Resources D

This section contains:

The toolset includes the following tools:

Suggested structure for a local hypertension strategy

Tool **H1**

Strategy section	Sections of this toolkit that can help
Introduction: the need for action The introduction to the strategy should outline the main elements and give the reasons why local action is necessary to tackle hypertension. For example: • national and local policy drivers • an estimate of the local prevalence and costs of hypertension • an outline of the benefits of preventing, detecting and controlling hypertension.	*Pages 33-35* **Tool H1** Suggested structure for a local hypertension strategy **Tool H2** National policy drivers (1) **Tool H3** Hypertension prevalence ready-reckoner
Strategic partnerships This section details the key partners who will help to plan, implement and evaluate the strategy, the establishment of a hypertension action team and who it will include.	*Pages 35-36* **Tool H4** Local partners and their potential roles **Tool H5** A settings approach to tackling hypertension
Current activity and gaps This section of the strategy looks at what is currently happening at local level on prevention, detection and control. It could include the results of an audit to map local action and identify gaps, and the action each partner agency needs to take.	*Page 36* **Tool H6** Checklist for reviewing current activity
Priorities and target groups This section considers how resources will be targeted and where to focus efforts.	*Pages 15-21, 25-31 and 37-38* **Tool H7** Cardiovascular disease risk prediction charts **Tool H8** Proforma for developing a hypertension action plan
Aims, objectives, standards, targets and milestones The broad aims of the strategy, specific objectives and standards, and time-scheduled targets and milestones.	*Pages 39-40* **Tool H2** National policy drivers (1)

Strategy section	Sections of this toolkit that can help
Key interventions Using a settings approach, this section suggests interventions to: • prevent hypertension, and • detect and control hypertension. It also outlines how to develop a local hypertension action plan.	*Pages 25-31 and 41-50* **Tool H5** A settings approach to tackling hypertension **Tool H8** Proforma for developing a hypertension action plan **Tool H9** Salt and hypertension **Tool H10** National policy drivers (2) **Tool H11** The GMS contract: quality indicators for hypertension
Potential barriers This section outlines the obstacles which prevent people from adopting healthier lifestyles or adhering to treatment, ways in which these can be overcome, and the roles of the individual and of health professionals and partner agencies.	*Pages 26-27 and 50-54* **Tool H12** Patients' thoughts and feelings about taking medicines for hypertension **Tool H13** Suggested minimum content of care plans and patient-held records for hypertension **Tool H14** Ways of involving patients and the public in tackling hypertension
Infrastructure support This section details the structures that need to be in place at local level to implement a hypertension strategy, such as capacity, IT systems, sufficient funding, and public and patient involvement.	*Pages 54-57* **Tool H14** Ways of involving patients and the public in tackling hypertension
Monitoring and evaluation How to monitor progress, assess performance and evaluate the strategy should be detailed in this section.	*Page 58* **Tool H11** The GMS contract: quality indicators for hypertension **Tool H15** Performance assessment: examples of indicators
Mainstreaming and sustainability Plans on how to ensure that local action to prevent, detect and control hypertension is mainstreamed and sustained should be included in the strategy.	*Pages 58-60*

National policy drivers (1)

Tool H2

Government health priorities, standards and targets related to blood pressure

For details of policies and programmes on healthy eating, physical activity and the wider determinants of health, see Tool H10 National policy drivers (2).

ENGLAND

Choosing Health: Making Healthy Choices Easier
(2004)
www.dh.gov.uk

This public health white paper is a national strategy for improving health in England, focusing mainly on individual lifestyle changes, supported by fiscal, legislative, environmental, commercial and other changes to encourage, enable and empower the individual. It builds on the relevant national service frameworks described below and introduces a number of new initiatives including:

- tough targets for salt reduction in processed and prepared foods
- an expanded Healthy Schools Programme
- nutrient-based standards for school meals and public sector catering
- a specialist anti-obesity service in each PCT
- NHS-accredited health trainers offering lifestyle advice
- personally-held health guides containing personal health goals
- boosted smoking cessation services
- a big expansion and enforcement of smoke-free workplaces, restaurants, pubs and bars
- boosted active workforce schemes
- an online/telephone advisory service for healthy lifestyles (Health Direct)
- new campaigns to reduce binge-drinking, obesity and smoking, and increase physical activity.

National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08
(2004)
www.dh.gov.uk

Describes national targets and standards for NHS and social services authorities. Core standards must be complied with, while developmental standards set the 'direction of travel'.

Core Standard C5: Healthcare organisations ensure they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.

Developmental Standard D2: Patients receive effective treatment and care that conform to nationally agreed best practice, particularly as defined in national service frameworks (NSFs), NICE guidance, national plans and agreed national guidance on service delivery.

Core Standard C15: Where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice, and that it is prepared safely and provides a balanced diet.

Core Standard C23: Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the NSFs, and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking and substance misuse.

Developmental Standard D13: Healthcare organisations:

- identify and act upon significant public health problems and health inequality issues, with PCTs taking the leading role
- implement effective programmes to improve health and reduce health inequalities, and
- take fully into account current and emerging policies, and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services for the public, and the commissioning and provision of services.

Securing Good Health for the Whole Population: Final Report
(2004)

Securing Our Future Health: Taking a Long-term View
(2002)
www.hm-treasury.gov.uk

The Wanless reports are likely to become major drivers of change (in England and Wales) in the allocation of resources over the next 20 years. Wanless' underlying theme is that progress in life expectancy and health status is heavily dependent on people becoming more fully involved in all aspects of their health, and that the health service should be responsive to this.

Improvement, Expansion and Reform: The Next 3 Years' Priorities and Planning Framework, 2003-2006
(2002)
www.dh.gov.uk

Department of Health Public Service Agreement
(2002)
www.hm-treasury.gov.uk

The priorities in the Priorities and Planning Framework (PPF) for 2003-06 are based on the Department of Health's Public Service Agreement (PSA).

The aim of the underlying PSA is to transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities. The objectives of the PSA relevant to policies on blood pressure are:

Objective 2: Improve health and social care outcomes for everyone.

- Reduce substantially the mortality rates from the major killer diseases by 2010: from heart disease by at least 40% in people under 75 years, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators, and the population as a whole.
- By 2010 reduce inequalities in health outcomes by 10% (from a 1997-99 baseline), as measured by infant mortality and life expectancy at birth.
- To improve the health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings.

Tackle the underlying determinants of ill health and health inequalities by:

- Halting the year-on-year rise in obesity among children under 11 years by 2010 – in the context of a broader strategy to tackle obesity in the population as a whole (joint target with the Department for Education and Skills, and the Department for Culture, Media and Sport).

Within these priority areas, the key targets of the PPF related to hypertension are:

Coronary heart disease

- In primary care, update practice-based registers so that patients with coronary heart disease and diabetes continue to receive appropriate advice and treatment in line with NSF standards.
- Ensure that practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of coronary heart disease, particularly those with hypertension, diabetes or a BMI greater than 30kg/m^2.

Reducing health inequalities

- Deliver an increase of two percentage points per year in the breastfeeding initiation rate, focusing especially on women from disadvantaged groups.
- Contribute to a national reduction in death rates from coronary heart disease (CHD) in people under 75 years, targeting the 20% of areas with the highest rates of CHD.

National Service Framework for Renal Services – Part Two: Chronic Kidney Disease, Acute Renal Failure and End of Life Care
(2005)
www.dh.gov.uk

There are two quality requirements relevant to hypertension:

Quality requirement 1: Prevention and early detection of chronic kidney disease
People at increased risk of developing or having undiagnosed chronic kidney disease, especially people with diabetes or hypertension, are identified, assessed and their condition managed to preserve their kidney function.

Quality requirement 2: Minimising the progression and consequences of chronic kidney disease
People with a diagnosis of chronic kidney disease receive timely, appropriate and effective investigation, treatment and follow-up to reduce the risk of progression and complications.

Both of these require close monitoring of blood pressure to detect and control hypertension.

National Service Framework for Children, Young People and Maternity Services (2004) www.dh.gov.uk	Action taken to promote and deliver health and well-being (as called for in Standard 1) will help prevent the rise of blood pressure with age.
National Service Framework for Diabetes (2001) www.dh.gov.uk	Three standards are relevant to hypertension: *Standard 1:* Strategies to prevent Type 2 diabetes in the general population and reduce inequalities in the risk of developing Type 2 diabetes. Key interventions include local strategies for the prevention and reduction of the prevalence of overweight and obesity, and reducing risk by eating a balanced diet, losing weight and increasing physical activity. Implications for service planning include continuing education for health professionals about the interventions that are effective in these areas. *Standard 3:* Empowering people with diabetes. Includes help to adopt and maintain a healthy lifestyle, such as tools to support behaviour – for example, affordable healthier food options both at home and in the workplace. *Standard 4:* Clinical care of adults with diabetes. Emphasises that weight loss and increased physical activity are the first interventions for people with newly diagnosed Type 2 diabetes. All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimise the control of their blood glucose, blood pressure and other risk factors.
National Service Framework for Older People (2001) www.dh.gov.uk	This is a 10-year programme of action with eight standards, two of which are directly relevant to blood pressure. *Standard 5:* Stroke. Working in partnership with other agencies where appropriate, to reduce the incidence of stroke in the population and to ensure those who have had a stroke have prompt access to integrated services. *Standard 8:* The promotion of health and active life in older age. "The health and wellbeing of older people is promoted through a coordinated programme of action led by the NHS with support from councils." Key interventions include programmes for improved diet and nutrition. Local health systems should be able to demonstrate year-on-year improvements in measures of health and well-being among older people including flu immunisation, smoking cessation and blood pressure management.
National Service Framework for Coronary Heart Disease (2000) www.dh.gov.uk	Sets national standards for the treatment and prevention of coronary heart disease (CHD). Reducing health inequalities is a guiding principle. Standards 1, 3, 4, 8, 11 and 12 are relevant to action on blood pressure. *Standard 1:* Reducing the prevalence of CHD risk factors in the population and reducing inequalities in risk of developing heart disease. Directors of public health are expected to produce an 'equity profile' for their population. A community development approach is sought, with health visitors as a vital resource. All NHS bodies, working closely with local authorities, are required to have an effective local policy and programmes on promoting healthy eating, reducing overweight and obesity and increasing physical activity. NHS and local authorities are asked to be exemplary employers in the promotion of physical activity and healthy eating. *Standards 3 and 4:* Identifying and treating all people with established cardiovascular disease (CVD) and those at high risk of developing CVD, particularly those with hypertension, diabetes and a BMI greater than 30kg/m^2. By 2006 to ensure practice-based registers and systematic treatment regimes, including appropriate advice on physical activity, diet and weight, diabetes and alcohol consumption, as well as advice and treatment to control blood pressure. *Standard 8:* People with symptoms of angina should receive appropriate investigation and treatment to relieve their pain and reduce their risk of coronary events. This includes advice on physical activity, diet and weight, diabetes and alcohol consumption, and advice and treatment to control blood pressure.

