



Cheshire and Merseyside FYFV Working

Group

Cross-Cutting Theme/LDS Programme:

Demand Management and Prevention at scale

Service/Theme: **High Blood Pressure**

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1st C&M BP system

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Executive Summary

The challenge

With 625,000 people in Cheshire & Merseyside (C&M) affected by high blood pressure (BP) and almost half of this number thought to be unaware that they have the condition, it is critical that urgent action is taken to prevent, identify and manage people at risk of developing serious diseases such as heart attack, stroke, heart failure and chronic kidney disease.

The 'no change' scenario

The implications for population health outcomes and health and care finances of continuing with the current way of working would be stark.

- Health and Wellbeing:** We know that around a quarter of people are suffering from hypertension but we are only treating around 16%. We have an ageing population who are increasingly at risk of hypertension due to age, obesity and drinking to excess. If we do not start to address this disease right across the system at scale we will have increasing cases of stroke, heart attacks and vascular dementia that will require long term care and give people poor quality of life.
- Financial:** The financial costs of this scenario are huge. Even taking a relatively narrow perspective of the costs of managing heart attacks, strokes and heart failure costs are estimated at £71m over 5 years for C&M (or £31m, £18m, and £22m respectively for Cheshire and Wirral, Mid Mersey, and North Mersey LDSs, respectively). This is likely to be a significant underestimate of true costs however. If vascular dementia, CKD and other costs are considered the true cost is likely to be towards £500m for Cheshire and Merseyside. The relatively narrow 'no change' costs perspective has been presented here for consistency with net financial benefits presented below.

Closing the Five Year Forward View 'Gaps' by tackling high BP

Addressing high BP will contribute to the closing of the three 'gaps' highlighted in the Five Year Forward View, i.e. Health and Wellbeing, Care and Quality, and Finance and Efficiency.

1. Closing the Finance and Efficiency Gap

Closure of the Finance and Efficiency Gap will be evidenced by a **net financial benefit** of proposed interventions.

In order to deliver the BP programme of work, financial resource is needed over a five year period, 'pump-priming' in the early stages to increase capacity and capability through staff training, capital costs, communications, marketing and evaluation.

Investment of around £500k per annum across C&M will deliver a net financial benefit of between £7m and £8.2m in five years (discounted) based on 5% to 15% increase in diagnosis, and all GP practices performing as well as the 75th best percentile for managing blood pressure in people with hypertension.

Based upon the estimated total number of people with high BP in each CCG, at LDS-level this equates to net financial benefits of £2.8-£3.3m (Cheshire and Wirral LDS), £2-£2.3m (Mid Mersey LDS), and £2.2 to £2.6m (North Mersey LDS).

While this does not factor in any additional costs for the extra cases diagnosed, net benefits are likely to be an underestimate as they do not include savings related to dementia or CKD, and do not take into account the value of Quality Adjusted Life Years (QALYs) gained.

While total financial benefits are calculated for a five year period, benefits will be realised gradually over the five years, not only at the five year point.

2. Closing the Health and Wellbeing Gap

Health and wellbeing benefits will be realised on 3 levels; operational, tactical and strategic.

On an **operational level**, preventing identifying and controlling high BP will benefit patient outcomes by reducing medical complications such as stroke and heart attack, and reduce demand on health and social care, with net financial benefit.

On a **tactical level within the C&M FYFV**, upstream approaches to address high BP through modifiable lifestyle factors will also benefit other cross-cutting themes within the FYFV (e.g. cancer, CVD, neurology, alcohol) by reducing the prevalence of risk factors for a wide range of conditions in addition to high BP.

On a **strategic level**, the longer term benefits of the prevention of future illness, both in terms of those related to high BP, as well as those in other cross-cutting themes, is to strengthen the future sustainability of the wider C&M FYFV.

Closure of the Health and Wellbeing gap will be evidenced by progress against KPIs 1&2:

- **KPI1 (Impact):** fewer CCGs with higher than the national average hospital admissions for heart attacks and strokes
- **KPI2 (Prevention):** more NHS providers meeting meet HWB CQUIN 1b (Healthy food for staff, patients and visitors)

3. Closing the Care and Quality Gap

In C&M if all GP practices performed as well as the 75th best percentile for managing known BP patients, over 5 years could prevent 183 strokes, 118 heart attacks, 256 cases of heart failure, 96 deaths.

At LDS level this would mean prevention of

- **Cheshire and Wirral LDS:** 262 events could be prevented over 5 years: 74 strokes, 47 heart attacks, 103 heart failures, 38 deaths
- **Mid Mersey Alliance LDS:** 188 events could be prevented over 5 years: 52 strokes, 34 heart attacks, 74 heart failures, 28 deaths
- **North Mersey LDS:** 203 events could be prevented over 5 years: 57 strokes, 37 heart attacks, 79 heart failures, 30 deaths

Closure of the Care and Quality Gap will be evidenced by progress against KPIs 3&4:

- **KPI3 (Detection):** Gap between observed and expected prevalence of BP
- **KPI4 (Management):** Increase in the % patients treated to target levels, and a reduction in practice-level variation

The Vision

The collective vision of partners across C&M is that our communities will have the best possible blood pressure.

The Cheshire and Merseyside cross-sector system strategy to tackle high BP

C&M partners identified high BP as a priority for cross-sector collaborative action over two years ago and have made great progress in forging a cultural shift towards integrated working and prevention. Cheshire and Merseyside is nationally recognised as 'leading the way' with its cross-sector strategy to tackle high BP 'Saving lives: Reducing the pressure', and the programme of work proposed here build on this strategic system leadership approach.

Stakeholders

Key partners include Cheshire and Merseyside Public Health Collaborative (Champs), Public Health England NW, NHS England, nine Local Authorities, 12 CCGs (covering the 3 C&M LDS), the C&M CVD SCN, Voluntary Sector organisations, the National Institute of Clinical Excellence, Innovation Agency, Health Education England, C&M Fire and Rescue Services, industry partners, academic institutions, and more.

Proposed Service Model: priority interventions to reduce demand

A shift in BP outcomes and reduction in demand on the health and care system will be achieved by a continuation of the C&M cross-sector systems approach, including the C&M BP Board, networks and collaborations that contribute to delivery of the C&M Strategy to tackle high BP 'Saving lives: Reducing the pressure. Priority interventions include:

Reducing demand on primary care:

PRIORITY 1) Empowering patients and communities to live better:

- An **NHS settings approach to prevention at scale (e.g. 'Healthy Provider Declaration')**: Supporting all the 20 of the large NHS provider organisations in the sub-region to develop healthy local policy to support healthy eating as a key modifiable risk factor for staff, patients and visitors, and putting in place a package of support around implementation
- Roll out **Making Every Contact Count** at scale and optimise impact through workforce development and use of supporting conversational tools/ technologies

- **Changing behaviour through awareness raising campaigns:** Maximise the impact of existing national campaigns, particularly Blood Pressure UK's 'Know Your Numbers' campaign

PRIORITY 2) Strengthening the role of community pharmacies in the prevention, detection and management of high BP through BP testing, 24 hour BP monitoring, and increased uptake and focus of medicines optimisation services

- Increasing **availability** of **BP machines and Ambulatory Blood Pressure Monitors** to support detection and diagnosis in community settings

Reducing demand on secondary care:

PRIORITY 3) Primary care education and training programme to accelerate and support quality improvement in primary care with dedicated education and training programme that utilises Sector Led Improvement principles

Monitoring Progress

Progress against the programme will be demonstrated by four key performance indicators (KPIs):

- **KPI1 (Impact):** CCGs with higher than the national average hospital admissions for heart attacks and strokes
- **KPI2 (Prevention):** NHS providers meeting meet HWB CQUIN 1b (Healthy food for staff, patients and visitors)
- **KPI3 (Detection):** Gap between observed and expected prevalence of BP
- **KPI4 (Management):** Increase in the % patients treated to target levels, and a reduction in practice-level variation

1. National, Regional, Local Context

The Case for Change

a. National context

High BP is the **second highest cause of premature death and disability** (second to smoking) in England. It is the most common long term condition in the UK, affecting more than 1 in 4 adults and accounts for 12% of all visits to general practice in England

High BP is caused by mostly **modifiable risk factors**, such as being overweight or obese, smoking, physical inactivity, poor diet, and too much alcohol.

