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Cheshire and Merseyside General Practice High Blood Pressure Quality Improvement Package Insight Report

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Champs Public Health Collaborative

British Heart Foundation

01. Background

According to the National Institute for Health Care Excellence (NICE), hypertension or high blood pressure (BP) is 'one of the most important preventable causes of premature morbidity and mortality in the UK'[1].

In the UK, high BP is the greatest known risk factor for Cardio Vascular Disease (CVD) and related disability[2]. A reduction in high BP reduces pathological complications, such as heart attacks and strokes, as well as offering significant economical savings. Approximately 625,000 people are thought to be affected by high BP across Cheshire and Merseyside[3], which is around 26 percent of the total population of those areas. Cheshire and Merseyside's BP strategy vision is that, 'our communities will have the best possible blood pressure'. Given the potential benefits of reducing the BP of these areas, as well as owing to concerns regarding the variation of care for high BP patients, high BP was a priority for collaborative action by the Cheshire and Merseyside Directors of Public Health in 2014 and was included as one of three prevention priorities.

NICE guidelines outline best practice for the management of high BP. However, a baseline assessment across Cheshire and Merseyside showed that practice knowledge of these guidelines was inconsistent. Improving practice performance against these guidelines has the potential to significantly reduce incidences of strokes, heart attacks and failure, and prevent 96 deaths over 5 years. Financially, savings of £7-8.2 million (net discounted) from an investment of £500,000 (per annum) could also be made over the same period. The Blood Pressure Quality Improvement (BP QI) Package was developed to meet the strategic objectives of the regions' BP plans, which aim to bring these ambitions to fruition.

Building on insight from primary care workshops and NICE-led 'Ketso'* focus groups and online survey, the BP QI package was built with primarily Practice Nurses (PNs) and Health Care Assistants (HCA) in mind, given that feedback suggests they have the most patient contact with regard to BP. Patient information (in order to support self-care) and a need for accessible consultation templates, protocols, training and audit-support were identified as crucial to the success of the package in practice. The package was co-developed and implemented by the British Heart Foundation (BHF) and local practice, with Champs Public Health Collaborative in support. The package includes an Emis Web-based template, practice-level data dashboard/audit tool, a 'Gold Standard' practice protocol and patient information prescription, which is supplemented by training support. The template is designed to be intuitive, focused on lifestyle factors and promote good practice whilst providing support to the practitioner through guidance (e.g. red flags) and supporting documents. This is further supported by a patient information prescription (a resource for

patients which, as well as documenting their current and target BP, encourages medication and lifestyle concordance) and an education package for practitioners. The dashboard, also developed with support from NICE, benchmarks practices against NICE quality standards and allows for the practices' BP progress over time to be measured.

Implementation of the BP QI package was gradual. As of January 2018, nine early adopting practices had been established across Knowsley, South Sefton and Liverpool and West Cheshire Clinical Commissioning Groups (CCGs) with three practices agreeing to take part in a more detailed evaluation. Each practice has received one-to-one support from BHF.

Champs Public Health Collaborative, BHF, the Cheshire and Merseyside General Practice Nursing Collaborative and the Cheshire and Merseyside Blood Pressure Partnership Board were looking to gather insight from the early adopting practices to understand early learning and inform any refinements/ adjustments needed to optimise use of the BP QI at practice level. Champs approached Hitch to conduct the research for this project, with the insights serving to inform the recommendations that will optimise the BP QI package for upscaling across Cheshire and Merseyside, and potentially nationally. The research, conducted by Hitch's behavioural insight team, is presented in this report.

* 'Ketso' is a hands-on kit for creative engagement which aims to ensure each participant is able to contribute.

[1] www.nice.org.uk/guidance/qs28/chapter/Introduction-and-overview

[2] www.nhs.uk/conditions/cardiovascular-disease/

[3] www.nice.org.uk/sharedlearning/a-quality-improvement-package-for-high-blood-pressure-bp-management-in-general-practice-part-of-a-systems-leadership-approach-to-tackling-high-bp-in-cheshire-and-merseyside

02. Methodology

Two main approaches were initially designed to undertake this research: secondary desk research and face-to-face qualitative interviews. Following attempted engagement with GP practices one group requested the use of an online survey.