	Standard 11: Heart failure and palliative care for people with CHD. This includes advice on physical activity, diet and weight, diabetes and alcohol consumption, and advice and treatment to control blood pressure. *Standard 12:* Cardiac rehabilitation. This includes assessment of individuals' risks and needs, and developing individualised plans to meet those needs. Plans might include advice on physical activity, diet and weight, diabetes and alcohol consumption, and advice and treatment to control blood pressure.
SCOTLAND	
Improving Health in Scotland: the Challenge – Framework for Action (2003) www.scotland.gov.uk	This document builds on *Towards a Healthier Scotland* and is the first in a series. It includes the following two objectives for health improvement: • By 2010 improve the life expectancy and healthy life expectancy for all men and women living in all areas of Scotland. Also reduce inequalities between the most affluent and most deprived groups. • By 2020-22, further improve life expectancy and healthy life expectancy of men and women living in all areas of Scotland. Also further reduce inequalities between the most affluent and most deprived groups. The document acknowledges that improved health requires linkages with local authorities, education, social justice, environment and sport. It seeks to support people at critical times in their lives and works through four areas: early years, teenage transition, the workplace and communities.
Coronary Heart Disease and Stroke Strategy for Scotland (2002) www.scotland.gov.uk	This document includes recommendations on prevention, managed clinical networks, workforce issues and IT. The prevention recommendation is: "All NHS boards should, through their local Managed Clinical Networks, develop explicit CHD and stroke prevention strategies...These should link to, and may be an integral part of, more general strategies for primary/secondary prevention/health improvement plans. The strategies should adopt a 'population approach' to improving the health of communities that they serve, complemented by a 'high risk' approach targeted at certain key groups, such as those with hypertension, hypercholesterolaemia, or diabetes, as well as the more socially disadvantaged groups within the population."
Towards a Healthier Scotland (1999) www.scotland.gov.uk	This white paper sets out action at three levels: improving life circumstances that impact on health, unhealthy lifestyles and the health priorities. These include heart disease and effective support for children in their early years, and for their parents. Tackling health inequalities is the overarching aim of all three levels. There are targets for coronary heart disease and stroke, physical activity, alcohol, diet and smoking: *CHD and stroke:* By 2010 to reduce the age-standardised mortality rate from CHD and stroke in people under 75 years by 50% (from 1995 baseline). The ratio of CHD deaths among the 20% of the population living in deprived postcode sectors to the 20% living in the most affluent postcode sectors has been chosen as an indicator of health inequalities. *Physical activity:* The targets for physical activity have now been superseded by those set in *Let's Make Scotland More Active* (see Tool H10). *Alcohol:* To reduce the incidence of men and women aged 16-64 exceeding weekly limits of 21 and 14 units of alcohol, respectively, from 33% in 1995 to 29% by 2010 for men, and from 13% in 1995 to 11% by 2010 for women. To reduce the frequency and level of drinking among 12-15 year olds from 20% in 1995 to 16% by 2010. *Diet:* The targets for healthy eating have now been superseded by those in the *Scottish Diet Action Plan* (see *Eating for Health* in Tool H10). *Smoking:* To reduce the rate of smoking among adults aged 16-64 in all social classes to an average of 31% by 2010. There are also smoking targets for pregnant women and young people.

WALES	
Securing Good Health for the Whole Population: Final Report (2004) **Securing Our Future Health: Taking a Long-term View** (2002) www.hm-treasury.gov.uk	See page 66.
Health, Social Care and Well-being Strategies, and Policy Guidance (2003) www.wales.gov.uk	Local health boards and local authorities have to produce these strategies in conjunction with other organisations and through public consultation. This is based on *Well Being in Wales* which sets an integrated approach to tackling the economic, social and environmental factors that affect people's health.
Improving Health in Wales. A Plan for the NHS with its Partners (2001) www.wales.gov.uk	This white paper set the direction for health services in Wales over 10 years. It states that the NHS will work with local government and its other partners to create healthier communities. It increased the power of local health groups in commissioning and delivering services, and widened their membership to include local authority members. Local health groups were also given the responsibility of achieving effective local joint working across the statutory and non-statutory sectors to deliver strong community-based health and social care services.
Tackling Coronary Heart Disease in Wales: Implementing through Evidence (2001) www.wales.nhs.uk	There are five evidence-based standards for tackling CHD in Wales. Those relevant to hypertension are: • *Standard 1.* Health authorities through their local health groups and with local authorities in partnership through local health alliances should develop, implement and monitor evidence-based programmes to address tobacco use, diet and physical activity targeted at the most disadvantaged communities in Wales. • *Standard 2.* Everyone at high risk of developing coronary heart disease and all those who have been diagnosed as having the disease should have access to a multifactorial risk assessment and be offered an appropriate treatment plan. This should address those at high risk. • *Standard 4.* Everyone with heart failure should be recognised and offered appropriate evidence-based care. The health outcome target for coronary heart disease is: • To reduce deaths from coronary heart disease (measured by the European age-standardised ratio) in 65-74 year olds from 600 per 100,000 in 2002, to 400 per 100,000 by 2012. • Health inequality target – to improve CHD mortality in all groups and at the same time aim for a more rapid improvement in the most deprived groups. • Other indicators to be monitored include CHD premature mortality in males and females under 75 years at local and national level, and progress towards the National Service Framework standards.
Promoting Health and Well-being: Implementing the National Health Promotion Strategy (2001) www.wales.gov.uk	Sets out the action programme for implementation of the health promotion strategy highlighted in *Better Health, Better Wales.* It outlines its commitment to preventing ill health and reducing inequalities.

NORTHERN IRELAND	
Priorities for Action 2004/05: Planning Priorities and Actions for the Health and Personal Social Services (2004) www.dhsspsni.gov.uk	Health and Social Services Boards will be required to submit Health and Wellbeing Investment Plans (HWIPs) setting out how they will secure effective health and social services for their local populations, improve health and well-being, and reduce inequalities with a view to achieving the *Investing for Health* targets by 2010. Boards are expected to work with other organisations as part of the Investing for Health Partnership to take forward the implementation of cross-departmental strategies and action plans in the interrelated areas of drugs and alcohol misuse, mental health promotion, physical activity, food and nutrition, breastfeeding, and teenage parenthood. Boards should also provide for improved outcomes for people with diabetes by taking forward prioritised recommendations of the CREST taskforce on the prevention and treatment of diabetes (see *The Joint Task Force Report on Diabetes*, below).
The Joint Task Force Report on Diabetes (2003) www.diabetes.org.uk	The Clinical Resource Efficiency Support Team (CREST) and Diabetes UK produced a joint report which highlighted relevant issues in diabetes, and collated them into an integrated health service framework. This framework is made up of 18 key building blocks which cover five main areas: prevention and early detection; care, monitoring and treatment; targeting vulnerable groups; planning and managing services; and implementation issues. It is anticipated that the development and implementation of the framework will be a 5- to 10-year programme.
Investing for Health (2002) www.dhsspsni.gov.uk	This is a framework for a new strategy to improve the health and well-being of people in Northern Ireland through a multidisciplinary approach including social, economic, physical and cultural environments and health policy. The targets include: • reducing the gap in life expectancy between the average life expectancy of those living in the fifth most deprived electoral wards and the average life expectancy for both men and women between 2000 and 2010 • reducing the mortality rate from circulatory diseases (in particular deaths from heart disease and stroke) by at least 20% in people under 75 years by 2010 • stopping the increase in levels of obesity in men and women so that by 2010 the proportion of men who are obese is less than 17%, and the proportion of women who are obese is less than 20%. Following on from this, cross-departmental strategies and action plans will cover a range of areas including: drugs and alcohol misuse, food and nutrition, mental health promotion, physical activity, tobacco and teenage parenthood.
Northern Ireland Evidence-based Stroke Strategy (2001) www.nichsa.com	This strategy provides a challenging agenda for the development of stroke services for the next 5-10 years. Implementation of this strategy will bring benefits to patients, carers and stroke survivors.

Hypertension prevalence ready-reckoner

Tool H3

This tool can be used to estimate the number of people within a primary care organisation's local area who have hypertension (persistent raised blood pressure of 140/90mmHg or above), treated and untreated, controlled and uncontrolled.

An electronic version of the Hypertension ready-reckoner – which can be completed online – can be found at: www.fph.org.uk. (See Policy and Communications, Publications, 'Easing the Pressure: Tackling Hypertension'.)

How to use the ready-reckoner

1 In cells A1-A7 and B1-B7 enter the actual numbers of residents in each age group, based on latest population estimates for your area.
2 Calculate the other cell values according to the formulae shown below.

