IMPERIAL COLLEGE HEALTH PARTNERS

Hypertension Management in Primary Care

Thursday 6th March 2025
12:00 – 13:30

Housekeeping:

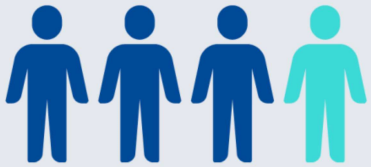
- Please remain on mute and with camera off unless speaking
- Questions? Enter into the chat, or, during our Q&A section at 12:50 using ‘raise hand’ function
- Please note we will be recording this meeting

Agenda: Hypertension Management in Primary Care

Agenda Item	Speaker	Time (mins)
Welcome & Introduction	**Dr Mohammed Haidar**, NWL ICS Clinical Lead for Cardiovascular Disease and Renal	5
Patient Experience	**Paul Quinn,** Lived Experience Partner	5
Hypertension in Focus: National, Regional & North London Updates	**Dr Neil Chapman**, Imperial College Health Trust, Clinical lead hypertension and cardiovascular disease prevention.	10
Enhancing Community Engagement	**June Farquharson,** NWL ICS Associate Director – Health Equity	10
Utilisation of Community Pharmacy	**Sonali Patel**, NWL ICS Medicines Management & Pharmacy First	10
MyHealthLondon: CVD & Hypertension	**Nithan Chandrakumar,** NWL ICS Digital Campaign Manager **John Shanko,** NWL ICS Project Officer	10
Q&A	Facilitated by ICHP	10
Sharing Via Break Out Rooms	Moderated by ICHP	25
Wrap Up and Close	**Dr Mohammed Haidar**	5

Why are we here today? The urgency of Hypertension

Hypertension is the leading cause of death worldwide a key focus in the **NHS Long Term Plan,** with an aim to prevent cardiovascular diseases by early identification and better management of high-risk conditions like high blood pressure. It's also a highlighted clinical area in the **CORE20PLUS5.**



Affects
1 in 4 adults

300K+

people in NWL with hypertension

People with undiagnosed hypertension likely DOUBLE that

Responsible for 54% of Strokes globally + 47% of Ischemic heart events

Health inequalities are evident, with **Black and Black British populations** facing a higher risk due to genetic and social factors, while **lower socioeconomic groups** experience increased vulnerability and higher mortality rates compared to more affluent populations.

Hypertension in NWL : A Collaborative Approach

As a programme team, we aim to **enhance collaborative relationships** with key stakeholders across community services, public health, and primary and secondary care.

This strategic approach allows us to optimise resource utilisation, minimise duplication, and alleviate system pressures, ultimately leading to **improved patient outcomes.**

Working closely in collaboration with:

- People with lived experience
- Health Innovation Networks
- North London ODN
- Health Equity
- Meds Management
- Community Pharmacy
- Primary Care
- Boroughs
- Personalisation
- & many more

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Patient Experience

Paul Quinn
Lived Experience Partner

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NHS North London Cardiac Operational Delivery Network

Hypertension in Focus: National, Regional & North London Updates

Dr Neil Chapman
Imperial College Health Trust,
Clinical lead hypertension and cardiovascular disease prevention.

NL HTN Working Group

NHS North London Cardiac Operational Delivery Network

- 👤 **Chair:** Dr Neil Chapman
  🤝 **Who We Are:** Healthcare professionals from primary care, secondary care, and community pharmacy across London.
- **Our Mission**
  - ✓ Share best practices
  - ✓ Develop clear guidelines and pathways where needed
  - ✓ Support all 5 London ICBs in improving hypertension care
- **Key Focus Areas**
  - 🔄 **End to end pathway**– Ensuring seamless, integrated hypertension management from early detection to long-term care, reducing gaps in treatment and improving patient outcomes.
  - 🩺 **BP@Home** – Supporting home blood pressure monitoring in secondary care
  - 🔍 **Secondary Screening** – Identifying and managing high-risk patients
  - 📌 **Advice & Guidance** – Helping clinicians with expert input
  - 🚨 **Severe Hypertension** – Improving management in A&E and the community

Objectives of presentation

NHS North London Cardiac Operational Delivery Network

- To provide **national updates** relating to hypertension:
  - NHS operating planning guidance
  - Recommendations from CVDPREVENT

- To provide North London updates:
  - CVD prevention priorities and how NWL is **tracking**
  - Increase **awareness** of the Network's purpose and the role of the North London Hypertension Working Group
  - To promote our new **Future NHS webpage** which aims to:
    - Share **best practice**, **guidelines** and **pathways** where there is an unmet need, across the 5 London ICBs and beyond
    - Promote **collaboration** across healthcare providers; primary care and secondary care
  - To share our new best practice guidelines for **severe hypertension**, promoting consistent practice across the community– further updates made since Sep 2024 webinar.

National: 1) NHS Operating Guidance 2) CVDPREVENT

Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

Source: [2025/26 priorities and operational planning guidance]

Recommendations (2)

CVDPREVENT

3. **ICBs should maintain blood pressure treatment to target as a key priority**, in line with the NHS England objective in the 2024/25 Priorities and Operational Planning Guidance. They should **focus on addressing unwarranted variation** between PCNs and GP practices **and prioritising patients with the highest blood pressures first** as these are at the highest risk of CVD events *(key findings 1,3)*.
   3. According to Size of the Prize, treating an additional 745,740 patients to reach an 80% achievement in England will prevent an estimated 4,475 heart attacks and 6,678 strokes saving over £125 million for the NHS in the next two years.
4. **ICBs should address health inequalities in CVD prevention within their local population** considering specifically, blood pressure control in the younger working age group *(key finding 2)*, LLTs in females and people of black or mixed ethnicity *(key finding 7)*, and those in the most deprived quintiles *(key finding 4)*.
5. **NHS England and Department for Health and Social Care should tailor future national ambitions** taking into account potential growth in the detected prevalence of conditions and patient numbers alongside % achievement. This should factor in the growing scale of the ask on the NHS to manage these conditions and properly capture progress in delivery across the patient pathway

Office for Health Improvement & Disparities

8

Source: [CVDPREVENT January 2025 Webinar]

North London updates: CVD Prevention Priorities 24/25

25/26 priorities in development

What are we trying to achieve over the next 5 years?

