patients on the hypertension register easier to prioritise."***
>
> Primary care colleague

Hear from Carole Bayliss, Project Manager at Health Innovation Manchester, sharing her experiences of living with hypertension and the value she sees in the UCLPartners Proactive Care Frameworks.

Watch Carole's video here

Carole Bayliss
Project Manager at Health Innovation Manchester

> ***"There have been times when we've been extremely short-staffed and risk stratification has helped."***
>
> Primary care colleague



The **Proactive Care Framework** leads to a better understanding of patient needs

Implementation of the UCLPartners Proactive Care Frameworks takes time and commitment from the primary care team. To work in this new way, colleagues have needed access to appropriate support to understand the resources, how to implement them and in some cases, clinical or behavioural skills training. As a result of this support, practices implementing the UCLPartners Proactive Care Frameworks have a greater awareness of their teams' skillsets, can utilise the wider workforce more efficiently and are able to stay up-to-date with guidance for clinical care.

> ***"The Proactive Care Frameworks, at the heart of the National Blood Pressure Optimisation Programme, have enabled primary care to do things differently; transforming how we manage patient care. This has only been possible through the support received from local AHSNs driving this work."***

Dr Jim Moore
President of the Primary Care Cardiovascular Society and GP

When asked, primary care teams told us their next steps are to:

Invest resource to embed the changes with a continued commitment to supporting workforce development

"To encourage all health care assistants and nursing staff to use the UCLPartners templates and educational resources."

Spread the use of the UCLPartners Proactive Care Frameworks and make the changes sustainable

"Support other practices in the PCN to work in this way."

Grow the work for the future

"Expand the work to include another long term conditions."

Section 3

How has the programme been delivered?

> ***"I have found the national Community of Practice and all the other learning and sharing events incredibly useful and I really valued having the chance to provide my input"***
>
> BPO lead

Section 3: How has the programme been delivered?

National approach

The national support package led by UCLPartners was structured to ensure effective delivery of the programme but also retained flexibility to respond to challenges and opportunities as they arose. Attention was paid to empowering all 15 AHSN delivery teams using the ethos **"ideas depend on people to move them"** (Scheuer, 2021).

1) Learning: Facilitation of learning workshops

The core elements of this support were the 6-weekly community of practice (CoP), the "A conversation with…" workshop series, plus ad-hoc workshops on appropriate and related topics e.g. community engagement and the Community Pharmacy BP Checks Service.

The **6-weekly CoP** was a friendly, safe place that AHSN teams could come together for peer support, to discuss topical challenges and, through facilitated structured activities, input into the programme design. Engagement rates were sustained, with the final community of practice in January 2023 was attended by 14 out of the 15 AHSNs, with 24 attendees. This commitment, as the programme entered its final quarter, demonstrates a marker of success.

> ***"I have worked on a number of national programmes and I have to say that the support from the UCLP team has been phenomenal and by far exceeded the support I have received for other programmes."***
>
> BPO lead

> ***"The Community of Practice & support provided has enabled us to learn from others, which we can then share with others, to support delivery in the region."***
>
> BPO lead

The support package was underpinned by a flexible approach to programme management and included:

1) **Learning: Facilitated-learning workshops**
2) **Resources: Development of implementation resources for AHSN delivery teams and their primary care colleagues**
3) **Connections: Mentorship and nurturing of peer connections**
4) **Clinical leadership: Supporting programme delivery and regional engagement**

> *"I have reaffirmed the importance of health inequalities in the work we do"*
>
> BPO lead

The **"A conversation with..." workshop series** facilitated by the national programme manager provided a confidential space to spotlight an AHSN's approach with a focus on practical implementation activities, their learning to date and any resources developed so that other delivery teams could 'pinch with pride' and reduce duplication of effort across the Network.

Conversation topics included:

- **The use of data to support clinical engagement**
- **Incorporation of the UCLPartners Proactive Care Frameworks into existing dashboards**
- **Development of patient surveys**
- **Approach to collection of metrics**
- **How to design and deliver workshops and communities of practice**

Thank you really good to hear about the work you are doing

👍 1

this is great!!!! Really interesting. Thanks so much for sharing

❤️ 5

The **community involvement and health inequalities educational series** provided AHSN teams with practical approaches to support community involvement that focused not on the 'why', but the 'how' of delivery. Content across five workshops included case studies, sharing of tools and techniques and meetingwith Wendy Burke, Director of Public Health North Tyneside. The educational series was well received by attendees as a space to learn and share enthusiasm for the work.

> *"Through this programme I have learnt, tried and tested different approaches and learning from other AHSNs and colleagues."*
>
> BPO lead

AHSNs shared their practical approaches and resources through the "A conversation with..." workshop series

> *"Really appreciate these sessions. You've managed to hit the right level of support."*
>
> BPO lead

Thanks for reconnecting us with our purpose

❤ 3 👍 2

Brilliant – thank you for your honesty and passion

❤ 2

MJ very helpfully shared these resources developed by KSS and BHF incl patient cards/surveys; thanks MJ and nice meeting you 🙂 https://improvement.kssahsn.net/our-work/heart/cvd-central/

❤ 1 👍 2

All 15 AHSNs were supported by the initiative with 35 different people attending the educational series.

Workshops showcasing complementary national programmes such as the NHS England Community Pharmacy BP Checks Service, NHS Health Checks and the national AHSN Lipid management and Familial Hypercholesterolemia programme were offered to promote partnership working. This collaborative leadership resulted in regional delivery being joined-up and initiatives such as case finding task and finish groups and hypertension collaboratives being established that will drive a sustainable delivery model for BPO.

2) Resource development – how and why

The programme benefited from having an already-established library of implementation resources as part of the UCLPartners Proactive Care Frameworks. These were iteratively added to throughout the year as needs arose.

For instance, a UCLPartners Proactive Care Framework implementation workbook and supporting **monthly webinar** for primary care teams across England has been developed to focus on the "how to" of implementation.

> *"The national team were very helpful in making sure we could connect the dots with other programmes at a local level."*
>
> BPO lead

This has had input from the 15 BPO leads and formed part of the sustainability model for the programme.

The Size of the Prize has been a particularly successful resource in making the case for focus on BP at an ICS level. AHSNs have been able to use it to engage ICBs and PCNs about the local impact potential.

Additionally, well received was the Financial Levers two-page summary of 22/23 incentives for CVD prevention activities developed with the national Lipid Management and Familial Hypercholesterolemia programme team. The summary introduced Quality and Outcomes Framework, the Primary Care Network Directed Enhanced Service, Investment and Impact Fund, listed the indicators related to CVD prevention improvement work and signposted to support from the AHSN Network.

These resources were developed by the national team and disseminated, with guidance for utilisation, to the BPO leads to bolster regional engagement and equip the programme leads with knowledge to enable primary care transformation.

Regionally developed resources

The multiple opportunities to bring AHSNs together and learn about each other's work meant that the national team could disseminate locally developed resources for others to benefit across England. For example, a database to analyse and present practice hypertension QOF data in accessible graphs and BPO implementation toolkits designed for ICB engagement.

Resources generated by the national and regional teams are also available on the NHSFutures workspace open to all health and care professionals interested in implementing the Proactive Care Frameworks.

3) Mentorship and nurturing of peer connections

The national team provided bespoke support for each AHSN, shaped to their needs. At all times the ethos of the team was to be approachable and responsive to questions and suggestions.

An example of this is the series of drop-in sessions that were delivered as part of the community involvement and health inequality initiative. BPO leads brought queries related to completing health inequality impact assessments to the sessions and benefited from the informal space to ask questions to experts and to learn from each other.

Mutually beneficial relationships were established between the AHSNs and the national team in quarterly 1:1s. The 30 minute meetings provided an opportunity for the national team to understand each AHSN's delivery trajectory, challenges and needs for support. These insights then informed the development of the national support package, ensuring that workshops and resources met specific needs to drive forwards programme delivery.

4) Clinical leadership

The BPO programme design and delivery was led by the UCLPartners national team, including clinicians with expertise in primary care and CVD prevention and in the implementation of the UCLPartners Proactive Care Frameworks. In addition, the UCLPartners' clinicians were available to support AHSN regional delivery where needed.

The **BPO roadshow** was the main vehicle for this regional support. The clinical leads presented at workshops led by AHSNs, ICBs and PCNs, focused on the why, what and how of the UCLPartners Proactive Care Frameworks. The content was regularly complemented by regional speakers and offers of support, ensuring ownership remained with the leading organisation, with UCLPartners' clinicians available to provide expert content and advice as needed.

The **BPO clinical leads network** was established to grow the capability of local clinical leadership to support the roll out of the BPO programme with a focus on sustainability and handing over to the system. The initiative comprised of workshops bringing together 'would be' BPO clinical leads from across the 15 AHSNs and highlighting common challenges and questions related to implementation of the UCLPartners Proactive Care Frameworks. The clinicians were equipped with the knowledge and confidence to support engagement and delivery in their AHSN regions.

The clinicians were equipped with the knowledge and confidence to support engagement and delivery in their AHSN regions

UCLPartners' clinical leads were **present and available** to respond to frontline challenges throughout the delivery of the programme. They regularly attended the learning workshops meaning BPO leads were provided with immediate feedback to clinically related challenges, preventing possible barriers to delivery or engagement.

The four elements of the support package were underpinned by a flexible collaborative approach to national programme management.

During the programme design phase, three task and finish groups were set up, with AHSN colleagues helping to navigate complex design challenges resulting in an effective runway for the programme launch. BPO leads were regularly consulted throughout the programme to input to delivery.

Throughout the year, the national team promoted ownership of the programme by AHSNs and the ICBs through various methods. For instance, by using clear communication of the three key population health management principles under pinning the programme:

1. **Risk stratification and prioritisation of people with hypertension**
2. **Optimisation of care**
3. **Use of the wider workforce**

Delivery teams were encouraged to retain these principles but to adapt the programme to meet local needs and to complement existing CVD prevention initiatives, resulting in multiple bespoke approaches nationally that retained standardised robust objectives. For instance, where local solutions existed the UCLPartners Proactive Care Frameworks were not positioned as an essential element of the programme.

When asked, the BPO leads identified these elements of the national team support as the most valuable:

- 6 weekly community of practice- for peer support, programme updates and inputting to programme design
- Connecting BPO leads to share learning and resources
- Financial Levers document and supporting explanation
- **Size of the Prize** highlighting the opportunity for financial savings and patient benefits per ICB
- Quarterly 1:1 x 30 minute meetings with the BPO leads for the national team to listen and learn

> ***"The flexibility from UCLPartners allowing us to incorporate their framework into our local approach gave us a 'running start' and enabled us to encourage spread far more quickly."***
>
> BPO lead

> ***"The BPO programme has consolidated the work that we already had underway with one ICB and provided us with the strategic influence to gain engagement within another."***
>
> BPO lead

Section 3: How has the programme been delivered?