		PCO* population		Estimate of number of hypertensives	
		Male	Female	Male	Female
	Age	A	B	C	D
1	15-24	Enter actual number	Enter actual number	A1 x 0.06	B1 x 0.02
2	25-34	Enter actual number	Enter actual number	A2 x 0.11	B2 x 0.05
3	35-44	Enter actual number	Enter actual number	A3 x 0.20	B3 x 0.11
4	45-54	Enter actual number	Enter actual number	A4 x 0.35	B4 x 0.23
5	55-64	Enter actual number	Enter actual number	A5 x 0.51	B5 x 0.47
6	65-74	Enter actual number	Enter actual number	A6 x 0.64	B6 x 0.64
7	75 plus	Enter actual number	Enter actual number	A7 x 0.64	B7 x 0.75
8	**TOTALS**	Sum of A1-A7	Sum of B1-B7	Sum of C1-C7	Sum of D1-D7

Of those who are hypertensive:				
9		Estimated number receiving treatment:	C8 x 0.37	D8 x 0.46
10		Estimated number not receiving treatment:	C8 x 0.63	D8 x 0.54

Of those receiving treatment:				
11		Estimated number controlled:	C9 x 0.46	D9 x 0.44
12		Estimated number uncontrolled:	C9 x 0.54	D9 x 0.56

* PCO = primary care organisation

Source: Formulae based on the *Health Survey for England 2003* [1]

Note: This ready-reckoner takes no account of ethnicity, deprivation or other factors that might affect hypertension prevalence; nor of recent changes in the proportion controlled. It can give only a rough approximation based on all-England data collected in 2003.

EXAMPLE

The following is a worked example of how to use the ready-reckoner, based on 2003 mid-year population estimates (rounded) for Southwark Primary Care Trust, London. (Numbers are in 000s.)

		Population of Southwark PCT (000s)		Estimate of number of hypertensives (000s)	
		Male	Female	Male	Female
	Age	A	B	C	D
1	15-24	17.0	17.2	A1 x 0.06 = 1.02	B1 x 0.02 = 0.34
2	25-34	29.5	25.9	A2 x 0.11 = 3.25	B2 x 0.05 = 1.30
3	35-44	24.4	22.7	A3 x 0.20 = 4.88	B3 x 0.11 = 2.50
4	45-54	13.0	13.1	A4 x 0.35 = 4.55	B4 x 0.23 = 3.01
5	55-64	8.5	9.3	A5 x 0.51 = 4.34	B5 x 0.47 = 4.37
6	65-74	6.4	7.4	A6 x 0.64 = 4.10	B6 x 0.64 = 4.74
7	75 plus	4.6	7.5	A7 x 0.64 = 2.94	B7 x 0.75 = 5.63
8	**TOTALS**	Sum of A1-A7 = 103.4	Sum of B1-B7 = 103.1	Sum of C1-C7 = 25.08	Sum of D1-D7 = 21.89

Of those who are hypertensive:			
9	Estimated number receiving treatment:	C8 x 0.37 = 9.28	D8 x 0.46 = 10.07
10	Estimated number not receiving treatment:	C8 x 0.63 = 15.80	D8 x 0.54 = 11.82

Of those receiving treatment:			
11	Estimated number controlled:	C9 x 0.46 = 4.27	D9 x 0.44 = 4.43
12	Estimated number uncontrolled:	C9 x 0.54 = 5.01	D9 x 0.56 = 5.64

Thus:

The total estimated number of people in Southwark PCT with hypertension is:

C8 + D8 = 25.08 + 21.89 = 46.97 (000s) = 46,970

The total estimated number of hypertensives not receiving treatment is:

C10 + D10 = 15.80 + 11.82 = 27.62 (000s) = 27,620

The total estimated number of those receiving treatment who are uncontrolled is:

C12 + D12 = 5.01 + 5.64 = 10.65 (000s) = 10,650

Reference

1 Joint Health Surveys Unit. 2004. *Health Survey for England 2003. Volume 2 Risk Factors for Cardiovascular Disease.* London: The Stationery Office.

Local partners and their potential roles

Tool H4

AGENCY	POTENTIAL ROLE
LOCAL NHS	**Strategic and operational lead for tackling hypertension at local level.** **Role model as major employer.**
General practices	• Protocol for systematic detection and control of hypertension, preferably through a call-recall approach. • Lifestyles advice and referral to appropriate specialist lifestyles support (eg smoking cessation groups, dietetic support, exercise referral, etc).
Pharmacists	• Help patients adhere to treatment. • Offer blood pressure checks.
Opticians	• Detect signs of hypertension in the eyes.
Primary care organisation	• Lead agency for implementing a hypertension programme as part of local delivery plans or local health plans. • Supporting and facilitating a proactive detection and control programme in primary care. • Ensuring an appropriate and targeted health education programme. • Lead agency for physical activity promotion through exercise referral schemes. • Lead agency for improving diet and nutrition through a local nutrition and food poverty strategy. • Personal health trainers.
Acute trusts	• Specialist hypertension clinics. • Specialist rehabilitation and secondary prevention programmes for patients with coronary heart disease, stroke or established renal failure.
Mental health trusts	• Specialist help for people with severe anxiety syndromes.
Strategic health authority	• Strategy and performance management.

LOCAL AUTHORITY	**Key partner through a variety of strategies and mechanisms, including the community strategy. Role model as local employer.**
Leisure and recreation services	• Lead agency on physical activity, recreation and sports development through the local cultural strategy, and recreation and sports development plans. • Access to allotments, parks and spaces.
Education and schools	• Work with young people on healthy eating and physical activity through the national curriculum, extra-curricular activities, Safe Routes to Schools and the National Healthy Schools Standard.
Environment, transport and planning	• Improved safety and security. • Changes to the built environment, eg traffic-calming, access to public spaces, play areas, parks and pathways, lighting improvements, green gym, and countryside spaces.
Social, care and housing services and cooperatives	• Access to 'at-risk' groups and those with specific needs, people who are socially excluded and experiencing health inequalities, people who may be housebound, and older people.
VOLUNTARY GROUPS	• Key role in helping to target 'at-risk' groups such as black African and black Caribbean communities, and older people. • Local campaigns and programmes, eg Sustrans's Safe Routes to Schools, traffic-free routes and food cooperatives. • Local branches of voluntary and charitable organisations, eg the Stroke Association, or the Blood Pressure Association's community programmes on self-management.
COMMERCE	• Workplace health initiatives. • Sponsoring community programmes.
SUPERMARKETS	• Helping people to make healthier choices. • Information on healthy eating. • Offering low-price healthier alternatives.
LOCAL MEDIA	• Providing information and encouragement to promote healthy eating, everyday physical activity and weight management, and local initiatives. • Providing information and encouragement to keep check-up appointments, and adhere to treatment. • Highlighting 'at-risk' groups.

Examples of partnership working

A partnership to promote healthy eating

Different partner agencies or professional inputs will be more or less appropriate depending on the target group. For example, to promote healthy eating in young children, with a particular emphasis on salt restriction, the following might be involved:

- parents and children
- midwives and health visitors (infant feeding)
- school nurses
- GPs and practice nurses
- community dietitians/public health nutritionists
- playgroup leaders
- community and voluntary group workers
- school nurses, teachers, headteachers and school governors
- health trainers, health promotion and public health specialists
- local food retailers, eating establishments and caterers
- local media.

Some of the above are likely to be already working together on existing partnership programmes, eg Sure Start. More detailed guidance can be found in the *Nutrition and Food Poverty* toolkit.[1]

A partnership to promote physical activity

Again, a different variety of partners will be needed. For example, to promote physical activity in middle-aged adults, the following might provide input:

- representatives of the community
- GPs and practice nurses
- lifestyle advisers, health trainers, physical activity facilitators, healthy walks coordinators
- leisure services staff
- sports development staff
- cardiac rehabilitation nurses
- regeneration planners
- local employers
- local media.

Some of the above are already likely to be engaged in local CHD or physical activity strategies. More detailed guidance can be found in the *Let's Get Moving* toolkit.[2]

A partnership to manage obesity

The partners for this element of hypertension prevention are likely to be a combination of those involved in promoting healthy eating and physical activity, but with more emphasis on the primary care input. For example, they might include:

- patients/carers
- GPs and/or practice nurses
- practice managers
- primary care quality facilitators
- primary care commissioners
- primary care IT officers
- public health specialists
- pharmacists

- hospital specialists
- community dietitians/public health nutritionists
- physical activity facilitators.

For more detailed guidance see the *Tackling Obesity* toolkit.[3]

References

1 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.

2 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.

3 Maryon-Davis A, Giles A, Rona R. 2000. *Tackling Obesity: A Toolbox for Local Partnership Action.* London: Faculty of Public Health Medicine.

A settings approach to tackling hypertension

Tool H5

A local hypertension strategy can most practically be constructed around the main settings for the various interventions. These are likely to include:

Home

- Early life influences such as breastfeeding, child nutrition and active play.
- Family eating habits and physical activity patterns.
- Sure Start programmes and children's centres.

Potential partners for this setting include:

Parents, midwives, health visitors, GPs, community dietitians or public health nutritionists, social workers, playgroup leaders, voluntary groups, food retailers, leisure services, health promotion and public health specialists.

School

- A whole-school approach – curricular and non-curricular.
- Reducing the salt content of school meals and snacks, and providing healthy choices.
- Developing food choice skills and cooking skills.
- Creating opportunities for sports and physical activities.
- Encouraging active travel to and from school.
- Developing family and community involvement.
- Advising on children's personal health guides.

Potential partners for this setting include:

Pupils and students, parents, school nurses, teachers, headteachers, school governors, local education authority, local communities, road safety officers, community dietitians or public health nutritionists, school caterers and lunchtime assistants, leisure services, health promotion, and public health specialists.

Workplace

- Reducing the salt content of all catering and providing healthy choices.
- Encouraging active transport and active team pursuits.
- Enforcing smoke-free workspaces.
- Developing family and community involvement.
- Promoting employee health checks.

The priority should be larger employers, beginning with the NHS and local authority(ies).

Potential partners for this setting include:

Employees and their families, managers, human resources staff, occupational health, facilities managers, leisure services, catering providers, trade unions, health promotion and public health specialists.

Communities

- Developing awareness of hypertension and its prevention, detection and control among vulnerable, 'at-risk' communities.

- Engaging local people in healthy lifestyles initiatives.
- Encouraging local advocacy for culturally appropriate, health-promoting environments and facilities.
- Fostering a culture of prevention and adherence to health checks.

