Community of Practice

Supporting General Practice post COVID-19 recovery:

Primary Care Support for Long Term Condition management

UCLPartners
May 2020
# Supporting General Practice post COVID-19 recovery Webinar

PCN Community of Practice

## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>6pm</td>
<td>Welcome and introductions</td>
<td>Mandeep Butt</td>
</tr>
<tr>
<td>6:05pm</td>
<td>Update on UCLPartners Primary Care Support Package</td>
<td>Dr Matt Kearney</td>
</tr>
<tr>
<td></td>
<td>Group discussion</td>
<td></td>
</tr>
<tr>
<td>6:25pm</td>
<td>Next steps: Hypertension and heart failure</td>
<td>Helen Williams</td>
</tr>
<tr>
<td></td>
<td>Community of Practice Poll</td>
<td>Mandeep Butt</td>
</tr>
<tr>
<td>6:40pm</td>
<td>Local case study: City and Hackney</td>
<td>Rita Shah and Sagal Hashi</td>
</tr>
<tr>
<td>6:55pm</td>
<td>Discussion and feedback</td>
<td>All</td>
</tr>
<tr>
<td>7pm</td>
<td>Close</td>
<td>Mandeep Butt</td>
</tr>
</tbody>
</table>
“LTC management is at risk of neglect during national emergencies”

But Recovery also offers major opportunity:

• To do things differently in primary care for the benefit of patients and clinicians
• To tackle variation in quality of care
• To target health inequalities
• To build capacity in the primary care workforce
A Framework for Optimising LTC Management and Self Management post COVID-19

• Digital technology will be at the heart of catalysing change
• But even transformative technology dropped alone into the system will not be enough to deliver sustainable change
• Transformation that deploys new technology will also need support for pathway change and for capacity building in workforce and patients to do things differently
• UCLPartners has modelled this approach for asthma, COPD, diabetes, high blood pressure and heart failure
• The UCLP framework and implementation support is now commencing roll out across North Central London and parts of North East London and Mid & South Essex
Principles underpinning this work

• Virtual by default

• Mobilising and supporting the wider workforce (including pharmacists, HCAs, other non-clinical staff)

• Step change in support for self-management

• Digital innovation including apps for self management and technology for remote monitoring
Primary Care Support package includes

1. Identification
   • Pre-defined searches with Sno-Med/Read codes
   • Virtual Training to undertake and access targeted searches

2. Stratification
   • Comprehensive stratification tools
   • Virtual training sessions on specific LTCs
   • Virtual clinical insight, where required

3. Management
   • Suggested pathways for local adaption
   • Detail as to staff types who can undertake interventions
   • Protocols for staff to follow informed by patient & public feedback
   • Virtual training sessions for different staff types with content adapted to the needs of the individual staff, e.g. HCA, clinical pharmacist

4. Enabling patient-self management
   • Self-management digital resources appraised and recommended
   • Support for implementation available
**The LTC Pathway – Asthma, COPD, Diabetes**

**Principles:**
- Virtual first
- Wider 1\(^{\circ}\) care workforce
- Step change in self management
- Digital technologies

**Identify**
Search for risk groups via health records

**Stratify**
Low risk
Medium risk
High risk

**Communicate**
Text/letter/call to let patient know they will hear from practice

**Management**
Match risk/need to professional role

**High Risk**
GP/specialist nurse/clinical pharmacist

**Medium Risk**
Nurse/clinical pharmacist

**Low risk**
Health Care Assistant

**Resources:** comprehensive search tools, protocols, scripts for HCAs, training, education, digital tools, project management, communities of practice uclpartners.com/work/support-for-long-term-conditions-during-the-covid-19-pandemic/
Conditions included:

- Asthma
- COPD
- Diabetes Type 2
- Cardiovascular Disease:
  - Hypertension and Heart Failure (in development), AF and high cholesterol

The following slides show indicative frameworks for stratification and management that can be adapted for local use depending on existing activity, workforce and pathways.
Asthma
1. Long Term Condition Pathway: Asthma

Identify & Stratify

Search tool identifies patients with asthma who are at higher risk of deterioration. These patients are then stratified into high, medium and low risk depending on clinical characteristics and Asthma Control Test™ score.

