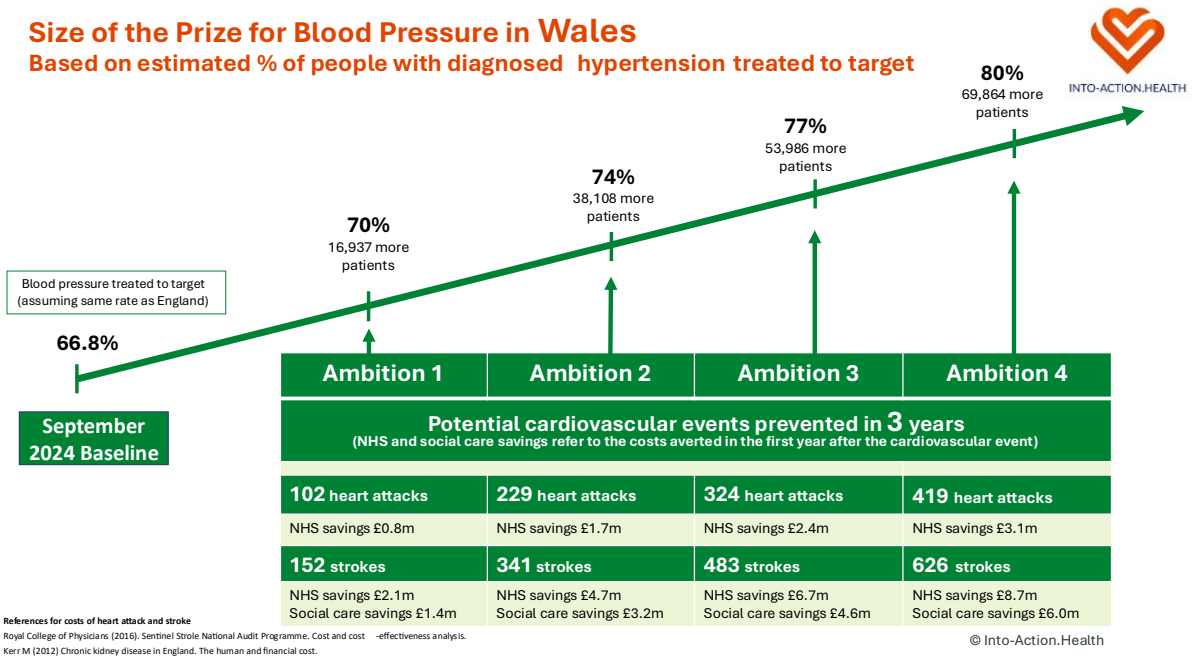
Practice guidance for CVD Prevention in People with High Blood Pressure QI project.

Year 2: 2026-27

Background

Cardiovascular disease (CVD) is one of the leading causes of death and disability in Wales and is a major contributor to health inequality. Chief Medical Officers across all UK nations advocate the beneficial effects of secondary prevention including risk-based advice and treatment of key CVD clinical risk factors. These key factors relate to **A**trial fibrillation, **B**lood pressure (hypertension), **C**holesterol, and **D**iabetes (**ABCD**). NICE guidance (NG136) recommend a holistic approach to CVD prevention which takes account of the person's life circumstances and includes support for healthy behaviours. The recently published CVD Prevention Plan for Wales: An ABCD Plus Approach details the importance of taking a person-centred approach to treating CVD risk factors.

The potential impact of optimising blood pressure in Wales: Size of the Prize



The model above shows the potential for preventing CVD events, such as heart attacks and strokes, as a result of optimising blood pressure. The model was developed prior to the start of the GMS QI Project CVD Prevention and at that time Welsh data, regarding hypertensive patients treated to target, was not available. Thus, England baseline data was used as a proxy, justified as the two countries have similar demographic and outcome data.

Early data from the first few months of year 1, of the GMS QIP CVD Prevention already shows progress, although the Wales baseline data is considerably lower than that in England.

The Primary Care Information Portal highlights that only 51.3% of hypertensive patients in Wales were treated to target in June (compared to 66.8% in England). However, by November an additional 15,900 patients with hypertension had been registered, and most importantly an additional 19,600 hypertensive patients in Wales had their blood pressure treated to target.

Year 2 Aims

The aims of the CVD QIP remain unchanged from Year 1:

The **primary aim** of this QI project is to improve mortality and morbidity associated with cardiovascular events through the enhanced detection and management of cardiovascular risk factors within the target population.

The **secondary aim** is to support Practices/ GMS collaboratives/ Health Boards to develop and evaluate service improvement projects so that learning from these interventions, can be shared and implemented by colleagues across Wales.

Target Population

Any person who is recorded on their GP record as having hypertension AND their most recent blood pressure reading is **≥**140/90 mmHg (people over 80 years **≥**150/90 mmHg).

Objectives

Year 2 Update:

The three options for CVD prevention for people with high blood pressure will remain unchanged from year 1. The extension of the project to 2 years allows practices to build upon the foundational work completed in year 1: identifying hypertensive patients and reviewing the practice recall system, prioritising highest risk patients first.

A further 12 months will enable practices to explore innovative ways to ensure recall systems are person-centred, with a focus on reducing inequalities within their practice population. And ensure each annual review takes an ABCD Plus approach to CVD risk modification. Practices are encouraged to maintain a quality improvement, rather than an 'audit' approach.