Almost half of those affected by high BP are **unaware**, in part due to a **lack of symptoms** until complications develop, e.g. heart disease, stroke, dementia, chronic kidney disease.

People from the most **deprived areas are 30% more likely** to high have BP, and to have poor health outcomes as a result, and due to the **ageing population** high BP and its consequences are likely to become more common over time.

If no action is taken, high BP is likely to contribute to reduced health and wellbeing, (more heart attacks, strokes, heart failure, chronic kidney disease and vascular dementia), an increase in health inequalities, and **greater demand** on primary, secondary, and social care services. PHE's 'Tackling High Blood Pressure' estimates 'no change' scenario costs related to BP to be £2.1billion a year across England. Taking no action is not an option.

b. Standards and Policy context

Best practice for clinical management of high BP is set out in **NICE guidelines** for hypertension and accompanying NICE Quality Standards enable assessment of performance against the guidelines.

The **Quality and Outcomes Framework (QoF)** for hypertension measures performance in primary care in relation to BP care. QoF standards do not however always align with accepted best clinical practice standards.

There is increasing recognition that high BP cannot and should not be the concern of primary care alone, and that a **cross-sector system approach** with greater emphasis on **integration and prevention** is key to improving outcomes and a sustainable approach. Key documents in this regard include:

- PHE and the National Blood Pressure System Leadership Board, published 'Tackling High Blood Pressure' in 2014
- NHSE Five Year Forward View, in particular in relation to prevention, public health and integrated working
- PHE's 'Action on cardiovascular disease: Getting serious about prevention', 2016

c. The Challenge in Cheshire and Merseyside (C&M)

Modifiable risk factors for high BP are common across C&M (two thirds of adults are overweight, one third are physically inactive, and up to a third of adults in some areas smoke), fuelled by high levels of deprivation (32% live in the most deprived areas) (Source: Saving lives: Reducing the pressure).

Approximately **625,000 people** are thought to be affected by high BP in C&M but around **275,000 are estimated to be unaware** they are affected.

Health checks uptake across C&M, an intervention that includes BP testing, ranges from 5%-12% across C&M CCGs (falling short of the national target of 20%)

There is considerable **practice-level variation**, including rates of diagnosis, exception reporting, and treating to target.

Despite a trend (from 2012/12 to 2014/15) towards a greater proportion of patients with high BP achieving a minimum QoF target of <150/90mmHg (Source: NCVIN CVD Profiles), **around 1/5 are still not controlled to a minimum standard**. As the QoF BP threshold differs from that set out in NICE guidelines, many more than this are likely to benefit from having their BP controlled to a more aspirational (lower) level.

It is estimated that around 800 heart attacks and strokes could be prevented annually through optimising BP treatment alone.

Most C&M Clinical Commissioning Groups (CCGs) have **higher than average Cardiovascular Disease (CVD) prevalence** (11/12).

Hospital admissions rates are higher than the England average for **heart attacks and for strokes** in 7 and 4 out of the 12 CCGs, respectively, and there has been little overall change in the rate of all age stroke admissions across C&M in more than a decade (2003/04 to 2014/15) (Source: NCVIN CVD Profiles).

Death rates are higher than the England average for **heart attacks and for strokes** in 10 and 8 out of the 12 CCGs, respectively.

Taking in to account demand on the health and care system from heart attacks, strokes, Heart Failure, CKD and dementia the **financial cost of the 'no change' scenario** is estimated to be in the region of £500m over 5 years for Cheshire and Merseyside (or around £71m over 5 years if complication costs are limited to heart attacks, strokes and heart failure).

d. Challenges at Local Delivery System Level

The following LDS-level figures are based on main constituent CCG boundaries rather than exact LDS boundaries so may be subject to minor changes, i.e. they are based on the following footprints:

- **Cheshire and Wirral LDS:** South Cheshire, Eastern Cheshire, West Cheshire , Wirral, Vale Royal CCGs
- **The Mid Mersey Alliance LDS:** Knowsley, Warrington, Halton, St Helens CCGs
- **North Mersey LDS:** Liverpool, Southport & Formby, South Sefton CCGs

Please note: the real picture is more complex, with some CCGs, e.g. Knowsley CCG, facing into more than one LDS. More accurate LDS-level figures will be calculated as part of the next stage in the FYFV process.

i. Cheshire and Wirral LDS

- Over 284,000 people are thought to be affected by high BP
- 162,000 people are on QoF hypertension registers
- A further 122,000 are estimated to be undiagnosed
- The value of an extra 15% diagnosis per annum is estimated at £550,000
- Nearly 1/5th of patients known to have high BP are still not controlled to minimum QoF standards (<150/90)
- Over 6,200 additional people would have their BP controlled if all practices achieved as well as the average of the best achieving practices in their CCG
- If all GP practices performed as well as the 75th best percentile
 - 262 events could be prevented over 5 years: 74 strokes, 47 heart attacks, 103 heart failures, 38 deaths
 - Saving >£6.8m NHS costs and ~£1.5m social care costs
- Emergency hospital admissions for heart attack and stroke are similar to the national average
- ‘No change’ scenario costs, including BP complication costs for heart attacks, strokes and heart failure, are estimated at £31m

ii. Mid-Mersey Alliance LDS

- Over 175,000 people are thought to be affected by high blood pressure
- Nearly 105,000 are on QoF hypertension registers
- A further 71,000 are estimated to be undiagnosed
- The value of an extra 15% diagnosis per annum is estimated at £319, 000
- Nearly 1/5th of those known to have high BP are not controlled to minimum QoF standards (<150/90mmHg). In one CCG, a trend towards fewer BP patients achieving this minimum target BP can be seen (2012/13 to 2014/15).
- Over 4,600 additional people would have their BP controlled if all practices achieved as well as the average of the best achieving practices in their CCG
- If all GP practices performed as well as the 75th best percentile
 - 188 events could be prevented over 5 years: 52 strokes, 34 heart attacks, 74 heart failures, 28 deaths
 - Saving over £4.8m NHS costs and £1m social care costs
- Emergency hospital admissions for heart attack and stroke are 30% and 4% higher than the national average, respectively

- ‘No change’ scenario costs, including BP complication costs for heart attacks, strokes and heart failure, are estimated at £18.5m

iii. North Mersey LDS

- Over 199,000 people are thought to be affected by high blood pressure
- Over 112,000 people are on QoF hypertension registers
- A further 87,000 are estimated to be undiagnosed
- The value of an extra 15% diagnosis per annum is estimated at £392,000
- Nearly 1/5th of those known to have high BP are not controlled to minimum QoF standards (<150/90)
- Nearly 4,400 additional people would have their BP controlled if all practices achieved as well as the average of the best achieving practices in their CCG
- If all GP practices performed as well as the 75th best percentile
 - 203 events could be prevented over 5 years: 57 strokes, 37 heart attacks, 79 heart failures, 30 deaths
 - Saving nearly £5.3m NHS costs and over £1.1m social care costs
- Emergency hospital admissions for heart attack and stroke are slightly higher and lower than the national averages, respectively
- ‘No change’ scenario costs, including BP complication costs for heart attacks, strokes and heart failure, are estimated at £22m

Cheshire and Merseyside: Taking a cross-sector systems approach

In response to the challenges that high BP poses to both health and wellbeing and the sustainability of the health and care systems in C&M, great progress has been made locally in forging the **cultural shift** necessary to address the issue.

The collective **vision** of partners across C&M is that **our communities will have the best possible BP**.