North London ODN & ICB CVD Networks: Improve cardiovascular health for London residents
Prevention Subgroups: Improve detection and management of cardiovascular risk factors

North West London Integrated Care System
NHS North East London
NHS North London Cardiac Operational Delivery Network
North Central London Integrated Care System

	Aim	Objectives
Blood pressure	Improve detection of undiagnosed hypertension	• Detect 80% of the expected population with hypertension and, (data source: manual calculation to be provided by ICB: compare PHE/OHID modelling to actual detected prevalence on QOF/CVDPREVENT)
	Ensure those with hypertension are controlled to target	• Ensure 80% of patients aged 79 years or under, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading) by March 2025 (QOF HYP008 2023/24 / HYP003 2022/23)
		• Ensure 80% of patients aged 80 years or over, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (or equivalent home blood pressure reading) by March 2025 (QOF HYP009 2023/24 / HYP007 2022/23

*** Reduce unwanted variation across London by continuing to address health inequalities and deliver on the Core20PLUS5 approach***

Aims and objectives align with Cardiac Transformation Programme (CTP), National NHS Objectives 2024/25 and Quality Outcomes Framework (QOF) where applicable

North London updates: CVD Prevention Priorities 24/25

How will we track performance?

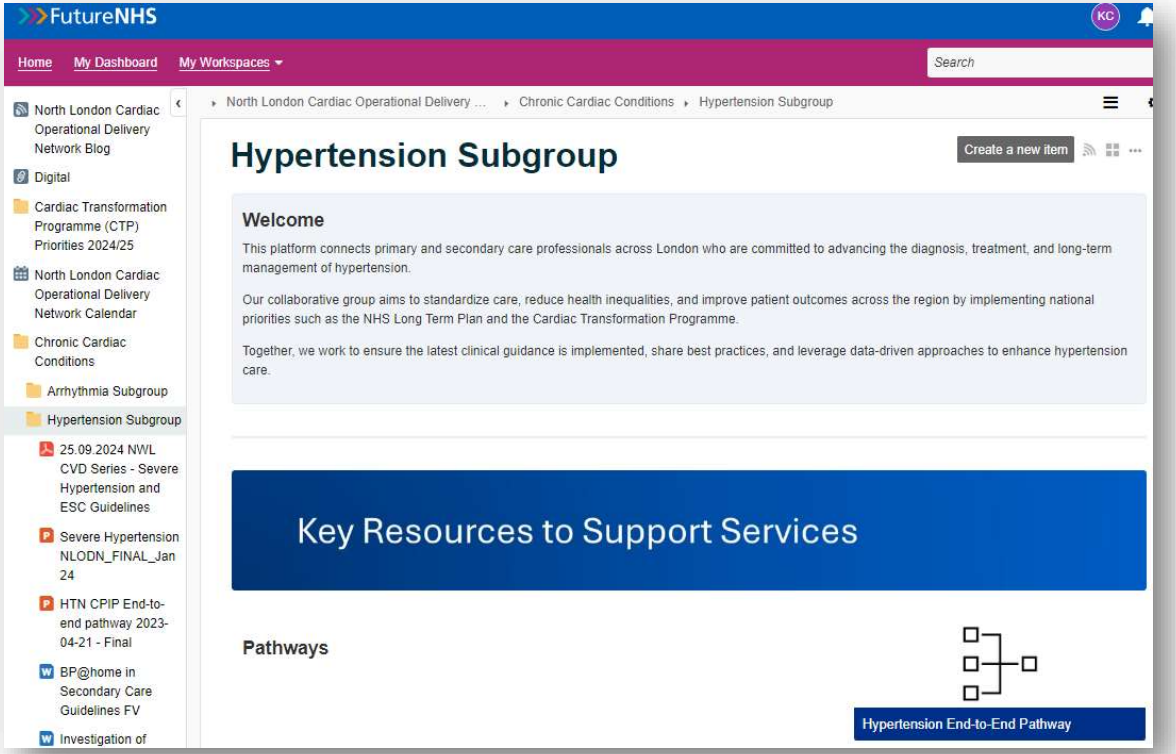
>10% under target <10% under target Meeting target Query figures

Data from CVDPREVENT (September 2024), QOF (2022/23), QOF	SEL	SWL	NEL	NCL	NWL
Detect 80% of the expected population with hypertension (?query data source: manual calculation: compare PHE/OHID modelling to actual detected prevalence on QOF/CVDPREVENT) CVD Prevent CVDP001HYP to September 2024: Prevalence of GP recorded hypertension in patients aged 18 and over. Figures do not correspond to the objective. Benchmarking: National average is 17.85%. NWL Data Dec 24: Detecting 61% of the expected population with hypertension (HT), falling short of the 80% target	13.86%	13.09%	13.02%	12.17%	13.6%
Ensure 80% of patients aged 79 years or under, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading) by March 2025 (QOF HYP008 2023/24) SEL, SWL, NCL not within 10% of target, NEL & NWL within 10% of target	66.7%	68.51%	71.28%	66.96%	74.05%
Ensure 80% of patients aged 80 years or over, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (or equivalent home blood pressure reading) by March 2025 (QOF HYP009 2023/24) All ICBs have met or are close to meeting target	79.91%	80.95%	81.88%	79.69%	85.25%

Join our Future NHS Workspace

Collaborate:

- Explore our new **FutureNHS Hypertension webpage** designed to share best practices, guidelines, and pathways across the five London ICBs.
- Tell us what additional resources would be useful—what would help you manage hypertension more effectively in the community



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Severe Hypertension

NHS North London Cardiac Operational Delivery Network

To be uploaded to Future NHS once finalised

180/120 mmHg or more

Assess for target organ damage as soon as possible:

- If target organ damage, consider starting drug treatment immediately without ABPM/HBPM
- If no target organ damage, confirm diagnosis by:
  - repeating clinic blood pressure measurement within 7 days, or
  - considering monitoring using ABPM/ HBPM and ensuring a clinical review within 7 days

Refer for same-day specialist review if:

- retinal haemorrhage or papilloedema (accelerated hypertension) or
- life-threatening symptoms or
- suspected pheochromocytoma

Severe Hypertension (HTN) in Community

See British & Irish Hypertension Society Guidelines *≥18 Only. Does NOT include management of HTN in Pregnancy

Severe HTN based on home blood pressure (BP) or measured in community services (e.g. pharmacy, community screening events) should be directed initially to the GP for review

BP ≥ 180/120 mmHg*

*Also termed Stage 3 HTN. Systolic ≥180 **and/or** diastolic ≥120 mmHg

Confirm BP

- Check cuff size (if too small may falsely overestimate BP and vice versa).
- **Measure 3 times consecutively** and repeat after 5-30 min depending on clinical condition.
- **Measure BP in both arms**

BP ≥ 180/120 mmHg

The BP cut-off used is arbitrary: treat the patient not just the BP!

