Primary Care Needs Assessment tool: indicator review

Google Chrome is advised to ensure this page displays/ functions as intended.

ⓘ You are now reviewing the PCNA indicator(s) for: **Prevalence of hypertension**

ⓘ **Caution**: The information on this page is provided for testing purposes and may be subject to amendment. It may contain errors or not be fully reflective of consensus public health advice or relevant services, therefore should only be used with care.

Strategic context

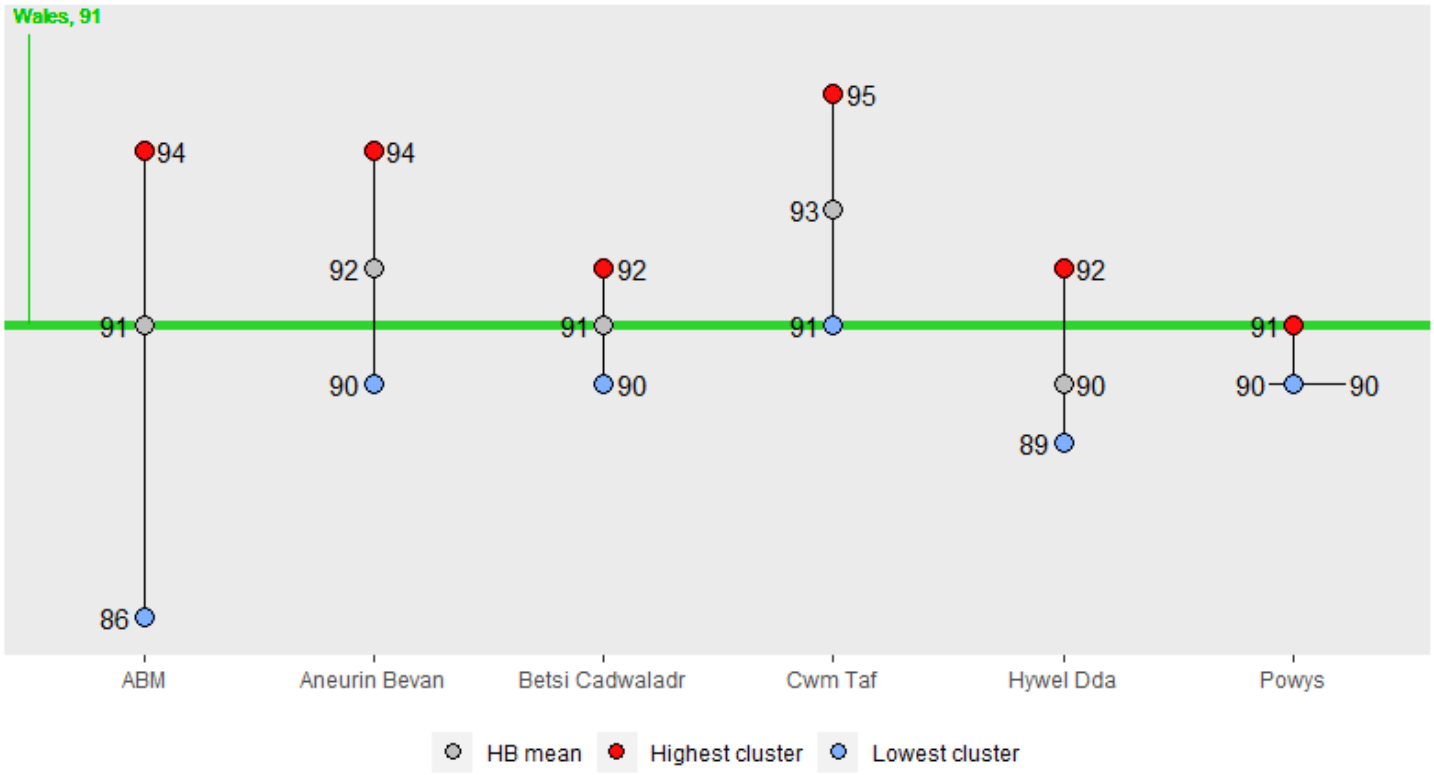
ⓘ Consider the national strategic context for prioritising improvement action in this area (in conjunction with your health board's IMTP and Regional Partnership Board's Area Plan):

