West Yorkshire and Harrogate
Health and Care Partnership

YORKSHIRE & HUMBER
ACADEMIC HEALTH SCIENCE NETWORK

Hypertension Implementation Resource

A support resource for:

GPs, Practice Managers and wider Primary Care teams

West Yorkshire and Harrogate
HEALTHY HEARTS

www.westyorkshireandharrogatehealthyhearts.co.uk

Index

Foreword

The nine Clinical Commissioning Groups within the West Yorkshire and Harrogate Health Care Partnership (HCP) have committed to tackling cardiovascular disease (CVD) and diabetes. We have been working together over the last year to share the learning from a number of local projects, including Bradford Healthy Hearts, in order to develop our own project.

Our project aims to contribute to an overall reduction in CVD events by 10% by 2021. This will be achieved through the detection of 18,000 more patients with undiagnosed hypertension and a further 39,000 people, who need to have their blood pressure tighter controlled.

This will potentially prevent over 250 heart attacks and 400 strokes; having not only a massive positive impact on the lives of the people of West Yorkshire and Harrogate, but also a significant economic impact to the health and social care system.

We can only do this by working together, and we hope that this implementation resource will help contribute to our overall ambition.

Your support is very much appreciated, and we welcome your feedback and involvement as we work along this journey together to improve CVD.

Dr Steve Ollerton (Project Sponsor)

Clinical Chair Greater Huddersfield CCG

"Our project aims to contribute to an overall reduction in CVD events by 10% by 2021."

An Introduction to Healthy Hearts

As a practicing GP I know first-hand the demands on Primary Care - so we have aimed to create a project that is as workload light to primary care as possible. The project will be delivered in three phases; firstly Hypertension, secondly Lipid Management, and the thirdly Glycaemic Control. The pack is focusing on the first phase, tackling Hypertension, which will consist of:

Increasing recorded prevalence of hypertension

- Identify patients already on anti-hypertensive medication but not on the hypertension register
- Identify patients who have high blood pressure readings but who are not yet diagnosed

Treatment optimisation

- Identify and optimising the treatment of patients already diagnosed with hypertension

In order to do achieve these objectives we have created a number of resources:

1. **Clinical searches** to identify patients likely to be in need of further investigation and management
2. Locally developed simplified **Hypertension treatment guidance** document
3. **West Yorkshire and Harrogate Healthy Hearts Website** with a range of useful resources for the for healthcare professionals, patients and the public
4. A **Hypertension dashboard** to help show those areas where we are improving and those that may need further support
5. This **Hypertension Implementation Resource** which brings together a range of information and a brief checklist to help support practices

I can speak first hand that in Bradford, by implementing such resources, we were able to improve the detection and management of patients with hypertension; leading to more than 6,200 people with improved treatment and blood pressure control. Feedback from the GP practices involved was that this was achieved with little impact on practice workload.

It is a real privilege to be able to build on this work through a wider West Yorkshire and Harrogate project. The local clinicians that we have been working with have shown an amazing commitment to working together; without them we could not have put this project together. I hope you will find this resource pack of value. If you haven't already, I would encourage you to speak to your Clinical or Programme Lead, details can be found on our **website**.

Alternatively, you can contact Pete Waddingham, Programme Manager at the Yorkshire and Humber Academic Health Science Network (AHSN), who are helping support the project. You can reach them by email: **WYHHealthyHearts@yhahsn.com**.

Once again, a massive thank you for your support - I hope we can work together and try and reduce the impact of CVD and diabetes across the area.

Dr Youssef Beaini
West Yorkshire and Harrogate Healthy Hearts Clinical Lead
CVD Lead Bradford CCGs

"I can speak first hand… in Bradford…we were able to improve the detection and management…leading to more than 6,200 people with improved treatment…"

Hypertension Implementation Resource - Section A

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Clinical Searches and Treatment Guidance Uncomplicated Hypertension

West Yorkshire and Harrogate HEALTHY HEARTS

(under 80yrs - exc.DM/CKD 3B+/IHD/MI/CVA/PAD)

Three clinical search areas have been developed in order to support Practices with recorded prevalence and treatment optimisation of hypertension:

1.
To help identify those patients under 80 years old on antihypertensive medication, but **not on the hypertension register**. This search excludes patients who are on other disease registers such as CHD, Diabetes, Heart Failure, PAD, Raynaud's etc. There is also a search for those who previously had a resolved code.

