

Developing a local hypertension strategy

This section of the toolkit provides a practical guide to developing a local strategy to prevent, detect and control hypertension. It covers the following aspects:

- making the case for a local hypertension strategy
- building the necessary partnerships
- establishing a local hypertension action team
- reviewing current activity and identifying gaps
- identifying priorities and target groups
- deciding aims, objectives, standards, targets and milestones
- choosing interventions to prevent hypertension
- choosing interventions to detect and control hypertension
- understanding barriers and facilitating change
- ensuring appropriate infrastructure support
- monitoring progress, assessing performance and evaluating the strategy, and
- mainstreaming and sustainability.



Tool H1 shows a suggested structure for a local hypertension strategy containing all the elements listed above.

Making the case for a local hypertension strategy

The case for a local hypertension strategy should be built on:

- the key policy drivers – both national and local
- an estimate of the local burden of hypertension, and
- an estimate of the potential benefits of local action.

Key policy drivers

National policy drivers

Action to tackle hypertension is driven mainly by policies and strategies concerning the prevention and management of coronary heart disease, stroke, diabetes and chronic kidney disease. For example, in England and Wales these comprise the National Service Frameworks (NSFs) for coronary heart disease, older people, diabetes and renal services respectively. There are also parallel strategies concerned with broader issues – such as healthy lifestyles, healthy children, healthy older people, reducing disability, tackling health inequalities, modernisation, management

of long-term conditions and primary care development – which contribute to the case for a comprehensive approach to hypertension.

These policies and strategies differ to some extent between England, Wales, Scotland and Northern Ireland, but all follow essentially similar lines.



Tool H2 lists the main national policy drivers relevant to blood pressure.

Local policy drivers

These are likely to include local agreements, targets, standards, policies and strategies which relate to the promotion of healthy lifestyles and the provision of high-quality management of long-term conditions (such as for coronary heart disease or diabetes).

For example, the following are likely to be most relevant to hypertension:

- healthy eating strategies
- physical activity and/or sports development strategies
- health inequalities strategies
- workplace or occupational health policies
- primary care development strategies
- locally derived standards and targets for the NHS
- national and local public service agreements concerning life expectancy
- community strategies
- National Healthy Schools Standards, and
- regeneration and neighbourhood renewal strategies.

Estimating the local burden of hypertension

Prevalence

Although some areas have local prevalence data derived from various ad hoc local surveys, in most areas estimates must be either extrapolated from national surveys or obtained from general practice registers.

For example, the Health Survey for England provides data on the proportion of adults with hypertension, and those treated and controlled. These data can be applied to the local demographic profile of a primary care organisation (PCO) to calculate an estimate of prevalence. Similarly, data from the Scottish Health Survey, Welsh Health Survey and the Northern Ireland Health and Social Wellbeing Survey can be extrapolated to estimate local prevalence in those parts of the UK.



Tool H3 is a ready-reckoner to help you estimate the prevalence of hypertension in your area.

The quality of general practice data has hitherto been patchy but the introduction of standardised clinical systems software, and the current Quality and Outcomes Framework of the General Medical Services (GMS) contract, mean that more reliable and more comprehensive data are now becoming available. These are collated centrally (in England by the Quality Prevalence and Indicator Database (QPID)) and provided to primary care organisations as an annual estimate of prevalence.

The validity of estimates based on GP data depends on:

- accurately and regularly calibrated sphygmomanometers (blood pressure measuring devices)
- regular and comprehensive blood pressure monitoring of the practice population, especially those over 45 years of age (eg by a call-recall scheme)

- blood pressure readings (preferably paired*) taken on three separate occasions under standardised conditions (see the British Hypertension Society,⁵ NICE¹ or SIGN² guidance)
- proper recording of blood pressures with Read coding (flagging) of patient records where a diagnosis of hypertension is made (based on national guidance).

Population attributable risk

Another approach to estimating the local burden of disease is by calculating the population attributable risk of hypertension as a cause of complications such as coronary heart disease, stroke/transient ischaemic attack (TIA), or chronic kidney disease. For example, McPherson *et al* estimated that 14% of deaths from coronary heart disease in men and 12% of deaths in women were attributable to high blood pressure (blood pressure over 140/90mmHg).³

Costs

Estimating the costs and benefits of tackling hypertension at local level is difficult, and depends on:

- the degree of complexity used in modelling
- the validity of the various assumptions used in calculations
- the clinical guidelines and prescribing regimes followed, and
- the current costs of various antihypertensive drugs.

Approximate values can be derived by applying national figures to the local estimates of prevalence, either as calculated using the process described in *Tool H3: Hypertension prevalence ready-reckoner*, or from the prevalence data derived from general practices through the current Quality and Outcomes Framework of the GMS contract, for example via QMAS (Quality Management and Analysis System) in England.

Estimating the potential benefits of local action

Health outcomes

In essence, this is an estimation of the amount of reduction in burden as a result of effective prevention and treatment of hypertension. Ideally it should include cost-benefit analyses, although these are extremely difficult to quantify. Theoretically, there are two components to analyse:

- the number of cases of hypertension prevented by lifestyle changes in the population (and hence the cost-benefits of prevention), and
- the number of cases of coronary heart disease, stroke, heart failure and chronic kidney disease prevented by effective identification and treatment of hypertension (and hence the cost-benefits of screening for hypertension).

However, in practice such analyses have proved difficult to model with any degree of accuracy.

Building partnerships

Tackling hypertension at local level requires a 'whole-systems' approach, involving a range of partners in planning the strategy, steering its implementation and ensuring that it meshes appropriately with a wide range of related parallel strategies and policies.

Many of these partnerships are likely to exist already, either formally or informally – for example, as part of a healthy lifestyles programme, a National Service Framework implementation programme or a management programme for long-term conditions.

* Paired blood pressure readings involve taking at least two blood pressure measurements (about 1-2 minutes apart) on each occasion.⁵

Establishing a local hypertension action team

A key partnership that may need to be created specifically is a 'hypertension action team' to coordinate and steer the elements most relevant to tackling hypertension. This team does not need to be large and unwieldy. Core inputs are health promotion, primary care and commissioning; others can be included as and when appropriate. For example, if the focus is on detection and control of existing cases, the team might include:

- patient or carer
- GP and/or practice nurse
- practice manager
- primary care quality facilitator
- primary care commissioner
- primary care IT officer
- hospital specialist
- public health specialist
- pharmacist
- public health nutritionist or community dietitian
- physical activity facilitator.



Tool H4 gives details of various local partners and their potential roles.

Reviewing current activity and identifying gaps

This involves a service review, a 'gap analysis' or audit of local services, initiatives and infrastructure including protocols, procedures, pathways and practice, to find out:

- What is currently happening?
- Where are the gaps?
- What are the priorities?
- What are the opportunities for development?



Tool H5 provides a framework for a 'settings' approach to shaping the hypertension strategy, based on the main settings in which services and initiatives can be delivered.

Tool H6 provides a checklist to use when reviewing current activity and assessing how well services and initiatives are being delivered in the various settings.

For each service, initiative or infrastructure component, the following questions should be addressed:

- How well does it meet needs?
- Which groups are missing out?
- What development or further action is needed?

Each partner agency is usually best placed to undertake the mapping for its own sphere of influence and to feed its findings into the audit.

Identifying priorities and target groups

With limited resources and capacity, and with such a wide range of possible initiatives and interventions, both in terms of prevention and control, decisions will have to be made about where to focus efforts.

First, the balance between prevention and control needs to be considered. How much of the available resources and capacity should go into lifestyle changes to prevent hypertension, and how much into case-finding and treatment?

Second, within each of these broad approaches, decisions have to be made about priority interventions and target groups. Each partner agency should contribute to this process, beginning with those interventions for which it has the lead role. So, for example, the leisure department of the local authority might propose that certain physical activity/sports programmes be focused on men over 35 years of age. Or the primary care organisation might propose a hypertension case-finding and treatment scheme aimed specifically at ethnic groups who have a high risk of hypertension, such as black Caribbean or black African communities.

Priorities and target groups for prevention

Theoretically, the greatest number of cases of hypertension can be prevented by lowering the average blood pressure of the whole population (see page 25 in section B: *Reducing the burden: tackling hypertension*). This is most likely to be achieved by preventing the rise in blood pressure with age, particularly by reducing the average salt intake and Body Mass Index in the population, and by increasing physical activity levels in children and young people. For example, given that schoolchildren are a 'captive audience', it might be a good idea to make school-based interventions the main priority for hypertension prevention. The focus would be on healthy eating (particularly with regard to salt and calories) and increasing physical activity.