- High blood pressure is the top-ranked clinical risk factor contributing to avoidable disability-adjusted life years (DALYs).
- Prevention and reduction of high blood pressure to reduce the burden of avoidable disease is identified as a joint priority for Directors of Public Health across Wales.
- The inverse care law (Hart 1971) states that the availability of good medical care tends to vary inversely with the need for it in the population served. The Inverse Care Law (ICL) Programme, established in the South Wales valleys, aims to increase ascertainment of people with or at risk of cardiovascular disease and cancer and supports them to make healthy behaviour changes.
- Indicators for this topic are reported via Primary Care Measures.

▼ PCM national variation

ⓘ Primary Care Measures (PCM) are a set of care quality indicators for primary care in Wales. The charts below emphasise variation between and within health boards; for further information see here. Beneath the charts are improvement action options that may inform cluster IMTPs. Variation is a natural phenomenon and can be healthy e.g. it can be a deliberate result of innovation in primary care settings that seeks to test improvements in processes or deliver better care outcomes. Variation that is observed in a healthcare context may be referred to as *inequality*; inequality that is judged to be both avoidable and socially unjust is termed *inequity* (sometimes alternatively described as *unwarranted variation*).

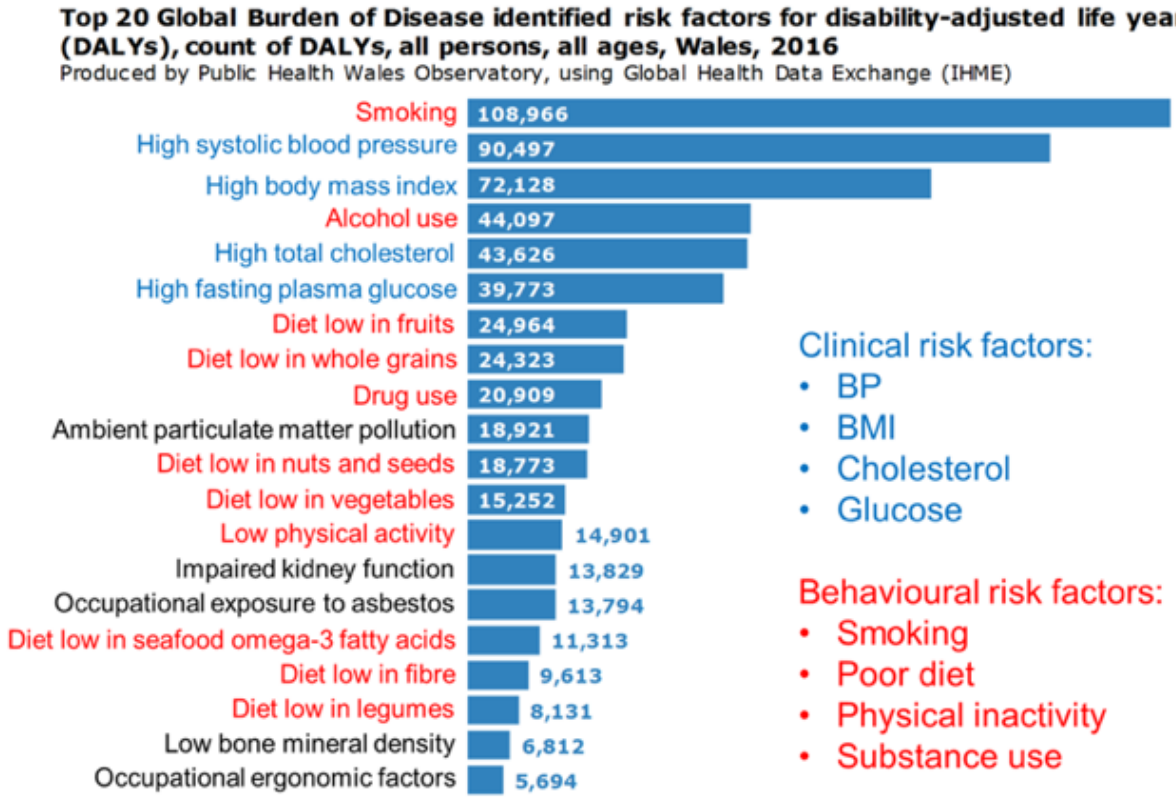
Variation in proportion of patients aged 50 or over who have a record of blood pressure in the preceding 5 years, by cluster within each health board, 2015/16 (*Source*: PCIP, Nov 2019):