2.
To help identify those patients under 80 years old with four or more readings in the last three years above 140/90, who are **not on the hypertension register**. These searches are split by bandings based on the last reading, in order to help Practices prioritise workload i.e. those with the highest last BP reading can be reviewed first. The searches exclude those patients who have been coded with a satisfactory HBPM /ABPM result.

3.
To help identify those patients **on the hypertension register**, but not controlled to target 140/90. It excludes those patients who are on maximum tolerated doses of hypertensive medication. This search has been split by bandings based on the last reading, in order to help Practices prioritise workload.

These searches should be run regularly by the Practice (it's recommended at least every quarter) in order to identify those patients who will benefit from being added to the hypertension register to help optimize their treatment.

Practices across West Yorkshire and Harrogate can access the Healthy Hearts hypertension clinical searches via a variety of methods (depending on the clinical system and CCG).

Those on SystmOne* can access the searches via a central organisational group hosted by NHS Calderdale (search for West Yorkshire and Healthy Hearts Project). EMIS* searches are located on reporting units hosted by your local CCG.

For any questions please email **WYHHealthyHearts@yhahsn.com**

Follow us on Twitter **@WYHHealthyHeart**

*Note all Leeds CCG Practices can access the searches via Clinical Reporting> Leeds Data Quality > Healthy Hearts Leeds > Healthy Hearts Leeds 2019

The treatment guidance opposite is a shortened version.
The full version is available to download at **www.westyorkshireandharrogatehealthyhearts.co.uk/professionals**

West Yorkshire and Harrogate Health and Care Partnership

Yorkshire & Humber AHSN

Version 11/03/2020. Created March 2019. Revised December 2019. Review Date November 2022.

Recommend use of ABPM for diagnosis.
(HBPM if not available/tolerated).
If Clinic BP >=140/90 confirm diagnosis with ABPM/HBPM.
If Clinic BP >=180/120 consider immediate treatment.

ABPM (or HBPM) <135/85	ABPM (or HBPM) >=135/85	ABPM (or HBPM) >=150/95	ABPM (or HBPM) >=180/120
	Lipids • U&Es • LFTs • TFT • HbA1c • ECG • Urine Dip • ACR		
NOT Hypertensive	STAGE 1 Hypertension	STAGE 2 Hypertension	STAGE 3 Severe Hypertension
	Hypertensive and if <10% CVD risk* and no target organ damage	Hypertensive and if ≥10% CVD risk* or target organ damage	
Offer lifestyle advice and signposting as required	Offer lifestyle advice and signposting (one year review)	Lifestyle advice+ Treat	Lifestyle advice+ Treat	Lifestyle advice+ Treat. Consider referral if accelerated

If not controlled check non-adherence, alcohol and lifestyle. Provide signposting to community pharmacy for medication support (MUR/NMS).

Check U&Es at various stages e.g. when changing dose/medication

Check potassium at regular intervals.

If low K+ thought due to indapamide:
Mild 3.0 - 3.4 – recheck K+ in 4 weeks.
If still low but mild, continue indapamide
Moderate 2.5 - 2.9 – recheck K+ in 24 hours.
If still moderately low, switch to losartan
Severe <2.5 – Admit

If still resistant hypertension consider repeat HBPM/ABPM and then consider referral for A&G.

Titrate up Amlodipine and Losartan to maximum tolerated before referral to A&G.

REMEMBER AKI SICK DAY RULES

*Amlodipine 5mg

If not controlled <135/85 HBPM or ABPM

+ Indapamide 2.5mg

1st, 2nd, 3rd Line Hypertension Therapy

*Amlodipine 5mg + Indapamide 2.5mg

Consideration can be given to a phased approach when initiating dual therapy at diagnosis(Amlodipine + Indapamide) e.g. start Amlodipine and then commence Indapamide one week later.