BP < 180/120 mmHg

Assess for Life or Organ Threatening Signs or Symptoms:

May include:

- **New neurological symptoms:** Headache, visual disturbance, focal neurology, confusion
- **Cardiac:** Chest pain, shortness of breath, palpitations. Clinical findings suggestive of heart failure or ECG suggestive of ischaemia.
- **Symptoms suggestive of pheochromocytoma:** Sweating, flushing, abdominal pain, palpitations, pallor
- **Fundoscopy** for stage III/IV hypertensive retinopathy (haemorrhage or papilloedema) - *inability to perform immediately is not on its own a reason for same day referral*

NO concerning features present

Uncontrolled HTN

(Previously termed 'Hypertensive Urgency')

- As soon as possible screen for **target organ damage**; U&E, urine ACR, fundoscopy, ECG & CV risk assessment: Lipid profile and HB1AC
- If already treated, discuss **adherence**
- Consider **starting/escalating** therapy in-line with NICE guidance
- Review in ~**7 days** with repeat clinic BP and ideally HBPM/ABPM
- Provide **safety-netting** advice re symptoms
- Consider referral to **specialist HTN clinic** in line with NICE guidance
- If indicated, **do not delay** treatment for secondary screen

Concerning features present

Possible Hypertensive Emergency

- Same-day review in secondary care
- 999 if concerned re stroke, MI, aortic dissection, encephalopathy – otherwise refer to SDEC/ED

See page 2 for:

- Definitions
- Hypertensive Emergencies
- Malignant Hypertension
- Local Emergency Pathways and Specialist HTN clinic details

This guideline is intended to support decision making by trained clinicians and must be interpreted appropriately in the clinical context. It covers management for adult (non-pregnant) patients only. The authors are not responsible for clinical decision making in individual cases.

Severe Hypertension (HTN) in Community

DEFINITIONS

- **Severe HTN** (Stage 3 HTN) is a BP >180/120 **mmHg** that requires urgent assessment to determine if the patient has Uncontrolled HTN or a Hypertensive Emergency
- Uncontrolled HTN (Previously termed Hypertensive Urgency) is the presence of severe hypertension WITHOUT hypertension-mediated organ damage
- Hypertensive Emergency is defined as severe HTN with evidence of new OR worsening **hypertension-mediated organ damage**

These include:

- Acute coronary syndrome / angina
- Acute LV failure with pulmonary oedema
- Acute Aortic Syndromes
- Haemorrhagic & ischaemic stroke
- Encephalopathy & Posterior Reversible Encephalopathy Syndrome (PRES)
- Pregnancy-related syndromes
- Phaeochromocytoma crisis
- Malignant Hypertension (See separate box)

CAUSES (NOT EXHAUSTIVE)

- **Uncontrolled Essential Hypertension**
- **Pain / Agitation**
- **Drugs:** Sympathomimetics (e.g. Cocaine, amphetamine), OCP, alcohol withdrawal
- **Secondary Hypertension** (e.g. renal artery stenosis, Conn's, phaeochromocytoma)

MALIGNANT HYPERTENSION

A rare, distinct pathophysiological form of severe HTN with arteriolar damage in vascular beds.

Manifestations may include:

- **Fundoscopic changes:** flame haemorrhages (Grade III) and/or papilloedema (Grade IV). May be absent or unilateral.
- **Acute Kidney Injury** (If no baseline renal function assume an AKI rather than CKD)
- **Left ventricular (LV) strain +/- impaired function**
- **Brain microbleeds**
- **Thrombotic microangiopathy**

May present as isolated fundal signs (not considered an emergency) OR involving multiple organs which is considered a HTN emergency.

LOCAL EMERGENCY & SPECIALIST HTN SERVICES

- **Emergency pathway details (eg local SDEC)**

Specialist HTN clinic:

Consider referral if:

- ✓HTN & < 40 years old
- ✓Resistant HTN (3 agents, BP >140/90 mmHg)
- ✓Presented with Hypertensive Emergency
- ✓High clinical suspicion for secondary cause
- ✓Multiple drug intolerances

Local specialist clinic details: XXX

- On referral signpost patients to:

British and Irish Hypertension Society
British Heart Foundation
Blood Pressure UK

Delete prior to local implementation

This guideline has been approved by the Hypertension Working Group of the North London Cardiac Operational Delivery Network on XXXX. It can be accessed online at our Future NHS Site. [insert hyperlink]
It may be edited locally by individual ICBs and should be subjected to local approvals prior to implementation

What we ask of you

NHS
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Cardiac Operational Delivery Network

- **Collaborate:** Explore our new **FutureNHS Hypertension webpage** designed to share best practices, guidelines, and pathways across the five London ICBs. Tell us what additional resources would be useful—what would help you manage hypertension more effectively in the community

- **Engage:** Help us identify hypertension care gaps by completing a brief survey **(Link in chat or QR code).** Your feedback will help us measure our progress and adjust our strategies to meet our ambitious goals.

