Health Innovation Kent Surrey Sussex

Cardiovascular Disease Prevention

CVD Central: Resource Pack

Blood Pressure (BP) Detection Checks

Health Innovation KSS – CVD Prevention Team compiled this resource document. created 1st June 2022, updated September 2024. V2

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Join the CVD Central mailing list: anyone is welcome to click here to: **join our mailing list**

Join our new FutureNHS CVD Central Community of Practice - you will be able to find the recordings and full copy of the slides from a range of topics from CVD webinars

Introduction

Cardiovascular disease (CVD) is the leading cause of death worldwide and hypertension is its number one risk factor. CVD is strongly associated with health inequalities. In the UK, the most deprived quintile of the population is four times more likely to die from CVD than the least deprived.

The Office of Health Improvement and Disparities (formally known as Public Health England), estimates that more than 30% of hypertension cases remain undiagnosed, and prevalence is rising across all age groups. Levels of detection through routine blood pressure (BP) monitoring have fallen since 2019 as a result of the COVID-19 pandemic.

Making Every Contact Count (MECC) is an evidence-based approach to improve people's health and wellbeing by helping them change their health behaviours. The NHS Long Term Plan reminds us that every 24 hours the NHS comes into contact with more than a million people at moments that, for those individuals, brings home the personal impact of ill health.

MECC is an approach to behaviour change that utilises the millions of day-to-day interactions that organisations and people have with others to support them in making positive changes to their mental and physical health and wellbeing.

MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.

MECC is not about adding to people's workloads, expanding job descriptions, becoming a health or lifestyle expert/counsellor, or about telling people how to live their lives and what they should or shouldn't do. MECC is about a healthy conversation either as a very brief intervention and signpost, or a more developed brief intervention and signpost. MECC conversations can help plant the seeds of change, even if change is not necessarily made there and then.

For organisations: MECC means providing staff with the leadership, environment, training and information they need to deliver the MECC approach.

For staff: MECC means having the competence and confidence to deliver healthy lifestyle messages, to encourage people to change their behaviour and to direct them to local services that can support them.

For individuals: MECC means seeking support and taking action to improve their own lifestyle by eating well, maintaining a healthy weight, drinking alcohol sensibly, exercising regularly, not smoking, and looking after their wellbeing and mental health.

MECC Training is also available nationally through the e-Learning for Healthcare platform at www.e-lfh.org.uk/programmes/making-every-contact-count and may be available locally through your local authority public health team.

This resource pack is designed to support healthcare professionals running BP detection events in clinical and community settings to adopt the MECC approach to reducing CVD. We can provide the document in a MS Word format to enable you to adapt the resources to suit your local delivery plans. **Wishing you every success in making every contact count.**

Getting started and identifying your patient cohort

1) Explore the CVDPrevent Audit

The CVDPrevent Audit – https://www.nhsbenchmarking.nhs.uk/cvdprevent-outputs

The audit and the data and improvement tool will support quality improvement in primary care for the prevention of CVD in England. They are designed to support organisations to identify variation, trends, and opportunities in the prevention and management of CVD conditions. Explore the data in your area in the data and improvement tool in this link: https://www.cvdprevent.nhs.uk/

2) Identify patient cohort

The UCLPartners CVD Proactive Care Frameworks provide a platform for optimising clinical care and self-care for people with these high-risk conditions, supporting primary care teams to do things differently and at scale. such as:

- enable practices to prioritise clinical activity by stratifying patients who are at the highest risk
- deploy the wider workforce to reduce the workload for GPs
- improve the personalised care offer for patients.

They are free and can be downloaded directly into a practices clinical system and help identify the individuals who would benefit from a review and possible referral.

The following slide packs include pathways and resources to support clinicians treating patients with single or multiple cardiovascular conditions.

- Atrial Fibrillation
- Heart Failure
- Hypertension
- Lipid management including Familial Hypercholesterolaemia
- Type 2 Diabetes

The frameworks include:

1. Comprehensive **search tools** to risk stratify patients – built for EMIS and SystmOne
2. **Pathways** that prioritise patients for follow up, support remote delivery of care, and identify what elements of LTC care can be delivered by staff such as Health Care Assistants and link workers.
3. **Scripts and protocols** to guide Health Care Assistants and others in their consultations.
4. **Training** for staff to deliver education, self-management support and brief interventions. Training includes health coaching and motivational interviewing.
5. **Digital and other resources** that support remote management and self-management

Blood Pressure Detection

Checking a person's blood pressure is important, because often high blood pressure does not have any symptoms and many with high blood pressure are not aware that they have it. In England, high BP is the number 1 risk factor for CVD mortality and morbidity. Discovering high blood pressure early can ensure the patient receives the appropriate treatment from their doctor and support to better manage their condition to reduce their risk of CVD.

In England there are estimated to be over 5 million people with undetected high blood pressure. There are also significant inequalities attached to high BP, where prevalence is 30% more likely in the most deprived areas of England compared to the least deprived. There are a variety of medications that can be taken to reduce blood pressure and behaviour changes such as weight loss, salt reduction, smoking cessation and increased physical activity can reduce blood pressure.