However, in section A: *Hypertension: the public health burden* we described a number of higher-risk groups in the population (see page 15) and it could be argued that preventive efforts could be more effectively focused on them. For example, in areas where there is a sizeable black African or black Caribbean community genetically predisposed to hypertension, it might be particularly cost-effective to aim preventive programmes at that group. In addition to offering healthy lifestyles interventions, an important message would be to have regular blood pressure checks.

In the primary care setting, preventive efforts should be focused on two broad groups of patients:

- Those whose blood pressure is already in what the British Hypertension Society refers to as the 'high-normal' range (systolic blood pressure 130-139mmHg, diastolic 80-89 mmHg). Without lifestyles intervention, this group is most likely to go on to develop hypertension.
- Those for whom the development of hypertension might be particularly risky – for example: those with existing cardiovascular disease (coronary heart disease, stroke/TIA) or diabetes, or evidence of target-organ damage such as chronic kidney disease or retinal disease; or those who are at higher risk of developing these conditions.

Both of these groups urgently require effective lifestyles advice and support, such as help to restrict salt intake, be more physically active, control their weight, drink alcohol in moderation and attend for regular check-ups.

Priorities and target groups for detection and control

The task of identifying those adults with existing hypertension (see page 45) is a daunting one, and in a general practice setting it makes sense to prioritise those patients at high overall risk of cardiovascular disease, or who show signs or symptoms of target-organ damage that may be due to hypertension (eg kidney damage or retinal damage).

Hierarchy of risk from existing hypertension

Those most likely to be at high risk of a cardiovascular event as a consequence of uncontrolled hypertension are, in order of greatest risk:

- 1 those with existing coronary heart disease, stroke, peripheral vascular disease, diabetes, chronic kidney disease or retinal damage
- 2 older people at high risk of coronary heart disease or stroke, but without existing disease
- 3 younger people at high risk of coronary heart disease or stroke, but without existing disease
- 4 older people not at high risk of coronary heart disease or stroke
- 5 younger people not at high risk of coronary heart disease or stroke.

Within each group, males, people from lower socioeconomic groups and certain ethnic groups are at greater risk (see pages 16 and 20 in section A: *Hypertension: the public health burden*). The absolute risk of a cardiovascular event occurring in hypertensive patients varies dramatically depending on age, sex, level of blood pressure and coexistence of other risk factors.⁴

Assessing overall cardiovascular risk

Current national and international guidelines emphasise the importance of assessing cardiovascular risk as a basis for prioritising patients for antihypertensive treatment.^{1,5,6}

The British Hypertension Society guidelines not only recommend cardiovascular risk assessment as a key part of blood pressure management, but also regard blood pressure measurement as a key element in the multifactorial approach to cardiovascular disease risk management. Persistently raised blood pressure is one of several risk factors for cardiovascular disease. Others include:

- older age
- male gender
- genetic tendency
- high blood cholesterol (specifically a high LDL:HDL ratio)
- diabetes
- history of smoking
- obesity
- lack of physical activity, and
- diet high in salt and saturated fats, and low in fruit and vegetables.

These risk factors influence cardiovascular risk in different ways and to different extents. Their effects are largely cumulative, so that the presence of two or more of them increases an individual's risk level accordingly. Ideally, they should all be taken into account when identifying people at high risk of cardiovascular disease – but in practice only a few are routinely used for risk assessment. The most widely used tools for this are the Joint British Societies' Cardiovascular Disease Risk Prediction Charts.⁷



Tool H7 contains the Joint British Societies' cardiovascular disease risk prediction charts which are used to assess the absolute risk of cardiovascular disease.

Patients with Type 2 diabetes often have concomitant hypertension which contributes significantly to their risk of cardiovascular disease. Blood pressure detection and control in these patients is particularly important.

Deciding aims, objectives, standards, targets and milestones

Aims and objectives set the 'direction of travel' of the strategy. Standards, targets and milestones are more specific operational goals against which the whole strategy and its component strands can be evaluated.

Aims

An **aim** is a general statement of strategic intent. For example, the overall aim of your local hypertension strategy could be along the following lines:

- to reduce the burden of death, disability and distress due to high blood pressure in the population served by (the named primary care organisation).
(The term 'high blood pressure' is used here to take account of levels of raised blood pressure which, although below the diagnostic threshold for hypertension, do nevertheless increase cardiovascular risk – see page 12.)

The strategy should have two basic subsidiary aims reflecting its two main approaches, such as:

- to prevent hypertension developing in the community, and
- to detect and control existing cases of hypertension.

Aim: To prevent hypertension developing in the community

This strand, also known as the 'population approach', involves promoting healthier lifestyles in the community, with an emphasis on reducing salt and alcohol intake, reducing obesity and increasing physical activity. It can be aimed at the whole population or targeted at groups who are particularly susceptible to hypertension or its consequences. In practice, healthy eating and active lifestyle programmes tend to be aimed at the whole population – but more specific components such as salt reduction or weight control are emphasised for particular target groups such as children, people from ethnic minorities, or women in manual socioeconomic groups (see page 15 in section A: *Hypertension: the public health burden*).

Aim: To detect and control existing cases of hypertension

This strand, also known as the 'high-risk approach', involves identifying people with hypertension ('case-finding') and ensuring that their blood pressure is effectively controlled and their clinical condition properly managed. This should also help people to self-manage their blood pressure. The high-risk approach should include an assessment of their overall risk of cardiovascular disease.



The challenge for local hypertension action teams is to choose the appropriate combination of prevention (population-wide) and high-risk individual-based detection and control approaches.

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Objectives, standards, targets and milestones

Objectives

Objectives are more specific than aims. They refer to particular outcomes or outputs of either the preventive or control elements of the strategy. For example, a 'prevention' objective might be:

- to reduce the consumption of salty foods by schoolchildren, or
- to increase the habitual level of physical activity in young women.

A 'detection and control' objective might be:

- to establish a call-recall programme for case-finding in patients aged 45 years or over.

Standards

A **standard** is an operational goal which usually prescribes a specific level of quality of a service. Standards are particularly useful as 'process' indicators – a way of assessing how well a service is delivering or developing its intended outputs. In practice, standards to be achieved within given timeframes are often used as targets and milestones. An example of a standard might be:

- 95% of patients on the diabetes register to have had their blood pressure measured at least once during the past 12 months.

Targets and milestones

A **target** is an objective or standard with a specified measurable outcome, output or level of quality within a timeframe. For example, a 'prevention' target might be:

- to reduce the average consumption of salt in the adult population to 6g a day by the year 2010.

A 'detection and control' target might be:

- by 2008, to achieve a blood pressure of 150/90mmHg or less in 70% of patients with coronary heart disease who have had their blood pressure measured in the past 15 months.
(150/90mmHg is the level used for GP audit purposes only.)

A **milestone** is an interim position on the way towards a target. It provides a useful means of demonstrating shorter-term progress and is used in monitoring and evaluation.