- **Join Us Again:** Keep an eye out for our next webinar in May to celebrate World Hypertension Day! We'll be sharing key insights, updates, and best practices to improve hypertension care across London

Contact us at: bartshealth.northlondoncardiacoperationaldeliverynet@nhs.net

What we ask of you - survey

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North London Cardiac Operational Delivery Network: Hypertension Questionnaire-Primary Care

https://forms.office.com/e/xs8E5FfTQ8

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Enhancing Community Engagement
Developing an In-Reach Model for Better Health Access

June Farquharson
NWL ICS Associate Director – Health Equity

A better approach to community in-reach will help support the delivery of our strategic objectives in Pillar 1 – particularly overcoming the trust barrier

1. Reducing healthcare inequalities
Understanding and addressing inequalities in access, experience and outcomes achieved by health and care services

2. Population health management building blocks
Put in place the building blocks of a population health approach – that will help us to reduce inequalities – across all of our work within the ICS

3. Partnership working on wider determinants
Work together with all of the partners in our ICS to improve social, environmental and healthy living factors that adversely affect health and wellbeing

Embedding a culture of tackling inequalities across the ICB

Embedding processes, cultures, and ways of working that tackle inequalities in everything that the ICB does, based on the Core20Plus5 framework

- Creating a robust set of **inequalities metrics and a dashboard** to enable tracking of progress in reducing inequalities
- Creating culture of **learning and sharing**, including the health equity summit, a systematic approach to gaining and sharing insights from communities, and the development of Core20Plus5 ambassadors
- Embedding inequalities in the **core processes** of the ICB, including commissioning and contracting –
- Using the impact of **Health Inequalities Transformation funding** to design and embed sustainable approaches to reducing inequity

Reducing healthcare inequalities in key focus conditions

Working with partners across the system and co-producing with communities to tackle specific inequalities in key clinical focus areas with a focus on specific communities who have a higher risk of morbidity and mortality. Immediate priority is black communities, but in later years will expand to other specific communities, including Plus groups

- Improving **maternity** experience and outcomes for black women (Aligned to Priority 7)
- Equitable and holistic approach for black men at increased risk of **prostate cancer** (Aligned to priority 8)
- More equitable approach to **mental health** for black men (Aligned to priority 4)
- Better identification and management of **hypertension** within black communities

Addressing cross-cutting barriers to equity in healthcare

Addressing cross-cutting barriers that impact on access to and experience of care

- Building **trust** with communities and approaches to reach communities where they are
- Increasing levels of **digital inclusion** to reduce access barriers
- Overcoming **barriers to leadership** so that the ICS workforce is reflective of the local population

Future projects include exploring the role of clear/accessible communication in reducing barriers

Population Health Management

- Upskilling system staff via the **PHM & Health Equity Academy** against 5 key PHM learning domains: Analytics, Engagement, Co-production, Leadership and Health Economics/Value-based Care
- **Aligning Resource to Need:** Mapping and analysis of activity and costs across the system, triangulated with demographics, geography and care setting data, to support decision making on system spend against need
- Delivering a NW London wide **evaluation framework** to support consistent tracking of impact/value
- Embedding PHM functions across delivery settings and organisational structures, starting with primary care (reactive, planned and preventative)
- Working with BI to embed a robust **intelligence function**, including linked data sets, in planning and delivery to enable data-driven decision making
- Embedding **research capacity** for inequalities in partnership with our academic institutions, creating a strong evidence base
- **Analytics:** Integration of population health data into operational ad strategic decision making, including cross-system needs analysis and Borough capacity

Promoting prevention and healthy living

Embedding a system wide approach to **prevention** and **healthy living**: embedding metrics, KPIs and governance in ICB programmes, identifying system roles and responsibilities and improving capability for promoting prevention by Making Every Contact Count, with a view to:

- Supporting **healthy behaviours** and the delivery of Long Term Plan prevention initiatives including **tobacco dependency and control** and a coordinated response to **tackling obesity**.
- Developing whole system approaches to **prevention for** immunisation and vaccination, oral health, and cancer screening – aligning public health and NHS services and re-thinking delivery approaches.

Tackling the wider determinants of health

Leading a whole system response to address the wider determinants of health, including:

- Creating **employment opportunities** for deprived communities and supporting people with health needs into work through e.g. SEND internships, interview schemes, apprenticeships and job fairs.
- Delivering **volunteering initiatives** to support our communities to build skills, find employment, address social isolation and build connected and supportive communities.
- Mitigating rising **cost of living**, including through co-locating social welfare advice in NHS services
- **Healthier homes**: reducing damp and mould and avoiding admissions due to unsuitable housing.
- Embedding **social value** into NHS procurement and using NHS assets for community benefit, including meeting spaces and warm hubs

Partnership with VCS organisations

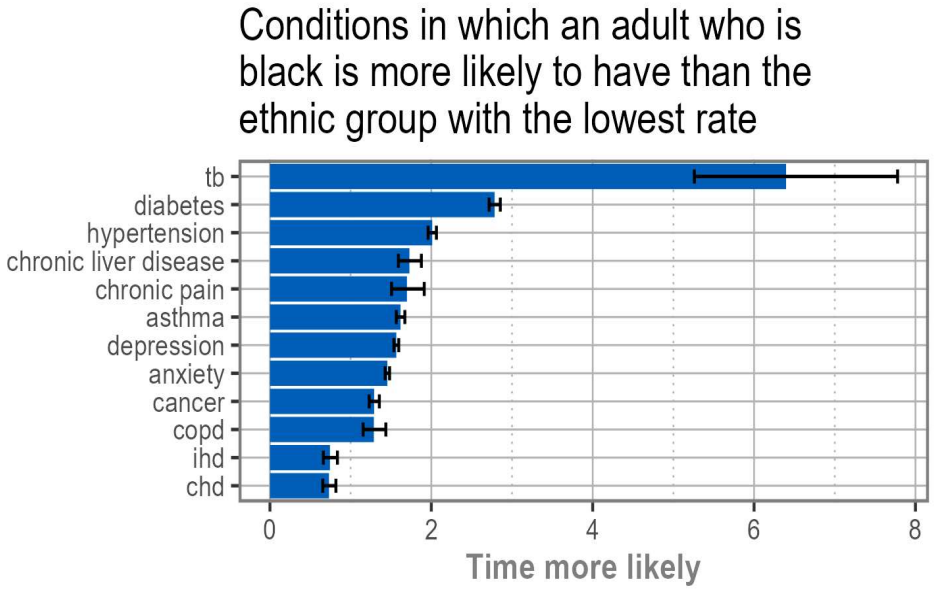
Building infrastructure to ensure **VCS organisations** inform and support health and care delivery across NW London; developing contracting and impact frameworks for smaller organisations.

Anchor institutions

Building effective partnership across our **Anchor institutions**, based around an Anchor Charter, to share best practice, build healthy, inclusive, workplaces and address the wider determinants of health for residents and employees.