Regional approaches

AHSNs have taken creative approaches to delivering the BPO programme objectives with their systems, which were to; implement the hypertension UCLPartners Proactive Care Framework, engage with case finding activities and focus on reducing health inequalities. AHSNs made best use of their limited resources to ensure they could plan, engage and deliver the programme in 12 months, with many leveraging additional resources to ensure successful delivery. The various approaches were enabled by flexible national programme management and regular opportunities to share learning and resources across the AHSN Network.

Common themes between delivery approaches were:

- Strategic engagement
- Building capability and momentum for changes to blood pressure management in primary care
- Healthcare inequality informed delivery
- Bespoke support

> ***"Working closely with local partners has been key."***
>
> BPO lead

> ***"This programme allowed us to start building a local coalition around hypertension proactive management"***
>
> BPO lead

The AHSN **case study map** provides a snapshot of each AHSN's approach to regional delivery.

Common elements of regional delivery approaches:

Strategic engagement – BPO leads invested time upfront to understand their local primary care CVD landscape and developed relationships with partners that resulted in invitations to join cardiac networks and ICB CVD programme boards, opening doors for collaboration and strategic alignment.

BPO leads led the development of hypertension case finding task and finish groups and worked closely with partners leading BP@Home, community pharmacy BP checks service and Public Health teams. Strategic engagement has also enabled sustainable programme delivery through incorporating the UCLPartners Proactive Care Frameworks into regionally available and endorsed CVD platforms and inclusion to local incentive schemes.

BPO lead top tip:

"Work closely with your CVD Clinical Network – it really helped that we have a good working relationship with them."

Building capability and momentum for changes to blood pressure management in primary care

A key part of the AHSN delivery plans was to address the need for workforce-support to enable the adoption of the UCLPartners Proactive Care Frameworks by growing capability and a momentum for change. This support was often offered directly to primary care teams by the AHSNs. The support took different forms across the AHSN Network and included a CVD fellowship programme, communities of practice (for ICB regions and specific primary care roles), the development of a medication pathway and free training opportunities such as motivational coaching and hypertension and lipid management.

Hear from Karen Verills, BPO Programme Manager, North East North Coast AHSN, describing their practical offer of support

Karen Verills
Project Manager (BPO),
North East North Coast AHSN

> ***"We have worked closely with the Training Hubs to support delivery – reaching a wider primary care audience than we might otherwise have, as they have excellent links within the area."***
>
> BPO lead

Healthcare inequality informed delivery

AHSN delivery plans incorporated an aspect aimed to reduce health inequalities related to deprivation or variation in hypertension treatment. These included funded pilots, targeted engagement plans and prioritisation of AHSN resources. These approaches were data-led and developed in collaboration with relevant stakeholders such as Public Health teams and ICBs. Supported by the national team, AHSNs completed healthcare inequality impact assessments to understand their local populations and areas of need.

Hear from Kate Mackay, CVD Programme Lead, North East North Cumbria AHSN, as she explains how the BPO programme has enabled them to focus AHSN activities on reducing healthcare inequalities.

Kate Mackay
CVD Manager Lead,
North East North Coast AHSN

BPO lead top tip:

"Focusing on workforce and how to manage their workload is the most crucial point and the main barrier"

Bespoke support

BPO leads tailored their programme delivery for each ICB, resulting in 42 bespoke approaches of support and many AHSNs flexed their approach and support for practices and PCNs. These tailored approaches included:

- **Facilitated practice and PCN sessions led by clinical and BPO leads**
- **The development of ICB specific kits that included nationally and regionally available resources and initiatives**
- **On the ground commitment to supporting community led case finding activities**
- **Analysis and presentation of data to articulate the opportunities for change**
- **Going with the willing whilst also identifying PCNs in areas of deprivation to offer targeted support**

> ***"It stimulated close collaborations with Public Health teams; it enhanced credibility; it stimulated focus."***
>
> BPO lead

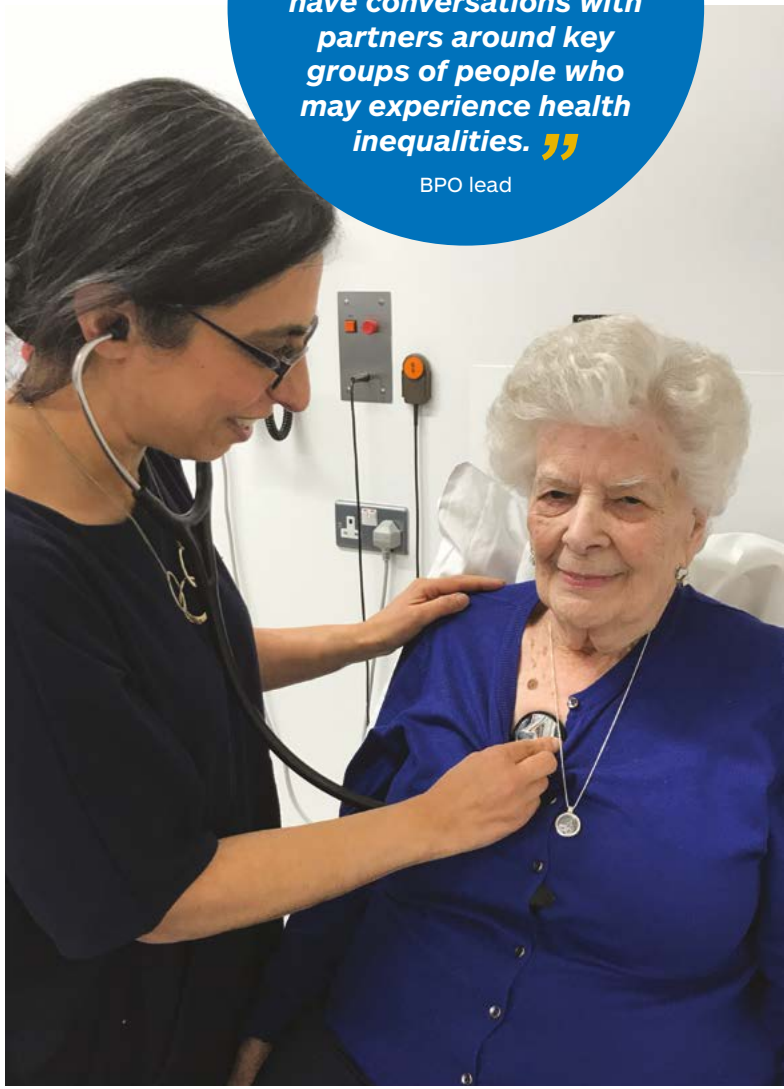
> ***"Our CVD prevention plans and ambitions have grown larger and gone faster due to the collaboration with our local AHSN on the national BPO programme. We would love BPO to remain an AHSN priority and for us to see what more we can achieve in the future with the AHSN network."***
>
> **Alex Lang**
> **Head of Transformation,**
> **Long Term Conditions,**
> **South West London ICB**

The wrap around offer from AHSNs to enable these bespoke offers of support included:

- **Project and event management**
- **Business development**
- **Evaluation**
- **Quality improvement coaching**
- **Communications and marketing**

Each individual BPO lead per AHSN was also supported by their wider AHSN team and areas of expertise, resulting in robust functional AHSN 'offers' to primary care to assist with hypertension management that were warmly received and appreciated.

> ***"It has helped us to focus activities in our most deprived areas and enabled us to have conversations with partners around key groups of people who may experience health inequalities."***
>
> BPO lead



Locally produced, nationally available resources to support hypertension optimisation

The focus for AHSNs was to develop resources that enabled regional delivery of the BPO programme, however some of the assets developed during the 12 months are now available nationally and form part of the legacy of this programme Including:

- In April 2022, the Health Innovation Network (HIN) launched its **CVD Prevention Fellowship Programme** which upskilled 85 primary care clinicians in different areas of CVD and quality improvement and resulted in 40 improvement projects. The **implementation toolkit** is aimed at AHSNs or other organisations planning a CVD prevention education programme for primary care and offers a practical guide to the HIN model.
- Eastern AHSN conducted an online survey to gain insight into people's understanding and perception of hypertension and the use of remote monitoring for blood pressure. The 723 responses are summarised in the **Eastern AHSN Blood Pressure survey report** and can be used to inform development of CVD prevention initiatives.
- In June 2022, Kent Surrey Sussex AHSN launched the **CVD central website** offering a range of free CVD central resources for any organisation in the country. These include patient result cards, patient experience surveys, A,B,C resource pack with clinical pathways and patient information and FAQs resource pack.
- Yorkshire and Humber AHSN worked with West Yorkshire Health and Care Partnership to develop **information leaflets for people recently diagnosed with hypertension.** These resources form part of the Healthy Hearts programme.

When asked, the BPO leads identified the following items as key enablers to programme delivery:

- **Senior decision makers engagement**
- **UCLPartners Proactive Care Framework resources**
- **UCLPartners central team programme leadership**
- **Wider primary care staff engagement**
- **Communication and dissemination of BPO workshops and resources**

Some of the assets developed during the 12 months are now available nationally

When the BPO Leads were asked "why are you proud to deliver the BPO programme?" They said...

Section 4
Opportunities for the future

“The greatest achievement for me has been establishing trusted and powerful system relationships from scratch”

BPO lead

Section 4: Opportunities for the future

Opportunities for reducing healthcare inequalities

Dr Bola Owolabi
Director
Health Inequalities at
NHS England

I am delighted to see the work of the AHSNs in supporting colleagues to systematically address hypertension and the explicit focus this programme has on tackling health inequalities.

When looking at blood pressure optimisation through a healthcare inequalities lens, the potential is stark. **One in five** avoidable deaths from cardiovascular disease in people under the age of 75 were among people in the most deprived decile of communities in England. Research suggests that the incidence of high blood pressure within the most deprived communities is **roughly double** that of the most affluent areas and CVD is more common where a person is male, older, has a severe mental illness or ethnicity is South Asian or African Caribbean.

Which is why hypertension case-finding and optimal management and lipid optimal management is one of the five clinical areas identified as requiring accelerated improvement in **NHS England's Core20PLUS5**.

I welcome the BPO programme bringing a structured, systematic method to identify and stratify people with hypertension whose blood pressure is poorly controlled and to optimise their treatment.

> ***"The greatest achievement for me is that we've created a coalition that is interested in hypertension and that can drive work forward next year"***
> BPO lead

When this is done at scale it has the greatest potential to prevent heart attacks and strokes and if Integrated Care Boards continue to prioritise support for blood pressure optimisation in communities at greatest risk of health inequalities (e.g. areas of deprivation, people with severe mental illness), this will prevent heart attacks and strokes in these communities and reduce health inequalities due to cardiovascular disease.