Hitch's behavioural insight team conducted extensive desk research, which included a review of the project history to date, including survey and workshop outcomes. This served to inform the insight work generally, as well as, the research materials produced. The steering group for the project ensured that the appropriate individuals were selected for participation at every stage of the research. Throughout, where an individual had experience with both the template and the dashboard, both were discussed in the interviews. For those who only had experience with the template, that was the sole focus of the discussion.

Detailed discussion guides were produced for the first aspect of the research, which involved conducting four face-to-face, semi-structured interviews with clinical staff from two practices in South Sefton and Knowsley CCGs. Across the two practices, the following individuals participated:

- **Two PNs;**
- **One HCA; and**
- **One Assistant Practitioner (AP).**

These interviews were recorded with the permission of all those who participated, the audio from which was then reviewed for analysis.

As one practice in Liverpool CCG was unavailable for interviewing, an online survey was created and distributed via email to the relevant individuals. The focus of the survey was to assess experience with the package in an effective but succinct manner. The survey was predominantly quantitative, with two open-ended questions that would allow those who participated to detail their experiences further. Two responses were received, from a General Practitioner (GP) and Practice Manager (PM). This data was then collated and analysed accordingly.

The third phase of the research involved returning to the South Sefton practice to interview their PN and HCA for a second time, in order to garner insights regarding the progress of updates to the template that had been implemented in the subsequent months since the first interviews were conducted. Another discussion guide was produced to inform this process. This interview was then reviewed and analysed thematically, along with the data from the first two stages.

03. Results

The main outcomes from all stages of the primary research (the online survey and face-to-face interviews) are presented below. Please note that these findings are supplemented by insight from practice based guided discussions, provided by the BHF.

ONLINE SURVEY

Two responses to the online survey were received from a GP and PM at the participating practice in Liverpool. Unfortunately, engagement in this element of the research was limited, with little time appearing to be committed to completing the survey. What information was gathered from this phase of the research is summarised below. Please note that, as a result of limited engagement by the practice and a sample size (n=2), and little to no qualitative data to support answers given, caution should be exercised when interpreting these results.

Both participants agreed that problems with patients BP was a definite issue for this practice. Overall, the face-to-face support received as part of the training was rated as helpful/somewhat helpful, and peer support forums and webinars were considered to be useful sources of support going forward. For the GP, the template was considered relatively easy to use in practice (rated 3 on a scale of 1-10, with 1 being very easy and 10 not at all easy) and has had a somewhat positive impact on their practice's management of BP (rated 4 on a scale of 1-10, with 1 being positive).

In terms of how the package has influenced their work, the response received was that it has 'improved recording of ambulatory and home BP monitoring' and that the system assists in helping patients set BP lifestyle targets well. By contrast, the PM rated the template difficult to use (9 on the 10-point scale) and found the level of information within the package 'mid-table'. The impact which the package has had on the work of this practice was considered neither positive nor negative (5 on a scale of 1-10) and how the dashboard can be used to identify 'case finding' patients is still being considered. However, there was a recognition that the system has led their practice to review how they highlight stage 1 hypertension, which is positive. In terms of improvements, this respondent felt that 'stricter criteria on the case-finding list (would be) less overwhelming for practices'.

Given the limited qualitative data provided to explain the results from this survey, it would be useful for any further evaluations if this practice could be encouraged to engaged more fully and, if possible, face-to-face. It may be that a financial incentive may be required to support this.

FACE-TO-FACE INTERVIEWS

There was some variation in the prevalence of high BP across the two practices, as well as in patients' compliance with regard to their treatment. A high level of comorbidity in patients was reported by all those interviewed.

In both practices, the HCA and AP are the clinical staff members who run the BP reviews, with the PN and GP being involved with BP patients at the treatment plan and medication level.