If not controlled <135/85 HBPM or ABPM

+
ARB - Losartan 50mg OD increase to 100mg if needed

If not controlled <135/85 HBPM or ABPM

4th Line Hypertension Therapy

+
Spironolactone 25mg daily
Monitoring Spironolactone
CAN START IF K+ <4.5 AND GFR >45
If K+ >4.5 then use alpha / beta blockers and titrate up

If not controlled <135/85 HBPM or ABPM

Referral for Advice and Guidance:
Same day: Accelerated Hypertension or suspected Pheochromocytoma
Routine: Age under 40 with Hypertension / If Secondary Hypertension suspected / unresponsive to 4th line therapy

AKI SICK DAY RULES

When unwell with any of the following: Vomiting, diarrhoea, or general dehydration due to intercurrent illness, then STOP taking the medicines listed below (restart after feeling well/after 24-48hrs of eating and drinking normally):

- ACE Inhibitors, ARBs, NSAIDs, Diuretics, Metformin, Sulfonylureas, SGLT2 inhibitors (e.g. Empagliflozin)

For further details, see: **www.nice.org.uk/advice/KTT17/chapter/Evidence-context**

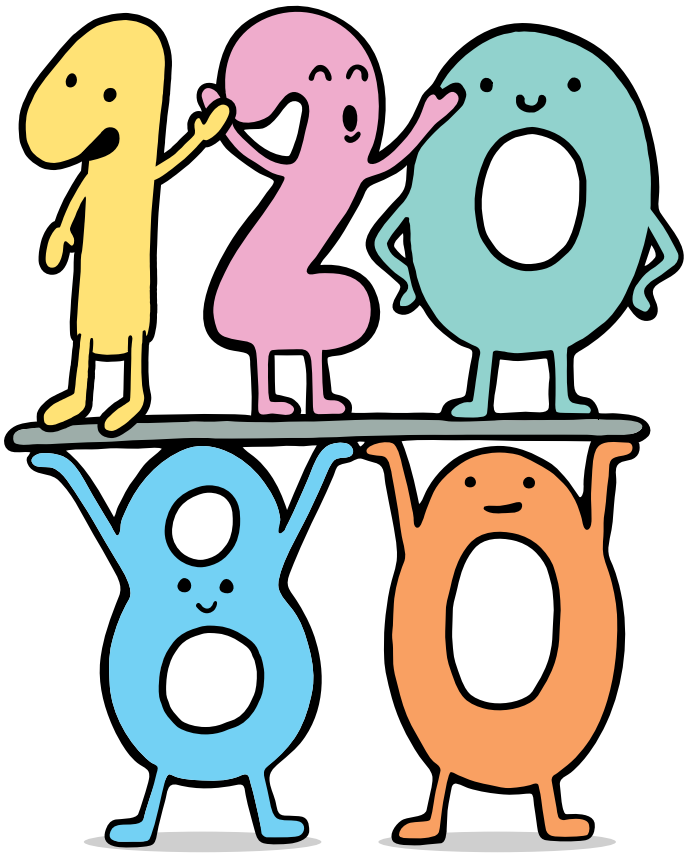
Version 11/03/2020. Revised December 2019. Review Date November 2022.

Hypertension Treatment Guidance

A West Yorkshire and Harrogate **Hypertension Treatment Guidance** document is available for the management of patients with uncomplicated hypertension. This document has been developed following the review of recent evidence and guidelines, and extensive engagement across the area with local clinicians in primary and secondary care, and other contributors.

A background document to the guidance, produced by Dr Youssef Beaini, can be found **here**.

- It is intended to be issued as guidance and is not mandatory – clinicians should continue to exercise their own clinical judgement as required
- The guidance emphasises lifestyle advice at every stage and the use of supporting services such as community pharmacy - in order for patients understand their medication
- It is strongly encouraged that shared decision making between the patient and the healthcare professional is at the heart of this treatment guidance



Clinical System Templates and Coding

In addition to the clinical searches, a hypertension template has been created in order to support consultations with hypertension patients.