When this is done at scale it has the **greatest potential** to prevent heart attacks and strokes

Section 4: Opportunities for the future

What happens next: the opportunity to prevent CVD at scale

Dr Matt Kearney
GP and Executive Clinical Director, Cardiovascular Health, UCLPartners

The **Size of the Prize** shows us the huge potential to prevent heart attacks and strokes at scale by optimising blood pressure and cholesterol. The blood pressure optimisation programme was built on the clear acknowledgement that improving the management of these conditions is a longstanding 'wicked issue' that will not be resolved by just disseminating guidance or sharing performance data. The programme has taken a structured approach to supporting transformation in primary care, with a framework that enables stratification, systematic optimisation of clinical care and use of the wider workforce to support broader proactive care.

The programme has run for only a year but has been very successful in laying the groundwork for transformation with over 600 PCNs actively implementing the Framework. Although it is too early to expect national improvement in blood pressure optimisation as a result of the programme, striking improvement has been seen in local examples, with large numbers of patients being newly treated to target or moving out of high-risk categories.

> ***"The greatest achievement for me has been establishing trusted and powerful system relationships from scratch"***
>
> BPO lead

AHSNs across the country have taken an active approach to ensuring that local delivery has been informed by the potential to reduce health inequalities – for example prioritising specific populations, and mobilising inequalities funding to support activity in areas of greatest deprivation.

The model of programme delivery has provided some rich learning for future programmes with a range of high impact methods to build distributed leadership across the AHSN Network. A wide range of improvement and implementation resources have been developed both by the central team and individual AHSN teams.

It is clear from the report that the programme has generated substantial energy and enthusiasm across the country for primary care transformation to drive blood pressure optimisation and CVD prevention. Significant progress has been made in laying the groundwork for this transformation, and the potential for shifting the dial in CVD prevention has been clearly demonstrated.

But it is only a start. If it is to prevent heart attacks and strokes at scale, blood pressure optimisation needs to be implemented at scale. The BPO programme has generated a momentum around the country and leaves a helpful legacy. I would urge Integrated Care Boards to ensure they build on this as it will help them deliver substantial and early population health improvement.

> ***"This programme allowed us to start building a local coalition around hypertension proactive management."***
>
> BPO lead

Section 5

Case Studies

“ The education tools, protocols and scripts are particularly valuable to upskill and build confidence ”

Dr Rowan Sil

Case Study

Leicester, Leicestershire & Rutland's Approach to Adopting the UCLPartners Proactive Care Frameworks as a model of care, in partnership with East Midlands Academic Health Science Network

Opportunity for change

Leicester, Leicestershire & Rutland (LLR) Integrated Care System (ICS) has always had a strong focus on long-term conditions (LTC) management and invested in several programmes to support primary care to effectively support patients. There was a good strategic foundation within LLR for improving proactive and personalised care. There was a real opportunity to grow and expand existing initiatives in LTC management using the UCLPartners Proactive Care Frameworks.

The partnership approach between EMAHSN and LLR has included:

- Aligning Framework implementation with ICS strategy and resources
- Roadshows to build system engagement, buy-in and commitment
- Enlisting system clinical champions
- Developing working groups and community of practice
- Upskilling to mobilise the primary care workforce
- Local template development (SystmOne/ EMIS)
- Local incentivisation scheme development
- Local evaluation strategy development

Intervention

LLR has been working with East Midlands Academic Health Science Network (EMAHSN) since January 2021 to implement the UCLPartners Proactive Care Frameworks as a model of care.

In 2022-23, as part of EMAHSN's Blood Pressure Optimisation Programme, a review of data led to prioritisation of the hypertension Framework. This complemented LLR's long-term condition care @home approach.

Health inequality improvement methodology is being used to tackle inequalities across LLR, particularly ensuring implementation of the Frameworks does not widen health inequalities. Local population health data, including local, up-to-date Quality Outcome Frameworks (QOF) reporting is being used to plan implementation approaches and inform targeted support from the ICS and EMAHSN.

A two-pronged approach has been taken to the Framework implementation. This includes both engaging willing GP practices to implement the Frameworks as well as actively working with practices identified that have the greatest backlog of unmanaged long-term-condition patients.

"The education tools, protocols and scripts are particularly valuable to upskill and build confidence to mobilise wider workforce roles to deliver proactive care; these tools are strengthening our systems' approach to LTC management. As a digital lead in LLR, I also particularly like the remote monitoring pathways and resources to support patients that can remote monitor to enable them to feel more in control of their conditions. Implementation of the Frameworks has fuelled the impetus in LLR around remote monitoring."

Dr Rowan Sil
LLR ICS Clinical Lead for UCLPartners Proactive Care Frameworks and Information Management & Technology lead

Impact/outcomes: hypertension focussed

(April 2022 – February 2023)

Training has been provided to upskill more than **97 various primary care roles** across LLR to support the mobilisation of the workforce to deliver the hypertension proactive care framework

51% of LLR practices are implementing the hypertension Proactive Care Framework

972 BP @home monitors have been distributed to 26 target practices with the most deprived population (Index of Multiple Deprivation) as part of remote monitoring pathway implementation

60% of LLR community pharmacies are delivering the BP check service, which has enabled practices to refer hypertensive patients for required BP checks as part of their condition management

15,246 BP checks have been carried out by LLR community pharmacies (management referrals and case finding combined figure; April 2022 – November 2022)

Prioritising the implementation of the hypertension framework has contributed to **8,231 fewer instances of unoptimised hypertension** patients in LLR (table 1)

Hypertension QOF Pt Gap (2 Indicators) – Different between unoptimised patients in Dec 2021 and Dec 2022

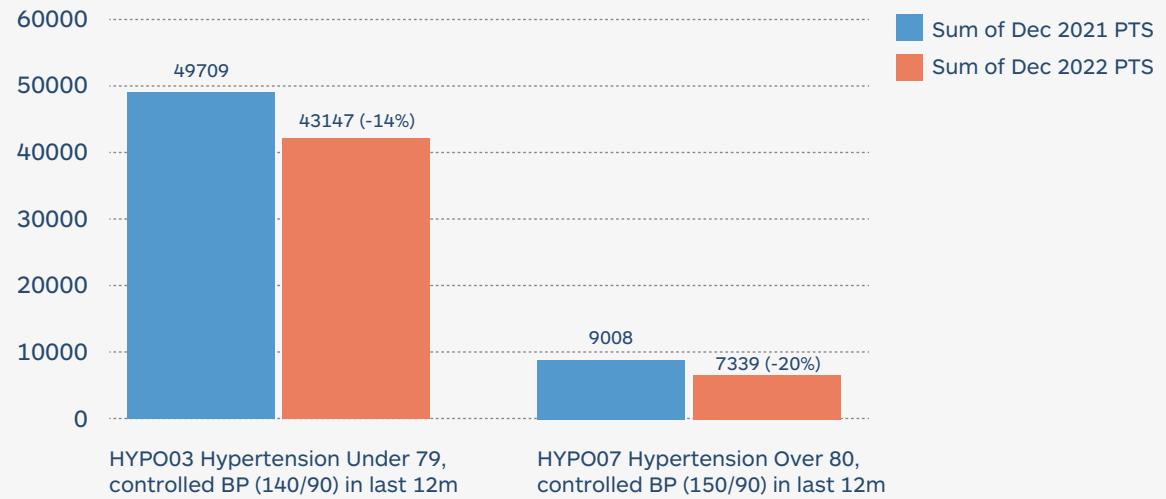


Fig. 7

- December 2021 is a comparison point as it is the first time we had monthly data for all practices
- This is compared with December 2022, 8 months into implementation.

Future Work

LLR is continuing the implementation of the UCLPartners Proactive Care Frameworks across their 26 PCNs and 131 practices, aligning implementation with their strategic priorities, including exploring future funding for sustainability alongside the personalised care agenda.

LLR ICS leads have shared their key learning and top tips so far in **this video**; this is to support other ICSs in the East Midlands to strategically plan and implement the UCLPartners Proactive Care Frameworks in collaboration with EMAHSN.

For more information, please contact, **emahsn@nottingham.ac.uk**

Resources

- **EMAHSN – Cardiovascular Disease Programmes**
- **EMAHSN – Proactive Care Frameworks**

51%
of LLR practices are implementing the hypertension Proactive Care Framework

Case Study

Great Yarmouth and Waveney Journey so far...

Eastern AHSN has been working with Great Yarmouth & North Villages Primary Care Network (GYNV PCN) to adopt the UCLPartners Proactive Care Framework for hypertension as part of a locally commissioned service.

Opportunity for change

The GYNV PCN consists of four practices: The Park Surgery, East Norfolk Medical Practice, Coastal Partnership and Fleggburgh Surgery. Currently, hypertension treatment to recommended thresholds varies significantly across the PCN (ranging between 48.16% and 69.41%).

David McConnell (Clinical Director and GP) and Amanda Sear (Senior Development Manager) are the locality leads, who set up a locally commissioned service to support the management of long-term conditions.

The aim was to:

- **Support practices to work together to address the disruption of routine management of long-term health conditions during the pandemic**
- **Establish a network approach to implementing the clinically led framework for optimisation, alongside natural support networks within local communities for those living with long-term conditions**
- **Create opportunities, together with local partners, to improve health outcomes with a particular focus on tackling health inequalities.**

Intervention

It was within this context that the Great Yarmouth and Waveney (GYW) locality worked to increase the optimisation of blood pressure across their practices.

The PCN were introduced to the UCLPartners Proactive Care Frameworks via presentations by Eastern AHSN:

- The Norfolk & Waveney cardiovascular disease primary care board about the UCLPartners Proactive Care Framework for hypertension programme in February 2022
- Transforming long term condition care post-pandemic talk at the primary care and public health conference in May 2022.

The PCN then advocated implementation of the Frameworks across its practices. Implementation support included:

- Monthly project meetings between the locality and Eastern AHSN BP team, including using AHSN implementation guides, and resources, and reviewing Quality on Outcomes Framework (QOF) and deprivation data across GWYV PCN
- The GYW locality team organised a protected time for learning event, where Dr Deep Shah, GP Partner and clinical lead at UCLPartners and Eastern AHSN were joined by over 80 clinicians working in general practice across Great Yarmouth and Waveney.

Initial searches were carried out and reviewed by the PCN in July 2022. Feedback as to progress on the searches and tools and actions arising from implementation were shared at monthly progress meetings. Data was also monitored in these meetings (e.g. age bands and potential links to deprivation.)

Each practice identified a clinical and management lead within their teams to support this project. The PCN agreed network adoption of the hypertension framework underpinned the locally commissioned service.

Monthly lunchtime meetings were held for practice leads to come together to develop ideas, agree on actions and provide feedback. David McConnell, Clinical Director, Great Yarmouth & Northern Villages PCN provides leadership and clinical oversight for the project, supported by GYW locality team.

"Working with EAHSN has been informative and useful – with time and ongoing conversations has come a better understanding of the framework as a whole and this has been particularly useful in encouraging practices to take the time to read and debate things in detail rather than pick a couple of elements that fit with what they already do!

The support from EAHSN has also been useful in keeping the momentum and enthusiasm of project leads – appreciating that everyone is doing this on top of an already challenging day job and that change isn't straightforward of painless has kept us going!"