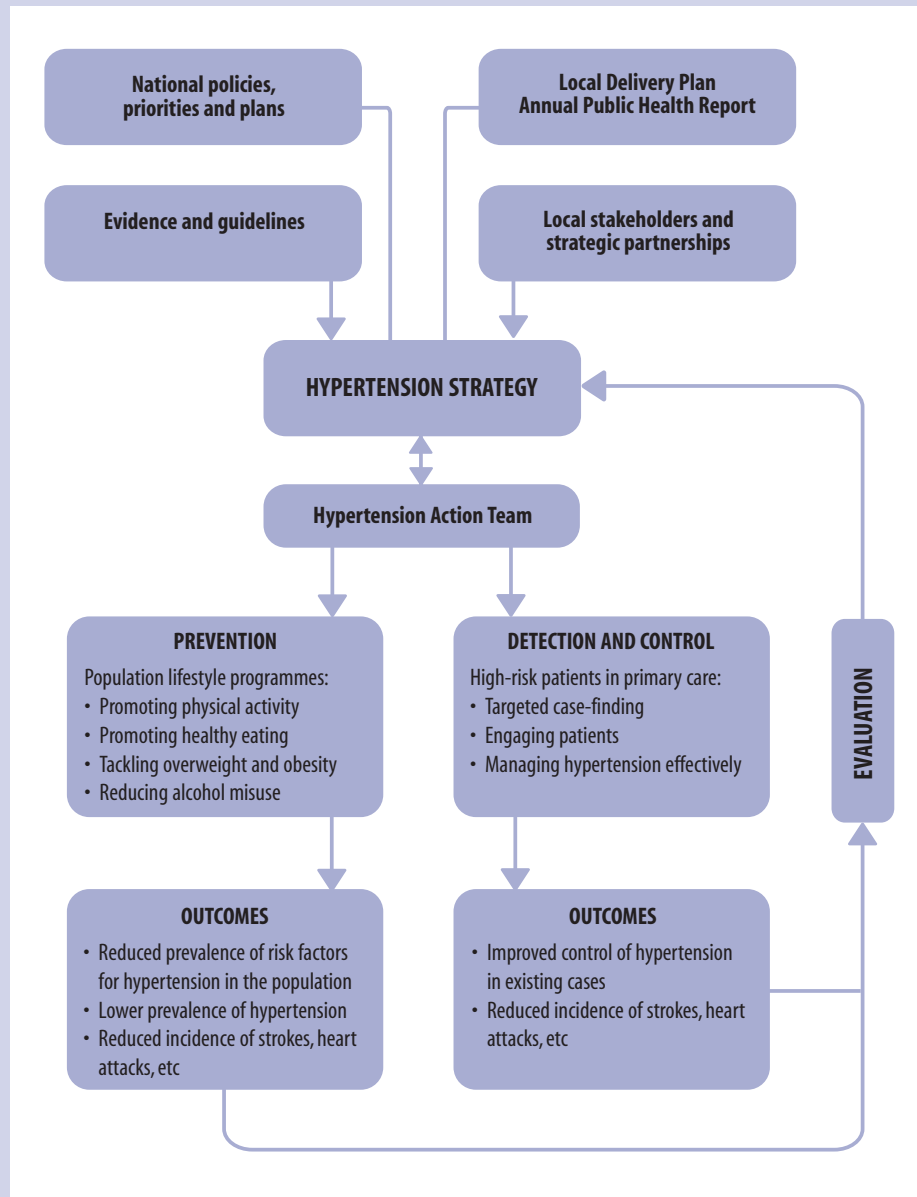
Local target-setting is being encouraged as a core principle of NHS and local partnership planning. For example, the Department of Health in England has issued the following checklist of principles for local target-setting in its latest planning guidance:⁸

Principles for local target-setting

In developing local plans primary care trusts should ensure that their local targets:

- are in line with population needs
- address local service gaps
- deliver equity
- are evidence-based
- are developed in partnership with other NHS bodies and local authorities, and
- offer value for money.

Figure 7 Inputs and outputs of a local hypertension strategy



Choosing interventions to prevent hypertension

The prevention strand of the hypertension strategy should be based on a 'healthy lifestyles' approach and include interventions to:

- reduce salt consumption
- increase fruit and vegetable consumption
- increase aerobic physical activity
- reduce levels of obesity, and
- reduce alcohol consumption.

This might involve:

- assessing the evidence for particular interventions
- where possible, considering the cost-effectiveness of particular interventions
- achieving a balance between the preventive and control strands of the overall strategy
- assessing what can be done within budget and infrastructure constraints
- developing action plans for the key settings and identifying specific ‘deliverables’, the lead agency/individual for each deliverable, and the date by which these must be achieved, and
- choosing appropriate settings for interventions (see Table 6).

Setting	Main target group(s)
‘Home’	Infants, pre-school children and their parents or carers
School	School-age children, parents, teachers, school nurses and governors
Community groups and faith groups	Minority groups, eg people with cultural or ethnic identities, refugees and asylum-seekers, travellers, homeless people
Workplace	Employees and employers, and their families, catering providers
Leisure outlets (for active leisure pursuits)	General public and specific subgroups (eg older people), leisure staff
‘High street’ – retail and commerce (for healthy eating and active leisure)	General public and specific subgroups (eg younger people), food retailers, catering providers
Primary and community care including community pharmacies, optometrists and community health services	Patients, carers, primary care staff
Hospital	Patients, carers, hospital staff, including catering providers
Local media	General public and specific subgroups (eg younger people, older people)



Tool H5 describes the various settings and how they can be used, and potential partners for each setting.



Tool H8 provides a proforma for developing a hypertension action plan.

EXAMPLE OF A LOCAL INITIATIVE

Tooting Healthy Living Initiative

The Tooting Healthy Living Initiative, a network of projects funded by the New Opportunities Fund, staged a one-day community conference to raise awareness and understanding of hypertension, particularly among the local African and Caribbean communities. As well as highlighting the importance of blood pressure monitoring, the conference sought to motivate participants to make healthy lifestyle changes. A referral protocol was developed specifically for the conference. Those attending the conference also had the opportunity to advise service deliverers on areas where services could be further improved.

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Types of interventions to prevent hypertension in the community

Interventions to reduce salt in the diet

For most local teams, the issue of salt reduction is likely to be tackled mainly through existing healthy eating programmes (for example, as part of the implementation of the National Service Framework for coronary heart disease in England and Wales), and related programmes such as Sure Start. The evidence base is provided in the Scientific Advisory Committee on Nutrition's report, *Salt and Health*.⁹ Comprehensive practical advice on choosing interventions to reduce salt is provided in the *Nutrition and Food Poverty* toolkit produced by the National Heart Forum, the Faculty of Public Health, the Government Office for the North West, the Government Office for the West Midlands and the West Midlands Public Health Observatory.¹⁰

Local health teams should consider setting local standards for school and NHS catering services regarding the salt content of publicly-procured foods and the appropriate use of salt in food preparation. It should also be possible to set local advisory standards for the preparation and marketing of foods in private catering outlets that have local autonomy. Local health teams could seek partnerships with their local dietetic department and catering managers to develop these standards. The annual Salt Awareness Day run by Consensus Action on Salt and Health, and the Blood Pressure Association's blood pressure awareness week provide a useful focus for this work.

Local health teams, together with the healthy schools programme coordinator, the local dietetic department and the local education authority should work with school caterers to encourage the implementation of the Caroline Walker Trust's standards for school meals¹¹ (revised to include the salt recommendations of the Scientific Advisory Committee on Nutrition⁹).

The Food Standards Agency has spearheaded a number of approaches at national level to tackle this issue, including the 'Sid the Slug' TV and billboard campaign. It also provides useful resources to support local action (see page 106 in section D: *Resources*).



Tool H9 provides target daily limits for salt intake and information on the main sources of salt in the average diet.

Interventions to reduce obesity

The issue of obesity is likely to be tackled through the local implementation strategies for National Service Frameworks for coronary heart disease and diabetes (or their equivalents). The evidence base for interventions has been recently reviewed,¹²⁻¹⁴ including interventions in primary care.¹⁵ Comprehensive practical advice for tackling obesity at local level is provided in the *Tackling Obesity* toolkit produced by the Faculty of Public Health Medicine and the National Heart Forum.¹⁶

Interventions to reduce alcohol consumption

Attempts to moderate alcohol consumption among those groups in the population for whom alcohol is an important social 'lubricant' have met with limited success. The approaches have combined fiscal measures, such as increasing the excise duty on alcoholic drinks, with public education programmes emphasising the benefits of sensible drinking and recommending sensible limits in terms of units of alcohol.

In England, for example, the Prime Minister's Strategy Unit has recently published its *Alcohol Harm Reduction Strategy for England*¹⁷ which includes an evidence base and a section on education and communication.

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Interventions to increase fruit and vegetable consumption

Interventions to increase fruit and vegetable consumption are likely to be an integral part of any local healthy eating strategy. One element is the national School Fruit and Vegetable Scheme which offers a free piece of fruit or salad vegetable each day to 4-6 year-old children in England (as part of the 5 A Day Programme – see Tool H10).

