

Practice guidance for CVD Prevention in People with High Blood Pressure QI project.

2025-26

Background

Cardiovascular disease (CVD) is one of the leading causes of death and disability in Wales and is a major contributor to health inequality. Chief Medical Officers across all UK nations advocate the beneficial effects of secondary prevention including risk-based advice and treatment of key CVD clinical risk factors. These key factors relate to **A**trial fibrillation, **B**lood pressure (hypertension), **C**holesterol, and **D**iabetes (**ABCD**). [NICE guidance \(NG136\)](#) recommend a holistic approach to CVD prevention which takes account of the person's life circumstances and includes support for healthy behaviours. Within this QI project, this approach is described as an **ABCD Plus** approach.

Supporting people to effectively manage their blood pressure through a range of approaches is an effective method for preventing adverse CVD outcomes. However, since the pandemic the task of identifying and treating hypertensive patients to target has become increasingly challenging.

GMS have a key role in the prevention agenda, as shown recently through the 2023/24 and 2024/25 Supporting Healthy Behaviours QI projects.

This project aims to support primary care clinicians, collaboratives/clusters, and Health Boards, to try new ways of ensuring patients with hypertension are registered and offered a holistic-person centred intervention. As appropriate, the intervention will include risk-based advice and treatment of key CVD clinical risk factors, healthy behaviours, and wider determinants.

Aims

The **primary aim** of this QI project is to improve mortality and morbidity associated with cardiovascular events through the enhanced detection and management of cardiovascular risk factors within the target population.

The **secondary aim** is to support Practices/ RMS collaboratives/ Health Boards to develop and evaluate service improvement projects so that learning from these interventions, can be shared and implemented by colleagues across Wales.

Target Population

Any person who is recorded on their GP record as having hypertension AND their most recent blood pressure reading is $\geq 140/90$ mmHg (people over 80 years $\geq 150/90$ mmHg).

Objectives

Contractors will be able to implement approaches to CVD prevention from a menu of options (see below) for people with high blood pressure by the end of the QI period 31st March 2026.

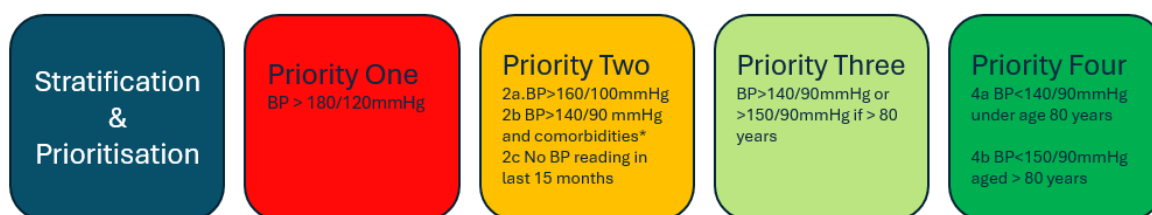
Practices will assess the impact of quality improvement projects undertaken, at the beginning and end of the QI cycle, by identifying and recording practice-level data, detailing the number of patients with high blood pressure who are treated to target.

Menu of Options for Quality Improvement Project Activity

1. **Increased identification of new patients not currently on the hypertension register** with a latest (within the last 15 months) blood pressure reading $\geq 140/90$ mmHg (80 years+ $\geq 150/90$ mmHg), and review, further assess, and record on register if diagnosis of hypertension confirmed.

(You may wish to focus on high-risk patients as well as those from ethnic minority groups and those from the most deprived segments of the practice population).

2. **Review of current annual hypertension recall and prioritisation process for patients on the hypertension register** aiming to improve patient response and attendance rates at their Annual Review, across the patient population to reduce health inequalities. Identify patients at highest risk and invite them for review and optimisation.



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*Co-morbidities/ risk factors
- Established CVD (prior Stroke/TIA, heart disease, peripheral arterial disease) - Diabetes - eGFR < 60 - Obesity with BMI > 35

3. **Enhancement of hypertension annual review.** Improvements in processes to treat and optimise CVD risk factors (**ABCD Plus**), including support for health behaviours, are to be actioned and recorded. This will require consideration of wider needs for people to engage e.g., culturally sensitive support, or difficulties being experienced e.g., in relation to housing, financial wellbeing, mental health etc.