C&M has been described by the national PHE team as **‘leading the way’** in its innovative cross-sector approach to tackle high BP, and the C&M high BP strategy (Saving lives: Reducing the pressure) has been described as **‘state of the art’** by Professor Norm Campbell, leader of a team in Canada responsible for world-leading transformations in BP detection, treatment and control. A link to the C&M strategy can be found as an example of good practice on the World Hypertension League website.

Cheshire and Merseyside cross-sector Blood Pressure Board was established in November 2015, and the Board launched its strategy, **‘Saving lives: Reducing the pressure’** in May 2016

Stakeholders of the C&M BP strategy are from a wide range of sectors and organisations including

- Public Health England NW
- NHS E C&M

- Cheshire and Merseyside Public Health Collaborative (Champs)
- 9 Local Authorities
- 12 CCGs (covering the 3 C&M LDS)
- Voluntary Sector organisations including Stroke Association, British Heart Foundation, Blood Pressure UK, Health Equalities Group
- NICE
- Innovation Agency
- Health Education England
- C&M Fire and Rescue Services

It is within the context of this local cross-sector BP strategy and system that this FYFV BP programme of work is proposed.

2. Assumptions & Constraints

Assumptions and constraints can be considered in two groups relating to the:

1. **Programme of BP work** (including the cross-sector systems approach)
2. **Economic modelling**

1. The programme of BP work (including a cross-sector systems approach)

Assumptions

Underpinning the high BP plan is a key assumption that the best way to improve outcomes for available resources is to take a **cross-sector system approach** to tackle high BP with networks of partners delivering pathways of care that cover prevention, detection and management (PHE 'Tackling high blood pressure, NHS Five Year Forward View, Pan-Canadian BP work)

- The relationship between prevention, detection and management is **not linear**, for example, secondary care can play an important role in prevention, and detection and management roles can be shared with non-clinical community partners in a range of settings
- Assumptions about the relationships between outputs (interventions) and short, medium and long term outcomes/ impacts are set out in the 'Saving lives: Reducing the pressure' **logic model-style indicator dashboard** (see link to strategy in annex).
- It is assumed that the **C&M Blood Pressure Board** will continue to provide cross-sector system leadership across the sub-region, facilitating true integrated working and realisation of how interdependencies can yield improved outcomes despite challenging constraints on resources
- Due to reduced prevalence of high BP and its complications, and the expansion of partner roles, it is assumed that overall primary care will benefit from a **net reduction in demand** despite 'asks' of the primary care team set out in this programme of work.

Constraints

- **Resources-** At present the majority of the work within the C&M BP strategy is being achieved through 'gift in kind' (partners giving their time and expertise), and financial resources are limited. Without additional financial resource to pump-prime the BP programme, the ability of the interventions set out in the action plan to close the three 'gaps' will be greatly lessened.
- **Evidence base-** C&M is recognised as being 'ahead of the curve' nationally in its cross-sector system approach to tackle high BP. As such the proposed programme of work is based on a combination of evidence of interventions that demonstrate impact where this is available, but for some areas, evidence of impact is not yet available as no-one has taken the next step. When this is the case, proposed actions

are based on available evidence blended with theory, pragmatism and peer consensus (in part achieved through the National Blood Pressure Board, on which the lead DPH for BP in C&M sits, as well as through the C&M BP Board and the C&M Health Care Public Health Leads Group). In doing so, C&M is adding to the available evidence base.

- **Risks**

A risk management policy is in place that will provide a standardised approach to the identification, assessment, recording and reporting of risks. An integrated risk log will be developed and will analyse the causes of a risk and identify current controls to manage the outcome to mitigate the likelihood and impact. The key controllable risks are outlined below

- i. We know 25% of people are suffering from hypertension but we are only treating circa 16%. We have an **ageing population who are increasingly at risk of hypertension** due to **age, obesity and drinking too excess**. If we do not start to address this disease right across the system at scale we will have increasing cases of stroke, heart attacks and vascular dementia that will inflate treatment costs, require long term care and give people poor quality of life.
- ii. **Public Engagement.** The costs for implementing a programme at scale are low but there is the risk that the public may not engage with the programme. Mitigated by good communications, engaging charities, public/patient groups/ community initiatives as part of a systems approach to implementation
- iii. There is a risk we lack the **capacity** to deliver the programme at scale. We can mitigate this by training local people in the community as well as staff and use community pharmacists.
- iv. **Managerial – Professional Engagement.** There is a risk that the system (CCGs and primary care clinicians) may fail to engage and implement the programme. Mitigated by Substantial engagement with clinicians including PHE/SCN, clinical champions, CVD-leads via SCN and a Sector Led Improvement approach.
- v. **Changes to National funding arrangements,** e.g. to Medicines Use Reviews (which are currently under review) would reduce opportunities for community pharmacies to work with primary care around medicines optimisation. Mitigate with alternative funding source (e.g. Enhanced Supply) to continue with and optimise impact of existing service.

2. Economic modelling

Assumptions

- Itemised estimated C&M BP **programme costs** are set out in section 7 'Facilities and Estates'

- Programme costs are **pro rata** based on estimated total number of people with hypertension in each CCG.
- Maximum net financial benefit is based on **15% increase in diagnosis**, and all GP practices performing as well as the **75th best percentile** for managing blood pressure in people with hypertension
- **Sensitivity analysis** was carried out varying the increase in diagnosis to **5% and 10%** in the event of assumptions around increased detection being difficult to achieve
- The estimated cost savings from increasing hypertension diagnosis are based on economic modelling commissioned by PHE for '**Tackling High Blood Pressure: From evidence into action**'; while the estimated cost savings from better blood pressure control in people diagnosed with hypertension are from a series of **CVD prevention opportunity tools** produced by PHE which are based on best current epidemiological and economic evidence.
- While total financial benefits are calculated for a **five year period**, benefits will be **realised gradually** over the five years, not only at the five year point. Within the modelling, benefits (outcomes) have been staged as follows: 0% in year 1, then 25%, 50%, 75% and 100% in years 2-5, in keeping with timeframes on the 'Saving lives: Reducing the pressure' indicator dashboard
- **Discounting at 3.5% per annum** has been undertaken for the main scenario (15% increase in diagnosis)
- The biggest and most sustainable way to impact on high BP is **prevention**, e.g. population level approaches, especially those that reduce salt intake.
- **MECC** is estimated to give a benefit to cost ratio of around £35 gained for each £1 spent
- Prevention benefits from population approaches and MECC will also be felt across the majority of **cross-cutting FYFV themes** and the other prevention priority, alcohol.

Constraints

- All LDS-level figures are based on **main constituent CCG boundaries** rather than exact LDS boundaries so may be subject to changes. LDS boundaries in this document are taken as:
 - **Cheshire and Wirral LDS:** South Cheshire, Eastern Cheshire, West Cheshire , Wirral, Vale Royal CCGs
 - **The Mid Mersey Alliance LDS:** Knowsley, Warrington, Halton, St Helens CCGs
 - **North Mersey LDS:** Liverpool, Southport & Formby, South Sefton CCGs
 The real picture is more complex, with some CCGs, e.g. Knowsley CCG, facing into more than one LDS. More accurate LDS-level figures will be calculated as part of the next stage in the FYFV process.
- Economic modelling does not factor in any **additional costs** for the extra cases diagnosed, but net benefits are likely to be an underestimate as they do not include savings related to dementia or CKD, and do not take into account the value of Quality Adjusted Life Years (QALYs) gained.

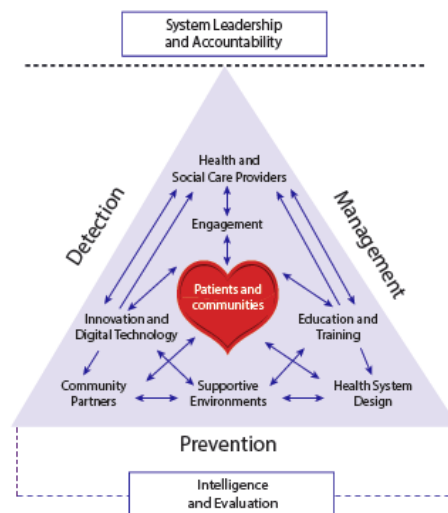
- Project costs and different scenarios relating to primary care performance **have not been varied** within the sensitivity analysis
- While project costs for a 'healthy provider declaration' and MECC have been included in the net benefit calculations, benefits gained from resulting prevention of BP and related complications have not been included. As such, net benefits for BP are likely to be **underestimated**.