The evidence base and comprehensive practical advice on choosing interventions to increase consumption of fruit and vegetables are provided in the *Nutrition and Food Poverty* toolkit produced by the National Heart Forum, the Faculty of Public Health, the Government Office for the North West, the Government Office for the West Midlands and the West Midlands Public Health Observatory.¹⁰

Interventions to increase aerobic physical activity

The form of physical activity that is most effective in preventing hypertension and reducing resting high blood pressure is moderate intensity, aerobic exercise. Activities in which this form of activity predominates include walking, running, cycling, swimming, dancing, skipping, stepping and stair-climbing. The evidence base is considered in the Chief Medical Officer's (England) recent report on physical activity and health.¹⁸ Evidence-based advice on choosing effective interventions for a local physical activity strategy has been provided in the *Let's Get Moving* toolkit, published by the Faculty of Public Health Medicine and the National Heart Forum.¹⁹

An evidence briefing on the effectiveness of public health interventions for increasing physical activity among adults, published by the Health Development Agency, gave as its main conclusions:²⁰

- Interventions promoting changes to more active living (eg walking) which are not facility-dependent are associated with longer-term adherence.
- Referral to an exercise specialist based in the community can lead to longer-term changes in physical activity.
- Brief advice from a doctor based in primary care, supported by written materials, is likely to be effective in producing a modest, short-term effect on physical activity.
- Interventions using motivational approaches are associated with longer-term adherence.

Creating an enabling environment: making healthy choices easier

People's lifestyle habits are more likely to change for the better if healthier choices are also easier choices (see page 27). Most people behave in a way that seems to them to best fit their circumstances at the time. Their diet and exercise habits are influenced by peer pressure, custom and tradition, their living and working environment, and how much they can afford to spend.

An 'enabling environment' can mean lots of things – from the environment in the home, at school, in the workplace and in the community, to transport policies, urban design policies, and the availability of healthy food choices. The ideal is an environment and culture that supports and promotes healthy living, making it possible, for example, to walk or cycle to work or school in safety, and to buy fresh fruit and vegetables, and low-salt foods cheaply and conveniently.

Above all, local programmes need to be underpinned by appropriate national legislative, regulatory and fiscal policies. Unless there is an enabling national context, the potential for change at local level will be limited. This is generally recognised by all UK governments. For example, the *Choosing Health* strategy for England has set out a comprehensive programme for lifestyle change.²¹ To give a key example of national action relevant to tackling hypertension: the Minister for Public Health in England has asked food companies to reduce the salt in their prepared foods in a stepwise fashion. The Government has set a target to reduce population average salt intake to 6g per day by 2010.

At local level, creating an enabling environment to tackle hypertension could mean anything from working with local schools and catering outlets to ensure that healthy food choices are provided (particularly in terms of low-salt alternatives, and fruit and vegetables), to working with town planners to ensure that the environment is conducive to safe active leisure and active transport.



The challenge for local hypertension action teams is to make best use of the opportunities created by action at national level.



Tool H10 lists policies and programmes that address the wider determinants of health that are relevant to blood pressure, including healthy eating and physical activity.

Choosing interventions to detect and control hypertension

The second broad strand of any local hypertension strategy is detecting and controlling cases of established hypertension, mainly in the primary care setting.

This toolkit does not provide detailed clinical guidance but simply gathers some of the basic elements and points to where you can find useful guidance. The following key documents are all available to download from the internet:

- NICE guidance on the management of essential hypertension in primary care¹
- BHS guidance on the management of all types of hypertension⁵
- NICE guidance on the management of hypertension in Type 2 diabetes²²
- SIGN guidance on hypertension in older people.²

Note that guidelines are subject to ongoing review and should be checked regularly.

Identifying patients with hypertension

This is also known as 'case-finding'. There are three main ways of doing this:

- opportunistic case-finding in various settings
- systematic screening programmes, and
- targeted case-finding in general practice.

Opportunistic case-finding

This is a non-systematic approach to detecting hypertension, often undertaken during a consultation on another health matter or as part of a simple 'MOT-type' health check. Detection can take place not just in general practices but also in a wide variety of other settings including community pharmacies, workplaces, health fairs, individuals' homes, nursing homes, clinics or hospital wards.

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EXAMPLE OF A LOCAL INITIATIVE

Rolls Royce: Blood pressure monitoring

During a Stroke Awareness week, Rolls Royce employees at sites around the UK were invited through their occupational health services to have their blood pressure checked. Leaflets on stroke prevention were also distributed. Of the 835 people who had the check-up, 20% had a diastolic blood pressure of more than 90mmHg and were asked to attend the occupational health department to have it re-checked. A few people had diastolic pressures of more than 110mmHg and were urgently referred to their GP. The response from employees was very positive: they appreciated that the company was offering the check-up and that, if a previously undiagnosed high reading was found, it was followed up. The project lasted for one week and cost less than £1,000. A Stroke Awareness week has been held each year at Rolls Royce and has been rolled out to all global sites, and all employees, both on and off site, are encouraged to get their blood pressure checked.

For more information visit: www.rolls-royce.com/community/health_safety/default.jsp

National Blood Pressure Testing Week

The Blood Pressure Association runs a National Blood Pressure Testing Week in September each year. The objectives are to raise awareness of blood pressure by giving people the chance to get a free blood pressure check at 'pressure stations' throughout the UK, and to drive home the important message that we should all 'know our number' – our up-to-date blood pressure.

For further information see: www.bpassoc.org.uk

Screening

Unlike opportunistic case-finding, screening is routine and systematic, and is usually based on a proactive call-recall programme.

The latest British Hypertension Society guidelines⁵ recommend that all adults should have their blood pressure measured routinely at least every five years. However, universal screening of adults is not current UK policy. The NICE guideline in England does not cover screening.¹

The feasibility and cost-effectiveness of population screening is currently being investigated by the National Screening Committee.

Targeted case-finding in general practice

This approach focuses on those patients most likely to have hypertension or most likely to suffer complications from it. To implement it successfully, practices need:

- well-maintained disease registers for coronary heart disease, diabetes and stroke, and a register of patients at 'high risk' of coronary heart disease (for England and Wales this is in line with the National Service Framework for coronary heart disease²³)
- a protocol for updating risk factor assessments
- identified individuals with responsibility for maintaining the disease registers
- practice policies for capturing information obtained opportunistically (eg in clinic or discharge letters), as well as systematically (eg at coronary heart disease review clinics)
- an IT system that allows identification of patients with risk factors such as target-organ damage, diabetes, or a history of smoking, and which avoids double-counting

- an effective call-recall system based on agreed risk thresholds for intervention, and
- well-maintained and regularly calibrated sphygmomanometers.

The General Medical Services (GP) contract

Targeted case-finding has been given a considerable boost by the General Medical Services (GMS) contract for general practices which includes a major focus on service quality and treatment outcomes.²⁴ The importance of hypertension has been highlighted by the current Quality and Outcomes Framework of the contract, in which identification and effective management of hypertension can account for up to 173 of the total 550 quality points available in the clinical domain – 31%. The more points a practice scores, the greater its financial reward.

The GMS contract only specifically rewards case-finding for hypertension in patients aged 45 years or over, plus patients of any age on the practice's coronary heart disease, stroke/TIA and diabetes registers.

In England, participating practices submit monthly reports to the national Quality Management and Analysis System (QMAS) central database. This is used to calculate payments based on case-finding as a proportion of estimated prevalence, but can also be used for epidemiological analysis.²⁵



Tool H11 shows the quality indicators in the GMS contract and their points for hypertension.

Organising effective management of hypertension

Effective management of hypertension is based on partnerships between primary care professionals and patients, and between primary and secondary care (see Figure 8). The roles of doctors, nurses and pharmacists have to be considered. For example, nurse practitioners have been shown to be at least as successful as doctors in managing hypertension.²⁶ With the advance in nurse prescribing, this option seems even more attractive. The contract for pharmacists in England, Wales and Scotland will have a profound impact on the detection and management of hypertension. The role of patients in self-management is discussed on page 50.

Using clinical guidelines

Clinical guidelines for hypertension management have been produced by WHO⁶ and SIGN.² The latest guidance from the British Hypertension Society details a classification of blood pressure levels and algorithms for thresholds of intervention and treatment for different types of hypertension.⁵ (See also page 13 in section A: *Hypertension: the public health burden*.)