Within the Annual Review process follow an **ABCD Plus** approach (as described in the Background section above):

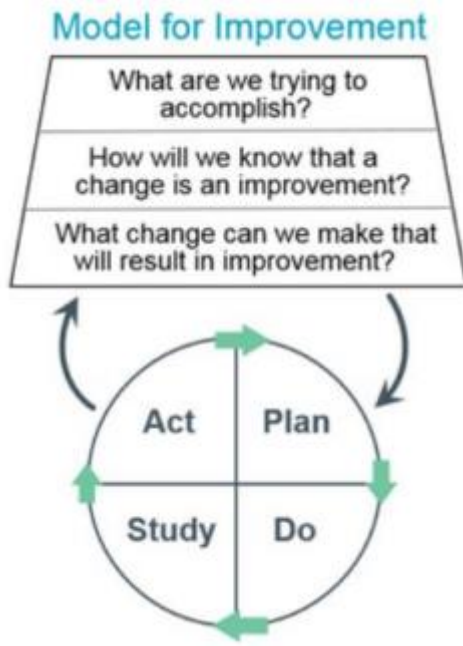
- i. Review hypertension medication, (taking into account polypharmacy and possible frailty).
- ii. Undertake manual pulse palpation to assess presence of atrial fibrillation.
- iii. Test for total and HDL cholesterol.
- iv. Test for HbA1C as per [NICE Guidance: NG28](#)
- v. Test for Urine albumin to creatinine ratio (ACR).
- vi. Measure and record patient's weight and height.
- vii. Assess CVD risk using appropriate tools such as QRISK and review and adjust CVD risk factor medication accordingly. (taking into account polypharmacy and possible frailty).
- viii. Discuss health behaviours and signpost to support if available.¹

Requirements of the QI Project

Practice Level:

- Practices will have a named QI Project lead clinician.
- Practices will use practice hypertension read codes, to collate baseline data detailing the number of patients with high blood pressure who are treated to target.
- Practices will collect data before and after any interventions (e.g., Using IHI Quality Improvement Methodology and by using searches and share any learning (whether positive or negative) within their practice teams, collaborative/clusters and more widely.
- Practices will complete a nationally agreed QI Poster for sharing at the final collaborative meeting before 31/3/2026 confirming conclusion of the project and highlighting outcomes achieved.

¹ Further information to support practices in undertaking the project and suggested QI activity is available in the Public Health Wales guide: [Supporting Healthy Behaviours: A Guide for General Practice.](#)



- Practices to adopt a QI methodology, including:

- o Review of baseline data
- o Review of their processes
- o Introduction of tested small cycles of change.

[How to Improve | IHI - Institute for Healthcare Improvement](#)

[Dr Mike Evans: An Illustrated Look at Quality Improvement in Health Care \(youtube.com\)](#)

- Practices to review progress at least quarterly.

- Practices will discuss their learning with

their GMS collaborative. Minutes of this meeting should be submitted to health boards as confirmation that this discussion has taken place.

GMS Collaborative Level

- Practices to share aggregate practice-level data on the number of hypertensive patients treated to target.
- Practices to discuss accuracy of data and process for refinement.
- Discuss, share best practice, and consider adaptation of QI processes if applicable across collaborative.
- The GMS Collaborative lead should bring themes for discussion to the wider cluster professionals e.g., identification of hypertensive patients, uptake variation of Annual Reviews
- The GMS Collaborative or Cluster may consider introducing collaborative/cluster initiatives to benefit the delivery of improved interventions in identified behaviours.
- The GMS Collaborative or Cluster should escalate deficiencies in systems/services or suggestions for system-wide improvement to Pan Cluster Planning Group for consideration of improved commissioning or inclusion in IMTP process.

DHCW Level

- A definitive data specification will be provided to DHCW to enable them to support the selection of agreed read codes and creation of a minimum data set.

- DHCW will support either a solution via dataset & business rules for each GP system supplier to implement; or make available pre-authored searches to enable Practices to undertake their own local searches.
- Develop a PCIP tile for displaying required data and for practice upload of project materials for verification purposes.

Health Board Level

- Health Boards to ensure practice completion is verified against agreed indicators/contractual agreement via completion of a nationally agreed Poster shared at the collaborative meeting.
- Health Boards will collate the posters to allow thematic review at national level

Verification and achievement

Practices:

- Practices will need to demonstrate achievement of one or more of the options listed in the Menu of Options for Quality Improvement Activity, by 31st March 2026, by completion of the nationally agreed QI Poster shared and discussed with the collaborative and shared with the LHB. Minutes of the collaborative meeting should also be shared as evidence of the discussion.
- The contractor should ensure that the poster details both pre and post intervention data relating to hypertensive patients treated to target.
- The contractor should ensure that the poster states where the QI activity has resulted improved outcomes.
- A poster template and further guidance for completion will be circulated to practices by end of October 2025.

LHB:

- LHBs will be required to verify that practices have undertaken one or more of the options listed in the Menu of Options for Quality Improvement to confirm achievement and award payment.
- This will be done by reviewing each individual practice's nationally agreed QI Poster shared and discussed with the collaborative and shared with the LHB by 31st March 2026.