3. Service Model

Background context: The C&M BP strategy

The proposed programme of work is embedded within the C&M Cross-sector approach to tackle high BP, as set out in the Cheshire and Merseyside cross-sector strategy to tackle high BP 'Saving lives: Reducing the pressure', launched May 2016. The strategy has been described by PHE as nationally 'pace-setting', and as 'State of the art' by the leader of the world-leading team for tackling high BP, Professor Norm Campbell.

The main objectives of the strategy are represented schematically below:



The full strategy is available to download via the following link:

www.champspublichealth.com/high-blood-pressure

A 'coalition of the willing' has been building in Cheshire and Merseyside for two years, culminating in 'Saving lives: Reducing the Pressure', and service model builds on this, including a wide range of stakeholders across the BP 'system';

- Patients and communities
- Community partners, e.g. voluntary sector, Fire and Rescue Service
- Community pharmacies
- The primary care team (GPs, PNs, HCAs)
- Secondary care

Through enhanced prevention, detection and management of high BP, the programme of BP work proposed here builds on the C&M BP strategy and will reduce demand on primary, secondary and social care services by focusing on:

1. **Empowering patients and communities to live better**
2. **Enhancing the role of community pharmacies in detecting and managing high BP**
3. **Consistent delivery of best BP management in primary care.**

Reducing demand on primary care

PRIORITY 1) Empower Patients and Communities to Live Better

Prevention of high BP and its consequences by helping populations to lead healthy lives and to self-care is the most sustainable way to improve outcomes and reduce demand on primary care. This can only be achieved by working hand in hand with partners from a range of organisations and sectors as part of a cross sector strategy that includes population-based approaches, and ties in with local authority Early Intervention & Prevention Agendas, Integrated Transformation Programmes and the Pioneer and Vanguard initiatives across the FYFV footprint.

Aim: Reduce the impact of high BP on primary care by preventing it developing in the first place, and by empowering patients and communities to self-manage through lifestyle change if high BP does develop.

CCGs can contribute to the C&M BP system achieving this through:

- **Healthy local policy** (including in relation to reducing salt intake) within local health and care provider settings, and advocacy for healthy national policy as part of the C&M BP System.
- **Making Every Contact Count/ brief interventions** focusing on High BP (including BP checks), smoking cessation, alcohol, diet, physical activity. MECC can be rolled out widely in partnership with health care organisations and non-clinical community partners including voluntary sector organisations.
- **Social Marketing** campaigns to raise awareness around BP and support the MECC work

Case Studies 1 a and b

1a. Health and wellbeing study for NHS staff, Clatterbridge Cancer Centre (CCC)

Dr Robbie McDermott, Dr Peninah Thumbi, Yang Liu, Nick Bain, June 2015.

Why should NHS provider organisations support healthy eating, and how can they do it?

With increasing evidence that NHS staff behaviours influence the behaviour of patients and the public, Clatterbridge Cancer Centre (CCC) was keen to reduce unhealthy risk behaviours amongst their staff. The CCC is one of the largest networked cancer centres in the UK, but engagement around prevention and promotion of healthy lifestyles amongst staff and patients was limited. NHS provider organisations can be ideal settings for population approaches to improve health and wellbeing (including healthy eating and BP), but the supply of cheap, high energy food may contribute to them achieving the opposite.

Intervention; CCC and the Health Equalities Group, HEG (a Liverpool-based charitable health and wellbeing alliance) commissioned research into the barriers and drivers for staff adopting healthier lifestyles.

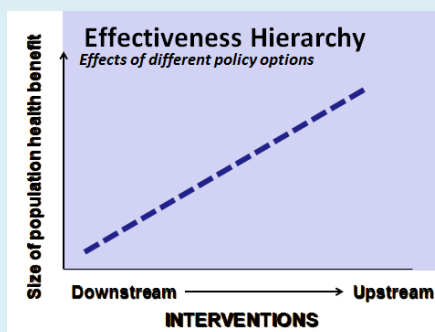
Results; Weight (a key risk factor for high BP) was identified as the risk factor affecting most staff (45%), and the majority were keen for change and support to do so. Workplace-based support was considered essential, including 24 hour access to healthy food, and reduced access to unhealthy food (e.g. in vending machines).

“If I forget to bring in my own lunch, it’s a nightmare. I’m like, ‘I either queue up my whole break or I eat rubbish instead’” Radiographer.

Relevance; This report underlines the importance of NHS providers increasing availability of healthy food, and that this will be beneficial to staff, patients and visitors.

1b. Local Authority Declaration on Healthy Weight, Food Active, spring 2016.

Upstream population-level policies have a larger impact on public health outcomes than interventions that target individuals.



The Local Authority Declaration on Healthy Weight (Food Active, HEG) was designed to support local government to exercise their responsibility in developing and implementing policies which promote healthy weight. In January 2016 Blackpool became the first local authority to adopt the Declaration, and has since made significant progress with vending machines, procurement, healthy packed lunches, awareness raising campaigns, healthy catering awards and other areas. The evidence base behind the Declaration is equally relevant and important to NHS provider organisations, hence the proposal for the development of a ‘Healthy Provider Declaration’ on healthy food to support development and implementation of provider-level policy.

For more information on the Local Authority Declaration on Healthy Weight go to http://www.hegroup.org.uk/images/resources/Healthy_Weight_Briefing_paper.pdf

Link to a blog about the Blackpool Declaration:

<http://www.foodactive.org.uk/blackpool-council-the-first-adopters/>

Implementation of this evidence base can directly support provider organisations to meet requirements for part 1b of the recently introduced health and wellbeing CQUIN, ‘Healthy food for staff, patients and visitors’.

PRIORITY 2) Enhanced role of Community Pharmacy in BP detection and management

For those who do develop high BP, some of the roles traditionally carried out in general practice can be undertaken in, or in partnership with community pharmacies, improving outcomes whilst reducing demand on primary care.

Aim: Reduce the impact of high BP on primary care by supporting primary care to and community pharmacy to work more closely in relation to high BP detection and management.

This can be achieved through Enhanced Services that support:

- **Diagnosis:** BP testing and 24 hour ambulatory BP monitoring in community pharmacies, with appropriate advice and signposting
- **Medicines optimisation:** Increase uptake of existing services such as Medicine Use Reviews and New Medicines Service, and greater focus of these reviews on antihypertensive medications in line with C&M prevention priorities

Case Study 2

The impact of interventions by pharmacists in community pharmacies on control of hypertension: a systemic review and meta-analysis of randomised controlled trials.

Ejaz Cheema, Paul Sutcliffe & Donald R. J. Singer, June 2014. British Journal of Clinical Pharmacology. DOI:10.1111/bcp.12452

A recent systematic review and meta-analysis of randomised controlled trials (RCTs) confirmed that community pharmacists can make a clinically important contribution to the management of hypertension in patients with or without associated cardiovascular co-morbidities.

16 RCTs (3,032 patients) were included, and the pharmacist-led interventions were patient education on hypertension, management of prescribing and safety problems associated with medication, and advice on lifestyle. These interventions were associated with significant reductions in systolic (-6.1mmHg, 95% confidence interval -0.8 to -8.4mmHg, $p < 0.00004$) and diastolic blood pressure (-2.5mmHg, 95% confidence interval -1.5 to -3.4mmHg, $p < 0.00001$). As addition to improvements in blood pressure, the analysis demonstrated that in comparison to patients receiving usual care medication adherence improved, as did control of other cardiovascular risk factors, including both diabetes and cholesterol.