This includes

- **Read Codes to use**
- **Suggested pathways to follow**

These templates can be imported using files that will be provided as part of this implementation resource. Your local CCG is likely to have located these files on central folders. Details will be provided separately if this is the case. Practices are encouraged to use the system templates provided since it fulfils QoF and includes the simplified treatment guidance, but it is recognised that some may wish to continue to use their own customised versions. If you're having trouble importing the searches into your system please read our 'Importing Templates and Searches' document on our **website.**

Supporting Notes

Occasionally, some patients who have had a normal home BP or 24 hour BP may appear in the searches with BP apparently not to target. **This happens if clinicians incorrectly code the home BP or 24-hour BP with BP values entered as free text, instead of coded numeric values.** Please take care when coding home or 24-hour BP to ensure you do not use free text. This will help practices' QoF achievement.

If a patient's Home BP is below 135 systolic, please record it using Numeric Results function, or you could add the code for "normal blood pressure" Ua1fM.

When adding the code for the newly diagnosed hypertensive patient this should be added as a new episode for QOF.

Review of patients on antihypertensive medication may identify those with a "hypertension resolved" code - these should all be reviewed as per suggested guidance (they should not be bulk coded as hypertensive).

For patients that became hypertensive several months or years ago, the new diagnosis of hypertension should be added at that date, so that there is a correct clinical indication in the medical record for the medication the patient has been prescribed. If it is subsequently decided that the hypertension resolved code was added incorrectly then this code should be removed from the record.

Useful codes which are QoF-active - these are all on our Healthy Hearts template

Average 24 hour BP	S1 – XaF4b EMIS – 246v and 246w
Average Home BP	S1 – XaKFw EMIS – 246c and 246d
Blood pressure	S1 – 246A EMIS – 246
Blood pressure (refused)	S1 - XaJkR
Blood pressure (Normal blood pressure) *If not using a non numerical figure	S1 – Ua1fM
Essential Hypertension	S1 - XE0Ub EMIS – G20
Ex – smoker	S1- Ub1na EMIS – 137S
Lifestyle advice regarding hypertension	S1 – XaQaV EMIS – 67H8
Never smoked tobacco	S1 – XE0oh EMIS – 1371
Patient on Maximal tolerated antihypertensive therapy	S1 – XaJ5h EMIS – 8BL0
Smoker	S1 – 137R EMIS - 137R
Smoking Cessation advice	S1 – Ua1Nz EMIS – 8CAL

Information and Shared Decision Making

A WY&H Healthy Hearts website has been created to help support professionals, patients and the public with key information on CVD.

The main pages will contain generic information on a number of topics, and links to CCG area specific pages, so that the information can be tailored to the needs of people who are using the site.
For example, patients wishing to find information about lifestyle services in their area can do so by clicking the CCG that covers the area where they live.

www.westyorkshireandharrogatehealthyhearts.co.uk

As not every patient will have access to the internet a range of supporting materials will be made available to practices which can be printed out for patients as required. These will be made accessible on the website and via clinical system templates. They are also available as appendices to this resource pack.

If you would like to see other content on the website, please use the **contact form** on the websiteto share your ideas.

Hypertension Dashboard

The last key support resource is a West Yorkshire and Harrogate Hypertension dashboard. This builds on the current hypertension dashboard that is currently in operation and includes information on the three new search areas described in section one.

The dashboard will help us, and you, to understand where we are improving, as well understand those areas that may need further support.

No patient identifiable data will be used in the creation of this dashboard. Practices will therefore need to conduct their own searches (as described in section one) to ensure numbers are accurate and that patient records can be viewed.

Further information regarding the use of non-patient identifiable (anonymised) data for healthy planning can be found **here.**

The dashboard will be circulated by your CCGs or can be requested by **email.**

Suggested Operational Implementation - Section B

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Clinical Champion

It is recommended that each practice identifies a lead clinician to act as a clinical champion for the project. The clinical champion e.g. a GP, practice nurse, pharmacist or healthcare assistant is encouraged to help determine practice policy and operational implementation in the wider clinical team, monitor the roll out of the project within the practice, monitor its success and inspire the practice team to adopt the principles. Practices in Bradford Districts CCG reported that identifying a clinical champion was a significant part to the success of their implementation.