Potential partners for this setting include:

Community members and leaders, local charities, faith groups, voluntary groups, outreach workers, project workers, primary care staff, regeneration and neighbourhood renewal workers, community safety workers, road safety officers, local businesses, leisure providers, primary care staff, local media, health promotion and public health specialists.

Primary care

- Contributing to the primary prevention of hypertension by providing appropriate lifestyles advice and motivation.
- Referring suitable patients for specialist dietetic advice or an exercise programme.
- Setting up a weight control programme for the most 'at-risk' patients.
- Setting up a hypertension case-finding and management programme.

Potential partners for this setting include:

Patients and carers, practice staff, pharmacists, optometrists, community dietitians or public health nutritionists, exercise facilitators, fitness coaches, leisure providers, secondary care providers, health promotion and public health specialists.

Other settings

These might include the 'high street' (retail opportunities), health fairs, major sporting events and media campaigns.

Potential partners for these settings

Potential partners might include most of those previously mentioned, as well as local media resources, such as newspapers, radio and television.

Checklist for reviewing current activity

Tool H6

Carrying out an audit of local services and initiatives to identify priorities and target groups (and gaps in provision) is particularly helpful when resources and budgets are limited.

The audit checklist below can be used to help map current services and initiatives, grouped under various settings, and any identified gaps will help shape the development of a local hypertension strategy. For ease of use, use the proforma provided online (see details below).

For each service or initiative in the checklist below, assess:

- How well does it meet needs? (Score +, or ++, or +++)
- Which groups are missing out? (Specify)
- What development or further action is needed? (Specify)

Add your own local services or initiatives as appropriate.

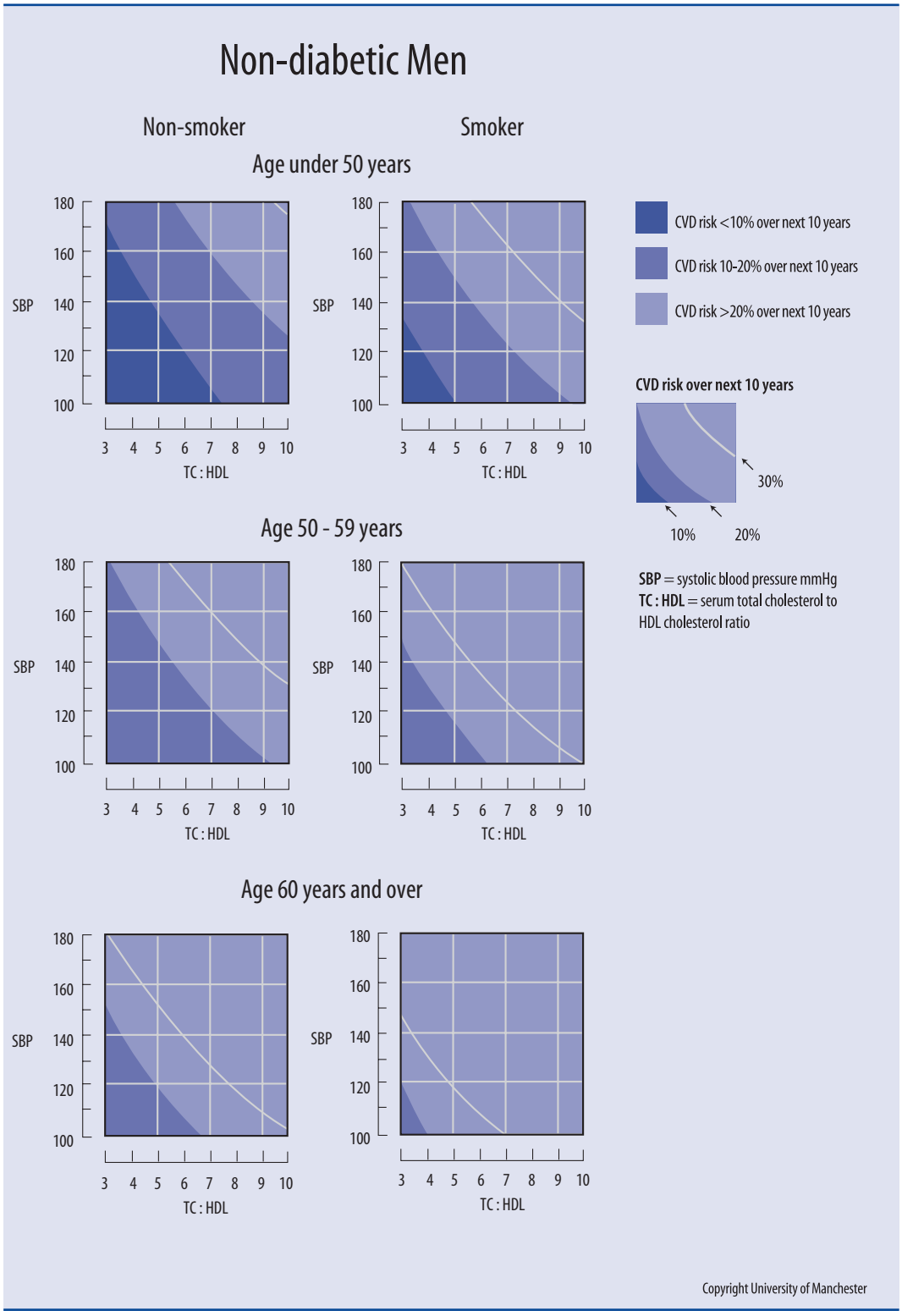
www *A copy of the proforma below – which can be completed online – can be found at: www.fph.org.uk. (See Policy and Communications, Publications, 'Easing the Pressure: Tackling Hypertension'.)*

Service/initiative	How well does it meet needs? Score + or ++, or +++	Which groups are missing out?	What development or further action is needed?
PREVENTION			
Home setting			
Infant nutrition eg breastfeeding			
Pre-school child nutrition eg Sure Start			
Pre-school child active play eg playgroups			
School setting			
School child nutrition eg school fruit and vegetable scheme, school meals, vending machines, water			
School child physical activity eg PE and sports, travel to and from school			
Leisure setting			
eg healthy walks, exercise referral scheme, etc			
Workplace setting			
(Specify)			
Community group setting			
(Specify)			

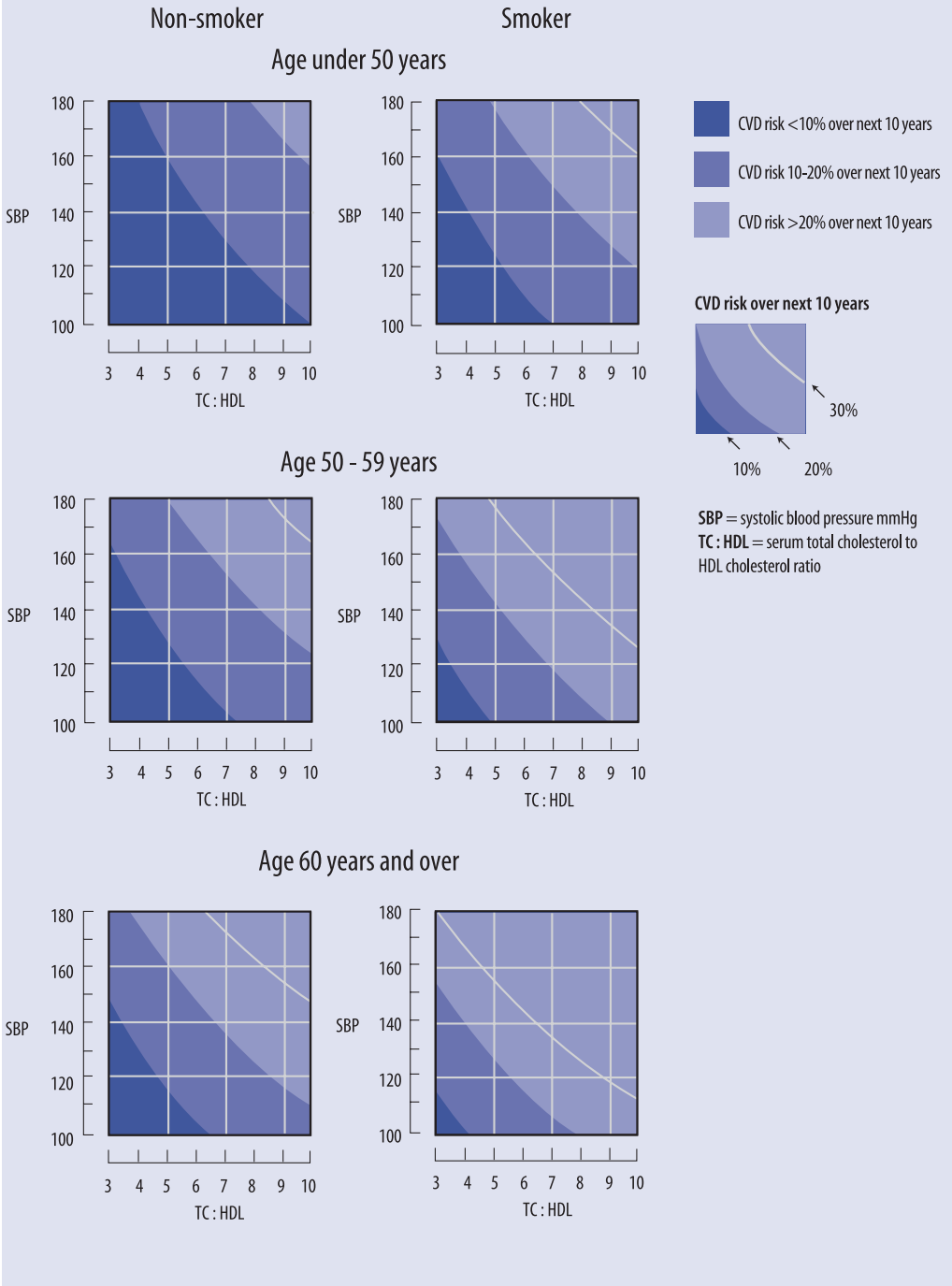
Service/initiative	How well does it meet needs? Score + or ++, or +++	Which groups are missing out?	What development or further action is needed?
Primary care setting			
(Specify)			
'High street' setting			
(Specify)			
Local media			
(Specify)			
etc.			
DETECTION AND CONTROL			
General practices			
(Specify)			
Pharmacies			
(Specify)			
Walk-in centres, etc			
(Specify)			
Hospitals			
(Specify)			
etc.			
INFRASTRUCTURE			
Training			
(Specify)			
IT systems			
(Specify)			
Premises			
(Specify)			
Workforce planning			
(Specify)			
Sustainable funding			
(Specify)			
etc.			