This case study supports the community pharmacy interventions set out here in relation to BP detection and medicines optimisation.

Reducing demand on secondary care

PRIORITY 3) Support consistent delivery of best practice across Primary Care

While there is much scope to strengthen prevention, a proportion of patients will still develop high BP and require clinical care. As a risk factor for heart disease, stroke, dementia and chronic kidney disease, controlling high blood pressure to target in primary care plays a key role in reducing demand on primary and secondary care in dealing with the health and social consequences of high BP. However, there is variation in the standard of BP care delivered across primary care.

Aim: Reduce the burden of the medical consequences of high BP on secondary care by supporting best practice and reduced variation in primary care in relation to BP management.

CCGs can accelerate and support primary care quality by supporting education and training in primary care aimed at improving:

- a. Insight into practice-level benchmarking data
- b. Improved use of hypertension registers and case-finding, coding
- c. Clinical skills, e.g. BP measurement, prescribing guidelines etc.
- d. Use and interpretation of 24 hour ambulatory and home BP monitoring
- e. Implementation of NICE Guidance
- f. Audit of performance against NICE Quality Standards
- g. Closer working with community pharmacies around medicines optimisation
- h. Knowledge of the sub-regional BP pathway and strategy

Case study 3

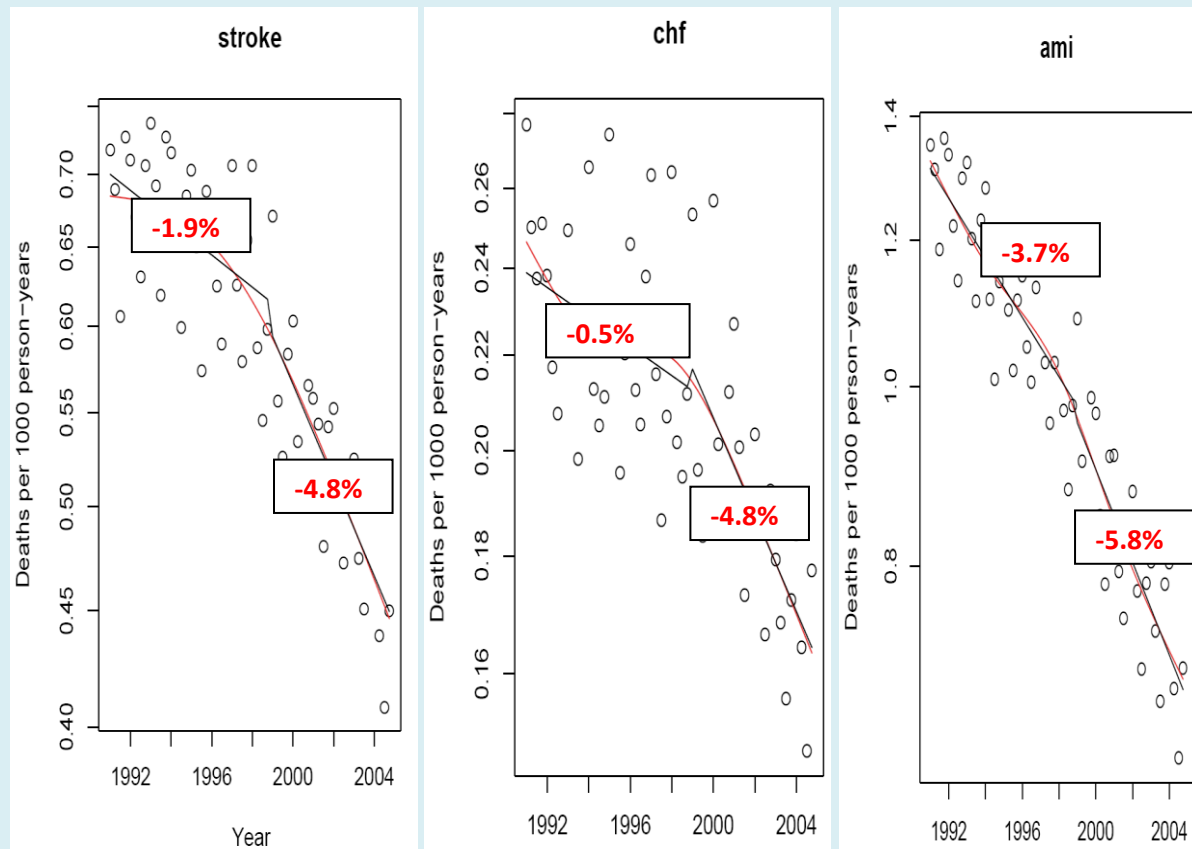
The Canadian Hypertension Education Program (CHEP), part of the Pan-Canadian Framework on the Prevention and Control of Hypertension, led by Professor Norm Campbell and the Healthy Blood Pressure Steering and Drafting Committee

In the early 1990s Canada had a high prevalence of hypertension and poor rates of treatment and control (13%). In 2000 the hypertension community in Canada developed a National Strategy for High Blood Pressure Prevention and Control which included the Canadian Hypertension Education Program (CHEP), a knowledge translation programme targeted originally at primary care practitioners to detect, treat, and control hypertension. Ten years later Canada has highest reported rates of treating and controlling hypertension in the world (66% 2007-2009).

Key messages of the CHEP knowledge translation programme included: know the current BP of all your patients, encourage the use of approved devices and proper technique to measure BP at home, assess and manage CV risk in hypertensive patients including modifiable risk factors, and treat high BP to target (more than one drug is usually required).

Impact: The introduction of CHEP in 1999 was associated with improvements in BP awareness, treatment, control and outcomes, including a marked reduction in deaths from stroke, heart failure and heart attacks (acute myocardial infarction), see figures below.

Changes in Stroke, Heart failure (chf) and Acute Myocardial Infarction (ami) deaths after CHEP starts in 1999:



Evidence from world-leaders in this field supports the introduction and roll out of a primary care BP education and training programme across Cheshire and Merseyside, building on local initiatives such as the Beacon Practice Pilots, developing originally in Wirral.

Prof Campbell who led the Canadian team in this work has endorsed the C&M BP strategy on which this BP plan is based, describing it as 'state of the art'.

For further information see 'Pan Canadian Framework on the Prevention and Control of Hypertension: a discussion paper on the way forward. Prof Norm Campbell et al, March 2012.

Delivering the 3 dimensions of quality

The programme of work will deliver the 3 dimensions of quality (patient safety, patient experience and clinical effectiveness):

- **Patient safety**
In order to ensure public and patient safety is paramount, it is proposed that the C&M BP Board Embed systematic triangulation and review of cross-sector patient safety measures into strategy dashboard (e.g. complaints, litigation, incidents etc.).
- **Patient experience**
The cross-sector approach will enhance patient experience by ensuring interventions are available at the right place and time, enabling de-medicalisation where appropriate, self-empowerment, and quality care closer to home.
The health benefits from reducing the risk of blood pressure will also benefit a wide range of conditions, improving overall health and wellbeing.
Patient/ lay representation on C&M BP Board and ongoing patient/lay consultation to ensure patient experience is improved
- **Clinical effectiveness**
Clinical practice will be more closely and consistently aligned with best practice (NICE guidelines on hypertension). This will be captured in KPI4, an increase in the percentage of patients treated to target levels (150/90mmHg) and a reduction in practice-level variation.

4. Performance

Key Performance Indicators (KPIs)

The KPIs for the programme of work reflect impact, prevention, detection and management of high BP, aligning to the three Five Year Forward View 'Gaps' around Health and Wellbeing, Care and Quality, and Finance.