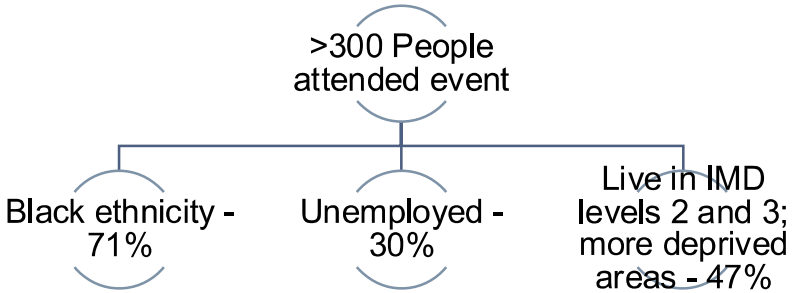
We know that people in our black and ethnic minority communities have higher levels of disease, often caused by poor access to and experience of services

- Evidence shows that those in the most deprived (Core20) communities are most likely to engage in health risk behaviour and in turn most likely to have a significant number of long term conditions. We also know that the black community makes up a greater percentage of these communities (23%) compared to the proportion in the rest of the North West London population (8%).
- Additionally, even when controlling for deprivation, age, gender and presence of a learning disability the black ethnic groups are the most likely to be obese and have hypertension compared to all other ethnic groups. Equally, when looking across multiple disease the black community are more likely to have the disease across all 12 diseases compared to the ethnic group with the lowest rate
- We also know that the cause is not always driven by prevalence of disease but by poor access and experience of services for our black and other BME communities, and that this is across the system including within maternity services, mental health services, and primary care.



Summary of outcome measures to date – Wembley

- The first event at Wembley stadium had a focus on specific Health priorities pertinent to the Black community (Hypertension, Maternity, Child obesity, unemployment and Mental Health).
- This was designed in response to people reporting that having someone who **understands your background and experiences** can help in healing trauma.
- Around 8 out of 10 (81%) of those who gave feedback, reported that they **learnt something new about their health** at the event
- Nearly 9 out of 10 (87%) of those who gave feedback, reported that they **felt better able to manage their health** after the event
- Attendees reported on the benefit of having **professionals in one place** that could support you in a range of areas such as debt, children, employment, health and rent.
- Attendees benefitted from the format of the event and fed back that the consultations didn't feel rushed and encouraged **open and honest conversations.**



Proposed hub approach

Model

- In-reach hubs within 5 boroughs
- **Incorporating** a range of health checks including blood pressure and diabetes
- Delivered in a way that people feel listened to, by trusted community organisations
- Within trusted local community venues on Saturday mornings

Deliverables

- Existing health conditions are identified earlier at these hubs and information passed to GP systems
- People have greater levels of trust in health services
- Build the sustainable model into local INT ecosystems.

Follow-up

- System learnin that support GPs engaging with individuals who have had health needs identified
- People come forward proactively and with confidence to use health services as needed as they are better informed
- People are more engaged and empowered with their health

Measureable Impact

- Fewer exacerbations as health needs have been picked up earlier
- Earlier identification of conditions
- Greater use of out of hospital services
- Fewer unplanned bed days
- Higher levels of activation
- Healthier lifestyles
- Lower prevalence of health conditions
- Longer term narrow the gap in life expenctancy

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Utilisation of Community Pharmacy

Exploring the role of community pharmacies in hypertension case-finding and management.

Sonali Patel
NWL ICS Medicines Management & Pharmacy First

NHS Hypertension case-finding service

On 9th May 2023, NHS England (NHSE) and Department of Health and Social Care (DHSC) published: Delivery plan for recovering a primary care.

The plan includes a commitment to increase provision of the community pharmacy services:

- NHS Hypertension case-finding Service
- NHS Pharmacy Contraception Service (PCS)

Additionally, the NHS England Network contract directed enhanced service Guidance for 2024/25 states the following under CVD prevention and diagnosis:

Primary Care Networks (PCNs) should be "working with partners, including community pharmacy, to proactively identify and manage CVD risk, through in particular the identification and management of hypertension and raised lipids, in line with national guidance and pathways."

1) Improve detection and management of CVD risk factors:

ensure processes are in place to support the exchange of information with community pharmacies, including a process for accepting and documenting referrals between community pharmacies and GP practices for the Community Pharmacy Blood Pressure Check Service

2) Improve the detection of hypertension:

undertake activity to improve the coverage of blood pressure checks including work pro-actively with community pharmacies to improve access to blood pressure checks