All those interviewed were hoping that the BP QI would give structure to their consultations, as well as lifestyle-driven guidance and hints and reminders all in one place. There was also a hope from the Knowsley practice that the template would assist in standardising guidelines across their practice.

Although, as a result of their different roles, there was variation in the manner by which the participants used the template, feedback from all participants regarding the package was very positive. For those who used it regularly, it was considered an intuitive addition to their consultation processes: one that was comprehensive, easy to use and pitched at the right level for all users and one which met, if not exceeded, their expectations.

Participants noted that the level of detail the BP QI provides far surpasses their experience with other templates, yet the similarity in design to other systems was reassuring. Furthermore, the prompts and red flags were considered especially helpful by both the HCA and AP. For the HCA, the template has transformed their consultations by increasing their confidence when interacting with patients, particularly with regard to BP target setting and the relevant lifestyle prompts. The AP felt that, although the template hasn't changed how they conduct their consultations, it has provided invaluable guidance (particularly regarding next steps) in a familiar configuration which has thereby increased their confidence and saved valuable time. Uptake of the patient information prescriptions has been good for all, which in turn has helped patients take responsibility of their own BP (due, in a large part, to the action plan element).

For the practice nurses, the familiarity of the design of the template was also reassuring and they felt it would be to other nurses too. In the Knowsley practice, being able to explain to a patient 'what you are doing while you're doing it', rather than simply instructing them to do something will mean that they are more likely to adapt to it; the template assists greatly in this. It was reported often that the template has helped patients to take ownership of their BP. For the PN at the Sefton practice, being able to 'dip in' and out of the template (to the specific pages needed for particular quick codes (e.g. ECG result, refer to optician etc.) when diagnosing patients (as well as coding home BP results) has had a positive impact on their role. For all, the feedback illustrates that the template works around and adopts to each practitioner and their own consultation style.

Neither PN had participated in the initial training (nor did they feel that they would have the protected time available to utilise any additional sources of support in the future)

but felt that younger nurses, HCAs and APs would. One of the PN nurses had, however, given feedback to the template developers in the early stages of implementation and reported that good, regular communication was ongoing, and their suggestions were being incorporated.

Both the HCA and AP found the initial training valuable in helping them to feel comfortable with the template. Participants also commented that those conducting the training were experienced and approachable. Neither felt that any additional face-to-face support was necessary, although others may find links to support directly accessible from the relevant element of the template helpful. Being able to access the support directly from/within the template would be more time efficient as 'lots of resources are fantastic but you also have to know how to find them, which is very time consuming'.

Whilst all those who participated were pleased with the BP QI package and the impact it had had on both their own consultations and their respective practices, a few suggested refinements emerged from the research that participants felt would optimise the package going forward. These refinements are presented in Table 1 below.

With regard to NICE hypertension guideline compliance, the practice in Sefton already diagnoses, but not necessarily treats, hypertension at NICE guideline levels and so there has been no contention within the practice from BP QI guidelines and existing diagnostic levels. Practitioners generally, however, do not tend to think of hypertension in terms of stages. There has been no contention for the Knowsley practice either, although there was an acknowledgement that, while most within the practice align with NICE guidelines, the focus is on the individual and their circumstances and therefore there is some flexibility in their diagnostic levels. Whilst the BP QI does highlight stage 1 hypertension in a way which is, potentially, different to early adopting practices' previous systems, little resistance to this change was recorded across all interviews. In fact, it was reported that this allowed both practices to code stage 1 hypertension for the first time, which in turn has benefited patients and been valuable in regard to organising patient data. All participants found the data generated by the template to be reliable and accurate.

With regard to the data element of the package, only the PN at the Sefton practice had experience with the dashboard which was, admittedly, limited. This was because, although the PN did acknowledge that it is a useful resource, they had very little protected time with which to explore it in detail. Furthermore, the amount of information was considered overwhelming and, owing to having received no training on how to use it, the PN felt unequipped to handle the data correctly.