C&M BP Programme KPIs

KPI1 (Impact): CCGs with higher than the national average hospital admissions for heart attacks and strokes

KPI2 (Prevention): NHS providers meeting meet HWB CQUIN 1b (Healthy food for staff, patients and visitors)

KPI3 (Detection): Gap between observed and expected prevalence of BP

KPI4 (Management): Increase in the % patients treated to target levels, and a reduction in practice-level variation

Current performance against the KPIs is as follows:

Performance against KPIs at LDS level

KPI	Description	Cheshire and Wirral LDS	Mid Mersey Alliance LDS	North Mersey LDS
KPI1	Number of CCGs with higher than national average hospital admissions for heart attacks	1	4	2
	Number of CCGs with higher than national average hospital admissions for stroke	1	2	1
KPI2	NHS providers meeting meet HWB CQUIN 1b (Healthy food for staff, patients and visitors)	0/20		
KPI3	Reduction in gap between observed and expected prevalence of BP	0.569 (n=161,921)	0.597 (n=104,838)	0.564 (n=112,414)
KPI4	% patients treated to target levels (<150/90mmHg) is increased	80.80% n=130,944	80.60% n=84,453	81.60% n=92,087
	Practice-level variation in % patients treated to target is reduced	26%	36.50%	43.60%

Progress targets (including timeframes) for the KPIs are set out below:

KPI targets

KPI	Target KPI change
KPI1. CCGs with higher than national average hospital admissions for heart attacks and strokes, respectively	Annual decrease from baseline evident from Y3, down to 0 by Y5
KPI2. NHS providers meeting meet HWB CQUIN 1b (Healthy food for staff, patients and visitors)	Annual 25% increase from baseline evident from Y2, to give 100% by Y5.
KPI3. Reduction in gap between observed and expected prevalence of BP	Measurable increase in O/E hypertension prevalence ratio (equivalent to a 2.83% annual increase in prevalence from baseline, or a 15% increase from baseline by end Y5)
KPI4. a. % patients treated to target levels (<150/90mmHg) is increased b. practice-level variation is reduced	a. ~1% increase per annum in patients achieving target BP levels (<150/90mmHg). (Equivalent to increases in the no. of additional people who would have BP controlled if all practices achieved as well as the average of the best achieving practices at baseline by year 5) b. 50% reduction in practice level variation by Y5, or approximately 10% reduction per annum

For expected **LDS-level progress against KPIs**, see section 9, 'Benefits'.

5. Staffing

In terms of staffing, this programme of work has direct and indirect implications for staffing.

Direct implications

Investment in posts needed:

- to support the system leadership approach
- to lead on the development and implementation of education and training programme

Due to the nature of the cross-sector approach, the staffing groups that contribute to the delivery of the BP pathway reach into many thousands. The number of HCWs with direct patient across C&M is over 55,000 (figures from NHSE Seasonal Flu Report 2016). This will enable actions at pace and scale. A targeted rolling programme of training for staff around Making Every Contact Count (MECC) is needed, including for

- Non-clinical community partners, e.g. voluntary sector staff, Fire and Rescue Service staff
- Community pharmacy staff, including Healthy Living Pharmacy leads and champions (estimated to be around 1,200 community pharmacists working regularly in C&M with patient access)
- Primary care teams including GPs, Practice nurses, Health care workers, receptionists
- Secondary care staff

Indirect implications

Indirect implications include the need for clear and consistent communications and engagement across the system, and engagement of key partners to mobilise the system.

An indirect benefit of the healthy provider policy intervention will be a contribution to a healthier and more productive workforce, thus supporting sustainability of the wider FYFV.

6. Information Management & Technology

The C&M BP System partners have a strong background in exploring the art of the possible in terms of how digital technology and innovation can facilitate delivery of key strategic objectives. In 2015 C&M got to the final stages of an NHSE Innovate UK Test Bed Bid Process, a process which itself galvanised the C&M BP partners and gave clarity as to which elements of the system would benefit from digital innovation and investment.

The three areas developed were broadly:

1. **Applications, devices and sensors** for the detection and management of high BP in community settings (e.g. kiosks, Phone apps etc.)
2. **Decision support** to facilitate standardised best clinical care in primary care
3. **Shared digital platform** to enable cross-sector interoperability and analytics

While the bid was not successful, C&M have been acting on the constructive feedback from NHSE by better defining the BP pathway, and how patients and the public will move through the system and addressing information governance issues. This is being done by:

- **Warrington shared digital platform pilot**, focusing on BP detection and management providing proof of concept for health kiosks in the community and a shared platform approach to enable data to be shared with primary care
- **Defining of 'front end' of BP pathway** through FRS Safe and Well checks pilot, and forging the way to strengthen the role of community pharmacies, including through the Beacon Practice pilots and Healthy Living Pharmacies programme

As such, C&M is now in a much stronger position to realise the potential that digital solutions have to offer the BP strategy.

Within the 3 priority interventions in this programme of work, use of digital technologies could include;

1. **Empowering patients and communities**
 - Developing a conversational tool to support delivery of MECC
 - Standards compliant BP testing devices/ apps
2. **Community pharmacies**
 - Standards compliant BP testing devices
 - 24 hour BP monitors
 - Home BP monitoring equipment
 - electronic referrals from primary care for Medicine Use Reviews and New Medicine Services
3. **High Quality BP Management in primary care**
 - Shared digital platform for patient records with key partners, e.g. community pharmacy
 - Decision support software

7. Facilities & Estates

For the most part the actions can be put into place within existing facilities and estates belonging to key stakeholder partners, largely in community pharmacies, primary and secondary care.

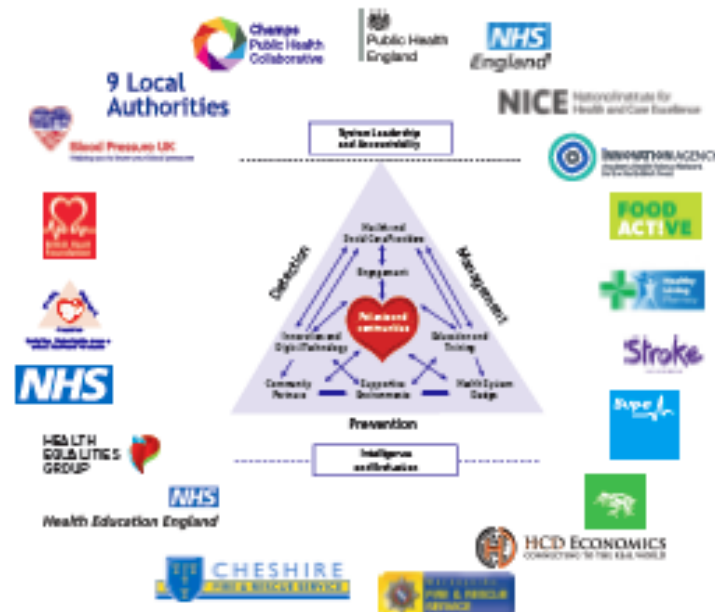
- System leadership Staffing costs
- 'Healthy Provider Declaration'
- MECC: workforce development
- Behaviour change campaigns and communications
- BP technologies
- Primary care education and training programme
- Evaluation
- Non labour and Overheads (rent, equipment etc.)

8. Interdependencies

Interdependencies can be identified at 3 levels; operational, tactical and strategic.

Operational level interdependencies

The priorities outlined here are embedded within the C&M Cross-sector strategy to tackle high BP.



Within this system, a wide range of interdependencies and partnership working is evolving between key stakeholders including, but not limited to:

- Public Health England (NW and national)
- NHS England C&M
- Cheshire and Merseyside Public Health Collaborative (Champs)
- 9 Local Authorities
- 12 CCGs (covering the 3 C&M LDS)
- Voluntary Sector organisations including Stroke Association, British Heart Foundation, Blood Pressure UK, Health Equalities Group
- NICE
- Innovation Agency
- Health Education England
- C&M Fire and Rescue Services

By capturing key outputs and outcomes from across the system into a single indicator dashboard, the importance of interdependencies is demonstrated and embedded within the C&M BP strategy, 'Saving lives: Reducing the pressure'.