Administrative Team

The administration team are likely to be a key part to the running of clinical system searches and communicating with patients who are identified during each phase of the programme. It is therefore advisable to ensure that they are well briefed on the project.

Feedback and Learning

The clinical champion of the project is advised to feedback regularly to other members of practice team, including administrative staff, to encourage continued support of the project. The clinical champion may wish to benchmark against other practices, and feedback to the CCG (via the Clinical Lead) any learning and observations.

Inclusion/Exclusion Criteria

The project is aimed at patients aged 40 - 80 years old who are identified by the clinical system searches. It is recognised that the clinical searches may identify patients who the practice deem to be not suitable for inclusion. Practices should use discretion to eliminate any patients for clinically informed reasons. It is recognised that some patients will refuse to have blood pressure tests either in the surgery or as an ambulatory test at home. Any refusal should be reviewed at appropriate intervals to ensure that it is still relevant.

Patients who have high blood pressure readings but aren't yet diagnosed

Part 1) Identify those with four or more readings (including the last) above 140/90

Key Steps	Responsibility	Comments	Support/Resources
Clinical system searches	Administration	Run system searches to identify currently undiagnosed patients	System searches
Sub-divide patients based on systolic BP level	Clinical	Allow clinicians to prioritise work to do based on a rag-rated display of patient information	System searches hypertension dashboard
Confirm hypertension	Patient/Clinical	In line with NICE guidance, those patients identified should be invited to take an ambulatory 24-hour BP monitor/home monitoring test to confirm hypertension, before the addition of the hypertension code and commencement of treatment	In-house ambulatory BP monitor or home BP monitor
Prescribe antihypertensive medication	Patient/Clinician	Subject to clinical judgement - the antihypertensive treatment prescribed should be considered in line with the Healthy Hearts hypertension treatment guidance - taking into account shared decision making and lifestyle advice.	Hypertension Treatment Guidance Website Community Pharmacy
Contact with patients	Administration/ Clinical	Contact with patients to discuss a new diagnosis and commencement of treatment should be conducted in line with practice policies.	Practice policies
Review	Clinical/ Administration	The continuing review of patients commenced on antihypertensive medications should be in line with practice repeat prescribing policies. Support can be provided by Community Pharmacy Services. Practice policies may need to be reviewed following learning of this project.	Hypertension Treatment Guidance Website Community Pharmacy Practice policies

Part 2) Identify those on antihypertensive medication but not on the hypertension register

Key Steps	Responsibility	Comments	Support/Resources
Clinical system searches	Administration	Run system searches to identify patients currently on antihypertensive medication but not on the hypertension register	System searches
Determine the prescribing need	Clinical	The clinical records for the patients identified should be reviewed to determine if the prescribed antihypertension medication is for the treatment of hypertension. If not, then appropriate code to link the medication to the condition it is prescribed for should be used to ensure future clarity.	Patient clinical record
Confirm hypertension	Patient/Clinical	Where appropriate following clinical review of record, in line with NICE guidance, those patients identified should be invited to take an ambulatory 24-hour BP monitor/home monitoring test to confirm hypertension before the addition of the hypertension code and commencement of treatment	In-house ambulatory BP monitor or home BP monitor
Prescribe antihypertensive medication	Patient/Clinical	Continue with current medication if well controlled, if not review the medication in line with the hypertension treatment guidance - taking into account shared decision making and lifestyle advice.	Clinical record or Hypertension Treatment Guidance Website Community Pharmacy
Contact with patients	Administration Clinical	Contact with patients to discuss a new diagnosis and commencement on treatment should be conducted in line with practice policies	Practice policies
Review	Clinical/ Administration	The continuing review of patients commenced on antihypertensive medications should be in line with practice repeat prescribing policies. Support can be provided by Community Pharmacy Services. Practice policies may need to be reviewed following learning of this project.	Hypertension Treatment Guidance Website Community Pharmacy Practice policies