Providing the service- Patient eligibility

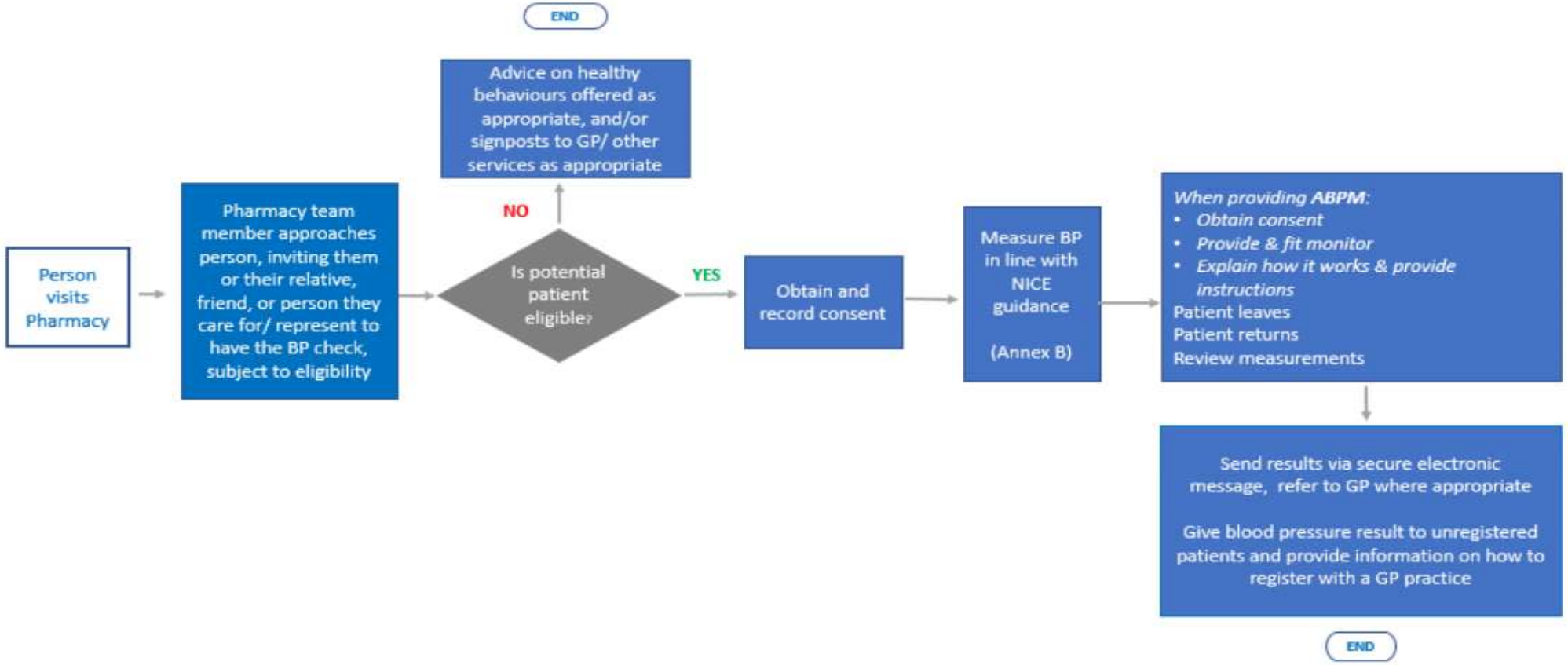
Inclusion criteria

- Adults ≥ 40 years with no diagnosis of hypertension
- By exception, < 40 years with family history of hypertension*
- Approached or self-requested 35-39 years old*
- Adults with or without a prior diagnosis of hypertension specified by a general practice (clinic and ambulatory blood pressure checks)

Exclusion criteria

- Under 40 years old unless at the discretion or specified by a general practice
- People who have their blood pressure regularly monitored by a healthcare professional
- People requiring daily blood pressure monitoring for any period of time
- People with a diagnosis of atrial fibrillation or history of irregular heartbeat

NHS England Blood pressure check process flowchart



General Practice referral process

General Practice:

- Can refer patients for both normal BP checks and ABPM
- Need a locally agreed process - there is no specific requirements for the process
- ABPM referrals ideally should be undertaken electronically
- Template referral form at: cpe.org.uk/hypertension

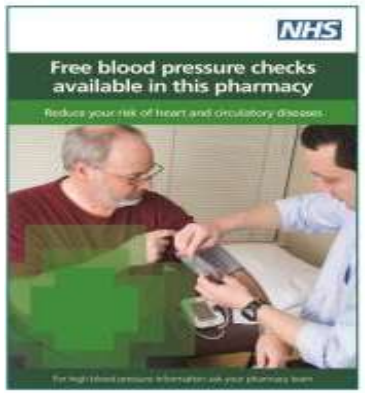
Community Pharmacy Hypertension Case-Finding Service – Referral form from GP practice to community pharmacy

To (pharmacy name)	
Patient name	
Address	
Patient DOB	NHS number
I am referring this patient to you for:	
• Their blood pressure to be measured (clinic check)	☐
• Ambulatory Blood Pressure Monitoring	☐
Additional comments	
GP name	
GP practice name and address	
Telephone	

Community pharmacies:

- Should engage with local general practices and/or PCN colleagues to make them aware of their participation in the service.
- All consultation results must be sent to patients registered general practices via NHSmail or another secure digital process (such as GP Connect).
- Urgent results require immediate communication with the general practice.

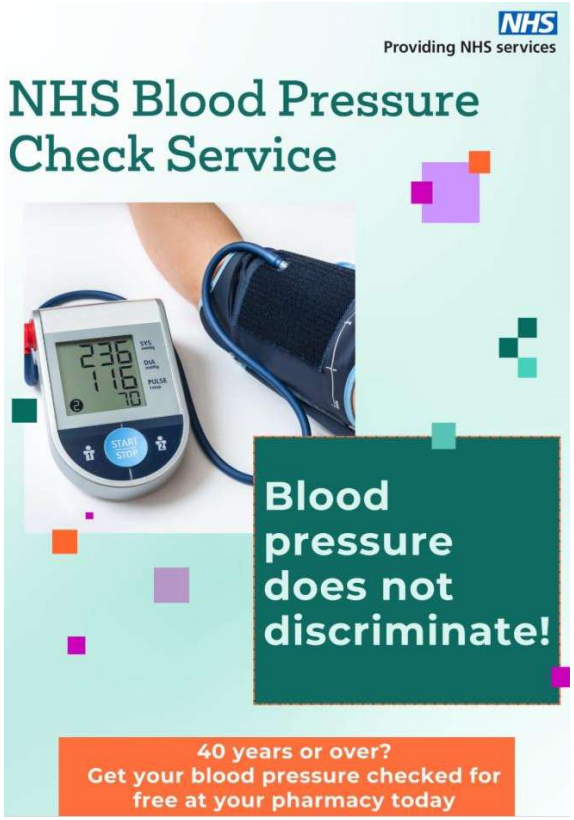
Promoting the service



Posters

Digital marketing

Blood pressure Service Finder



Community Pharmacy England

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MyHealthLondon
CVD & Hypertension

Nithan Chandrakumar
NWL ICS Digital Campaign Manager

John Shanko
NWL ICS Project Officer

MyHealth London | Background

My Health London (MHL) officially launched on **World Hypertension Day, 17th May,** to support people living with or at risk of Cardiovascular Disease (CVD) through self-management (potential to support **150,000 NW London residents**):

- MHL is a digital service in NW London that offers patients the opportunity to create an online account, via NHS Login, that provides access to multiple options to help improve their selfcare and live life to the full
- Intended to replicate for CVD what the Know Diabetes Service (KDS) delivers for diabetes:
  - ✓ 20% reduction in primary care consultations
  - ✓ improve patient outcomes in blood sugar and blood pressure
  - ✓ Account holders reflecting demographics of NWL, specifically ethnicity and deprivation in Q1,Q2,Q3.
- 38 GP practices signed up for initial patient onboarding

Building on success of Know Diabetes

- The NHS Know Diabetes digital health platform supports people living with diabetes, or at risk of type 2 diabetes, with self management.
- Open access information website and a database of NW London clinical health data that is used for digital health marketing
- Over 60,000 people have since created an account and are accessing:
  - Online personalised health record
  - QISMET-accredited eLearning courses
  - Behaviour change email campaigns
  - Interactive content and resources

A culturally tailored, person-centred platform

The comprehensive platform provides:

- ✓ Access to **curated information and structured education** covering hypertension, CVD, and related conditions.
- ✓ Guidance and tools for implementing lifestyle changes, including **culturally-tailored** meal plans and exercise support.
- ✓ Information on local programmes and support offers.
- ✓ **Person-centred communication** via email, delivering timely and relevant info aligned with **individual needs and preferences.**
- ✓ Access to latest readings via a personalised health dashboard.