The most recent guidance from NICE¹ covers the management of essential hypertension in primary care, including:

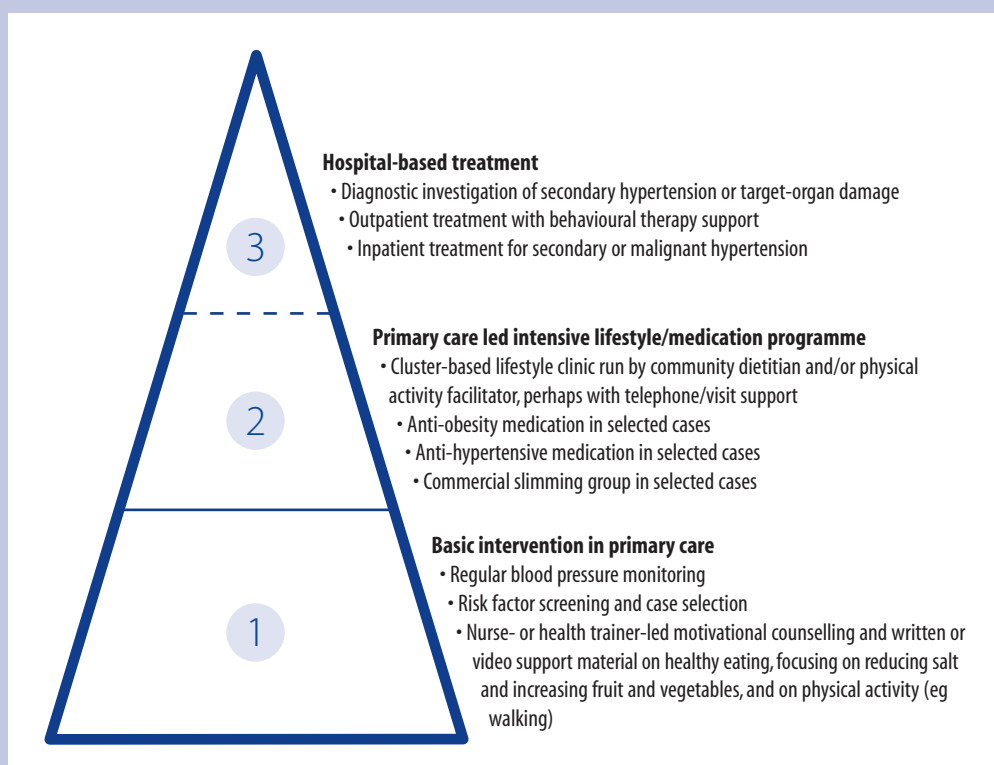
- measuring blood pressure (and identifying persistent raised blood pressure)
- estimating cardiovascular risk
- providing lifestyle interventions
- providing pharmacological interventions, and
- providing continuing treatment and support.

Local hypertension action teams will need to decide which guidelines to recommend and to ensure that these are clearly communicated to local practices and adhered to.

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Figure 8 Triple-tier pathway for hypertension control



Implementing guidelines locally

The following actions are needed to ensure guidelines can be used effectively:

- Establish clinical leadership through the CHD or stroke lead (CHD/Stroke Managed Clinical Network clinical lead in Scotland) responsible for delivering consensus on the various aspects of hypertension management.
- Review existing local guidelines, pathways, protocols and practice concerning the treatment and management of hypertension in the light of national guidelines, and revise accordingly. The review should also consider the resources required, the people and processes involved, and the timeline for full implementation.
- Customise guidelines to reflect local circumstances: for example, local formulary decisions, local referring protocols and where to refer, and information on local services for physical activity, smoking cessation and weight management.
- Develop local agreement on guidelines between primary and secondary care clinicians.
- Hold local meetings to highlight the importance of effective management of hypertension.
- Provide education and training for members of primary care teams on the agreed guidelines.
- Provide a multidisciplinary team of facilitators to visit practices and help them organise their clinical systems to support case-finding and dedicated hypertension clinics.
- Develop an appropriate audit system, based on criteria such as those in the current Quality and Outcomes Framework of the GMS contract.
- Promote professional adherence to the guidelines by incentives and feeding back audit results, including comparisons between practices.
- Produce patient information which explains the risks of hypertension, gives lifestyle advice, describes the various treatments, and outlines the standards for treatment that have been set.
- Assess the implications for primary care budgets of the likely increase in costs of implementing the guidelines, and develop a plan for dealing with this. (See *Capacity* on page 55.)

EXAMPLE OF A LOCAL INITIATIVE

North Derbyshire: Producing local hypertension guidelines

The North Derbyshire CHD NSF Local Implementation Team decided to develop a local hypertension guideline as there was general consensus that a single, up-to-date district hypertension guideline was needed. It was envisaged that the guideline would include comments on managing resistant hypertension and would be specific to the local district general hospital which provided secondary care to the majority of North Derbyshire residents. The guideline would be implemented across all three North Derbyshire PCTs.

To develop the guideline, a literature review was undertaken and local health professionals, both in primary care and at the local hospital, were interviewed on what they felt should be included. The developed guideline was then ratified by the North Derbyshire Priorities and Clinical Effectiveness Forum and presented to North Derbyshire PCT Clinical Governance Leads. It was left to individual North Derbyshire PCTs to decide how best to disseminate the guideline in their own areas. The guidelines were made available on PCT websites and the North Derbyshire Public Health Network also placed them on its intranet.

For more information contact: Public Health Department, Chesterfield PCT. T 01246 231255

EXAMPLE OF A LOCAL INITIATIVE

Lambeth and Southwark: A primary care hypertension facilitating team

The Lambeth and Southwark Hypertension Project aims to support local practices to optimise the treatment of known hypertensive patients. A small team consisting of GPs, IT staff and pharmacists initially visited a few practices to assess their needs. Based on the outcome of these pilot visits the team developed a variety of tools to support clinicians. These ranged from helping them set up disease registers, to advice on complex therapeutic problems and motivational interview skills for clinicians. Key to the success of the project was helping clinicians set up partnerships with patients to optimise concordance.

For more information see the Medicines Partnership website: www.medicines-partnership.org/projects/current-projects/hypertension. Or contact: Dr John Balazs at john.balazs@lambethpct.nhs.uk

Managing the primary-secondary care interface

Locally agreed guidelines will indicate which patients need investigation in secondary care in addition to those investigations routinely offered in primary care, and should ensure that the facilities are available. There are several models of good practice for managing the interface between primary and secondary care. Two examples are described below.

The outreach nurse practitioner²⁷

Nurse practitioners can provide an outreach service to appropriately referred patients and work closely with the secondary care expert clinic. They can offer access to CT or other imaging. They can also review test results before an appointment at an expert clinic and so help to target the resources of that clinic, and reduce the need for appointments. Such a system can also offer good, comprehensive audit of all referrals and the potential for outcome audit by linking with primary care datasets. There are clear guidelines for when a patient requires further review by either the nurse practitioner or secondary care, and when it is more suitable for the patient to return to primary care for ongoing management.

*Annual secondary care based assessment of management*²⁸

In this model, the GP sends the consultant the patient's blood pressure readings, medication history, biochemistry, history of cardiovascular disease and any other relevant information. This allows a paper review without the patient being present. This is, in effect, audit by an expert and allows more patient reviews per expert hour than if the patients were all seen in person.

Understanding barriers and facilitating change

Barriers to prevention

The main barriers to eating a healthier diet and being more physically active have been discussed elsewhere in this toolkit. They are also extensively considered in the public health white paper for England, *Choosing Health: Making Healthy Choices Easier*²¹ and other key policy documents (see Tools H2 and H10). They include psychological, social, cultural, environmental and economic barriers. Overcoming such barriers is clearly key to success.

One mechanism by which this can be achieved is through the involvement of the public and patients in the planning of healthy lifestyle programmes. For example, in England local residents are represented on local strategic partnerships in three important ways: through direct representation of community councils; through elected members (councillors); and through the voluntary sector. There are also statutory requirements for effective patient and public involvement (PPI) throughout the NHS in all parts of the UK. Public and patient involvement is further discussed on page 54.

Helping people to self-manage their blood pressure

A key principle in coping with chronic disease is the concept of 'self-management'. In England and Wales, this theme has been developed by the Wanless reviews into the concept of people becoming 'fully engaged' in their health and healthcare.^{29,30} A range of mechanisms for patients, the general population and health professionals needs to be in place before people can fully self-manage their blood pressure. These are outlined in Table 7 and are described more fully below.