Amanda Sear
Senior Manager Primary Care Network Development Great Yarmouth & Waveney

Resources

- **Eastern AHSN CVD webpage**
- **Eastern AHSN Blood pressure survey summary report**
- **Blood Donation Infographic**

Case Study Timeline: Great Yarmouth and Waveney Journey so far...

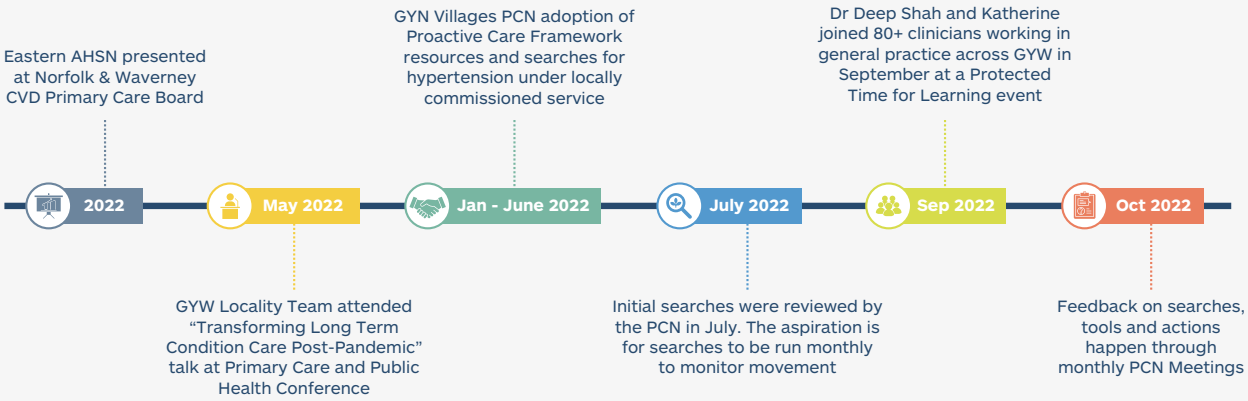


Fig. 8

Impact/outcomes

Initial searches were reviewed by the PCN in July 2022, and the network agreed to focus on Priority groups 1, 2a and 2B (approximately 1000 patients across the network).

The network pharmacy team has joined the project team and an additional care coordinator working with the pharmacy team was appointed.

Health pods are now installed at all nine surgery sites to support remote-monitoring, including blood pressure. The equipment (funded by Impact and Investment Funding) is multi-lingual, user-friendly and records outcomes directly into patient records. **Patients can access equipment at any site**, regardless of which practice they are registered with as a patient.

Future Work

Future work will focus on what further interrogation would be helpful to direct resources appropriately at practice, network, and neighbourhood levels. The GYW locality team and Eastern AHSN aim to demonstrate the value of this work, by considering what data could be usefully shared with wider partners to support targeted work by other place partners (e.g. community pharmacy and borough council) in the prevention arena (e.g. expanding the BP@home model to include community hub sites).

For more information, please contact **cvdteam@eahsn.org**

Case Study

Health Innovation Manchester blood pressure medication pathway optimisation

Health Innovation Manchester, the AHSN, worked in partnership with the Greater Manchester (GM) Strategic Clinical Network (GMSCN) and key clinical stakeholders to form a hypertension task and finish group with the aim of improving blood pressure optimisation in the region. This group has developed a single GM Medication Pathway for adoption across all Primary Care Networks within the region.

Opportunity for change

GM remains one of the worst places in England for cardiac deaths in the under 75's with hypertension identified as a contributory factor. Across GM there are an estimated 215,000 people with undiagnosed hypertension, a further 123,000 are diagnosed but not treated to the NICE targets for a clinic blood pressure reading.

NHS GM identified hypertension as high priority and formed a GM recovery and prevention oversight group which recommended the establishment of a hypertension task and finish group.

There are 67 Primary Care Networks (PCNs) and 460 individual practices of which 93 represent the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD) and were therefore designated as high priority.

Intervention

The hypertension task and finish group was established in October 2022. The group's key role was to achieve several specific objectives in the Greater Manchester Cardiovascular Prevention Plan (GMCVD plan -published Dec 22) which supports the optimisation detection and management of hypertension across GM.

Twelve organisations and thirty-seven people form the core membership with representation across both primary and secondary care, health system partners and stakeholders.

Virtual meetings (initially meeting each week for 6 weeks) and a specialist subgroup for the medication pathway met virtually for 4 weeks. The AHSN facilitated the meetings and also provided administrative support this work.

> ***"We are only just getting going with true system working in GM and the task and finish group relating to our medication pathway is a great example. By bringing together a range of different stakeholders and perspectives from traditionally clinical and non-clinical areas we have been able to produce a medication pathway that is more than just a simple medication pathway. It includes nuggets of helpful information and integrating community pharmacy as well. I'm looking forward to seeing what we can do together to tackle hypertension in the coming year."***

Aseem Mishra
NIHR ACF GPST4,
Clinical Lead CVD Prevention,
NHS Greater Manchester
Integrated Care GMEC SCN CVD and Stroke

Impact/outcomes:

One of the key objectives of the hypertension task and finish group was to create a point of care medication pathway based on current NICE guidance.

The task and finish group delivered on this objective having produced a GM hypertension medication pathway, scheduled for approval in May 2023.

Before agreeing on the final version for approval the pathway was widely shared in primary and secondary care where it was tested and feedback incorporated. The socialising of the document in both primary and secondary care gained support and positive feedback at each stage of its development. The final version incorporated feedback from an additional twelve clinicians.

The pathway is in the process of being approved for GM system adoption and aims to:

- **Simplify the medication pathway (whilst compatible with NICE)**
- **Incorporate community pharmacy**
- **Enable quicker BP control with less steps and fewer side effects**

Having an agreed medication pathway for BPO across Greater Manchester will help to ensure that all patients with high blood pressure receive optimal management, reducing variation in prescribing practice. We will also be able to measure quality more effectively via our soon to be live Greater Manchester shared care record CVD dashboard (GM Care Record).

Future Work

As a high priority for NHS GM the focus will remain on hypertension. The GMCVD plan will drive further developments as it delivers on its objectives. In addition, the team are in the process of planning a CVD day in summer 2023, raising awareness of the new medication pathway and promoting achievement of our agreed Greater Manchester standards for BPO. Education webinars will also support the launch of the new pathway once ratified.

For more information and to receive the GM Medication Pathway, please contact **info@healthinnovationmanchester.com**

Resources

Greater Manchester Cardiovascular Prevention Plan

Greater Manchester Hypertension Strategy

One key objective was to create a point of care medication pathway based on current NICE guidance

Case Study

Health Innovation Network Cardiovascular Disease Fellowship – Quality Improvement Project

Hurley & Riverside Practice (HARP) and South Lambeth Group Practice (North Lambeth PCN) with the Health Innovation Network

Opportunity for change

In April 2022 the Health Innovation Network (HIN) introduced a Cardiovascular Disease (CVD) prevention Fellowship programme for primary care clinicians in south London. The programme aimed to:

- **Enhance the clinicians' knowledge of CVD prevention with CPD-accredited learning**
- **Develop skills to improve the delivery of care in their practice or Primary Care Network (PCN).**

85 primary care clinicians completed the programme, which included 19 education sessions. 40 cardiovascular quality improvement (QI) projects were delivered, covering a PCN population of 1,451,300 people. The Fellowship formed one part of the HIN's BPO delivery approach for south London and was part of their wider work to support the NHS workforce.

The following case study highlights one QI project that came out of the Fellowship.

Luca Proudfoot is a clinical pharmacist based across two practices in Lambeth, south east London. He focused on hypertension for his quality improvement project. He worked across the two practices to target hypertension in patients at great risk – focusing on lowering blood pressure in patients who fell into UCLPartners Priority Groups 1 and 2a, with a blood pressure of 160/100 or above.

Luca Proudfoot
Clinical Pharmacist
Lambeth, south east London

Intervention

- Luca Proudfoot joined the HIN CVD Fellowship in summer 2022. As part of the Fellowship he attended a series of clinical webinars over seven months covering topics across CVD. He also attended a series of quality improvement sessions and developed a quality improvement project – focusing on hypertension.
- The project focused on patients with a blood pressure of 160/100 across the two practices. The practices ran the UCLPartners Proactive Care Framework searches for hypertension, with 35 patients identified as having a last BP above 180/120 and 190 patients with a reading above 160/100. Patients in Priority group 1 were managed by clinicians, and blood pressure reviews were carried out with treatment and lifestyle addressed.
- Patients in group 2a were texted and invited to submit an up-to-date blood pressure reading or book an appointment to see a clinician.
- When seeing patients, other routine tests were run to offer a holistic approach and proactively address other health issues.

Case study story

One patient, a 60-year-old male, had a blood pressure of 190/120. During the consultation where this was discovered the GP advised the patient's daughter to take the patient to A+E, but the patient did not want to go.

During this project this patient was contacted again. It was discovered the real reason why the patient refused was due to alcoholism. We persuaded him to visit A+E and got him support from the drug and alcohol team. The daughter also received support from the social prescriber.

The patient's blood pressure medication was modified in secondary care and optimised in primary care and he is normotensive now. This has also slowed his progression of chronic kidney disease.

Impact/outcomes

By the end of the project there was a **57% reduction of patients in group 1** who had had a BP higher then 180/120. Of the remaining patients, 10 had been inactive for over 5 years, and 3 were abroad. 2 still had very high blood pressure and were being supported to address this.

Within Priority group 2a there was a **51% reduction** in the number of patients with a blood pressure above 160/100. Work was continuing with this group.

The project has recognised that the **most effective way** of reviewing patients was for a clinician to book the appointments themselves, however this is time consuming.

Maintaining ongoing communication with clinicians and keeping them engaged was challenging, as it is a massive target and not a quick win. However the practices are continuing to work on this.

Resources

HIN CVD Fellowship

Future Work

The practices involved have continued the work. Protocols have been put in place with the team running monthly searches to identify patients for hypertension reviews. Coding has been a focus, with more staff being trained in this to ensure it is accurate. The practices have also created specially designed blood pressure follow up appointment slots for seeing patients.

HIN plans to deliver a second intake of the CVD Fellowship.

For more information, please contact **hin.cvd@nhs.net**

Case Study

Imperial College Health Partners – Supporting the Harness PCNs (North & South) in a highly deprived area to improve hypertension case finding and management

Opportunity for change

Brent has some of the greatest health inequalities in North West London. Imperial College Health Partners (ICHP) were approached by the Harness PCNs in Brent where over half the patient population lives within the 20% most deprived postcodes nationally.

PCN patients living with hypertension have many co-morbidities and challenges associated with significant deprivation, variations in healthcare education, disease understanding and medication adherence, resulting in an average of 17 contacts with GP practices a year compared to four contacts a year for those without a Hypertension diagnosis.

This increased burden on GP time highlights the need for greater education, improved management and treatment optimisation for people living with hypertension in order to improve outcomes and reduce health inequalities.