Cardiovascular disease risk prediction charts

The following cardiovascular disease risk prediction charts were produced by the Joint British Societies.[1]



Non-diabetic Women



How to use the coronary risk prediction charts for primary prevention

These charts are for estimating CVD risk (nonfatal MI and stroke, coronary and stroke death and new angina pectoris) for individuals who have not already developed CHD or other major atherosclerotic disease. They are an aid to making clinical decisions about how intensively to intervene on lifestyle and whether to use antihypertensives, lipid-lowering medication and aspirin.

The use of these charts is not appropriate for the following patient groups. Those with:

- CHD or other major atherosclerotic disease;
- familial hypercholesterolaemia or other inherited dyslipidaemias;
- chronic renal dysfunction;
- type 1 and 2 diabetes mellitus.

The charts should not be used to decide whether to introduce antihypertensive medication when BP is persistently at or above 160/100 or when TOD [target organ damage] due to hypertension is present. In both cases, antihypertensive medication is recommended regardless of CVD risk. Similarly, the charts should not be used to decide whether to introduce lipid-lowering medication when the ratio of serum total to HDL cholesterol exceeds 7. Such medication is generally then indicated, regardless of the estimated CVD risk.

To estimate an individual's absolute 10-year risk of developing CVD, choose the table for his or her gender, smoking status (smoker/non-smoker) and age. Within this square, define the level of risk according to the point where the coordinates for SBP and the ratio of the total cholesterol to HDL-cholesterol meet. If no HDL cholesterol result is available, then assume this is 1.00 mmol/l and the lipid scale can be used for total serum cholesterol alone.

Higher risk individuals (light blue areas) are defined as those whose 10-year CVD risk exceeds 20%, which is approximately equivalent to the CHD risk of >15% over the same period, indicated by the previous version of these charts. As a minimum, those at highest CVD risk (greater than 30% shown by the line within the light blue area) should be targeted and treated now. When resources allow, others with a CVD risk of >20% should be progressively targeted.

The chart also assists in the identification of individuals whose 10-year CVD risk is moderately increased in the range 10–20% (mid-blue area) and those in whom the risk is lower than 10% over 10 years (dark blue area).

Smoking status should reflect the lifetime exposure to tobacco and not simply tobacco use at the time of assessment. For example, those who have given up smoking within 5 years should be regarded as current smokers for the purposes of the charts.

The initial BP and the first random (nonfasting) total cholesterol and HDL cholesterol can be used to estimate an individual's risk. However, the decision on using drug therapy should generally be based on repeat risk factor measurements over a period of time.

Men and women do not reach the level of risk predicted by the charts for the three age bands until they reach the ages 49, 59 and 69 years, respectively. Everyone aged 70 years and over should be considered at higher risk. The charts will overestimate the current risk most in the under 40s. Clinical judgement must be exercised in deciding on treatment in younger patients. However, it should be recognised that BP and cholesterol tend to rise most and HDL cholesterol to decline most in younger people already possessing adverse levels. Thus untreated, their risk at the age 49 years is likely to be higher than the projected risk shown on the age-less-than 50 years chart.

These charts (and all other currently available methods of CVD risk prediction) are based on groups of people with untreated levels of BP, total cholesterol and HDL cholesterol. In patients already receiving antihypertensive therapy in whom the decision is to be made about whether to introduce lipid-lowering medication or vice versa, the charts can act as a guide, but unless recent

pre-treatment risk factor values are available it is generally safest to assume that CVD risk factor than that predicted by current levels of BP or lipids on treatment.

CVD risk is also higher than indicated in the charts for:

- those with a family history of premature CVD or stroke (male first-degree relatives aged <55 years and female first-degree relatives aged <65 years), which increases the risk by a factor of approximately 1.5;
- those with raised triglyceride levels;
- women with premature menopause;
- those who are not yet diabetic, but have impaired fasting glucose (6.1–6.9mmol/l).

In some ethnic minorities, the risk charts underestimate CVD risk, because they have not been validated in these populations. For example, in people originating from the Indian subcontinent, it is safest to assume that the CVD risk is higher than that predicted from the charts (1.5 times).

These charts may be used to illustrate the direction of impact of risk factor intervention on the estimated level of CVD risk. However, such estimates are crude and are not based on randomised trial evidence. Nevertheless, this approach may be helpful in motivating appropriate intervention. The charts are primarily to assist in directing intervention to those who typically stand to benefit the most.

Reproduced with kind permission from the British Hypertension Society.

Reference

1 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: 139-185.

Proforma for developing a hypertension action plan

Tool H8

This tool can be used to help build up the key elements of a local hypertension action plan (including prevention, detection and control), and to keep track of what is to be delivered by whom and by when. For ease of use, use the proforma provided online (see details below).

A copy of this proforma – which can be completed online – can be found at: www.fph.org.uk. (See Policy and Communications, Publications, 'Easing the Pressure: Tackling Hypertension'.)

HOME				
Intervention	**Deliverable(s)**	**Lead partner**	**By when**	**Notes**
1 (eg breastfeeding)				
2				
etc				
SCHOOL				
Intervention	**Deliverable(s)**	**Lead partner**	**By when**	**Notes**
1 (eg healthy school meals)				
2				
etc				
LEISURE				
Intervention	**Deliverable(s)**	**Lead partner**	**By when**	**Notes**
1				
2				
etc				
WORKPLACE				
Intervention	**Deliverable(s)**	**Lead partner**	**By when**	**Notes**
1				
2				
etc				
COMMUNITY				
Intervention	**Deliverable(s)**	**Lead partner**	**By when**	**Notes**
1				
2				
etc				
PRIMARY CARE				
Intervention	**Deliverable(s)**	**Lead partner**	**By when**	**Notes**
1				
2				
etc				
OTHER				
Intervention	**Deliverable(s)**	**Lead partner**	**By when**	**Notes**
1				
2				
etc				

Salt and hypertension

Tool H9

Why is too much salt a problem?

There is a strong link between a high salt intake and elevated blood pressure.[1] Hypertension can contribute to cardiovascular disease – including coronary heart disease, heart failure and stroke – and kidney disease.

Recommended maximum intakes of salt

Babies and children

Babies and children require a much smaller amount of salt than adults (see chart on the right). For babies, appropriate amounts can easily be supplied through breast milk. The 'target' levels shown on the right represent an achievable *maximum* for health – not what is *optimal*.

Daily target average salt intakes for infants and children†

Age	Target average salt intake (grams per day)
0-6 months	Less than 1g
7-12 months	1g
1-3 years	2g
4-6 years	3g
7-10 years	5g
11-14 years	6g

Source: Scientific Advisory Committee on Nutrition, 2003 [1]

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Older children and adults

It is recommended that older children and adults should not exceed the *maximum* daily intake level of 6g of salt per day. Again, this reflects what is *achievable* – not what is recommended (which is 4g per day for adults).[2]

Salt and sodium in food

People often use the terms 'salt' and 'sodium' interchangeably. However, salt is a compound of sodium and chloride. Too much sodium can cause ill health. Salt is by far the biggest source of sodium in the diet.

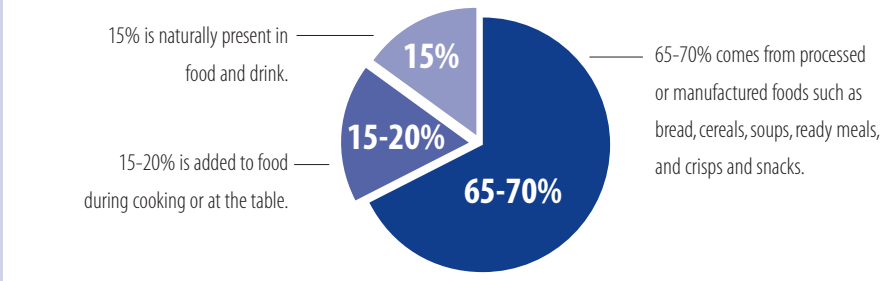
Some food labels give the sodium level but not the salt levels. Levels of salt can be roughly calculated by multiplying the sodium (per 100g) by 2.5. The Food Standards Agency provides an online calculator (at www.salt.gov.uk) to work out levels of salt in food.[3]

Guide to salt levels in food

A lot	A little
1.25g salt (or 0.5g sodium) or more per 100g	0.25g salt (or 0.1g sodium) or less per 100g

Source: Food Standards Agency, 2005 [3]

Main sources of salt in the diet



Source: Scientific Advisory Committee on Nutrition, 2003;[1] and Food Standards Agency website[3]

Percentage contribution of food types to average daily intake of sodium, by age and sex *			
Food	**Men**	**Women**	**All**
	(%)	**(%)**	**(%)**
Cereals and cereal products	35	36	35
Milk and milk products	7	9	8
Eggs and egg dishes	2	2	2
Fat spreads	3	3	3
Meat and meat products	28	23	26
Fish and fish dishes	3	5	4
Vegetables (excluding potatoes)	6	7	7
Potatoes and savoury snacks	3	4	4
Fruit and nuts	0	1	0
Sugars, preserves and confectionery	1	1	1
Drinks**	2	2	2
Miscellaneous***	8	10	9
TOTAL	98	103	101

* Data are for intakes from food only and do not include further additions of salt in cooking or at the table.