▼ ⓘ Tell me about: DALYs

What are DALYs?

- Disability-adjusted life years (DALYs) are a combined measure of early deaths (i.e. premature mortality) and disability-weighted impact on quality of live from living with poor health.
- Because DALYs capture both what kills us and what makes us ill, they describe the overall 'burden of disease' (reported by risk or condition) more effectively than mortality or disability prevalence does alone.
- The relative contribution of known risk factors for DALYs is illustrated in the figure below (*Health and its determinants in Wales*, PHW 2018).



Behavioural risk factors for DALYs:

- Behavioural risk factors for DALYs relate to both individual behaviours and the choice environment (i.e. the people and things around a person that influence their health choices).
- Four behaviours—smoking, substance misuse (alcohol and drugs), inactivity and unhealthy diet contribute considerably to identified risk factors for DALYs in Wales.
- Behavioural risk factors are generally reduced via mix of population and targeted approaches, with the aim of preventing or reversing health-harming behaviours that contribute to DALYs.

Clinical risk factors for DALYs:

- Four clinical risk factors are among the top five ranked risks for DALYs, these being: high systolic blood pressure (i.e. hypertension); high body index (i.e. overweight and obesity); high total cholesterol; high fasting plasma glucose (a prelude to diagnosis of diabetes).
- Clinical risk factors may be secondary (in part) to behavioural risk factors.
- Clinical risk factors are generally reduced via targeted approaches.

▼ ⓘ Tell me about: Prevention

Definitions:

- Zola's river analogy is a useful way of thinking about prevention of ill health (Zola 1970). It describes **primary** prevention (stopping everyone from falling into a river and coming to harm e.g. never smoking), **secondary** prevention (ensuring any individuals at risk who do fall in get to safety quickly; minimising the chance of complications through early identification and intervention e.g. screening) and **tertiary** prevention (search-and-rescue for those taken downstream; mitigating the

worst consequences of established disease e.g. vascular surgery).

- The Welsh Government definition of prevention is broader: working in **partnership** to co-produce the best outcomes possible, utilising the strengths and **assets** people and places have to contribute.

Building a healthier Wales (Feb 2019) sets out six key principles for implementing prevention in Wales:

- Adhere to the **five ways** of working (as outlined in the Well-being of Future Generation Act).
- Commit to investing in **evidence-based** interventions (where available or evaluate small and scale up if appropriate).
- Ensure evidence-based interventions have sufficient **scale** and **reach** to make a measurable population impact and to reduce inequalities.
- Ensure services are provided to a sufficient **quality** to achieve the best possible **outcomes** for each intervention; continually improve by drawing upon quality improvement techniques.
- Balance intervention benefits for **short and long-term** outcomes (including investing in one sector to realise a return in another).
- Optimise **value** by taking an agile approach to evaluating interventions and approaches and disinvesting in those that do not yield benefit/ value.