Adherence*

Over half of patients treated for hypertension drop out of care entirely within a year of diagnosis. Of those who remain in treatment, around half do not take their medicines as prescribed.³¹ Some patients may have the medicines dispensed but do not take them, while others may take them erratically or stop taking them abruptly, which can cause a rebound increase in their blood pressure. There are a number of reasons for poor adherence. Some patients may have difficulty in remembering to take their medication or in physically opening medicine bottles. People may also experience difficulty with reading written instructions, either because they have difficulty with reading or perhaps because instructions are not available in their first language. Further reasons are outlined in *Concordance* on page 52.

Poor adherence to prescribed medicines is the most important cause of uncontrolled blood pressure and accounts for three-quarters of patients not achieving optimum blood pressure levels.³¹



The challenge is to increase the proportion of patients who take their medicines as prescribed.

* The terms 'adherence' and 'compliance' are both used to describe the action of taking medicines as prescribed. However, 'compliance' can suggest that the patient passively accepts the prescriber's instructions, and describing the patient as 'non-compliant' can infer blame. For these reasons, many health professionals now prefer to use the less judgmental term 'adherence' rather than 'compliance'.

Table 7 Promoting self-management in the prevention and treatment of hypertension	
Role of the individual	Role of the health professional or partner agency
<i>Awareness and understanding</i>	<i>Awareness and understanding</i>
Gaining awareness and understanding of: <ul style="list-style-type: none"> • the potential dangers of hypertension • its causes, and • how to reduce the risk factors through healthy lifestyles and the avoidance of overweight. 	Raising awareness and understanding of hypertension through media campaigns and other methods. Developing information materials with the involvement of the public and service users. Working with specific at-risk groups to improve communication.
<i>Shared responsibility</i>	<i>Shared responsibility</i>
Developing the ability to take increased responsibility for one's own health.	Promoting shared responsibility through such initiatives as: <ul style="list-style-type: none"> • delivering personal, social and health education and citizenship programmes in schools • delivering self-management courses such as the Expert Patients Programme (see page 54).
<i>Adherence* and concordance</i>	<i>Adherence and concordance</i>
Achieving adherence to medical treatment through concordance with healthcare professionals.	Promoting concordance by: <ul style="list-style-type: none"> • exploring the beliefs, preferences and priorities of individual patients in relation to proposed treatment³² • offering a treatment regime which is simple to adhere to and which minimises side-effects³¹ • agreeing a care plan jointly with each patient³³ • providing continuing support and follow-up as part of the care plan, including regular review of difficulties and progress.

EXAMPLE OF A LOCAL INITIATIVE

Bristol South and West PCT and Bristol North PCT: Raising awareness in the local African and Caribbean communities

The overall aim of this project (managed by the Health Improvement Performance Scheme on behalf of Bristol South and West PCT, and Bristol North PCT) was to develop appropriate hypertension management and prevention guidelines with the African and Caribbean communities in Bristol. To ensure that health promotion initiatives were relevant, accessible and culturally appropriate, a qualitative research framework was used. Focus groups explored people's views and beliefs on high blood pressure, including causes, symptoms, treatment and management, information sources and prevention. Semi-structured interviews were carried out with health professionals to explore issues about risk factor reduction and management of patients with hypertension.

A community-based health awareness day on diabetes and hypertension was also held, providing the opportunity for people to have their blood sugar and blood pressure checked and to obtain information through talks and displays.

For more information contact: Nicola Ravenscroft, South Gloucestershire PCT, Monarch Court, Emerald Business Park, Emerson Green, South Gloucestershire; or Natalie Field, Assistant Director of Public Health, Joint Bristol Public Health Directorate, Bristol North and Bristol South and West PCT. T 0117 900 2445

* See footnote on page 50.

Concordance

Research shows that patients are more likely to be motivated to take their medicines as prescribed when:³⁴

- they fully understand and accept the diagnosis
- they agree with the proposed treatment, and
- their concerns about medicines have been specifically and seriously addressed.

The process necessary to achieve this is described as ‘concordance’ – an approach to the prescribing and taking of medicines, based on partnership.³⁵ Concordance means shared decision-making and arriving at an agreement that best represents the intentions of both the patient and the clinician.

The requirements for effective concordance include:

- appropriate information for patients
- effective ways for health professionals to communicate risks and benefits
- training for doctors on simplifying dosage regimes and minimising side-effects
- training on shared decision-making for health professionals and patients
- follow-up support to review difficulties and progress, and
- aids to help patients remember to take their medicines.

Concordance facilitators

The Medicines Partnership Professional Development Programme has funded over 70 ‘concordance facilitators’ across England, with professional development and training remits from medicine, pharmacy, nursing and patient backgrounds. They are testing out and exploring ways of promoting medicines concordance within their own learning and training contexts.

For more information see: www.medicines-partnership.org

Communicating effectively with patients

Up to 80% of information given to patients during a typical consultation is forgotten within a few minutes, and about half of what patients are able to recall is incorrect.³⁶ Follow-up information, in a form that the patient can readily understand, is essential for good patient care. This may be through leaflets, tapes, interactive computer programmes or videos, and is best developed with patient involvement from the outset.³⁷ Reliable evidence-based information on hypertension is available from organisations such as the Blood Pressure Association, the British Heart Foundation and the Stroke Association, and through the Expert Patients Programme. (For details see page 54.)

Information given to patients by a variety of health professionals must be consistent. For example, advice from the GP should be corroborated by the pharmacist dispensing the medication, and by the practice nurse undertaking the long-term management of the patient.

Delivering good information is also a matter of repeating it as often as the person needs to have it reaffirmed, timing it to be useful at the right moment, and allowing the person the opportunity to scrutinise and ask questions relating to any information given.



The challenge is to ensure that people have easy access to appropriate information and support on hypertension.

Communicating risk and benefits

There is evidence that health professionals are not good at calculating and communicating risk.³⁸ The way in which risks are communicated can make the risks confusing or seem bigger or smaller than they really are:

- Relative risks can inflate effects and should not be used. For example, an increase in relative risk of 50% may be an absolute increase from 1 to 1.5 per 1,000.
- Percentages often confuse and numbers should be used instead. For example, instead of saying that 96% of people will benefit, it is better to say that out of 100 people, 96 will benefit but four will not.

Communicating risks is important and needs to be done in a positive and reassuring way. The understanding of risk varies from person to person and so the way it is explained will need to be tailored to the individual. The following are some examples of methods of explaining risks.

- Explain how someone's risks reduce with the positive action they take and when they manage to reach certain goals.
- Use the Joint British Societies' cardiovascular disease risk prediction charts (see Tool H7) to show level of risk. This enables people to see that lowering their blood pressure to a certain level will take them out of one zone and into another. It is also a way of showing how blood pressure is one of several risk factors that all play a part in their overall cardiovascular risk.

Sources of information for patients can also be found on page 105.

Understanding patients' beliefs

Patients have their own belief systems that determine what advice and treatment they are willing to adhere to. These beliefs may be very different to those of their health professional. The health professional needs to understand and appreciate not only the patient's beliefs but also the way that the patient weighs up the perceived risks and benefits of adhering or not adhering to advice or treatment. It is often difficult for the health professional to let go of the decision-making role and to let the patient decide on treatment following discussion. The discussion may be at different levels depending on the patient's ability and willingness to take on board different levels of information.



Tool H12 shows an analysis of patients' thoughts and feelings about taking medicines for hypertension.

Care plans and patient-held records

A care plan is a document that provides a comprehensive, up-to-date record of antihypertensive care, including all issues considered important by both the person with hypertension and his or her healthcare providers.

Patient-held records enable people with hypertension and their professional team to keep track of how their risk profile is being managed. The information recorded should reflect the individual's needs. The format should also be suited to individual preferences. For example, it could be in a handy ring-binder format or in the form of a patient-accessible electronic record. The benefits of patient-held records are:

- The patient with hypertension has ownership of his or her care.
- Both the patient with hypertension and the health professionals know at all times what care is planned.
- Contact details of health professionals are readily to hand.

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England's public health white paper, *Choosing Health*, has proposed the use of personalised patient-held 'health guides' completed with the assistance of 'NHS health trainers' giving lifestyles advice.²¹



Tool H13 shows the suggested minimum content of a care plan and a patient-held record for hypertension.