** Includes soft drinks, alcohol drinks, tea, coffee and water.

*** Includes powdered beverages (except tea and coffee), soups, sauces, condiments and artificial sweeteners.

Source: Adapted from the National Diet and Nutrition Survey, 2003 [4]

Tips for salt reduction

Comprehensive guidance on reducing salt intake is available from the Food Standards Agency and CASH (details below). Key tips include:

- Avoid adding salt to cooking or to food at the table.
- Eat more fruit and vegetables – they're lower in salt and saturated fats than processed foods.
- Choose products with less salt/sodium. Go for the 'low salt' option and look at the information on food labels.
- Take particular care with children's diets. (See page 87 for recommended levels for children.)

For more information on salt

Consensus Action on Salt and Health (CASH)

Runs an annual campaign to reduce the amount of salt in our diet, including a Salt Awareness Day.
www.actiononsalt.org.uk

Food Standards Agency

Includes the *Sid the Slug* salt campaign.
www.salt.gov.uk

Scientific Advisory Committee on Nutrition

www.sacn.gov.uk

References

1 Scientific Advisory Committee on Nutrition. 2003. *Salt and Health*. London: The Stationery Office.

2 Department of Health. 1991. *Dietary Reference Values for Food Energy and Nutrients for the United Kingdom*. London: HMSO.

3 Food Standards Agency website. Accessed on 18 January 2005 from: www.salt.gov.uk

4 Henderson L, Irving K, Gregory J et al. 2003. *National Diet and Nutrition Survey: Adults Aged 19 to 64 Years. Volume 3 Vitamin and Mineral Intake and Urinary Analytes*. London: The Stationery Office.

National policy drivers (2)

Tool H10

Policies and programmes related to healthy eating, physical activity and the wider determinants of health

For fuller details of these documents, and how they relate to hypertension, see www.fph.uk, under Policy and Communications, Publications, 'Easing the Pressure: Tackling Hypertension'.

ENGLAND

HEALTHY EATING

Alcohol Harm Reduction Strategy for England (2004)
www.strategy.gov.uk

Better Hospital Food Programme (Ongoing)
www.betterhospitalfood.com

Food and Health Action Plan (2005)
www.dh.gov.uk

Food in Schools Programme (Ongoing)
www.dh.gov.uk

Healthy Start (2005)
www.dh.gov.uk

National Healthy Schools Programme (Ongoing)
www.wiredforhealth.gov.uk

The Strategy for Sustainable Farming and Food: Facing the Future (2003)
www.defra.gov.uk

5 A DAY Programme (Ongoing)
www.5aday.nhs.uk

PHYSICAL ACTIVITY

Activity Co-ordination Team (Ongoing)
www.dh.gov.uk

Game Plan: A Strategy for Delivering Government's Sport and Physical Activity Objectives (2002)
www.number10.gov.uk

Local Exercise Action Plan (Ongoing)
www.dh.gov.uk

New Opportunities in PE and Sport Initiative (Ongoing)
www.nof.org.uk

Safe Routes to School (Ongoing)
www.saferoutestoschools.org.uk

WIDER DETERMINANTS

Every Child Matters: Change for Children (2004)
www.everychildmatters.gov.uk

Health and Social Care Act 2001: Health Scrutiny Provisions
www.legislation.hmso.gov.uk

Health Inequality Targets (2002)
www.dh.gov.uk

Healthy Living Centre Programme (Ongoing)
www.nof.org.uk

Local Government Act 2000
www.hmso.gov.uk

New Deal for Communities (Ongoing)
www.neighbourhood.gov.uk

NHS Plan. A Plan for Investment. A Plan for Reform (2000)
www.nhs.uk/nhsplan

Opportunities for All: Tackling Poverty and Social Exclusion (Ongoing)
www.dwp.gov.uk

Skills and Knowledge Programme (Ongoing)
www.neighbourhood.gov.uk

Sure Start (Ongoing)
www.surestart.gov.uk

Tackling Health Inequalities. A Programme for Action (2003)
www.dh.gov.uk

SCOTLAND

HEALTHY EATING

Eating for Health – Meeting the Challenge (2004)
www.scotland.gov.uk

Heart Health National Learning Network (Ongoing)
www.phis.org.uk

Healthy Living Programme (Ongoing)
www.healthyliving.gov.uk

Healthy Start (2005)
www.dh.gov.uk

Hungry for Success: A Whole School Approach to School Meals in Scotland. Final Report of the Expert Panel on School Meals (2002)
www.scotland.gov.uk

Plan for Action on Alcohol Problems (2002)
www.alcoholinformation.isdscotland.org

Scottish Community Diet Project (Ongoing)
www.dietproject.org.uk

Scottish Healthy Choices Award Scheme (Ongoing)
www.shcas.co.uk

PHYSICAL ACTIVITY

Active Schools Strategy (Ongoing)
www.scotland.gov.uk

Let's Make Scotland More Active: A Strategy for Physical Activity (2003)
www.scotland.gov.uk

New Opportunities in PE and Sport Initiative (Ongoing)
www.nof.org.uk

Safe Routes to School (Ongoing)
www.scotland.gov.uk
www.saferoutestoschool.org.uk

WIDER DETERMINANTS

Being Well – Doing Well (Ongoing)
www.healthpromotingschools.co.uk

Coronary Heart Disease, Stroke and Cancer Programme (Ongoing)
www.nof.org.uk

Early Years National Learning Network (Ongoing)
www.ltscotland.org.uk

Fair for All (2002)
www.scotland.gov.uk

Health and Homelessness Guidance (2001)
www.scotland.gov.uk

Healthy Living Centre Programme
www.nof.org.uk

NHS Reform (Scotland) Act (2004)
www.legislation.hmso.gov.uk

Our Community's Health: Guidance on the Preparation of Joint Health Improvement Plans (2001)
www.show.scot.nhs.uk

Partnership for Care (2003)
www.scotland.gov.uk

Scotland's Health At Work Scheme (Ongoing)
www.shaw.uk.com

Starting Well (Ongoing)
www.phis.org.uk

Sure Start (Ongoing)
www.surestart.gov.uk

WALES

HEALTHY EATING

Community Food Initiative (Ongoing)
www.cmo.wales.gov.uk

Food and Fitness Health Promoting Grants (Ongoing)
www.wales.gov.uk

Food and Well Being – Reducing Inequalities through a Nutrition Strategy for Wales (2003)
www.food.gov.uk

Healthy Start (2005)
www.dh.gov.uk

Investing in a Better Start: Promoting Breastfeeding in Wales (2001)
www.wales.gov.uk

National Healthy Schools Programme
www.wiredforhealth.gov.uk

Nutrition and Catering Framework (2002)
www.wales.nhs.uk

5 A DAY Programme (Ongoing)
www.5aday.nhs.uk

PHYSICAL ACTIVITY

Climbing Higher – Sport and Active Recreation in Wales (2003)
www.wales.gov.uk

Healthy and Active Lifestyles in Wales: A Framework for Action (2003)
www.cmo.wales.gov.uk

New Opportunities in PE and Sport Initiative
www.nof.org.uk

Physical Education and School Sport Task Force (Ongoing)
www.hpw.wales.gov.uk

Road Safety Strategy for Wales (2003)
www.wales.gov.uk

Safe Routes to Schools Initiative (Ongoing)
www.saferoutestoschool.org.uk

Transport Framework for Wales (2001)
www.wales.gov.uk

Walking and Cycling Strategy for Wales (2002)
www.wales.gov.uk

WIDER DETERMINANTS

Coronary Heart Disease, Stroke and Cancer Programme
www.nof.org.uk

Inequalities in Health (Ongoing)
www.cmo.wales.gov.uk

The Review of Health and Social Care in Wales (2003)
www.wales.nhs.uk

Sure Start (Ongoing)
www.surestart.gov.uk

NORTHERN IRELAND

HEALTHY EATING

Catering for Healthier Lifestyles – Compulsory Nutritional Standards for School Meals (Ongoing)
www.deni.gov.uk

Fit Futures: Focus on Food, Activity and Young People (2004)
www.investingforhealthni.gov.uk

Fresh Fruit in Schools (Ongoing)
www.investingforhealthni.gov.uk

Health Promoting Schools Initiative (Ongoing)
www.investingforhealthni.gov.uk

PHYSICAL ACTIVITY

A Five Year Physical Activity Strategy and Action Plan (2004)
www.dhsspsni.gov.uk

Northern Ireland Cycling Strategy (2000)
www.healthpromotionagency.org.uk

Walking Northern Ireland: An Action Plan (2003)
www.roadsni.gov.uk

WIDER DETERMINANTS

Coronary Heart Disease, Stroke and Cancer Programme (Ongoing)
www.nof.org.uk

A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025 (2004)
www.dhsspsni.gov.uk

People and Places: A Strategy for Neighbourhood Renewal (2003)
www.dsdni.gov.uk

Sure Start (Ongoing)
www.surestart.gov.uk

Workplace for Health (Ongoing)
www.workingforhealthni.gov.uk

The GMS contract: quality indicators for hypertension

Tool H11

In the GMS contract[1] there are 173 quality points available for blood pressure measurement, and hypertension detection and control (which can be found under the sub-domains of hypertension, coronary heart disease, stroke and diabetes) out of a total of 550 points in the entire clinical domain. All *minimum* thresholds are 25%.

Indicator	Points	Maximum Threshold
Records		
BP 1 The practice can produce a register of patients with established hypertension.	9	N/A
Records 11 The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 55% of patients.	10	N/A
Records 17 The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 75% of patients.	5	N/A
Diagnosis and initial management		
BP 2 The percentage of patients with hypertension whose notes record smoking status at least once.	10	90%
BP 3 The percentage of patients with hypertension who smoke, whose notes contain a record that smoking cessation advice has been offered at least once.	10	90%
Ongoing management		
BP 4 The percentage of patients with hypertension in which there is a record of the blood pressure in the last nine months.	20	90%
BP 5 The percentage of patients with hypertension in whom the last blood pressure (measured in the last nine months) is 150/90 or less.	56	70%
Stroke 5 The percentage of patients with TIA [transient ischaemic attacks] or stroke whose notes have a record of blood pressure in the previous 15 months.	2	90%
Stroke 6 The percentage of patients with a history of TIA or stroke in which the last blood pressure reading (measured in the last 15 months) is 150/90 or less.	5	70%
CHD 5 The percentage of patients with CHD whose notes have a record of blood pressure in the previous 15 months.	7	90%
CHD 6 The percentage of patients with CHD in whom the last blood pressure reading (measured in the last 15 months) is 150/90 or less.	19	70%
Diabetes 11 The percentage of patients with diabetes who have a record of the blood pressure in the last 15 months.	3	90%
Diabetes 12 The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less.	17	55%

Reference

1 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

Patients' thoughts and feelings about taking medicines for hypertension

Tool H12

This information is taken from a qualitative study on patients' views of antihypertensive drugs.[1]

Reservations about drugs generally

- Drugs are best avoided.
- Drugs are unnatural or unsafe.
- Drugs are perceived adversely because of previous experience.
- Drugs are signifiers of ill health.
- Patient brought up to avoid drugs.
- Doctors prescribe drugs too readily.