Table 1: Suggested refinements to the BP QI package

SUGGESTED REFINEMENT	DETAILS
Additional codes:	'Patient chosen to monitor BP at home' as currently only available option is for 'monitor loaned' (NB: including code as 'advised patient to monitor…' may lead to exclusion for patients in areas of social deprivation);
	'Patient reading high as a result of circumstance' (because of rushing to their appointment or missing their medication the previous day etc);
	'No relevant family history' (currently no option for this so have to leave empty);
	'Urine ACR test completed';
	'Leaflet(s) distributed' (see last section);
	Adding 'family history' to the 'hypertension monitoring' page as it is currently on the diagnostic page which the HCA doesn't use.
Additional prompts:	To advise APs/HCAs to bring their home BP monitors to the practice to be calibrated and checked;
	To remind patients not to measure with wrist monitors.
Expansion of the package to include:	Diabetes, cholesterol management, CVD and atrial fibrillation. Although this would a large template, it was felt that this would reduce the risk of one template being completed and not another (NB: participants reported that in Sefton, CVD management has been removed from primary care).
Links:	Direct links from the template to short videos which explain BP management to patients;
	Links to both local and national initiatives.
GPAC:	One participant commented that a more nuanced means of assessing a patient's physical activity (which is representative of all ages) would improve their consultations.
Training:	The dashboard.
Printable leaflets:	Participants felt that information on the following would be valuable for patients given that in-consultation information retention can be poor:
	Low salt diet;
	Low fat diet;
	Alcohol unit guidance;
	Active lifestyle recommendations.

There was also a certain amount of ambiguity surrounding the dashboard in that this practice was unaware of how the data is run and how or if this data will be re-run (they only had access to data from October 2017). There was some confusion expressed as to why the dashboard stated that the practice had made no ECG referrals and concern; it was felt that there may be a coding error as the practice does in fact frequently make these referrals (this had not been reported).

SEFTON FOLLOW-UP

The third phase of the research involved returning to the Sefton early adopting practice to interview their PN and HCA regarding the updates to the template which had been implemented in the time since their first interview. At this point in the research, both participants had been using the template for approximately one year.

To the knowledge of both participants, although aware that they are currently using version two of the template, there had not been any noticeable updates in the five months since last being interviewed. However, aside from a few minor adjustments, both felt that the template is more than satisfactory in its present condition and should remain unchanged. Please note that any suggested refinements emerging from this interview are also included in Table 1 above.

Both continued to be extremely pleased with the template, which was still regarded as a valuable addition to both their consultations and the practice generally. Whilst there was an acknowledgement that the template seemed to contain an overwhelming amount of information initially, the familiarity both have fostered with the system over the preceding year has greatly increased their confidence in putting this information into practice.

Being able to access a list of all patients, their last BP readings and where they are compared to NICE targets is helpful (the time with which to utilise this was, however, a concern), as is the capability to track the practices' BP progress over time. In order to maximise this element of the package, full training/ advise available for PNs and PMs needs to be provided, as well as more information as to how the data is processed (they would like an automated version sent monthly) and the potential to fully integrate it on to their system in order that it could also be run by the practices. They would also like a hypertension tab to be added in order that a list of patients requiring treatment be available.

04. Conclusions

The BP QI package was generally considered to be a valuable resource that requires only a few adjustments in order for maximal uptake to be achieved as the package is implemented across Cheshire and Merseyside.

The research shows that familiar style of the template has the potential to reassure future users, with the level of detail affording confidence in consultation scenarios, particularly for HCAs. Training should emphasise the benefits of the patient prescriptions and their value for both practitioners and patients, as well as expanding to cover the dashboard element of the package.

With a few minor adjustments and refinements, the BP QI has the potential to significantly improve hypertension management to NICE guidelines and improve the consultation experience for those on the front-line of BP management at practice-level. This in turn would enhance patient's treatment experience, empower them to manage their BP effectively and, ultimately result in, improved health outcomes.

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