DETECT - Find new cases of hypertension:

1) Check blood pressure on all patients attending for a check
2) On completion of the blood pressure measurement you may find it helpful to direct all patients to the 'Manage your blood pressure at home hub' which has been created by The BHF to provide support and advice to help patients understand and control their blood pressure.
3) Once you have completed the blood pressure reading, you may find it helpful to follow this example Blood Pressure Clinical Pathway to determine what next steps should be taken.
4) If home blood pressure monitoring is required, BP@Home, it is advised to provide the patient with a home monitoring dairy to enable them to record their twice daily readings for 7 days.

- Here is an example of an online diary that calculates the average measurements.
- You may also find this example of a Home blood pressure monitoring diary from NHS Sussex ICS helpful. It is possible to change the logo should you wish to do so.

Access here the full: MECC CVD Toolkit, Sussex Health and Care ICB , which was developed to address cardiovascular disease in clinical and community settings to make every contact count.

Order Patient Information ahead of inviting them in for a check

The following resources are available online to download and share with patients electronically, in a link by text message or print. They are also available to order for free in hard copies delivered to you ahead of you inviting them in for a check

British Heart Foundation (BHF):

- Hard copies of 'Understanding Blood Pressure' and a variety of quick guides and other 'Understanding Risk Factors' booklets can be ordered or downloaded via: Understanding risk factors | BHF
- To order hard copies of the leaflet, entre how many you would like, then click 'ADD TO BASKET.' Create an account to complete the order (very quick and simple process).

Stroke Association:

- On the website have a wealth of information and other resources, can be found here.
- Factsheets, that explain the link between high blood pressure can stroke can be downloaded and printed. Hard copies can also be purchased.

Diabetes UK:

- Diabetes UK have produced excellent guides explaining the importance of blood pressure control for those with diabetes. The information that can be shared with patients via this link.
- They have developed an information prescription for healthcare professionals. These are personalised pieces of information that are easy to read, have clear images and have individual goals to help prevent diabetes and high blood pressure. You can access this document here.

Resources listed for professionals and patients:

- Sussex Health and Care ICB, compiled a list of Resources for professionals and patients
- Within their MECC CVD Toolkit, Sussex Health and Care ICB

Public Health/Wellbeing Services

Most local authority public health teams commission a variety of wellbeing and behaviour change services that can help patients to reduce their risk of CVD such as stop smoking, weight management and physical activity. You may wish to make contact with your local public health team or service providers to understand what resources or support they may be able to provide for your event or approach to offer BP checks at your practice or in a community setting.

NICE guidance Shared Decision Making

The Shared decision making [NG197] guideline covers how to make shared decision making part of everyday care in all healthcare settings. It promotes ways for healthcare professionals and people using services to work together to make decisions about treatment and care. It includes recommendations on training, communicating risks, benefits and consequences, using decision aids, and how to embed shared decision making in organisational culture and practices.

In addition to the guideline NICE have also worked with NHSE to develop a Standards framework for shared-decision-making support tools, including patient decision aids which is for people who use healthcare services and healthcare professionals. It helps them identify and understand the elements of a good quality patient decision aid (PDA), providing a clear guide to the content they should expect and how content should be presented. The framework also supports those commissioning, developing, assuring or reviewing PDAs by including an easy-to-use self-assessment tool. This helps show how they have met standards essential in a PDA and identify further standards that might enhance the quality of their process or product.

The framework is divided into 2 sets of standards – essential and enhanced. Each set covers:

- the content of a PDA and its presentation, **and**
- the process for developing the PDA, including supporting information published alongside it to assess quality, rigour and reliability.

NICE has also worked with Keele University to develop a SDM learning package**,** which has been designed to support the NICE shared decision making guideline and aims to equip healthcare professionals with the skills and knowledge they need have good quality shared decision making conversations with the people they are caring for.

The package is made up of 6 modules:

- Orientation and background
- Cognitive psychology: the science of how we all make decisions
- Evidence-based medicine
- Probability and uncertainty
- Consultation skills
- Knowledge: getting and staying up to date

Resources to support patients having a Structured Medication Review

The Health Innovation Network, in partnership with patients and partners, have developed a range of patient information materials in different community languages to support and prepare people who have been invited for a medication review with their GP, pharmacist or other healthcare professional.

These materials are free to use and can be printed and used in paper format, or shared electronically with patients by email, text or any other electronic systems used within your workplace.

The resources are available in the following languages, including audio versions for visually impaired people and easy read versions for people with learning disabilities. Please follow the link to find resources relevant to your ICB.

Resources to support patients having a Structured Medication Review - The Health Innovation Network

(Languages include English, Arabic, Chinese Traditional (Cantonese), Chinese Simplified (Mandarin), Bengali, Gujarati, Somali, Polish, Punjabi Gurmukhi, Punjabi Shahmukhi, Romanian, Urdu)

An animation is available to help patients think about their medicines and to prepare for a Structured Medication Review: Animation

- Download a subtitled version of the animation here to show in your GP practice. (Right-click to save the video to your computer.)
- An alternative version of the animation without sound is also available to download here.