MHL Features

Website

Read, listen, watch or interact with **hundreds of resources**, from meal plans to patients' stories.

Online Learning

Patients can now access **behaviour change and lifestyle courses online** and complete them at their own pace.

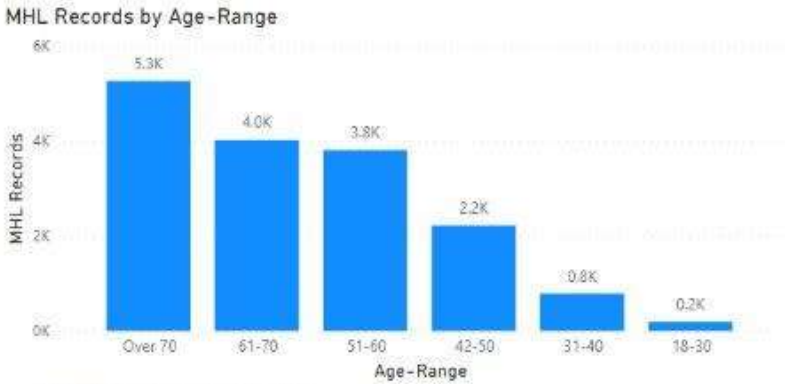
Email Campaigns

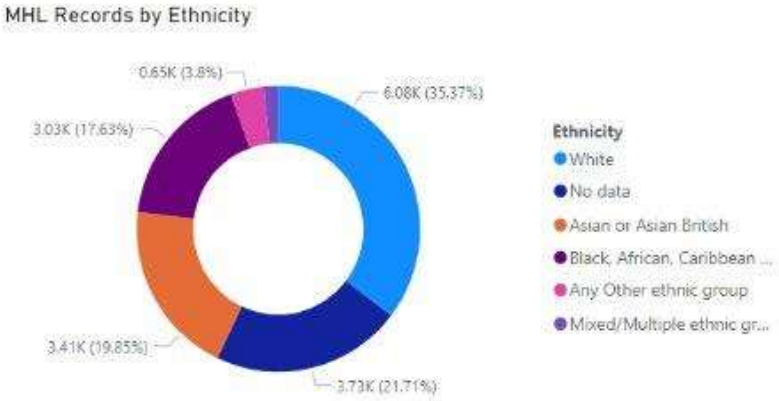
Tailored to personal needs and desires, covering topics such as **weight management, healthy eating, and well-being**.

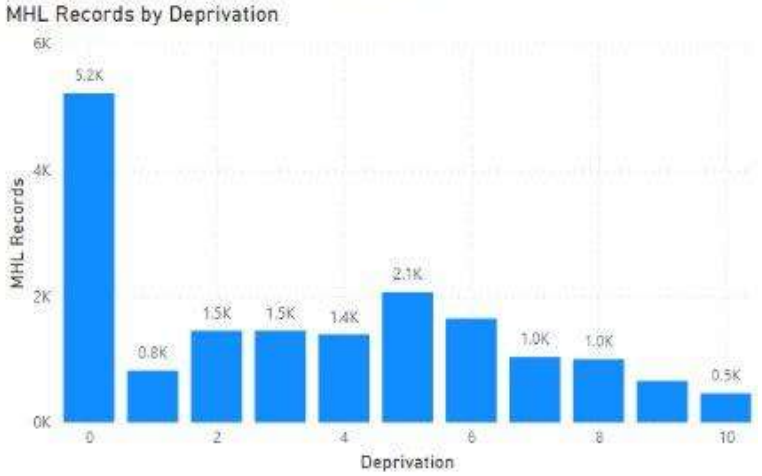
Health Record Access

Patients can view **their personalised health dashboard** with and get advice on how to improve their treatment target by setting goals and objectives.

