Hypertension Implementation Resource

A support resource for:
GPs, Practice Managers and wider Primary Care teams

www.westyorkshireandharrogatehealthyhearts.co.uk
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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.”
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

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@yahsn.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.

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.

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**Dr Youssef Beaini**  
West Yorkshire and Harrogate Healthy Hearts Clinical Lead  
CVD Lead Bradford CCGs
Clinical Searches and Treatment Guidance
Uncomplicated Hypertension
(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 SystemOne* 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@yahhsn.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
Recommend use of HBPM or ABPM for diagnosis. If using clinic BP, follow suggested Clinic BP threshold targets.

HBPM or ABPM <135/85
- Offer lifestyle advice and signposting as required

HBPM or ABPM >=135/85
- Hypertensive and if <20% CVD risk* and no target organ damage
- Offer lifestyle advice and signposting (one year review)

Lipids • U&Es • LFTs • TFT • HbA1c • ECG • Urine Dip

Not Hypertensive

Stage 1: Clinic BP <140/90
Stage 2: Clinic BP <160/100
Stage 3: Clinic BP <180/120

HBPM or ABPM >=135/85
- Hypertensive and if >20% CVD risk* or target organ damage
- Lifestyle advice+ Treat

Stage 1: Hypertension
Stage 2: Hypertension
Stage 3: Hypertension

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

REMEMBER AKI SICK DAY RULES

Check potassium at regular intervals.

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

Consider adding alpha or beta-blocker.

Tritrate up all agents to maximum tolerated before referral for A&G.

REMEMBER AKI SICK DAY RULES

AKI SICK DAY RULES
When unwell with any of the following: Vomiting or Diarrhoea (unless minor) OR fevers, sweats and shaking.
Then STOP taking the medicines listed below (restart after feeling well/after 24-48hrs of eating and drinking normally)
- ACE Inhibitors: medicines ending in ‘pril’ e.g. lisinopril, perindopril, ramipril
- ARBs: medicines ending in ‘sartan’ e.g. losartan, candesartan, valsartan
- NSAIDs - anti-inflammatory pain killers e.g. ibuprofen, diclofenac, naproxen
- Diuretics (water pills) e.g. furosemide, spironolactone, indapamide, bendroflumethiazide
- Metformin - a medicine for diabetes
- Sulfonylureas (e.g. gliclazide)
- SGLT2 inhibitors (e.g. empagliflozin)

Contact Pharmacist, GP or nurse for further guidance or visit www.nice.org.uk/advice/KTT17/chapter/Evidence-context
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 website to 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
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**

<table>
<thead>
<tr>
<th>Key Steps</th>
<th>Responsibility</th>
<th>Comments</th>
<th>Support/Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical system searches</td>
<td>Administration</td>
<td>Run system searches to identify currently undiagnosed patients</td>
<td>System searches</td>
</tr>
<tr>
<td>Sub-divide patients based on systolic</td>
<td>Clinical</td>
<td>Allow clinicians to prioritise work to do based on a rag-rated display of patient information</td>
<td>System searches hypertension dashboard</td>
</tr>
<tr>
<td>BP level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirm hypertension</td>
<td>Patient/Clinical</td>
<td>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</td>
<td>In-house ambulatory BP monitor or home BP monitor</td>
</tr>
<tr>
<td>Prescribe antihypertensive medication</td>
<td>Patient/Clinician</td>
<td>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.</td>
<td>Hypertension Treatment Guidance Website Community Pharmacy</td>
</tr>
<tr>
<td>Contact with patients</td>
<td>Administration/</td>
<td>Contact with patients to discuss a new diagnosis and commencement of treatment should be conducted in line with practice policies.</td>
<td>Practice policies</td>
</tr>
<tr>
<td></td>
<td>Clinical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review</td>
<td>Clinical/</td>
<td>The continuing review of patients commenced on antihypertensive medications should be in line with practice repeat prescribing policies.</td>
<td>Hypertension Treatment Guidance Website Community Pharmacy</td>
</tr>
<tr>
<td></td>
<td>Administration</td>
<td>Support can be provided by Community Pharmacy Services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practice policies may need to be reviewed following learning of this project.</td>
<td></td>
</tr>
</tbody>
</table>

**Key Steps Responsibility Comments Support/Resources**

**Practice policies may need to be reviewed following learning of this project.**
### Part 2) Identify those on antihypertensive medication but not on the hypertension register

<table>
<thead>
<tr>
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<th>Comments</th>
<th>Support/Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical system searches</td>
<td>Administration</td>
<td>Run system searches to identify patients currently on antihypertensive medication but not on the hypertension register</td>
<td>System searches</td>
</tr>
<tr>
<td>Determine the prescribing need</td>
<td>Clinical</td>
<td>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.</td>
<td>Patient clinical record</td>
</tr>
<tr>
<td>Confirm hypertension</td>
<td>Patient/Clinical</td>
<td>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</td>
<td>In-house ambulatory BP monitor or home BP monitor</td>
</tr>
<tr>
<td>Prescribe antihypertensive medication</td>
<td>Patient/Clinical</td>
<td>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.</td>
<td>Clinical record or Hypertension Treatment Guidance Website Community Pharmacy</td>
</tr>
<tr>
<td>Contact with patients</td>
<td>Administration/Clinical</td>
<td>Contact with patients to discuss a new diagnosis and commencement on treatment should be conducted in line with practice policies</td>
<td>Practice policies</td>
</tr>
<tr>
<td>Review</td>
<td>Clinical/Administration</td>
<td>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.</td>
<td>Hypertension Treatment Guidance Website Community Pharmacy Practice policies</td>
</tr>
</tbody>
</table>
### Treatment Optimisation

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

<table>
<thead>
<tr>
<th>Key Steps</th>
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<th>Comments</th>
<th>Support/Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical system searches</td>
<td>Administration</td>
<td>Run system searches to identify currently uncontrolled patients</td>
<td>System searches</td>
</tr>
<tr>
<td>Review current management plan</td>
<td>Clinical</td>
<td>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.</td>
<td>Hypertension treatment Guidance Website</td>
</tr>
<tr>
<td>Review</td>
<td>Clinical/ Administration</td>
<td>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.</td>
<td>Hypertension Treatment Guidance Website Community Pharmacy Practice policies</td>
</tr>
</tbody>
</table>
Frequently Asked Questions

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

Practices can contact the leads for their CCG or the Yorkshire and Humber Academic Health Science Network (WHYHealthyHearts@yhahsn.com) who will ensure that your questions are answered.

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, New Medicine Service and Medicines Use Reviews 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.
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).

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

You can contact us through our website or by email.

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.