An average of **17 contacts** with GP practices a year compared to **four contacts** a year for those without a hypertension diagnosis

Intervention

This PCN was already adopting **Omron/Hypertension Plus**, a remote patient monitoring platform for hypertension, for digitally literate patients. Following a talk at their local GP forum in November 2022 they engaged with ICHP for support to scale their broader approach to hypertension case-finding and management. ICHP has been supporting them by signposting to resources and relevant contacts in the region and helping to capture relevant data.

This PCN is focused on two main goals:

Case finding:
2 pharmacists are focused on case-finding new patients to meet the IIF CVD01 indicator for the PCN, following up with patients with an elevated Blood Pressure (BP) reading; patients are then remotely monitored or brought in for confirmation of diagnosis and onboarded on Hypertension Plus where appropriate.

Optimisation:
UCLPartners Framework searches are being used to monitor existing hypertension patients and higher risk patients (groups 1 and 2) are offered different follow up options:

- If they are digitally literate, they are set up on Omron/Hypertension Plus app
- Patients that do not have their own blood pressure monitor can request one via the BP@Home programme
- If they are happy to take their BP at home but not to use the app, readings are submitted to the practice either in person at the practice, via local Community Pharmacy providers, online template tools or SMS functionality built into practice systems
- If they are not comfortable or unable to take their own BP they can have it checked in the practice

Impact/outcomes:

These are early days of the programme but there are significant numbers of people living with hypertension (approximately 20,000) in the PCN catchment area and early results are promising:

30% patients identified in the high-risk groups 1 and 2 (not controlled to target) reached control within 4 months of the programme

Future Work

The AHSN team is supporting the PCN to capture their case study and outcomes and to present these at a CVD education session for other clinicians in the region. In addition, the approach will be written up into a wider case study including some insights from patients. This should support spread of the approach within the local area (to reach all eligible patients) and to other areas in North West London that may want to replicate the approach.

For more information, please contact:
EA@imperialcollegehealthpartners.com

Increased burden on GP time highlights the need for **greater education, improved management** and **treatment optimisation** for people living with hypertension

Case Study

Innovation Agency

Healthy South Wirral primary care network blood pressure project

Aims of the project

The Innovation Agency (the Academic Health Science Network for the North West Coast) aimed to test a more intensive community-focused approach to CVD prevention – focussing on:

- Hypertension management
- Quality improvement
- Digital tools
- Tackling the wider determinants of health, alongside health professional input

Opportunity for change

The work supported patients to take control of their health and promote self-management and self-determinism. The Healthy South Wirral Primary Care Network (PCN) recruited a community Health Coach as a key part of supporting population-health improvements. The improvements include providing personalised care and responding to population needs, which include messages and support tools that resonate with the community alongside the locally developed **Blood Pressure Quality Improvement toolkit** (BPQI) incorporating the UCLPartners Proactive Care Framework.

Intervention

At the start of the project, the Innovation Agency led a pathway design workshop for proactive BP monitoring at home. This involved staff from the GP practices to get the fundamentals in place and help with role clarity such as appointing the clinical/admin leads at practice level and agree key milestones.

The BPQI was used to both increase identification of patients with undiagnosed hypertension and risk-stratify hypertensive patients and improve control to target. Baseline data was created using this BPQI Tool and revisited at regular intervals. The work is aligned with the National BP@home Programme and a digital process for management at home was implemented.

Baseline data was created using this BPQI Tool and revisited at regular intervals

The work supported patients to take control of their health and **promote self-management** and self-determinism

Impact/outcomes

Baseline data showed 150 hypertensive patients risk stratified in priority 1 group (Clinic BP ≥ 180/120mmHg). Practices focused on the priority 1 patients to improve their hypertension management and the group size reduced by 50% over 8 months.

Findings from a co-production event and case studies indicated that patients are coping better and feel more in control of their condition following input by the Health Coach. We are also able to demonstrate an increase in the use of a digital approach for hypertension management, with 4249 more hypertension text messages sent requesting BP readings to patients across the PCN. Patients can submit readings via a reply text message.

> ***"Our whole team approach enabled us to take on the challenges of reducing CVD risk in a post pandemic environment and make use of the UCLPartners risk stratification tools and digital platforms."***

Karen Livesey
Strategy and Transformation Lead
Healthier South Wirral

Learnings

However, all practices experienced non-engagement from a number of priority 1 patients meaning they had a continued heightened CVD risk. Therefore, the final stage of the project is now aiming to better understand why some patients with high-risk blood pressure do not respond to invitations to update their bp reading and receive advice/treatment.

It is important to be aware that these results were achieved, in the main, by the employment of 0.8WTE Health Coach, with support from a proactive PCN manager and clinical oversight from a GP.

Future Work

In terms of future work, sustainability plans are underway. The PCN has recently recruited a second Health and Wellbeing coach and is looking to combine this approach with cholesterol management using the UCLPartners Frameworks. The PCN has presented at the regular place-based shared learning meetings on the approach and progress. Regularly the Healthy South Wirral PCN is approached by surrounding PCNs to understand better how they can implement the approach too. From an AHSN perspective we promote the approach and outcomes within our ICB hypertension steering groups and CVD subgroups.

For more information, please contact **info@innovationagencynwc.nhs.uk**

Resources

- **Cardiovascular disease (CVD) management improvement programmes, Innovation Agency**
- **High Blood Pressure & Cardiovascular Disease Prevention, Champs, Public Health Collaborative**
- **Is your blood pressure too high? Happy Hearts**

Case Study

Kent Surrey Sussex Academic Health Science Network

Bexhill Primary Care Network
NHS Bexhill Primary Care Network: case finding via community events

Kent Surrey Sussex Academic Health Science Network (KSS AHSN) launched its new **CVD Central website** which offers free CVD Central resources for any organisation in the country to order or download and use. The CVD Central project is delivered in collaboration by KSS AHSN, British Heart Foundation and NHS Benchmarking. It uses the Make Every Contact Count (MECC) approach to help with understanding and demonstrating the impact and outcomes from health checks of various types in a variety of clinic and community settings.

CVD Central provides resources to support detection of high-risk conditions: atrial fibrillation (AF), blood pressure (BP), cholesterol and familial hypercholesterolaemia (FH). The free resources may be helpful to any organisation in the country offering blood pressure and pulse checks, in any clinic or community setting.

Bexhill PCN is within the Kent, Surrey, Sussex region and is supported by KSS AHSN. The following case study highlights how the CVD Central resources were utilised in case finding events by Bexhill PCN.

> ***"We know that raised blood pressure is the number one cause of preventable death worldwide that's why across Bexhill we want to make it as easy as possible for people to have their blood pressure checked. We want to say a big thank you to everyone who gave up their time on a Saturday morning and especially the team at Little Common and Old Town surgery for hosting the event"***
>
> Dr Phil Stocks, Lead Partner, Little Common and Old Town Surgeries

Opportunity for change

Bexhill PCN and Little Common and Old Town Surgery ran a blood pressure awareness and pulse check event in targeted populations to increase detection of the high risk conditions.

The event enabled them to meet one of the CVD prevention and diagnosis requirements in the Network Contract Directed Enhanced Service (DES). The event enabled a follow up appointment to take place to confirm, or exclude, hypertension and also to do opportunistic pulse checks to detect atrial fibrillation.

This case finding example demonstrates how the CVD central resources were applied in a real life setting and underpinned the PCN' wider Blood Pressure Optimisation work.

Intervention

The event was held on a Saturday morning between 9-12pm in the surgery. Patients were identified from a search on the EMIS clinical system which identified those who required a follow up appointment for their blood pressure management along with those who had not had a blood pressure check in the last 5 years.

Once the cohort was identified, the PCN used accuRx, a digital communications platform, to send text messages inviting people to book a convenient time slot during the event. Over 200 people booked an appointment and on the day, 126 people attended.

The event was supported by colleagues from across the practice and the PCN including a GP, Health Care Assistants and CVD PCN Care coordinator. The event was also attended by the local healthy lifestyle service, One You East Sussex (OYES) who provided information on the range of support and programmes they offer.

> ***"We know that if left untreated high blood pressure, hypertension, can lead to heart problems, strokes and damage to other vital organs. That's why events such as these are so important in making people aware of the risks and how they can reduce them."***
>
> Sue Venables, Cardiovascular Care Coordinator, Bexhill PCN

Impact/outcomes:

Patients had their blood pressure taken with results entered on their GP record using a template. Those attending were also given a British Heart Foundation (BHF) leaflet and a small card with their result on from **CVD Central website**. The card can also be used to record results measuring cholesterol and blood sugar levels. A QR code on the card allows people to give feedback on their experience of having a CVD check; BHF incorporates this information to produce visual reports on the feedback every quarter.

All patients were directed to the **'Manage your blood pressure at home hub'** which has been created by The BHF to provide support and advice to help patients understand and control their blood pressure.

Key findings from the event showed that:

BP >180/120

- **2 patients were identified, reviewed by GP, and received same day treatment**

BP >140/90

- **36 patients had raised blood pressure**
- **All 36 agreed to BP@Home which involved taking their blood pressure at home for seven days; these results were then analysed by the practice and appropriate action taken**
- **5 patients were loaned a BP monitor for 7 days by the PCN**

BP <140/90

- **90 patients had BP in normal range and were given advice**

We also picked up 3 irregular pulses, but no new cases of Atrial fibrillation were identified.

One You East Sussex the local healthy lifestyle service received:

- 6 referrals to weight management
- 2 referrals to Stop Smoking services.

Roles and organisations involved in facilitating the event:

- 6 HCAs from the GP Practice taking BP and pulse checks
- 2 receptionists from the GP practice checking people in and encouraging people to complete feedback via QR code on their card
- 1 Practice GP (organised the event along with PCN coordinator)
- 1 CVD PCN Care Coordinator taking BPs and Pulse checks
- 1 engagement worker from One You East Sussex (healthy lifestyle service) engaging with the patients and taking referrals to their healthy lifestyle services

(The GP practice mentioned above is Little Common and Old Town and the PCN is Bexhill Primary Care Network)

Resources

KSS AHSN CVD Central resources listed below are all available for free on the **CVD Central website**

- Results card for patient (credit card sized)
- Patient Experience survey after first A,B,C check in any setting – access via QR code, text or paper
- Patient Experience survey one month later for patients found to have BP>140/90 – via text or paper
- A,B,C Resource pack with clinical pathways and patient information
- Inclisiran Implementation and FAQs Resource Pack to support Primary Care

For more information, please contact:
kssahsn.cvdprevention@nhs.net

Visit KSS AHSN's CVD Central website for full details on how to order, download and use the free resources direct from the website.

Future Work

Due to the success of this event the PCN is now exploring how it can be replicated across other practices in the PCN. KSS AHSN will continue to support Bexhill PCN and all PCNs with AF, BP and Cholesterol detection.