STEP B Improvement actions for GP practice cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ Modify behavioural risk factors to prevent or lower high blood pressure

- Behavioural risk reduction is beneficial to lowering BP (BMJ 2016;355:i5719): Diet rich in fruits, vegetables, and low-fat dairy with reduced fat intake: 8-14 mmHg decrease in systolic BP; Regular aerobic activity at least 30 minutes a day: 4-9 mmHg; No more than 2400 mg (ideally 1600 mg) of sodium daily: 2-8 mmHg; Max 2 oz ethanol/ day (men) 1 oz ethanol/ day (women): 2-4 mmHg; Achieve/ maintain BMI of 18.5-24.9: 3 mmHg per 4-8% bodyweight reduction.
- A 3 g reduction in daily salt intake (a reasonably conservative estimate of what could be achieved) would reduce systolic blood pressure by approximately 2 mmHg (NICE PH25, 2010).
- Optimise primary/ secondary preventive actions for smoking (BRF-001), unhealthy diet (BRF-002), physical inactivity (BRF-003) and alcohol misuse (BRF-004).

▼ Modify other clinical risk factors to prevent or lower high blood pressure

- Optimise primary/ secondary preventive actions for childhood (CRF-002) and adult (CRF-003)

obesity.

▼ Focus on improving detection of high blood pressure

- BHF Cymru advise that, in relation to detection of high blood pressure, GP practices can take the following improvement actions:
- Audit practice records to identify people with high BP recordings who do not have a hypertension code. To prioritise, consider starting with those with readings above 150/90 mmHg.
- Increase opportunistic blood pressure testing in the practice: Think BP in routine consultations. Make blood pressure testing routine in all nurse led-clinics such as asthma, COPD, diabetes, weight management, smoking cessation, as well as other local enhanced service clinics – prompt by adding to templates.
- Take the opportunity to promote community BP campaigns. Please note patient may present with a BP record from these events.
- If a reading is high, always offer ambulatory or, when appropriate, home blood pressure monitoring in order to confirm a diagnosis of high BP and always include assessment of lifetime cardiovascular risk as part of the diagnosis.
- Promote high standards in BP measurement, including machine calibration, signposting patients and staff to resources on high blood pressure and self-testing through NHS Choices.

▼ Focus on improving management of high blood pressure

- BHF Cymru advise that, in relation to management of high blood pressure, GP practices can take the following improvement actions:
- Audit practice records to identify individuals with poor control of high BP - focus first on people under 85 years with BP above 140/90 who are not on a three-drug combination.
- Use shared decision making resources to help the individual make informed decisions about behaviour change and drug treatment.
- Agree BP treatment targets with patients as part of shared management plan, taking account of comorbidity, adverse effects and patient preference.
- Offer therapy according to NICE/BIHS guidelines and have a clear protocol to ensure regular review and intensification of therapy to maintain BP targets.
- Make BP testing routine in nurse-led clinics and ensure that identification of poor BP control is the responsibility of all clinicians.
- When blood pressure is above target always ask about adherence to treatment.
- Advise patients of the option to buy clinically validated blood pressure machines advised by the British and Irish Hypertension Society and provide advice on how they can monitor their own blood pressure.
- Explore use of remote monitoring via telehealth or blood pressure apps.

▼ **Ensure awareness and implementation of NICE guidelines/ quality standards**

- *Hypertension in adults: diagnosis and management*. Clinical guideline [CG136] (Published date: August 2019) includes recommendations suitable for adoption by healthcare professionals. This guideline covers identifying and treating primary hypertension (high blood pressure) in people aged 18 and over, including people with type 2 diabetes. It aims to reduce the risk of cardiovascular problems such as heart attacks and strokes by helping healthcare professionals to diagnose hypertension accurately and treat it effectively.
- *Hypertension in adults: Quality standard* [QS28] (Published date: March 2013; Last updated: September 2015) sets out six quality statements, any of which could form a focus for collective local improvement action. This quality standard covers managing hypertension in adults. It includes diagnosis and investigations, treatment and specialist referral. It describes high-quality care in priority areas for improvement.