The Expert Patients Programme

The Expert Patients Programme (EPP) is a national NHS-based self-management training programme which provides opportunities for people who live with long-term conditions to develop new skills to manage their condition better on a day-to-day basis. Set up in 2002, it is based on research from the US and UK over the last two decades which shows that people living with long-term illnesses are often in the best position to know what they need to manage their own condition. Provided with the necessary 'self-management' skills, they can make a tangible impact on their disease and quality of life more generally. EPP courses are being run by primary care trusts throughout England. Similar programmes are also being developed in other parts of the UK.

The core module of the EPP programme is the same for a range of long-term conditions, and additional modules for specific diseases including coronary heart disease and hypertension are being developed and trialled. (For further details, see www.expertpatients.nhs.uk)

Self-monitoring of blood pressure at home

There is conflicting evidence regarding the value of self-monitoring of blood pressure. NICE, in its clinical guideline on hypertension, does not advocate home blood-pressure monitoring and recommends the need for further research.¹

Ensuring appropriate infrastructure support

The main issues concerning infrastructure support are around the need to:

- involve the public, patients and carers
- build capacity in terms of staff, equipment and facilities
- set up appropriate education and training programmes
- ensure effective IT systems in primary care
- ensure good communications, and
- provide sufficient funding for all elements of the strategy.

Involving the public, patients and carers

Services cannot be truly responsive without effective input by the people they are designed to serve. There is a wide variety of ways of involving people in the planning and evaluation of services – both preventive and care services. There are also various statutory requirements for involving the public and patients which differ slightly in the four countries of the UK.



Tool H14 outlines the various ways in which patients and the public can be involved in tackling hypertension.

Capacity

Workforce development needs to deliver a service that identifies people with hypertension and then ensures adequate investigation and management, including expert intervention when necessary. It also needs to develop the preventive strand of the strategy by developing a 'wider public health' workforce. This should involve a joint approach with local partners, including joint appointments and shared budgets.

The clinic time needed in each practice for case-finding in order to reach current Quality and Outcomes Framework targets can be calculated from average consultation time. Prescriber time to deal with pharmacological management will increase, since more patients will be identified, requiring initiation and titration of dosage. In some general practices, healthcare assistants and reception staff are being trained to take blood pressures.

Other important aspects include: adequate administrative support, well-maintained and calibrated blood pressure measuring equipment, and sufficient space for a nurse-led cardiovascular risk assessment service.

Demand and capacity planning might include novel approaches to provision such as:

- health trainers and lifestyle coaches
- nurse-led blood pressure assessment services
- community pharmacy-based services
- cluster-based approaches, and
- primary care staff (eg GPs) with a special interest.

Education and training

Where appropriate, multidisciplinary or multiagency training programmes should be set up to provide education and training for a range of professionals and lay workers on:

- raising awareness of the issue of hypertension as an important chronic disease
- promoting health in 'at-risk' groups
- accurate blood pressure measurement
- motivational counselling for lifestyle behaviour change
- appropriate investigations and prescribing, and
- ongoing care.

The training issues around the clinical aspects of the management of hypertension and use of the agreed guidelines, as well as around related use of IT systems, will need to be considered and appropriate training packages put in place. Training all staff within a practice during protected learning time could address all these issues at once. Primary care organisations could provide a menu of training opportunities to suit a variety of needs, and baseline awareness and expertise, both clinically and in relation to IT.

Effective IT systems in primary care

Current general practice IT systems vary greatly in how well they can support hypertension case-finding, cardiovascular risk assessment, clinical decision-making, appointment booking, records, prescription sharing and audit. A major programme of standardisation to preferred IT-based clinical systems is currently being coordinated throughout the UK (eg by the National Programme for IT in England).³⁹

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Audit is focused on the current Quality and Outcomes Framework (QOF) of the GMS contract (with a parallel process for Personal Medical Services contracts), which contains a specific component for hypertension, as well as related issues such as CHD, stroke and diabetes. Practices make monthly returns to the QMAS centre and are financially rewarded for achieving QOF standards (see Tool H11).

EXAMPLE OF A LOCAL INITIATIVE

Scottish Borders: LHCC Hypertension Project

This project began in 2001 as the main clinical priority for the two Local Healthcare Cooperatives (LHCCs) in the NHS Borders area and involved all primary care teams. It consisted of several coordinated elements:

- the creation of computerised disease registers for hypertension
- screening of the initial target population group (men and women aged 35-64 years)
- staff training and calibration of instruments
- agreement on the local hypertension guideline and its dissemination
- educational events and support for primary care teams via a project nurse facilitator
- use of standard software for inputting data to the General Practice Administration System for Scotland, and development of a system for central collation and analysis of practice data, and
- audit of the target population by individual practices and across all practices.

The project was coordinated by both the local primary prevention project for CHD, stroke and cancer, and the local secondary prevention of CHD project. A local guideline which was developed using national guidance has wide ownership.

The initial focus was on developing systems and increasing screening to identify people with hypertension. Once all practices had the standard software and had undergone IT training, the intention was to move on to audit the control of blood pressure.

Progress included the following:

- All practices developed a register of all identified patients with hypertension.
- Screening of blood pressure in the target group (35-64 year olds) improved from a mean of 58% for both LHCCs in 2002, to 70% in 2003.
- Standard software for data collection in primary care was agreed by all local practices and roll-out proceeded, with training provided by a central IT learning resource centre.
- A central database was developed to collate data from all practices and facilitate collaborative clinical audit.

The project has placed NHS Borders primary care teams in a good position to respond to the GMS contract quality indicators for hypertension. It has also facilitated the development of data collection systems which are now used for quality indicator data within the contract for all chronic diseases.

For more information contact: Borders LHCC Office, NHS Borders, Newstead, Melrose TD6 9DB. T 01896 825508

Ensuring good communications

With the public and 'at-risk' groups

Communications is a key element of the local strategy – not only to raise awareness of the dangers of hypertension and its risk factors, but also to get across the importance of having blood pressure checks and adhering to treatment.

Methods of effective communication might include:

- encouraging healthy early nutrition and active play through parents, health visitors, childminders, playgroup leaders and Sure Start programmes
- supporting school-based learning and whole-school initiatives
- posters and leaflets in general practices, pharmacies and clinics
- working with 'at-risk' groups
- blood pressure measuring stands at health fairs and events
- news and features in local media
- local advertising campaigns.

For more on communicating with patients, see page 50.

With secondary care

An important part of the work-up of identified cases of hypertension is the need for tests to eliminate secondary hypertension and related disorders. This requires effective and efficient communication with secondary care services, particularly diagnostics and medical outpatients. Local planners need to agree clinical protocols and pathways which ensure appropriate referral to secondary care. New IT systems for electronic booking and record-sharing will greatly assist efficient referral and improve patient experience.

Funding

Prescribing

The primary care organisation will need to identify the additional prescribing costs associated with fully implementing the hypertension case-finding and management programme. The costs will mostly lie in ACE (angiotensin-converting enzyme) inhibitors and calcium channel blockers.

Additional investigations

Additional laboratory tests will be needed to assess and monitor, for example, kidney function, in those patients identified through a more systematic approach to case-finding.

Behaviour-change programmes

There should be sufficient resources for behaviour-change programmes which can support the management of hypertension. This involves support for increasing physical activity, and for promoting healthy eating and weight management through additional health trainers, physical activity facilitators, community dietitians or public health nutritionists.



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Monitoring progress, assessing performance and evaluating the strategy

Evaluation of strategies and programmes for hypertension is central for:

- clinical governance
- audit and quality improvement
- providing information to the public
- strategy and programme development
- assessing value for money
- assessing sustainability, and
- increasing the evidence base.

There are two basic rules for successful evaluation:

- The evaluation process must be developed at the start, at the same time as aims, objectives and targets of the intervention are worked out.
- Adequate funding must be set aside for the evaluation. A good guide is 10% of a programme's budget.



Tool H15 gives examples of indicators that could be used to assess performance of a local hypertension prevention and control programme.

Mainstreaming and sustainability

A perennial problem facing local healthcare planners and providers is ensuring that effective practice is sustainable and 'mainstreamed' in terms of continued funding. Many innovative approaches are piloted using short-term funding streams but, despite favourable evaluation, are difficult to build into budget baselines due to intense competition for mainstream funding. This is particularly true of preventive lifestyle initiatives which often have less measurable, less attributable, and shorter-term outcomes than interventions to control hypertension.