Treatment Optimisation

Part 3) Identify and optimise treatment of patients already diagnosed with hypertension, whose BP is > 140/90

Key Steps	Responsibility	Comments	Support/Resources
Clinical system searches	Administration	Run system searches to identify currently uncontrolled patients	System searches
Review current management plan	Clinical	For those patients identified, commence hypertension treatment in line with the hypertension guidance. It is at practice discretion whether a patient who requires a change of medication, to fall in line with the guidance, is asked to attend for an appointment or whether a new prescription is issued without the need for an appointment. However, shared decision and lifestyle should be taken in to account.	Hypertension treatment Guidance Website
Review	Clinical/ Administration	The continuing review of patients commenced on antihypertensive medications should be in line with practice repeat prescribing policies. Support can be provided by Community Pharmacy Services. Practice policies may need to be reviewed following learning of this project.	Hypertension Treatment Guidance Website Community Pharmacy Practice policies

Frequently Asked Questions

1 We don't understand what we are being asked to do - who should we contact?

Practices can contact the West Yorkshire and Harrogate Healthy Hearts team at Yorkshire & Humber AHSN who will ensure that any questions are answered: WYHHealthyHearts@yhahsn.com

2 Why are we deviating from NICE guidance?

Guidelines have increasingly focused on the stepped-care approach, initiating treatment with different monotherapies and then sequentially adding other drugs until BP control is achieved. This traditional method requires numerous attendances at the GP practice and lots of repeated blood tests early on in treatment. Currently there are local inequalities in implementation of NICE hypertension guidance, since a large proportion of the population are not controlled to NICE BP targets. Many local GPs and nurses have fed back that 2011 NICE hypertension guidance is not straightforward to use. This simplified guidance is designed to get blood pressure down more quickly (evidence shows this saves lives) and more efficiently. It is evidence-based and draws on world-class European Society of Cardiology guidance.

3 Do I have to follow this treatment guidance?

The treatment guidance is not mandatory, but we believe it will help to ensure a patient's blood pressure is kept under control more effectively. However, there is clear evidence that the main benefit from hypertension treatment is from the blood pressure drop, not the drug chosen. Lifestyle is a key contributing factor.

4 We are already busy, how do you expect us to conduct this work?

In Bradford Districts the feedback from the practices involved was that this was achieved with very little impact on practice workload. We hope that by providing you with this resource we can minimise any additional workload constraints. There is lots of support available including; the **Community Pharmacy** services **and** **New Medicine Service** who will be able to talk to patients about their condition and medication. We will also be ensuring the website has lots of resources for use in Primary Care, such as; patient letters and information, system templates, and links to a vast range of external supporting materials.

5 How often should I review my patients?

At each treatment stage, we would suggest monthly review until blood pressure is controlled.

6 What successes did Bradford have in implementing this project?

Bradford Districts CCG had more than 6,2000 people with improved treatment of hypertension as a result of their project.

7 What is the collective ambition for the West Yorkshire and Harrogate Project

Based on Bradford results we are aiming for the detection of 18,000 people with currently *undiagnosed* hypertension. For people with diagnosed hypertension, Bradford increased control to 140/90 from 63% to 76% in 16 months. If this effect was replicated across the West Yorkshire and Harrogate a further 39,000 people could have their blood pressure tighter controlled.

8 How often should I run the searches

As a minimum, practices should run these searches once a quarter. This will enable any trends to be monitored. However increased frequency will allow any impact to be assessed sooner.

❾ When should we refer patients to Secondary Care?

Refer all patients with new onset hypertension <30 years of age to cardiology for consideration of secondary causes.

Consider referral for those 30-40 years of age, especially if not controlled on three medications (Advice and Guidance)

Consider referral if low potassium, high sodium or recurrent unexplained spikes in Blood Pressure (Advice and Guidance).

❿ There is important information missing from the website - how do I provide feedback?

You can contact us through our **website** or by **email**.

⓫ What are the timescales for the rest of the project?

We hope to be able to start the Cholesterol/Lipid Management work in September 2019 and then the Diabetes/glycaemic control work in 2020.