For more information, please contact:
Josh Broadway
Digital and Transformation Lead, Bexhill PCN:
josh.broadway1@nhs.net
Sue Venables
Cardiovascular Care Coordinator, Bexhill PCN:
susan.venables3@nhs.net

Case Study

Case-finding: Testing approaches in North Tyneside

Academic Health Science Network
North East and North Cumbria

Opportunity for change

Evidence suggests that incidents of the two main CVD risk factors (smoking and obesity) are unevenly distributed across North Tyneside. People who live in the most deprived areas across the country are four times more likely to die prematurely **from cardiovascular disease** compared to those in the least deprived areas.

North Tyneside Council is leading a project to offer blood pressure and atrial fibrillation (AF) checks in community settings. The service will be delivered by their Active North Tyneside team (who are responsible for delivering their sports and leisure services) together with TyneHealth (the North Tyneside GP Federation), the Newcastle United Foundation (charitable arm of the football club) and Tyne and Wear Fire and Rescue Service.

North Tyneside Council is leading a project to offer blood pressure and atrial fibrillation (AF) checks in community settings

Intervention

The pilot is offering blood pressure and AF testing in the community. Residents will receive broad public health advice and signposting, using a **Making Every Contact Count** approach, regardless of whether AF or hypertension is detected.

There are two parts to this:

- Members of staff from Active North Tyneside carry out blood pressure and AF checks with people registered with GP practices in the Wallsend Primary Care Network. Information is then shared with GP practices and, where indicated, people will be provided with equipment on loan to carry out 5 days of home BP monitoring prior to being reviewed by practice staff.
- Members of staff from Newcastle United Foundation and Tyne and Wear Fire and Rescue Service (TWFRS) also carry out blood pressure and AF checks for people at workplaces and community events across North Tyneside. Information is not shared with GPs but, where appropriate, people will be encouraged to contact their practices.

AHSN NENC are active members on the local authority's CVD in the community steering group which is led by the Public Health team and includes a range of stakeholders. AHSN NENC has supported the development of a project proposal which was successful in securing funding.

Impact/outcomes:

This project is ongoing. A final evaluation and impact report will include:

- Data to demonstrate the impact of the project e.g. numbers referred for further investigation by GP, patients added to the hypertension register and/or medication prescribed as a result of a blood pressure check (if not possible to get practice-level data in this way, then changes in Quality on Outcomes Framework prevalence may be used as a proxy indicator).
- Data from Newcastle United Foundation and the Fire and Rescue Service on the number of people having BP and AF checks and if possible, how many of those people were advised to speak to their GP
- Analysis of different approaches and venues to determine whether different models of case finding in the community have different levels of engagement or identify more cases.

Future Work

The pilot will be evaluated and any relevant learning has the potential to be scaled up and rolled out more broadly if appropriate. Other PCN directors are also keen for similar work to be delivered in their areas, so roll out will be based on potential level of need and levels of interest.

For more information, please contact:
enquiries@ahsn-nenc.org.uk

"Here at North Tyneside Council, the health and wellbeing of our residents is a top priority for us.

We are therefore really excited to lead on this work to help our residents check on their wellbeing, in a quick, easy and accessible way without the need for an appointment or visit to their doctor.

High blood pressure and Atrial Fibrillation (AF) can increase the risk of strokes and heart attacks, but many people don't know they have these conditions as they don't always cause obvious symptoms."

Louise Gray
Consultant in Public Health, North Tyneside Council

Resources

- **AHSN NENC**
  Blood Pressure Optimisation
- **Cardiovascular health – North Tyneside Council**

Case Study

Supporting the development of case-finding initiatives at Primary Care Network level

Opportunity for change

Hatters Health Primary Care Network (PCN) consists of 6 practices in an area of high deprivation, with a combined list size of 46,000. Working with Oxford AHSN, Hatters Health PCN were keen to design and deliver a hypertension improvement programme with the aim of:

- Increasing the number of people diagnosed with hypertension
- Supporting practices to improve the management of hypertension in line with NICE guidance and Quality on Outcomes Framework (QOF) targets

Intervention

The AHSN supported Hatters Health PCN to develop and implement a project with the following aims:

- Review patients aged 18 or over with an elevated BP reading between 1 April 2020 and 31 March 2022 and not on the QOF hypertension register
- Invite patients aged 45 and over without a recorded blood pressure in preceding 5 years for an NHS health check
- Support practices within the PCN to identify, review and optimise patients with known hypertension and poorly controlled BP

The AHSN worked with the PCN team to establish what was currently working well in hypertension detection and management and to identify areas for improvement.

This included analysis of the available data, process mapping and solution development. The current process was mapped out and a new process was developed with input from the wider healthcare team. The AHSN supported the PCN to turn this new process into a standard operating procedure which was trialled, reviewed, and changed as appropriate in an iterative process.

As the project progressed the AHSN was available as a 'critical friend' to review progress and support with problem solving when issues arose.

Support was also provided with developing an evaluation framework and patient experience metrics. The AHSN continue to work with the PCN to provide ongoing monitoring and data analysis support.

The AHSN supported the PCN to turn this new process into a standard operating procedure

Impact/outcomes:

Between April 2022 and March 2023, the team at Hatters Health PCN delivered excellent results and ensured that nearly 1450 patients with elevated BP but no hypertension diagnosis received appropriate follow-up. Over the same time period the hypertension register increased by 344 patients and prevalence increased from 15% to 16%.

Feedback from the PCN team was positive with staff welcoming the opportunity to be involved in pathway redesign and in shaping the way in which they worked.

Future Work

The next steps for this work include:

- Focus on improving hypertension control
- Targeted education at practice level – focusing on offering consistent messaging to patients
- Ultilise health and wellbeing coaches to engage people with known hypertension who have not attended for BP reviews

For more information, please contact:
info@oxfordahsn.org

> ***"The AHSN team provided really valuable project management support during the development of our hypertension project as well as on going support in terms of data analysis and sharing of good practice. The early success of the project is testament to the robust planning and collaboration with our lead pharmacist"***
>
> **Sarah Bunn**
> **PCN Business Manager**
> **Hatters Health PCN**

Feedback from the PCN team was positive with staff welcoming the opportunity to be involved in pathway redesign

Case Study

South West Academic Health Science Network Case Study

Reducing Cardiovascular Disease in the South West by spreading best practice to improve the detection and management of high blood pressure

The South West AHSN worked together with UCLPartners and a local practice, Okehampton Medical Centre (OMC), to champion the UCLPartners Proactive Care Frameworks for management of cardiovascular diseases (CVD) in the population. The practice team's passion, expertise and knowledge in optimising clinical care and self-management of people with high blood pressure was used to share and spread best practices, thereby benefiting patients across the region.

Opportunity for change

Across the South West of England, prevalence of hypertension is higher than the national average (16-17% compared to 13%[1]) with rural and coastal areas particularly affected.

OMC, part of North Dartmoor Primary Care Network (PCN), represents a rural area with an ageing population, that had a 34% fall in the number of patients treated to target for blood pressure[2] during the pandemic.

Historically, BP patients were largely managed through face-to-face consultations. This meant patients and doctors spent a long time undertaking blood pressure measurements in an unfamiliar environment which potentially influenced the result. Rather than recruiting more staff, which is particularly challenging in the South West region with higher vacancies rates than the national average (Care Quality Commission, 2022), OMC set out to tackle hypertension differently.

The South West AHSN, alongside OMC as the first adopter of the BP optimisation programme, delivered a series of collaborative and peer-led CVD workshops throughout 2022 to support practices and PCNs to implement the UCLPartners Proactive Care Framework and prevent CVD. Subsequently, the South West AHSN was the catalyst for facilitating peer-mentorship and spread and adoption of optimised care across the region.

[1] Quality and Outcomes Framework (QOF) data

[2] CVDPrevent data

Intervention

With the adoption of the UCLPartners Framework for hypertension, OMC's ambition was to increase detection and management of high BP from 56% to 80% by 2027. This project was led by OMC's long-term-condition (LTC) non-medical-prescribing (NMP) nurse, Judith Magowan who involved the whole practice team of 14, the wider PCN team and patients with the following approach:

- **All patients** are educated about the BP target range, why it is important, signposted to known resources for BP monitoring (e.g. **British Heart Foundation**) and encouraged to monitor their BP at home.
- **The receptionist, audit and IT teams** work together using digital platforms to collect readings, communicate and follow-up with patients.
- **Health care assistants or junior nurses** gather information about BP, weight, pulse, and other long-term condition indicators. They also support patients with self-management and lifestyle changes.
- **LTC NMP nurses and pharmacists** manage all patient's risk factors, treatments and escalate or de-escalate interventions.
- **GPs** are involved in exceptional circumstances related to high-risk patients.

As a result, OMC has increased BP detection and management rates by an average of 25% with further increase expected as this new way of working becomes business as usual. Judith Magowan has also supported neighbouring GP practices and PCNs to adopt the Framework.

Impact/outcomes

The most surprising outcome from OMC's perspective has been the significant reduction of GP's workload in managing BP. It is difficult to quantify the small number of patients who require GP involvement in managing their BP, they tend to:

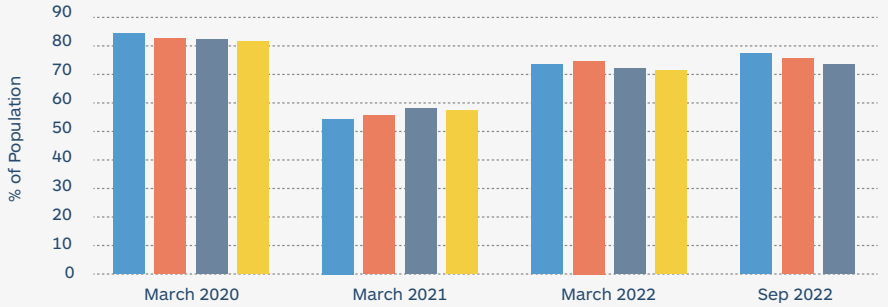
- Be patients who experience **multiple medication intolerances**
- Have BPs that are **not responding to several agents**
- Present with **extremely high presentation of BP** >180/120
- Have **complex comorbidities** or issue such as **orthostatic hypotension**.

These patients are managed as a collaborative approach by the LTC nurse and the GP. The practice team and patients have gained in confidence by feeling empowered to manage BP and associated risk factors.

OMC is now building on its success and combining BP with lipid management, thereby taking a step further in the prevention of CVD.

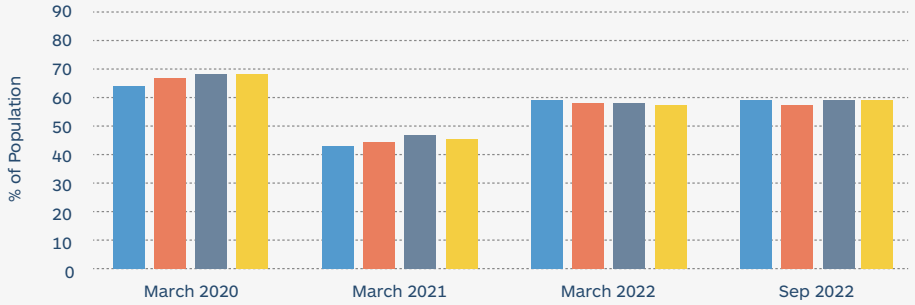
The South West AHSN has been instrumental in capitalising on OMC's example by setting up peer-to-peer mentoring sessions for practices across the South West, particularly within deprived rural and coastal communities.