However, in England, the public health white paper, *Choosing Health*,²¹ strengthens the focus on prevention and sustainable implementation. In particular it calls for:

- strong leadership and management
- effective partnership working
- a 'can-do' culture
- an effective workforce strategy
- appropriate education and training programmes
- sound governance arrangements
- aligned inspection, regulation, standards, targets, incentives and performance assurance.

The National Institute for Health and Clinical Excellence in England integrates preventive and treatment knowledge and guidance on issues such as hypertension, and works closely with the Healthcare Commission in developing appropriate tools for performance assessment. This will inform guidance for primary care organisations on implementation, coordination and monitoring.

As part of sustainability there is a need to strengthen the role of public health observatories in supporting local bodies by helping them to identify and measure local health problems and track progress towards targets.

At local level, the local strategic partnership, and its equivalent in all parts of the UK, can act as overall coordinator of a 'whole system' approach to hypertension prevention and control. Local targets can be set around promoting healthy eating, physical activity and reducing overweight and obesity. The local Health and Social Care Scrutiny Committee (or its equivalent) can choose to assess the performance of this integrated approach to local services.

National NHS improvement strategies such as the NHS Improvement Plan in England, and its parallels in Wales, Scotland and Northern Ireland, have endorsed the importance of prevention and management of long-term conditions such as coronary heart disease (CHD), diabetes, stroke and chronic kidney disease. In particular, implementation of programmes to prevent and manage CHD and stroke are core priorities for primary care organisations across the UK. Public Service Agreements on increasing life expectancy, preventing avoidable illness, reducing health inequalities and improving access to healthcare services add further impetus to delivery in each part of the UK.

References

- 1 National Institute for Clinical Excellence. 2004. *Management of Hypertension in Adults in Primary Care. Clinical Guideline 18*. London: National Institute for Clinical Excellence.
- 2 Scottish Intercollegiate Guidelines Network (SIGN). 2001. *Hypertension in Older People. A National Clinical Guideline. SIGN Publication No. 49*. Edinburgh: SIGN.
- 3 McPherson, Britton A, Causer L. 2002. *Coronary Heart Disease: Estimating the Impact of Changes in Risk Factors*. London: The Stationery Office.
- 4 Prospective Studies Collaboration. 2002. Age-specific relevance of usual blood pressure to vascular mortality: a meta analysis of individual data for 1 million adults in 61 prospective studies. *Lancet*; 360: 1903.
- 5 Williams B, Poulter NR, Brown MJ et al. 2004. Guidelines for management of hypertension: report of the fourth working party of the British Hypertension Society, 2004-BHS IV. *Journal of Human Hypertension*; 18: 139-85.
- 6 Guidelines Subcommittee. 1999. World Health Organization-International Society of Hypertension Guidelines for the Management of Hypertension. *Journal of Hypertension*; 17: 151-83.
- 7 Williams B, Poulter NR, Brown MJ et al. 2004. Guidelines for management of hypertension: report of the fourth working party of the British Hypertension Society, 2004-BHS IV. *Journal of Human Hypertension*; 18: 139-85.
- 8 Department of Health. 2004. *National Standards, Local Action – Health and Social Care Standards and Planning Framework 2005/06–2007/08*. London: Department of Health.
- 9 Scientific Advisory Committee on Nutrition. 2003. *Salt and Health*. London: The Stationery Office.
- 10 Press V, on behalf of the National Heart Forum, Faculty of Public Health, Government Office for the North West, Government Office for the West Midlands, and the West Midlands Public Health Observatory. 2004. *Nutrition and Food Poverty: A Toolkit for Those Involved in Developing or Implementing a Local Nutrition and Food Poverty Strategy*. London: National Heart Forum.
- 11 Crawley H, on behalf of Caroline Walker Trust and National Heart Forum. (In press.) *Eating Well at School: Nutritional and Practical Guidelines*. London: Caroline Walker Trust.
- 12 National Audit Office. 2001. *Tackling Obesity*. London: The Stationery Office.
- 13 Working Party of the Royal College of Physicians, the Royal College of Paediatrics and Child Health, and the Faculty of Public Health. 2004. *Storing Up Problems. The Medical Case for a Slimmer Nation. Report of a Working Party 2004*. London: Royal College of Physicians.
- 14 Mulvihill C, Quigley R. 2003. *The Management of Obesity and Overweight: An Analysis of Reviews of Diet, Physical Activity and Behavioural Approaches. Evidence Briefing*. London: Health Development Agency.
- 15 Maryon-Davis A. 2005. Weight management in primary care: how can it be made more effective? *Proceedings of the Nutrition Society*; 64: 1-7.
- 16 Maryon-Davis A, Giles A, Rona R. 2000. *Tackling Obesity: A Toolkit for Local Action*. London: Faculty of Public Health Medicine.
- 17 Prime Minister's Strategy Unit. 2004. *Alcohol Harm Reduction Strategy for England*. London: Cabinet Office.
- 18 Department of Health. 2004. *At Least Five a Week. Evidence on the Impact of Physical Activity and its Relationship to Health. A Report from the Chief Medical Officer*. London: Department of Health.
- 19 Maryon-Davis A, Sarch L, Morris M, Laventure R. 2001. *Let's Get Moving: A Physical Activity Handbook for Developing Local Programmes*. London: Faculty of Public Health Medicine.

- 20 Hillsdon M, Foster C, Naidoo B, Crombie H. 2004. *The Effectiveness of Public Health Interventions for Increasing Physical Activity among Adults: A Review of Reviews. Evidence Briefing*. London: Health Development Agency.
- 21 Department of Health. 2004. *Choosing Health: Making Healthy Choices Easier*. London: The Stationery Office.
- 22 National Institute for Clinical Excellence. 2002. *Management of Type 2 Diabetes – Management of Blood Pressure and Blood Lipids*. London: National Institute for Clinical Excellence.
- 23 Department of Health. 2000. *National Service Framework for Coronary Heart Disease*. London: Department of Health.
- 24 Department of Health. *General Medical Services (GMS) contract*. Accessed on 21 January 2005 from: <http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/fs/en>
- 25 NHS National Programme for Information Technology. 2004. *GMS IT – QMAS Bulletin*. Accessed on 12 January 2005 from: <http://www.dh.gov.uk/assetRoot/04/08/42/61/04084261.pdf>
- 26 Munding MO, Kane RL, Lenz ER et al. 2000. Primary care outcomes in patients treated by nurse practitioners or physicians: a randomized trial. *Journal of the American Medical Association*; 283 (1): 59-68.
- 27 Curzio JL, Rubin PC, Kennedy SS, Reid JL. 1990. A comparison of the management of hypertensive patients by nurse practitioners compared with conventional hospital care. *Journal of Human Hypertension*; 4: 665-70.
- 28 McInnes GT, McGhee SM. 1995. Delivery of care for hypertension. *Journal of Human Hypertension*; 9 (6): 429-33.
- 29 HM Treasury. 2004. *Securing Good Health for the Whole Population: Final Report*. London: Her Majesty's Stationery Office.
- 30 HM Treasury. 2002. *Securing Our Future Health. Taking a Long-Term View. Final Report*. London: Her Majesty's Stationery Office.
- 31 World Health Organization. 2003. *Adherence to Long-term Therapies: Evidence for Action*. Geneva: World Health Organization.
- 32 Medicines Partnership Organisation. See: www.medicines-partnership.org
- 33 Benson J, Britten N. 2002. Patients' decisions about whether or not to take antihypertensive drugs: qualitative study. *British Medical Journal*; 325: 873.
- 34 Medicines Partnership. *From Compliance to Concordance*. Accessed on 20 January 2005 from: www.medicines-partnership.org/about-us
- 35 Royal Pharmaceutical Society of Great Britain Working Party. 1996. *Partnership in Medicine Taking: A Consultative Document*. London: Royal Pharmaceutical Society and Merck, Sharpe and Dohme.
- 36 Kessels R. 2003. Patients' memory for medical information. *Journal of the Royal Society of Medicine*; 96: 219-22.
- 37 Duman M. 2003. *Producing Patient Information*. London: King's Fund.
- 38 Gigerenzer G, Edwards A. 2003. Simple tools for understanding risks: from innumeracy to insight. *British Medical Journal*; 327: 741-44.
- 39 National Programme for Information Technology. See: <http://www.npfit.nhs.uk/>