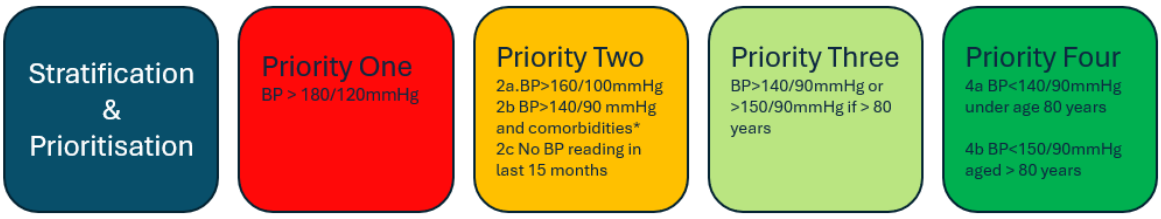
All practices should continue to demonstrate improvement from the options chosen in year one plus a minimum of one other option. If option 3 is not chosen practices should also consider ways to embed assessment of wider CVD risk using at least one element of the ABCD Plus approach detailed below.

Menu of Options for Quality Improvement Project Activity

1. **Increased identification of new patients** with a latest (within the last 15 months) blood pressure reading ≥140/90 mmHg (80 years+ **≥**150/90 mmHg), and review, further assess, and record for hypertension if indicated.

(You may wish to focus on high-risk patients such as those from ethnic minority groups as well as those from the most deprived segments of the practice population).

2. **Review of current annual hypertension recall and prioritisation process** aiming to improve patient response and attendance rates at their Annual Review, across the patient population to reduce health inequalities. Identify patients at highest risk and invite them for review and optimisation.



UCL Partners: Stratification and Management of High Blood Pressure

*Co-morbidities/ risk factors
• Established CVD (prior Stroke/TIA, heart disease, peripheral arterial disease) • Diabetes • eGFR <60 • Obesity with BMI > 35

3. **Enhancement of hypertension annual review**. Improvements in processes to treat and optimise CVD risk factors (**ABCD Plus**), including support for health behaviours, are to be actioned and recorded. This will require consideration of wider needs for people to engage e.g., culturally sensitive support, or difficulties being experienced e.g., in relation to housing, financial wellbeing, mental health etc.

   Within the Annual Review process follow an **ABCD Plus** approach (as described in the Background section above):

   i. Review hypertension medication, (taking into account polypharmacy and possible frailty).
   ii. Undertake manual pulse palpation to assess presence of atrial fibrillation.
   iii. Test for total and HDL cholesterol.

iv. Test for HbA1C as per NICE Guidance: NG28
v. Test for Urine albumin to creatinine ratio (ACR).
vi. Measure and record patient's weight and height.
vii. Assess CVD risk using appropriate tools such as QRISK and review and adjust CVD risk factor medication accordingly. (taking into account polypharmacy and possible frailty).
viii. Discuss health behaviours and signpost to support if available.[1]

Requirements of the QI Project

Practice Level:

• Practices will have a named QI Project lead clinician.

• Practices will use practice hypertension read codes, to collate baseline data detailing the number of patients with high blood pressure who are treated to target.

• Practices will collect data before and after any interventions (e.g., Using IHI Quality Improvement Methodology and by using searches and share any learning (whether positive or negative) within their practice teams, collaborative/clusters and more widely.

• Practices will complete a nationally agreed QI Poster for sharing at the final collaborative meeting before 31/3/2027 confirming conclusion of the project and highlighting outcomes achieved.

• Practices to adopt continuing QI methodology, including:

o Review baseline data, including the difference made to the baseline data from year 1 of the project

o Review of their processes

o Introduction of tested small cycles of change.

How to Improve | IHI - Institute for Healthcare Improvement

Dr Mike Evans: An Illustrated Look at Quality Improvement in Health Care (youtube.com)

• Practices to review progress at least quarterly.

[1] Further information to support practices in undertaking the project and suggested QI activity is available in the Public Health Wales guide: Supporting Healthy Behaviours: A Guide for General Practice.

• Practices will discuss their learning with their GMS collaborative. Minutes of this meeting should be submitted to health boards as confirmation that this discussion has taken place.

GMS Collaborative Level

• Practices to share aggregate practice-level data on the number of hypertensive patients treated to target.

• Practices to discuss accuracy of data and process for refinement.

• Discuss, share best practice, and consider adaptation of QI processes if applicable across collaborative.

• The GMS Collaborative lead should bring themes for discussion to the wider cluster professionals e.g., identification of hypertensive patients, uptake variation of Annual Reviews

• The GMS Collaborative or Cluster may consider introducing collaborative/cluster initiatives to benefit the delivery of improved interventions in identified behaviours.

• The GMS Collaborative or Cluster should escalate deficiencies in systems/services or suggestions for system-wide improvement to Pan Cluster Planning Group for consideration of improved commissioning or inclusion in IMTP process.

DHCW Level

• A definitive data set has been provided by DHCW to support this QIP, available as dashboards within audit plus.

All-Wales data is collated monthly and is visible via the Primary Care Information Portal. Primary Care Information Portal

Health Board Level

• Health Boards to ensure practice completion is verified against agreed indicators/contractual agreement via completion of a nationally agreed Poster shared at the collaborative meeting.

• Health Boards will collate the posters to allow thematic review at national level

Verification and achievement

Practices:

• Practices will need to demonstrate achievement of the objectives listed on page 2, by 31st March 2027, by completion of the nationally agreed QI Poster

shared and discussed with the collaborative and shared with the LHB. Minutes of the collaborative meeting should also be shared as evidence of the discussion.

• The contractor should ensure that the poster details both pre and post intervention data relating to hypertensive patients treated to target.

• The contractor should ensure that the poster states where the QI activity has resulted improved outcomes.

LHB:

• LHBs will be required to verify that practices have undertaken one or more of the options listed in the Menu of Options for Quality Improvement to confirm achievement and award payment.

• This will be done by reviewing each individual practice's nationally agreed QI Poster shared and discussed with the collaborative and shared with the LHB by 31st March 2027.