Reservations about antihypertensive drugs

- Desire to discontinue using antihypertensives.
- Preference for an alternative to drugs.
- Patients questioned continued necessity.
- Possible long-term or hidden risk.

Patients' reasons for taking antihypertensive drugs

- Advice from doctors.
- Trust in doctors.
- Improvement in blood pressure readings.

Perceived benefits of medication

- Achieving a good outcome.
- Feeling better.
- Gaining peace of mind.

Pragmatic considerations

- Absence of a practical alternative to drugs.
- Absence of symptoms to guide medicine use.
- Drugs use overshadowed by some other consideration.

Reference

1 Benson J, Britten N. 2002. Patients' decisions about whether or not to take antihypertensive drugs: qualitative study. *British Medical Journal*; 323: 873.

Suggested minimum content of care plans and patient-held records for hypertension

Tool H13

Care plans

Jointly agreed personal care plans should:

- be negotiated and agreed following a full explanation and discussion of the choices to be made between the person with hypertension (and/or their partner or carers, if appropriate) and the health professionals involved in that individual's care
- be set out in a way that is understandable and clear
- be kept in the patient's record and copied to the person with hypertension (and/or their partner or carers, if appropriate)
- be kept up-to-date
- set out the treatment plan, goals and management targets
- record blood pressure measurements, and give an explanation of how these relate to the goals and management targets
- specify what care the person should expect to support the treatment plan, who will provide it and where it will be provided
- advise on how to prevent and manage the complications of hypertension
- set the date of the next review.

Patient-held records

Records should contain as a minimum:

- background information on hypertension
- patient contact details, including those of the health professionals providing care
- medical and other relevant details
- treatment regime
- instructions for emergencies
- the care plan
- items to be covered at annual and other checks
- an education checklist
- a glossary of medical terms
- space for the patient's own notes.

Note: If a patient with hypertension has a co-morbidity, such as diabetes or coronary heart disease, the above information should be incorporated into their existing care plan and patient-held record.

Ways of involving patients and the public in tackling hypertension

Tool **H14**

Patient and public involvement is now a core part of health service development and decision-making. Without it, truly responsive services cannot be delivered. This tool outlines the benefits of public and patient participation in developing a local hypertension strategy, as well as the statutory requirements.

Benefits

Patient and public involvement has the following benefits.

- It informs the development of improved patient-centred services and service delivery.
- It increases patient satisfaction, through a sense of greater involvement and being listened to.
- Engagement in developing appropriate care plans and services can increase concordance.
- It improves relationships, through increased understanding and trust between, on the one hand, managers and professionals, and on the other, patients, carers and the public.
- It helps to provide services which are culturally sensitive and appropriate, and which are tailored to an individual's particular needs.
- It helps to inspire change and innovation in service delivery.
- It helps to build solid community partnerships.
- It demonstrates a willingness by organisations to be held more accountable to patients and the public.
- It meets statutory requirements.

Statutory requirements for patient and public involvement

Key policy drivers include:

In England:	Health and Social Care Act 2001 (www.legislation.hmso.gov.uk) The NHS Plan (www.dh.gov.uk) Planning and Priorities Framework 2005-2008 (www.dh.gov.uk) Local authorities also have a duty to scrutinise local NHS.
In Scotland:	Our National Health: A Plan for Action, A Plan for Change (www.scotland.gov.uk) Patient Focus and Public Involvement (www.scotland.gov.uk)
In Wales:	Improving Health in Wales (www.wales.gov.uk) Signposts – A Practical Guide to Public and Patient Involvement in Wales (www.wales.nhs.uk)
In Northern Ireland:	A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025 (www.dhsspsni.gov.uk) Good Practice Review on User Involvement – Proposed Guidelines (www.dhsspsni.gov.uk)

Performance assessment

Patient and public involvement processes are subject to performance assessment through bodies such as the Healthcare Commission (in England).

Ways of involving the public and patients

- Individual feedback or contributions to care plans
- Consultation and formal evaluation of services
- Focus groups for feeding back thoughts and feelings on services
- Project working groups
- Patient forums
- Planning groups
- Patient Environment Action Teams (PEAT)
- Expert Patients Programme
- Patient Advocacy and Liaison Services
- Independent Complaints Advocacy Services
- Commission for Patient and Public Involvement in Health (England)
- Patient and Public Involvement Forums (England)
- Voluntary and charity organisations
- Independent Local Authority Forums
- Local healthcare cooperatives

For more information on patient and public involvement

England

Commission for Patient and Public Involvement in Health

The Commission's role is to make sure the public is involved in decision-making about health and health services in England through Patient and Public Involvement (PPI) Forums – one for each NHS Trust. **www.cppih.org**

Health in Partnership

A research programme to support greater patient, carer and public participation in healthcare decision-making. Provides links to online publications and useful websites.
www.healthinpartnership.org

Medicines Partnership

This is an initiative supported by the Department of Health, aimed at enabling patients to get the most out of medicines, by involving them as partners in decisions about treatment and supporting them in medicine-taking. **www.medicines-partnership.org**

Scotland

Involving People

Part of the Scottish Executive's commitment to improving public and patient involvement. Provides details on training, initiatives and projects being undertaken in Scotland, and links to publications. **www.show.scot.nhs.uk/involvingpeople**

Wales

NHS Wales

Provides links to policy on patient and public involvement. **www.wales.nhs.uk**

Northern Ireland

Department of Health, Social Services and Personal Safety

Provides links to policy on patient and public involvement. **www.dhsspsni.gov.uk**

Performance assessment: examples of indicators

Tool H15

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

DOMAIN	INDICATOR
Fair access	• Equity of access to dietetic advice. • Equity of access to exercise advice. • Equity of access to blood pressure monitoring and control.
Effective delivery of appropriate healthcare	• As per current Quality and Outcomes Framework of the GMS contract.
Efficiency	• Annual cost per patient on the hypertension register who achieves satisfactory control as per current Quality and Outcomes Framework.
Patient/carer experience	• Waiting time for appointments. • Patient-reported control of side-effects. • Patient-reported quality of life.
Intermediate outcomes	• Percentage of population aware of hypertension and its importance. • Percentage of population who 'know their number'.
Health improvement	• Percentage of patients on the hypertension register who achieve satisfactory control as per current Quality and Outcomes Framework. • Percentage of target population who maintain or lose weight.
Final health outcomes	• Prevalence of uncontrolled hypertension in defined high-risk populations. • Incidence of stroke in the under-75s in the general population.
Inputs	• Partners involved. • Level of funding secured. • Number and types of professionals involved.

Further reading

This section gives a list of publications that may be useful for developing strategies on hypertension. For contact details of the organisations producing these documents see *Useful organisations* on page 107 (unless specified below).

UK

Fuel Poverty and Health. A Toolkit for Primary Care Organisations, and Public Health and Primary Care Professionals
National Heart Forum, the Eaga Partnership Charitable Trust, the Faculty of Public Health Medicine and the Met Office

Let's Get Moving: A Physical Activity Handbook for Developing Local Programmes
Faculty of Public Health Medicine and the National Heart Forum

A Lifecourse Approach to Coronary Heart Disease Prevention. Scientific and Policy Review
National Heart Forum

Nutrition and Food Poverty: A Toolkit for Those Involved in Developing or Implementing a Local Nutrition and Food Poverty Strategy
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.
Available from the National Heart Forum.

Salt and Health
Scientific Advisory Committee on Nutrition

Stroke – Good Practice in Primary Care
Stroke Association

Tackling Obesity: A Toolkit for Local Partnership Action
Faculty of Public Health Medicine (now Faculty of Public Health)

Young@heart. Towards a Generation Free from Coronary Heart Disease. Policy Action for Children's and Young People's Health and Well-being
National Heart Forum

CLINICAL GUIDELINES:
Guidelines for Management of Hypertension: Report of the Fourth Working Party of the British Hypertension Society, 2004-BHS IV
British Hypertension Society

England

DOCUMENTS AVAILABLE FROM THE DEPARTMENT OF HEALTH:
At Least Five a Week: Evidence on the Impact of Physical Activity and its Relationship to Health – A Report from the Chief Medical Officer

Choosing Health: Making Healthy Choices Easier
(Public Health White Paper)

Improvement, Expansion and Reform – the Next 3 Years: Priorities and Planning Framework 2003-2006

National Service Framework for Children, Young People and Maternity Services
National Service Framework for Coronary Heart Disease
National Service Framework for Diabetes
National Service Framework for Older People
National Service Framework for Renal Services (Parts 1 and 2)

National Standards, Local Action 2005/06-2007/08

NHS Plan. A Plan for Investment. A Plan for Reform

Saving Lives: Our Healthier Nation

Tackling Health Inequalities – A Programme for Action

OTHER PUBLICATIONS:

Game Plan: A Strategy for Delivering Government's Sport and Physical Activity Objectives
Department for Culture, Media and Sport and the Strategy Unit
www.number-10.gov.uk/su/sport/report/01.htm

Government Spending Review 2004
HM Treasury
www.hm-treasury.gov.uk

HDA Evidence Briefing: The Management of Obesity and Overweight: An Analysis of Reviews of Diet, Physical Activity and Behavioural Approaches
Health Development Agency