Improvement actions for wider cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ **Modify behavioural risk factors to prevent or lower high blood pressure**

- Behavioural risk reduction is beneficial to lowering BP (BMJ 2016;355:i5719): Diet rich in fruits, vegetables, and low-fat dairy with reduced fat intake: 8-14 mmHg decrease in systolic BP; Regular aerobic activity at least 30 minutes a day: 4-9 mmHg; No more than 2400 mg (ideally 1600 mg) of sodium daily: 2-8 mmHg; Max 2 oz ethanol/ day (men) 1 oz ethanol/ day (women): 2-4 mmHg; Achieve/ maintain BMI of 18.5-24.9: 3 mmHg per 4-8% bodyweight reduction.
- A 3 g reduction in daily salt intake (a reasonably conservative estimate of what could be achieved) would reduce systolic blood pressure by approximately 2 mmHg (NICE PH25, 2010).
- Optimise primary/ secondary preventive actions for smoking (BRF-001), unhealthy diet (BRF-002), physical inactivity (BRF-003) and alcohol misuse (BRF-004).

▼ **Modify other clinical risk factors to prevent or lower high blood pressure**

- Optimise primary/ secondary preventive actions for childhood (CRF-002) and adult (CRF-003) obesity.

▼ **Focus on improving detection of high blood pressure**

- BHF Cymru advise that, in relation to detection of high blood pressure, health boards and [primary care] clusters can:
- Examine the level of variation in the numbers of people with high blood pressure between [primary care] clusters and practices.
- Adopt quality improvement methods to support all practices to identify people with high blood pressure.
- Work with partners to promote public awareness of blood pressure and opportunities for testing and self-testing.
- Promote access to ambulatory blood pressure monitoring.
- Consider partnership opportunities with community pharmacists and community BP campaigns to offer blood pressure checking.
- Consider supporting practices to have self-test BP stations in the waiting room.

▼ Focus on improving management of high blood pressure

- BHF Cymru advise that, in relation to management of high blood pressure, health boards and [primary care] clusters can:
- Use local data where it is available to estimate how many people with high BP are controlled to the NICE/ BIHS guidelines.
- Examine the level of variation in achievement rates between practices.
- Adopt quality improvement methods to support all practices to perform as well as the top quartile in high BP.
- Expand adherence support by community pharmacists as part of medicine review service.
- Consider the role of community pharmacists to support BP monitoring and treatment optimisation.
- Support practices to evaluate emerging technologies that can help patients and clinicians to monitor and manage high BP.
- Promote and support opportunities for educational activities for GPs, nurses, health care assistants and patients.

▼ Consider adapting PHE's high blood pressure action plan locally

- Public Health England's *High blood pressure: action plan* provides evidence-based advice for partners including local government and the health system on how to effectively identify, treat and prevent hypertension.

What is happening in Wales?

ⓘ Consider whether shared learning/ local experience might guide your own implementation of the evidence:

▼ **Placeholder project description**

- *What problem was being addressed?* Placeholder.
- *What was done to address it?* Placeholder.
- *How does this evidence good practice?* Placeholder.
- *What key learning can be shared?* Placeholder.
- *Who did it or who can be contacted in the event of queries?* Placeholder.

ⓘ Have something to share? Please let us know here.

ⓘ **Caution**: Any text entered into the following sections will not be saved if you navigate away from this page, or close the browser window before selecting PRINT.

What do you know about community views on this?

ⓘ Consider any relevant citizen/ community voice information (e.g. from surveys, complaints, engagement events, or your health board's well-being or population needs assessments). Summarise this into the following box:

Type here

What assets or partnership opportunities can you identify?

ⓘ Consider any relevant local assets or potential partner organisations that might facilitate co-production. Summarise this into the following box:

Type here

Do you need more data before making a decision?

ⓘ If relevant, consider any additional data (or information) requirements that might ensure a more informed decision on determining action. Summarise this into the following box:

Type here

What is your provisional decision?

ⓘ Having reviewed indicator data on local needs and considered evidence-informed quality improvement options, please record initial thoughts on proposed actions. You may also wish to record related thoughts around potential service models, capacity requirements, workforce development or financial considerations. Ideally, discuss these with both the wider cluster and with your local public health team (LPHT). Summarise your proposals for action into the following box:

Type here

ⓘ Now PRINT this page (e.g. to PDF) so you have a record of your entries (Steps E-H). You may then close the Print view browser window and return to the PCNA workbook to review another indicator.