This bespoke targeted support has significantly facilitated the adoption and spread of best practices and new ways of tackling high BP in > 20 PCNs and GP practices so far.



CVDP003HYP: Percentage of patients age 80 years or over with GP recorder hypertension, in whom the last bood pressure reading within the preceding 12 months is 150/90 mmHg or less%

OMC SM ND PCN National Value



CVDP002HYP: HT<80yrs <140/90-

OMC SM ND PCN National Value

Resources

The South West AHSN Cardiovascular disease programme

Future Work

The South West AHSN will continue to capture more insights from staff and patients and analyse regional CVDPrevent data to track impact. This case study will be developed further and disseminated through stakeholders' channels to reach the widest audience possible.

Building on the spread and adoption momentum, the South West AHSN, in collaboration with Integrated Care Boards and training hubs plans to develop a package of regional CVD Prevent workforce training that will be offered to all primary care staff.

For more information, please contact **info@swahsn.com**

> ***"Our whole team approach enabled us to take on the challenges of reducing CVD risk in a post pandemic environment and make use of the UCLPartners risk stratification tools and digital platforms."***

Judith Magowan
LTC lead nurse

Case Study

Implementation of the UCLPartners Proactive Care Frameworks in Havering North Primary Care Network

Opportunity for change

UCLPartners supported the Havering North Primary Care Network (PCN) in implementing the UCLPartners Proactive Care Frameworks for hypertension, lipids and type 2 diabetes across its 14 practices. **The aims were to:**

- **Reduce workforce pressure** particularly for GPs
- **Integrate the new ARRS** (Additional Roles Reimbursement Scheme) roles into patient care
- **Earlier intervention** for patients with long term conditions and improvement of patient experience
- **Develop multi-therapy pathways** to ensure that at patients received the right care at the right time.

Intervention

Making the case for adoption was a key part of the early set up. Colleagues needed to know the programme would both relieve pressure on GPs as well as deliver against The Quality and Outcomes Framework (QOF) and other The Investment and Impact Fund (IIF) incentive schemes.

Dr Ann Baldwin, the programme lead for 5 PCNs across Barking, Havering and Redbridge and Havering North PCN clinical lead, led engagement and clinical leadership for the implementation, working to engage all 14 practices in the work. Also, key to success was Gee Gahir, the operational lead who coordinated the ARR team to develop strategies in Havering North PCN, this work was supported by the PCN's executive board. Education and training and ARR roles pathways were supported by BHR training hub team.

The PCN took the following key steps with the support of UCLPartners:

- Reviewing September 2020 data to prioritise long term conditions which led to the selection of hypertension, lipids and type 2 diabetes
- Adaptation of the UCLPartners Proactive Care Frameworks to reflect the staff mix at the PCN and to enable multi-therapy pathways for those patients living with complex multiple conditions
- Training for those relevant staff (health coaches, clinical pharmacists, social prescribers, mental health practitioners, practice nurses etc) who would deliver the UCLPartners Proactive Care Frameworks.

Enable multi-therapy pathways for those patients living with complex multiple conditions

Reduced pressure on the workload of GPs has been recognised across the PCN

Impact/outcomes

The PCN achieved 28% reduction in hypertensions Priority group 1 (i.e. highest risk) and 1,000 additional people had BP controlled to target.

Patients feedback was positive, with testimonies including: "The first time I have not felt dismissed or judged" and "I have been looking for this kind of service for years. Gee [Health Coach] helped me understand why I am so tired all the time, for the first time I slept soundly. Thank you."

Positive impact for the PCN's workforce:

The PCN also experience a reduced pressure on the workload of GPs has been well recognised across the PCN. The frameworks supported the wider ARRs workforce to have greater clarity as to their role in the delivery of care for patients.

"It made us feel valued and that we were actually contributing" Gee Gahir, operational lead and health coach, Havering North PCN.

The PCN achieved **28% reduction** in hypertensions priority group 1

1,000 additional people had BP controlled to target

Future Work

Havering North PCNs has been instrumental in championing this approach across neighbouring PCNs, the wider borough and ICS.

Dr Ann Baldwin said "There is no doubt that this success can be replicated in other localities.".

For more information, please contact **primarycare@uclpartners.com**

Resources

UCLPartners Blood Pressure Optimisation

> ***"The work done in Havering North has had real impact on not only patients, many of whom have had their hypertension brought under control, but also the colleagues across the PCN who have found this new way of working incredibly valuable"***

Dr Ann Baldwin
Programme lead for 5 PCNs across Barking, Havering and Redbridge and Havering North PCN clinical lead

Case Study

Wessex Academic Health Science Network Case Study

Wessex AHSN Blood Pressure Optimisation (BPO) Programme Support and Hampshire & Isle of Wight Primary Care Network pharmacy team

Opportunity for change

Hampshire and Isle of Wight's Integrated Care Board (ICB) pharmacy team was perfectly placed to support Primary Care Networks (PCNs) with an educational in-reach model to teach PCN staff about cardiovascular disease prevention, the use of the UCLPartners Proactive Care search and risk stratification tools, and how to identify and manage patients with high blood pressure within their practice.

Outreach sessions resulted in **high levels of engagement** and increased the quantity of education materials

50
educational in-reach sessions with PCNs, attended by around 300 people

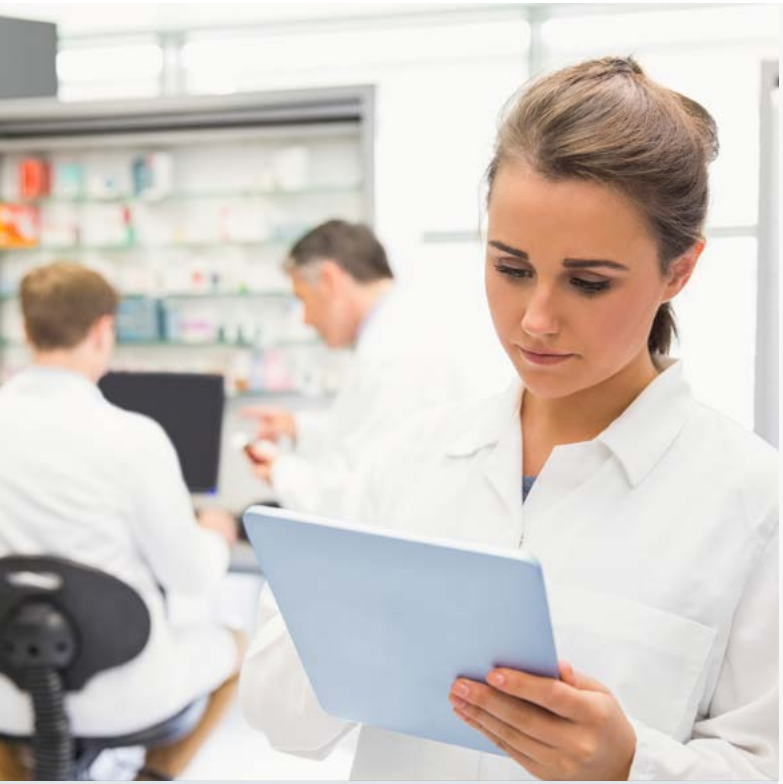
Intervention

The ICB pharmacy team carried out over 50 educational in-reach sessions with PCNs, attended by around 300 people. These were supported by national programme resources developed by the AHSN Network. Wessex AHSN's support included sharing national materials and initial teaching and engagement on the UCLPartners Proactive Care Frameworks approach.

The ICB pharmacy team met with PCN GP leads for cardiovascular disease (CVD) and PCN business managers to discuss nationally produced CVD prevent data and how each PCN compared to neighbouring PCNs. These outreach sessions resulted in high levels of engagement and increased the quantity of education materials cascaded to the PCN teams.

At Denmead Practice, part of Southeast Hampshire PCN, the Pharmacy Technician developed a protocol for their care co-ordinators on how to interpret blood pressure results and guide next steps with the patient. They then developed an educational package for the healthcare assistants to help them understand hypertension and how to identify high blood pressure readings. The ICB pharmacy team shared the UCLPartners Proactive Care Frameworks, with the PCN team using it to identify suitable patients and titrate and optimise treatment.

The **ICB pharmacy team met with PCN GP leads** for cardiovascular disease



The work has **enhanced system relationships** between the pharmacy workforce and PCNs

Impact/outcomes

This work has:

- **Increased awareness** of the CVD prevention agenda and priorities, including the UCLPartners Proactive Care Frameworks and its approach to patient risk stratification. This work has contributed to 43 practices across Hampshire and the Isle of Wight implementing the Frameworks.
- **Enhanced system relationships** between the pharmacy workforce (pharmacists and pharmacy technicians employed by ICB or PCNs working in GP practices) and PCNs.
- **Raised the profile** of the pharmacy profession and its role in this work.

One unexpected outcome was the interest from PCN pharmacy teams contacting the central PCN team to find out more about how they could engage with the blood pressure optimisation programme. The pharmacy workforce has been key to the delivery of this work and clearly demonstrated the value and expertise that pharmacy teams can provide to PCNs.

The pharmacy workforce **has been key** to the delivery of this work

Future Work

The ICB pharmacy team will continue its work and focus on blood pressure optimisation with the PCNs who are yet to fully adopt. This will be supported by AHSN resources and promotional materials. The learning and changes that PCNs have already made in this area can be spread and adopted by other networks, to encourage greater use of the PCN workforce and pharmacy teams.

For more information, please contact **weahsn.contactus@nhs.net**

"Thanks for your support with CVD. Following our first meeting we sat down and reviewed our processes for monitoring patients blood pressures, mnitoring hypertensives and identifying undiagnosed hypertension. We are really pleased to hear that the data is now showing an improvement."

Glenn Allen
Business Intelligence Manager, Portsdown Group, Portsmouth

Case Study

West Midlands Academic Health Science Network Case Study

Implementation of the UCLPartners Proactive Care Frameworks for the risk stratification of hypertensive patients in collaboration with West Midlands AHSN

Opportunity for change

To review all hypertensive patients at Broadway and Brook Surgery located in the SWB Urban Health PCN (Birmingham and Solihull ICB), risk stratify them and devise a plan for optimisation of their care.

Urban Health PCN has approximately 602 Coronary Heart Disease (CHD) admissions per 100,000 and falls within the 5th quintile (most deprived 20%) with high health inequalities. Brook surgery has approximately 4000 patients alone, of which 532 patients are currently on the hypertension register.