Tactical level interdependencies

Upstream approaches to address high BP through modifiable lifestyle factors (e.g. as 'Healthy Provider Declaration' and MECC at scale will also benefit other cross-cutting themes within the FYFV (e.g. cancer, CVD, neurology, alcohol) by reducing the prevalence of risk factors for a wide range of conditions in addition to high BP.

Strategic level interdependencies

The longer term benefits of the prevention of future illness, both in terms of those related to high BP, as well as those in other cross-cutting themes, is to strengthen the future sustainability of the wider C&M FYFV.

Also, the Boorman Report (2009) demonstrated that better staff health and wellbeing is associated with better organisational performance and improved patient outcomes. Interventions that increase staff health and wellbeing will therefore improve organisational productivity, outcomes and sustainability.

9. Benefits

Impact of the programme on addressing the 3 'Gaps' at the heart of the Five Year Forward View:

1. The Health and Wellbeing Gap
2. The Care and Quality Gap
3. The Finance and Efficiency Gap

Addressing the Five Year Forward View Gaps

All interventions that make up the C&M BP programme of work will address the Financial and Health and Wellbeing Gaps through enhanced prevention (primary, secondary or tertiary) and the cross-sector system approach, which will maximise value (benefits in health outcomes for available resources) across the system. The majority of interventions also contribute to the Care and Quality Gap. This is represented schematically below.

Schematic representation of how the C&M BP Interventions will address the 5YFV 'Gaps'.

Intervention	Aim		5YFV gap addressed		
			Finance and Efficiency	Health and Wellbeing	Care and Quality
1. FYFV demand reduction (BP) steering group	Overarching	Prevention	Y	Y	Y
2. System Leadership approach			Y	Y	Y
3. Population approach to prevention	Y		Y		
4. BP awareness raising campaigns	Y		Y		
5. Making Every Contact Count at scale	Detection	Management	Y	Y	
6. Blood pressure equipment			Y	Y	Y
7. Primary care education and training programme			Y	Y	Y
8. Medicines Optimisation	Y		Y	Y	

1. Closing the Health and Wellbeing gap

The Five Year Forward View states that 'if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness'.

Through a cross-sector system approach, LDSs across C&M will be ensuring patients receive the most appropriate interventions in the right places and at the right time, driving a cultural shift towards prevention and self-care.

On an **operational level**, the programme of work aims to prevent identify and control high BP. The impact of this will be a reduction in medical complications such as stroke and heart attacks, and reduced demand on health and social care. Progress against KPIS 1 to 4 will indicate progress towards this aim (see tables below).

On a **tactical level within the C&M FYFV**, upstream approaches to address high BP through modifiable lifestyle factors will also benefit other cross-cutting themes within the FYFV (e.g. cancer, CVD, neurology, alcohol) by reducing the prevalence of risk factors for a wide range of conditions in addition to high BP.

On a **strategic level**, the longer term benefits of the prevention of future illness, both in terms of those related to high BP, as well as those in other cross-cutting themes, is to strengthen the future sustainability of the wider C&M FYFV.

2. Closing the Care and Quality Gap

The Five Year Forward View states that 'unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist'.

The C&M BP programme of work aims to support delivery of best clinical practice across the sub-region. In particular, progress against KPIs 3 (Increase in observed and expected (O/E) BP prevalence ratio) and 4 (the percentage of patients who are treated to target levels (<150/90mmHg) and reduced practice-level variation) will reflect this (see tables below).

In C&M if all GP practices performed as well as the 75th best percentile for managing known BP patients, over 5 years could prevent 183 strokes, 118 heart attacks, 256 cases of heart failure, 96 deaths.

At LDS level this would mean prevention of

- **Cheshire and Wirral LDS:** 262 events could be prevented over 5 years: 74 strokes, 47 heart attacks, 103 heart failures, 38 deaths
- **Mid Mersey Alliance LDS:** 188 events could be prevented over 5 years: 52 strokes, 34 heart attacks, 74 heart failures, 28 deaths

- **North Mersey LDS:** 203 events could be prevented over 5 years: 57 strokes, 37 heart attacks, 79 heart failures, 30 deaths

3. Closing the Funding and Efficiency Gap - net financial benefit.

The Five Year Forward View states that 'if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments'.

Assuming that all areas move towards a 15% increase in hypertension diagnosis and all GP practices move towards performing as well as the current 75th percentile in terms of managing blood pressure in people with hypertension, the following net financial benefits (balancing total programme costs against 5 year savings) have been modelled at LDS level. Benefits are staged over five years with 0% in year 1, and 25%, 50%, 75% and 100% in years 2-5. See section 7 for estimated programme costs.

Scenario 1. Net financial benefit (assuming 15% increase in diagnosis) - base case scenario without and with future costs and benefits discounted at 3.5% per annum.

- Cheshire and Wirral LDS;** £3,716,502 (no discounting), £3,318,788 (discounted)
- Mid Mersey Alliance;** £2,558,913 (no discounting), £2,287,597 (discounted)
- North Mersey LDS;** £2,867,558 (no discounting), £2,563,136 (discounted)
- Cheshire and Merseyside;** £9,142,973 (no discounting), £8,169,521 (discounted)

Sensitivity analysis: In order to account for the possibility of LDSs being unable to achieve the 15% increase in BP diagnosis, a sensitivity analysis was carried out assuming 5% and 10% increases in diagnosis, respectively. Results (scenarios 2 and 3, respectively) demonstrate that while net benefit is reduced, net financial benefit is still very favourable.

Scenarios 2&3. Net financial benefit if LDS areas achieve 5% or 10% increase in high blood pressure diagnosis.

- Cheshire and Wirral LDS;** £2,797,871 (5%), £3,257,187 (10%)
- Mid Mersey Alliance;** £2,027,577 (5%), £2,293,245 (10%)
- North Mersey LDS;** £2,214,876 (5%), £2,541,217 (10%)
- Cheshire and Merseyside;** £7,040,324 (5%), £8,091,648 (10%)

Economic modelling does not factor in any additional costs for the extra cases diagnosed, but net benefits are likely to be an underestimate as they do not include savings related to dementia or CKD, and do not take into account the value of Quality Adjusted Life Years (QALYs) gained.

While total financial benefits are calculated for a five year period, benefits will be realised gradually over the five years, not only at the five year point.

For breakdown of economic calculations see appendices.

Local Delivery System performance and KPI targets

Progress towards closing the three 'gaps' will be monitored by a small number of KPIs. The tables below set out current performance and annual targets for each KPI at LDS and Cheshire and Merseyside levels.

Tables: Current performance and quantified targets at LDS and C&M levels for the BP programme KPIs (1-4).

a. KPI1: Number of CCGs with higher than national average hospital admissions for heart attacks and strokes, respectively.

KPI	Description	Target	Baseline and targets	Cheshire and Wirral LDS	Mid Mersey Alliance LDS	North Mersey LDS	Cheshire and Merseyside
KPI1	1a. Number of CCGs with higher than national average hospital admissions for heart attacks	Year on year decrease from baseline (from Y3 to Y5)	Baseline 2016/17	1	4	2	7
			2017/18	1	4	2	7
			2018/19	1	4	2	7
			2019/20	0	3	1	4
			2020/21	0	2	0	2
			2021/22	0	0	0	0
	1b. Number of CCGs with higher than national average hospital admissions for stroke	Year on year decrease from baseline (from Y3 to Y5)	Baseline 2016/17	1	2	1	4
			2017/18	1	2	1	4
			2018/19	1	2	1	4
			2019/20	0	1	0	1
			2020/21	0	0	0	0
			2021/22	0	0	0	0

b. KPI2: Large NHS providers (n=20) meet HWB CQUIN 1b, 'Healthy food for staff, patients and visitors'