Health Surveys for England (particularly 1998, 1999 and 2003)
The Stationery Office
Also available from the Department of Health

Investing in General Practice. The New GMS Contract
NHS Confederation and the British Medical Association
Available from NHS Confederation: www.nhsconfed.org

Local Government Act
Local Public Service Agreements
Public Service Agreements
Available from the Office of the Deputy Prime Minister
www.odpm.gov.uk

Storing up Problems. The Medical Case for a Slimmer Nation
Royal College of Physicians, the Royal College of Paediatrics and Child Health, and the Faculty of Public Health
Available from the Faculty of Public Health

CLINICAL GUIDELINES:
Management of Hypertension in Adults in Primary Care
National Institute for Clinical Excellence (now the National Institute for Health and Clinical Excellence)

PRODIGY Guidance
Offers advice on the management of conditions and symptoms commonly seen in primary care.
www.prodigy.nhs.uk

Scotland

DOCUMENTS AVAILABLE FROM THE SCOTTISH EXECUTIVE:
Coronary Heart Disease and Stroke: Strategy for Scotland

Improving Health in Scotland: the Challenge – Framework for Action

Let's Make Scotland More Active – A Strategy for Physical Activity

Towards a Healthier Scotland: A White Paper on Health 1999

CLINICAL GUIDELINES:
Hypertension in Older People (No. 49)
Scottish Intercollegiate Guidelines Network

Wales

DOCUMENTS AVAILABLE FROM THE WELSH ASSEMBLY GOVERNMENT:
Healthy and Active Lifestyles in Wales. A Framework for Action

Promoting Health and Well-being: Implementing the National Health Promotion Strategy

Well-being in Wales 2002

OTHER PUBLICATIONS:
Tackling Coronary Heart Disease in Wales: Implementing through Evidence
National Assembly for Wales

Northern Ireland

DOCUMENTS AVAILABLE FROM THE DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY:

Investing for Health

Northern Ireland Evidence-based Stroke Strategy

A Five Year Physical Activity Strategy and Action Plan

Well into 2000

International

DOCUMENTS AVAILABLE FROM THE WORLD HEALTH ORGANIZATION:

Global Strategy on Diet and Physical Activity

Diet, Nutrition and the Prevention of Chronic Disease: Report of a Joint World Health Organization/Food and Agriculture Organization Expert Consultation

World Health Report: Reducing Risks, Promoting Health

OTHER PUBLICATIONS:

European Society of Hypertension/European Society of Cardiology Guidelines for the Management of Arterial Hypertension
www.eshonline.org/esh/index.asp

Information for patients

Below is a list of resources – including publications and website information – which may be useful for patients with hypertension, and for their carers, family or friends. For further contact details of organisations see page 107.

Best Treatments

www.besttreatments.co.uk

Joint initiative from NHS Direct and BMJ Publishing to provide clinical evidence for patients.

Blood Pressure Association

www.bpassoc.org.uk

Booklets and leaflets

You and Your Blood Pressure

A general guide to high blood pressure, its management and treatments.

Healthy Eating and Blood Pressure

A guide to lowering blood pressure through changes to diet and lifestyle.

Medicines for High Blood Pressure

A guide to the groups of medicines available for high blood pressure, side-effects and commonly asked questions.

British Dietetic Association

Weight Wise website: www.bdaweightwise.com/bda

British Heart Foundation

www.bhf.org.uk

Provides information on high blood pressure for patients, their families and friends.

Booklets

Blood Pressure

Physical Activity and Your Heart

CASH

www.actiononsalt.org.uk

CASH (Consensus Action on Salt and Health) runs an annual campaign to reduce the amount of salt in our diets. This includes an annual National Salt Awareness Day. Their website gives information about salt, tips on how to reduce salt in the diet, and a collection of low-salt recipes.

Department of Health (England)

www.dh.gov.uk

The Expert Patients Programme

www.expertpatients.nhs.uk

T 0845 606 6040

Leaflet

5 A Day

Gives advice on how to achieve the recommendation of at least five portions of a variety of fruit and vegetables each day. (See www.5aday.nhs.uk)

Diabetes UK

www.diabetes.org.uk

Provides information on hypertension, its management and treatment, particularly for people with diabetes.

DIPEx

www.dipex.org

The Database of Individual Patient Experiences (DIPEx) is based on patients' personal accounts of their illness. To discover that you have a serious illness can be confusing and frightening. DIPEx gives patients access to the experiences of people who have gone through the same thing.

Patients can watch, listen to or read interviews, learn more about high blood pressure and its treatments, and find out where to get support and more detailed medical information.

DIPEx links to evidence-based information about the illness and its treatments, and covers other major diseases as well as hypertension. DIPEx is available both via the web and on CD-ROM.

Food Standards Agency

www.food.gov.uk

Provides an online resource on salt – as part of its 'Sid the Slug' information campaign. It also provides extensive information on food and diet – both online and published information.

Leaflets

Salt

Salt: Facts for a Healthy Heart (Produced jointly with the British Heart Foundation)

National Kidney Federation

www.kidney.org.uk

Provides information for people with kidney disease.

Prodigy

www.prodigy.nhs.uk

Offers advice on the management of conditions and symptoms commonly seen in primary care. Patient Information Leaflets are an integral part of PRODIGY guidance and are designed to be easily understandable by people who are not healthcare professionals.

Stroke Association

www.stroke.org.uk

Provides information on blood pressure.

Booklets

Blood Pressure and Stroke

How to Reduce Your Risk of a Stroke

Medicines for High Blood Pressure

Useful organisations

UK

Blood Pressure Association
60 Cranmer Terrace
London SW17 0QS
T 020 8772 4994
W www.bpassoc.org.uk

British Dietetic Association
5th Floor
Charles House
148/9 Great Charles Street
Queensway
Birmingham B3 3HT
T 0121 200 8080
E info@bda.uk.com
W www.bda.uk.com

British Heart Foundation
14 Fitzhardinge Street
London W1H 6DH
Heart Information Line: 08450 70 80 70
T 020 7935 0185
W www.bhf.org.uk

British Hypertension Society
Information Service
Blood Pressure Unit
Department of Physiological Medicine
St George's Hospital Medical School
Cranmer Terrace
London SW17 0RE
W www.hyp.ac.uk

Consensus Action on Salt and Health
Blood Pressure Unit (Administration)
Department of Medicine
St George's Hospital Medical School
London SW17 0RE
T 020 8266 6498
W www.actiononsalt.org.uk

Diabetes UK
10 Parkway
London NW1 7AA
Helpline: 020 7424 1030
T 020 7424 1000
E info@diabetes.org.uk
W www.diabetes.org.uk

Faculty of Public Health
4 St Andrews Place
London NW1 4LB
T 020 7935 0243
E enquiries@fph.org.uk
W www.fph.org.uk

Food Standards Agency
UK Headquarters
Aviation House
125 Kingsway
London WC2B 6NH
T 020 7276 8000
W www.food.gov.uk (provides links to other UK sites)
www.salt.gov.uk (dedicated online resource on salt)

National Heart Forum
Tavistock House South
Tavistock Square
London WC1H 9LG
T 020 7383 7638
E nhf-post@heartforum.org.uk
W www.heartforum.org.uk

National Kidney Federation
6 Standley Street
Worksop
Nottinghamshire S81 7HX
Helpline: 0845 601 0209
T 01909 487795
W www.kidney.org.uk

PharmacyHealthLink
1 Lambeth High Street
London SE1 7JN
T 020 7572 2265
E info@pharmacyhealthlink.org.uk
W www.pharmacyhealthlink.org.uk

Royal College of General Practitioners
14 Princes Gate
Hyde Park
London SW7 1PU
T 020 7581 3232
E info@rcgp.org.uk
W www.rcgp.org.uk

Royal College of Nursing
20 Cavendish Square
London W1G 0RN
T 020 7409 3333
W www.rcn.org.uk

Royal Institute of Public Health
28 Portland Place
London W1B 1DE
T 020 7580 2731
W www.riph.org.uk

Royal Pharmaceutical Society of Great Britain
1 Lambeth High Street
London SE1 7JN
T 020 7735 9141
E enquiries@rpsgb.org
W www.rpsgb.org.uk

Royal Society for the Promotion of Health
38a St George's Drive
London SW1V 4BH
T 020 7630 0121
E rsph@rsph.org
W www.rsph.org

Stroke Association
Stroke House
240 City Road
London EC1V 2PR
Stroke Helpline: 0845 30 33 100
T 020 7556 0300
W www.stroke.org.uk

UK Public Health Association
7th Floor
Holborn Gate
330 High Holborn
London WC1V 7BA
T 0870 010 1932
E info@ukpha.org.uk
W www.ukpha.org.uk

England

Alcohol Concern
www.alcoholconcern.org.uk

Department of Health
www.dh.gov.uk

Institute of Health Promotion and Education
www.ihpe.org.uk

Medicines Partnership Taskforce
www.medicines-partnership.org

National Institute for Health and Clinical Excellence
(Formed following the merger of the National Institute for Clinical Excellence and the Health Development Agency.)
www.nice.org.uk

Royal College of Physicians
www.rcplondon.ac.uk

Scotland

Alcohol Focus Scotland
www.alcohol-focus-scotland.org.uk

Chest, Heart and Stroke Scotland
www.chss.org.uk

NHS Health Scotland
www.healthscotland.com

Royal College of Physicians and Surgeons of Glasgow
www.rcpsglasg.ac.uk

Royal College of Physicians of Edinburgh
www.rcpe.ac.uk

Scottish Community Diet Project
www.dietproject.org.uk

Scottish Executive
www.scotland.gov.uk

Scottish Intercollegiate Guidelines Network
www.sign.ac.uk

Wales

National Assembly for Wales
www.wales.gov.uk

NHS Wales
www.wales.nhs.uk

Welsh Assembly Government
www.wales.gov.uk

Northern Ireland

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Northern Ireland Chest, Heart and Stroke Association
www.nichsa.com

International

European Society of Hypertension
www.eshonline.org

World Health Organization
www.who.int