The team aimed to ensure there was appropriate follow up for patients with a recorded BP reading of ≥140/90mmHg in a GP practice, or ≥135/85 in a community setting.

Urban Health PCN has approximately **602 Coronary Heart Disease (CHD)** admissions per 100,000

Searches were run in September 2022 to obtain a baseline of the current hypertension register

Intervention

The practice teams met with WMAHSN colleagues at the end of 2022 to discuss the UCLPartners Proactive Care Frameworks and how they can be utilised within the practice. UCLPartners Proactive Care Frameworks searches were run in September 2022 to obtain a baseline of the current hypertension register.

Patients at both practices were risk stratified, and colour coded as red, dark amber, amber and green (defining priority/need for review), which produced an extensive list, particularly for Broadway surgery. Before contacting patients, the pharmacy lead formulated a care plan for each patient, and patients were block-booked in for their BP check.

The surgery has strong links with community pharmacy, meaning Ambulatory Blood Pressure Measurements could be undertaken in a community setting and readings relayed to the practice.

Patients were then followed up with an AccuRX text message or a phone call if they did not respond initially.

All red patients (which were 8 patients) at Broadway have now been seen and the team has moved on to their Priority 2 list (the dark amber patients – which were 60 in total) 50% of which have been seen.

It was felt that there was a greater need at Brook surgery, and so all patients have now been risk stratified and treated. The Brook surgery had more patients that needed their blood pressure optimised and had an increased rate of failed encounters as well as poor concordance to medication. The Brook surgery is located in Sparkbrook Birmingham, which is in a highly deprived area of Birmingham.

This project has been a team effort with input from Pharmacists, GPs, HCAs and admin staff to risk stratify and reach out to patients.

> *"Achieving hypertension targets for patients is a huge task, especially with such large populations of hypertensive patients. Using the UCLPartners Proactive Care Framework and tailoring it for our needs has helped us improve the quality of care given to hypertensive patients and provided a structured approach to care. We have already seen a massive improvement in hypertensive control."*

Nasar Aslam
Pharmacist Independent Prescriber, Broadway Health Centre, West Birmingham CCG Vaccination Lead

Impact/outcomes

As a result of the work undertaken, patients that were previously risk stratified as red in Priority group one have turned to light amber or green with a developed care plan formulated for their treatment and management going forward in the form of initiating or optimising treatment.

However, the team are aware that patients stratified into the lower Priority groups (light amber and green) may now fall into a higher Priority group which require treatment, and so they are continuing with this work to re-run the searches and educate patients around diet, weight, exercise as well as their medication. The team has sought to empower patients, particularly in deprived areas with health inequalities with the addition of education and patient facing materials.

This work has revealed additional outcomes for patients such as non-compliance with medication and education for patients around the importance of blood pressure optimisation and management.

One example given was regarding a patient with raised BP during the night. This was identified following 24hr ABPM. This resulted in a change to their medication to be taken at night to reduce their blood pressure.

This work has also enabled identification of pre-diabetic patients and those with raised cholesterol; enabling intervention to address other co-morbidities that contribute to an individual's cardiovascular risk.

Future Work

This is an ongoing project, and the searches will continue to be re-run within the practice.

This work has already been scaled to a partner practice but has the potential to be scaled up across the whole locality.

Discussions are currently underway to consider scalability and to ensure equitable delivery of this service.

For more information, please contact

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Discussions are currently underway to **consider scalability** and to ensure equitable delivery of this service

The team has **sought to empower patients**, particularly in deprived areas

Case Study

West of England AHSN Case Study

Working with the West of England AHSN to improve the management of hypertension in the Gloucester Health Access Centre

West of England Academic Health Science Network

Opportunity for change

The Gloucester Health Access Centre (GHAC) operates in the most deprived area of Gloucestershire Integrated Care System (ICS) in inner city Gloucester. The Gloucestershire ICB cardiovascular lead connected the lead pharmacist, Richard Lee, for the Primary Care Network (PCN) with the AHSN to see how the BPO project could help support the work already being carried out to improve overall blood pressure management and case finding for the practice and PCN. This includes supporting PCNs to adopt a new care framework (the UCLPartners Proactive Care Frameworks) for optimising blood pressure.

Bring focus on blood pressure optimisation to the PCN pharmacist team

Regular review of reports to **identify target patients**

Intervention

With searches available from the UCLPartners Proactive Care Frameworks downloaded into the clinical system, the focus has been on identifying patients with very high blood pressure. In addition to a regular monthly search, a warning message now displays when a relevant patient record is accessed to encourage interventions.

Regular meetings were held, linking the AHSN and Richard Lee which ensured a continued focus on developing an approach to managing blood pressure in the practice.

As the lead pharmacist, Richard has been able to bring this focus on blood pressure optimisation to the PCN pharmacist team. Improvements have also included drawing up a new blood pressure protocol for all practice staff to use, increased use of blood pressure monitors and regular review of reports to identify target patients.

The AHSN linked Richard with a GP from Bristol that had worked with community groups in areas with health inequalities to share and spread best practice. He also attended health coaching training sessions to enhance patient interactions.

Improvements have also included drawing up a **new blood pressure protocol**

> *"The collaboration between GHAC and the ASHN has ensured a continued focus on identifying and managing blood pressure for this challenging patient group. Each meeting has raised new ideas and challenges which have lead to new ways of working and developing plans for new and sustainable projects."*

Richard Lee
Lead Pharmacist for Gloucester Inner City PCN

Impact/outcomes

During this time the practice hypertension register has increased: growing from 802 (7.9% of practice population) to 869 (9.1%). In addition, 199 patients, with a previous raised blood pressure reading, have had a hypertension diagnosis excluded through the improved use of home blood pressure monitoring.

After a blood pressure review with a nurse, all patients are followed up to review their bp reading and discuss their target. There is a copy of the British Hypertension Society targets in every clinic room and text messages are used to support communication with patients.

The most surprising outcome is that the high Priority group (BP more than 180/120) is not static, and the search is now monthly to ensure a plan is in place for everyone on the list. This led to the development of the pop-up warning that appears on the GP record so that all clinicians have an opportunity to engage with this difficult and important group of patients.

Future Work

Future work will focus on supporting, through an outreach programme, the circa 40% of GHAC patients that do not have English as a first language and ensuring communication and approach suits their needs.

This work will involve meeting the practice team, PCN leadership, community organisations, local shops and places of worship with the aim of supporting patients and registering those residents without a GP at GHAC.

The aim will be to get support from within the practice but also the community to run events and education sessions across the city with patients to further engage with their health needs and increase GP practice registration.

For more information, please contact **weahsn.contactus@nhs.net**

Resources

- **Reducing high blood pressure health inequalities – West of England Academic Health Science Network (weahsn.net)**
- **Blood pressure optimisation – West of England Academic Health Science Network (weahsn.net)**

Hypertension register has increased from **802** (7.9% of practice population) to **869** (9.1%).

All patients are followed up to **review their bp reading** and discuss their target

Case Study

Hypertension Management in Primary Care:
Improving the Detection and Management of Hypertension – A Simple Case of Initiative

Yorkshire & Humber AHSN

Opportunity for change

The objective of this work was to promote the UCLPartners Proactive Care Frameworks and resources for blood pressure optimisation (BPO) and by doing this support practices with hypertension management and recovery post-covid. The Quality and Outcomes Framework (QOF) data for 2020-21 showed that blood pressure optimisation rates deteriorated substantially during the pandemic as patients' access to healthcare was disrupted. The Yorkshire & Humber AHSN therefore identified practices where there was a combination of reduced hypertension management for 18-79 year olds (HYP003) and over 80 year olds (HYP007) and high levels of deprivation, based on the Index of Multiple Deprivation (IMD) scores 1 and 2. This was used to identify practices within primary care networks in need of support with BP optimisation and could benefit from some of the resources available via UCLPartners.

Birley Medical Centre fell in the combination category of deprivation and low rates of treatment for hypertension and was identified as the lowest performing practice in Sheffield's Townships 1 PCN, South Yorkshire ICB. The AHSN project manager, Ruth Pitman Jones and Ebun Ojo, Sheffield's Lead Pharmacist for Hypertension, met with the PCN lead, Dr Tom Holdsworth, the network manager Alison Smith and the practice nurse at Birley Health Centre. They highlighted work underway in the network to support Birley Medical centre to improve their BP optimisation and also to see what support could be offered. The AHSN was able to share the QOF data with the practice and also highlighted searches within the clinical system to help with prioritising patients for BP optimisation. The ICB had recently procured Ardens for all practices which meant that the UCLPartners searches were now readily available on the clinical systems to aid patient prioritisation.

Blood pressure optimisation rates deteriorated substantially during the pandemic

Birley Medical Centre was **determined to improve**

Intervention

Birley Medical Centre was determined to improve and had already been considering the need for a dedicated lead for hypertension as hypertension was being dealt with by different clinicians and no-one had specific accountability. The team at the practice decided that the practice nurse, Karen Howsham, would become this lead.

As hypertension lead, anything to do with hypertension now "lands on Karen's desk". Karen is a nurse prescriber with a team of Health Care Assistants (HCAs) undertaking the BP checks, with Karen doing the follow-ups which includes titrating the medicines. The clinical director of the practice is on hand for advice and guidance.

Birley Medical Centre hypertension services also **involved their local pharmacy**

> ***"Every practice needs a nurse prescriber like Karen, it is about accountability, mutual trust, and working as a team with someone who is dedicated to driving things"***
>
> **Sam Fellowes**
> **Practice Manager**

Impact/outcomes

Birley Medical Centre hypertension services also involved their local pharmacy. Collaboration with their pharmacy had been identified as an area which could be improved

To support this, the practice manager introduced informal monthly meetings with the practice and pharmacy staff. This led to the practice reception team visiting the pharmacy to see how their systems worked and vice versa with the pharmacy team visiting the practice to understand the practice systems. This helped to create a greater understanding between the two, with both working together for patient care. It also meant that patients could see them as one establishment and they were able to also work together to carry out BP checks.

The measurable outcome was seen when the QOF data was published for 21/22. Birley Health Centre had improved considerably for their treatment of hypertension, **increasing the treatment of the over 80s by 42% and the under 79s by 31%.**

Future Work

Birley Medical Centre undertook an opportunistic case finding initiative by using volunteers to take the BP of those attending the flu clinic. This resulted in 700 patients having their BP checked.

The vision for the future is to develop a community outreach initiative for the PCN that involves both a blood pressure check and wider lifestyle advice, for example, in the nearby Crystal Peaks Shopping Centre. This would be to catch those who cannot make standard surgery appointments or those who are averse to going to see their GP.

In addition, the practice would like a BP machine for the waiting room which links to SystmOne and automatically transfers data to patient records and has alerts for high BP. This could result in patients not having to make an appointment with a health care assistant and reception staff could show patients how to use the equipment. The PCN is currently seeking funding and a community partner to operationalise these plans.

For more information, please contact **info@yhahsn.com**