Initial patient data integration

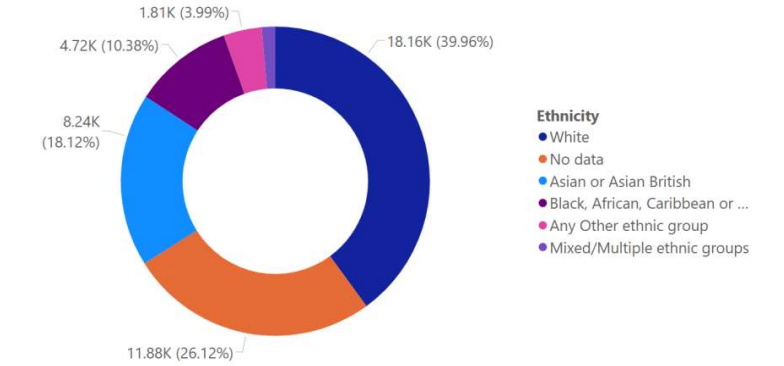


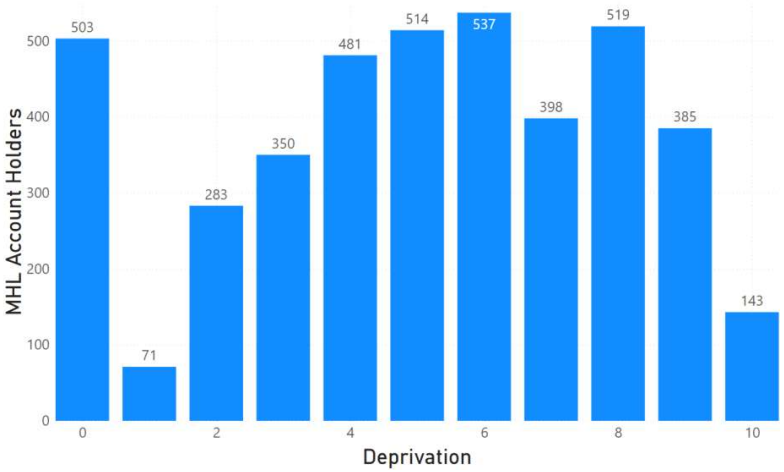


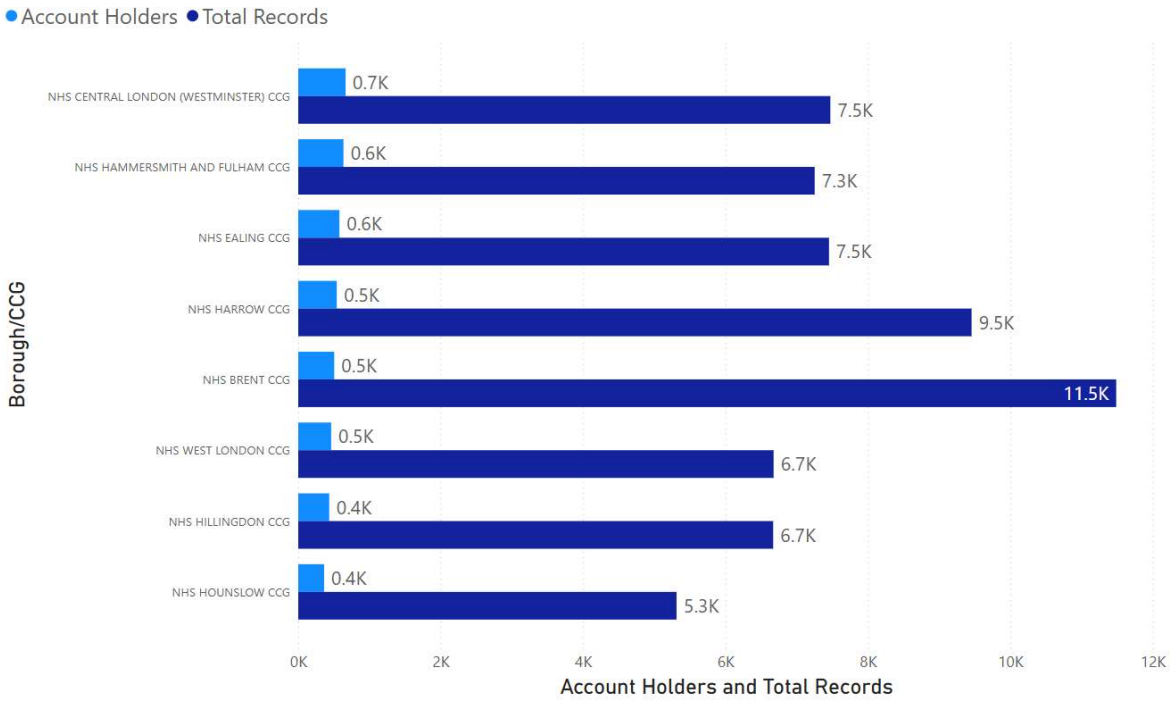


MHL account holders in CRM

61.77K
MHL Total Records







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NW London ICS supported by ICHP

Engage with the platform

Explore and share

Explore the platform via www.myhealthlondon.nhs.uk and share with your colleagues and patients.

Print our comms

We have developed a range of marketing assets, including both patient and HCP information leaflets, social media graphics, and QR posters: MyHealth London - comms pack

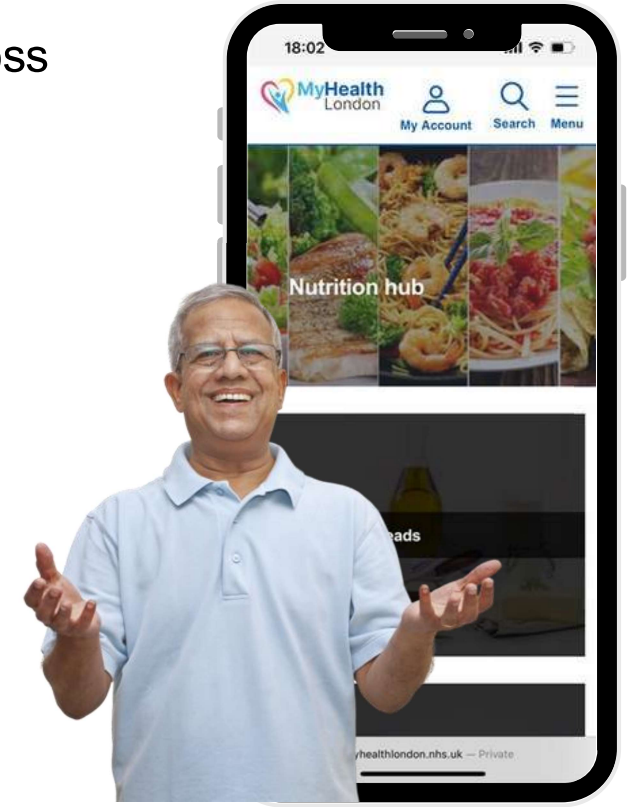
Give feedback

Please do give feedback on the site. We really want to ensure that it continues to meet the needs of patients.

Expression of Interest

There are currently more than **150 GP practices** onboard across NW London and we're now inviting all practices to sign up to provide patients with access to their personalised health dashboard. **To get involved:**

- **Fill in** in this expression of interest form here **or contact** Digital Programme Manager Ian Reddington i.reddington1@nhs.net.
- You will then be invited **to sign up** via the DCC (Data Controller Console).



IMPERIAL COLLEGE HEALTH PARTNERS

Q&A

IMPERIAL COLLEGE HEALTH PARTNERS

Breakout Rooms

To get involved in ICHP's CVD education series

Please provide feedback on what topics you think we should cover in this format by answering our survey.

CPD certificates can be provided following completion of the feedback survey.

Hypertension Management in Primary Care

For further information and/or to get involved with the ICHP CVD education series please contact: catherine.caldwell@imperialcollegehealthpartners.com

Resources

Please **click here** to visit the ICHP CVD webpage where we have collated clinical and patient resources for staff to access across NWL.

Past CVD Webinars can be accessed via the ICHP CVD Education Webpage

We have also linked the ICB Cardiology webpage, where future resources will be updated.