KPI	Description	Target	Baseline and targets	Cheshire and Merseyside
KPI2	Large NHS providers (n=20) meet HWB CQUIN 1b, 'Healthy food for staff, patients and visitors'	Year on year increase from baseline	Baseline 2016/17	0
			2017/18	0
			2018/19	5 (25%)
			2019/20	10 (50%)
			2020/21	15 (75%)
			2021/22	20 (100%)

c. KPI3: Increase in observed and expected (O/E) BP prevalence ratio

KPI	Description	Target	Baseline and targets	Cheshire and Wirral LDS	Mid Mersey Alliance LDS	North Mersey LDS	Cheshire and Merseyside
KPI3	Increase in observed and expected (O/E) BP prevalence ratio	Measurable increase in O/E hypertension prevalence ratio (equivalent to a 15% increase in diagnosis at 5 years, or 2.83% per annum)	Baseline O/E ratio 2016/17 (and no. on QoF register)	0.569 (n=161,921)	0.597 (n=104,838)	0.564 (n=112,414)	0.575 (n=379,173)
			2017/18	n=166,510	n=107,809	n=115,600	n=389,921
			2018/19	n=171,230	n=110,865	n=118,877	n=400,974
			2019/20	n=176,084	n=114,008	n=122,247	n=412,340
			2020/21	n=181,076	n=117,240	n=125,712	n=424,029
			2021/22	0.655 (n=186,209)	0.686 (n=120,564)	0.648 (n=129,276)	0.661 (n=436,049)

d. KPI4: Increase in % patients treated to target levels (<150/90mmHg) and reduced practice-level variation

KPI	Description	Target	Baseline and targets	Cheshire and Wirral LDS	Mid Mersey Alliance LDS	North Mersey LDS	C&M
KPI4	4a. Increase in % patients treated to target levels (<150/90mmHg)	~1% per annum increase in % patients achieving target BP levels of <150/90mmHg <i>(Equivalent to increases in the no. of additional people who would have BP controlled if all practices achieved as well as the average of the best achieving practices at baseline by year 5)</i>	Baseline 2016/17 no. patients treated to target (and as % on QoF register)	80.8% (n=130,944)	80.6% (n=84,453)	81.6% (n=92,087)	(n=30,7484)
			2017/18	81.80%	81.60%	82.60%	
			2018/19	82.80%	82.60%	83.60%	
			2019/20	83.80%	83.60%	84.60%	
			2020/21	84.80%	84.60%	85.60%	
			2021/22	85.8% (n=137,176)	85.6% (n=89,067)	86.6% (n=96,483)	(n=322,736)
	4b. Practice-level variation in % patients treated to target is reduced	10% reduction in practice level variation per annum, to target of 50% reduction by Y5	Baseline variation 2016/17	26%	36.50%	43.60%	
			2017/18	23.40%	22.85%	39.24%	
			2018/19	20.80%	29.20%	34.88%	
			2019/20	18.20%	25.55%	30.52%	
			2020/21	15.60%	21.90%	26.16%	
			2021/22	13%	18.25%	21.80%	

10. Proposed Action Plan

C&M BP Programme Action Plan (2017/18 to 2021/22)

The C&M BP Board will work with the evolving Accountable Care Organisations across C&M to ensure delivery of the action plan. The Senior Accountable Officer is Muna Abdel Aziz, Lead DPH for high BP.

Intervention	Aim	Objective	5YFV gap addressed			Lead	KPI	Target KPI change
			Financial	Health and Wellbeing	Care and Quality			
1. FYFV demand reduction (BP) steering group	Overarching	<p>Business case- work up a more detailed business case based on more accurate programme costings, including £ value for QALYs gained, and based on more accurate LDS boundaries.</p> <p>Develop the risk register (building on those set out in the PID document) and plans to mitigate risks, using a standardised approach to identification, assessment, recording and reporting of risks.</p> <p>Stakeholder engagement and communications plan to mitigate the risk of failure of partners to engage</p>	Y	Y	Y	Eileen O Meara (Lead DPH for PH contribution to FYFV) and Muna Abdel Aziz (Lead DPH for BP)	<p>KPI1 (Impact): No. of CCGs with higher than national average hospital admissions for heart attacks and strokes respectively</p>	<p>Year on year reduction from Y3 to target of 0 by Y5</p>
2. System Leadership approach		<p>Ensure a system leadership approach continues through the cross-sector Board, networks and collaborations that contribute to delivery of the C&M Strategy to tackle high BP 'Saving lives: Reducing the pressure</p> <p>Embed systematic triangulation and review of cross-sector patient safety measures into strategy dashboard (e.g. complaints, litigation, incidents etc.).</p>	Y	Y	Y	Muna Abdel Aziz, Lead DPH BP Supported by Mel Roche, Acting PH consultant, Champs Support Team and Gunjit Bandesha (PHE NW)		
3. Population approach to prevention	Prevention	Support the 20 large NHS provider organisations to develop healthy local policy to reduce modifiable risk factors for staff, patients and visitors, e.g. in the form of a 'Healthy Provider Declaration' and put in place a package of support around implementation	Y	Y		Robin Ireland, Health Equalities Group	<p>KPI2 (Prevention): NHS providers meet HWB CQUIN 1b, 'Healthy food for staff, patients and visitors'</p>	<p>Year on year increase from baseline from Y2 to target of 20/20 by Y5</p>
4. BP awareness raising campaigns		<p>Empower patients and communities to understand key messages: Maximise the impact of existing national campaigns, particularly Blood Pressure UK's 'Know Your Numbers' campaign (including but not limited to KYN week) linking with community pharmacies, community partners and voluntary sector partners to maximise impact</p>	Y	Y		Tracey Lambert, Champs Support Team		
5. Making Every Contact Count at scale		<p>Engage with patients and communities: Workforce development to enable roll out MECC at scale across primary and secondary healthcare settings, community pharmacies and with non-clinical community partners (e.g. Fire and Rescue Service and voluntary sector organisations). Include basic BP measurement skills and signposting in line with C&M BP pathway. Optimise impact of MECC through use of supporting conversational tool/ technologies.</p>	Y	Y		Collaboration (TBC) between: HEE (TBC) Gunjit Bandesha (PHE NW)- Re conversational tool		
6. Blood pressure equipment	Detection	Increase the availability of standards compliant BP machines and Ambulatory Blood Pressure Monitoring (ABPM) to meet local need in relation to MECC and diagnosis, e.g. community pharmacies, community partners (e.g. FRS), general practices, other NHS provider settings.	Y	Y	Y	Depending on funding source: Julie Kelly (NHSE C&M) Helen Cartwright (Champs Support Team)	<p>KPI3. Reduction in gap between observed and expected (O/E) prevalence of high BP</p>	<p>Measurable increase in O/E hypertension prevalence ratio (equivalent to a 15% increase in diagnosis at 5 years)</p>
7. Primary care education and training programme		Management	<p>Accelerate and support quality improvement in primary care with dedicated education and training programme that utilises Sector Led Improvement principles (e.g. through a 'Beacon Practice' pilot approach) to support:</p> <p>a. Insight into practice-level benchmarking data b. Improved use of hypertension registers and case finding c. Clinical skills, e.g. BP measurement, prescribing guidelines etc. d. Use and interpretation of 24 hour ambulatory BP monitoring e. Implementation of NICE Guidance f. Audit of performance against NICE Quality Standards g. Closer working with community pharmacies around medicines optimisation (see 7.) h. Knowledge of the sub-regional BP pathway and strategy</p> <p>Initial focus on practices with poorest performance against KPIs 3&4 would support achievement of rapid return on investment.</p>	Y	Y	Y		
8. Medicines Optimisation			Closer working with community pharmacies to improve medicines optimisation through increased uptake and focus of Medicines Use Reviews (MUR) and New Medicines Service (NMS) on antihypertensive medicines.	Y	Y	Y	Julie Kelly, NHSE	<p>KPI4</p> <p>a. % patients treated to target levels (<150/90mmHg) is increased b. practice-level variation in % patients treated to target is reduced</p>

a) Annex

b. Appendices

Link to the Cheshire and Merseyside cross-sector blood pressure strategy, 'Saving lives: Reducing the pressure'

<http://www.champspublichealth.com/high-blood-pressure>