**Group 1 criteria**
- Any biologic therapy
- Frequent steroid therapy
- Frequent antibiotics
- Tiotropium
- Combination inhaler (LABA+ICS) at a high daily steroid dose
- ICS with:
  - Leukotriene Receptor Antagonist
  - Theophylline
- Plus individual patients where clinician concern

**Group 2 criteria**
- Exacerbation of asthma in last 12 months
- Prednisolone and/or antibiotics in last 12 months
- Asthma patients with 6+ issues of SABA per year
- Asthma patients on LABA but no corresponding issue of an inhaled corticosteroid (ICS) inhaler
- Asthma patients with 3+ issues of SABA in last 6 months with no corresponding issue of an inhaled corticosteroid (ICS) inhaler

**Group 3 criteria**
- Inhaled corticosteroids in last 6 months
- SABA in last 12 months

Asthma Control Test™ (ACT) to risk stratify

- Score <15: HIGH RISK
- Score 15-20: MEDIUM RISK
- Score 20-25: LOW RISK

*The Asthma Control Test™ provides a snapshot as to how well a person's asthma has been controlled over the last four weeks and is applicable to ages 12 years or older. Available here: [www.asthma.com/additional-resources/asthma-control-test.html](http://www.asthma.com/additional-resources/asthma-control-test.html)*

Phase for later review
### 1. Long Term Condition Pathway: Asthma

#### Manage

<table>
<thead>
<tr>
<th>Staff type to contact</th>
<th>High risk</th>
<th>Medium risk</th>
<th>Low risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GP/ Nurse specialist/ Specialist Respiratory Pharmacist</strong></td>
<td><strong>Clinical Pharmacist/ Practice nurse/ physician associate</strong></td>
<td><strong>Health Care Assistant</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td><strong>Intervention</strong></td>
<td><strong>Intervention</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Titrate therapy, if appropriate</td>
<td>• Check optimal therapy; Titrate, if appropriate</td>
<td>• Check inhaler usage &amp; technique; signpost to education; spacer advice</td>
<td></td>
</tr>
<tr>
<td>• Ensure action plan in place</td>
<td>• Review triggers, e.g. hay fever</td>
<td>• Exacerbation management advice inc. mild hayfever symptoms</td>
<td></td>
</tr>
<tr>
<td>• Check adherence, inhaler technique (video), spacer advice</td>
<td>• Check adherence, inhaler technique (video), spacer advice</td>
<td>• Signpost to appropriate information for: Lifestyle information/management of stress</td>
<td></td>
</tr>
<tr>
<td>• Rescue packs prescribed if necessary</td>
<td>• Exacerbation management advice</td>
<td>• Smoking cessation support</td>
<td></td>
</tr>
<tr>
<td>• Review of triggers, e.g. hay fever</td>
<td>• Repeat ACT as per recommendation from ACT test result and escalate to GP/Nurse if red or amber</td>
<td>• Exercise</td>
<td></td>
</tr>
<tr>
<td>• Exacerbation safety netting</td>
<td></td>
<td>• Appropriate resources</td>
<td></td>
</tr>
<tr>
<td>• Follow up and referral as indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Digital Support Tools to support patient self-management**

- **Inhaler Technique:** [www.asthma.org.uk/advice/inhaler-videos/](http://www.asthma.org.uk/advice/inhaler-videos/) | [www.rightbreathe.com](http://www.rightbreathe.com)
- **Asthma deterioration:** [www.asthma.org.uk/advice/manage-your-asthma/getting-worse/](http://www.asthma.org.uk/advice/manage-your-asthma/getting-worse/)
- **General Health Advice** [www.asthma.org.uk/advice/manage-your-asthma/adults/](http://www.asthma.org.uk/advice/manage-your-asthma/adults/)
COPD
2. Long Term Condition Pathway: COPD

1 Identify & 2 Stratify

Search tool identifies patients with COPD who are at higher risk of deterioration. These patients are then stratified into high, medium and low risk depending on clinical characteristics and COPD Assessment Test result.

**Group 1 criteria**
- Fev1 % predicted - <50%
- Cor pulmonale
- On home oxygen
- MRC grade 4-5
- Plus individual patients where clinician concern

**Group 2 criteria**
- Exacerbation of COPD in last year
- Antibiotics or prednisolone in last 12 months
- LABA+LAMA +ICS
- Prophylactic antibiotics for COPD
- Fev1 % predicted 50 - 80%
- MRC grade 1-3

**Group 3 criteria**
- all other patients with COPD

COPD Assessment Test* (CAT) score to risk stratify

- Score >20: HIGH RISK
- Score 10-20: MEDIUM RISK
- Score <10: LOW RISK

Phase for later review

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*The COPD Assessment Test (CAT) is a questionnaire for people with Chronic Obstructive Pulmonary Disease (COPD). It is designed to measure the impact of COPD on a person’s life, and how this changes over time. [www.catestonline.org/](http://www.catestonline.org/)
# 2. Long Term Condition Pathway: COPD

## 3 Manage

### High risk
- GP/ Nurse Specialist/ Specialist Respiratory Pharmacist
- Titrate therapy if appropriate
- Ensure action plan in place
- Check adherence & inhaler technique
- Spacer advice
- Rescue packs – prescribe if needed
- Exacerbation safety netting
- If MRC 4/5 - offer Pulmonary Rehab via video consultation /My COPD App

### Medium risk
- Nurse/ Clinical Pharmacist/ Physician Associate
- Check optimal therapy; titrate if appropriate
- Check adherence & inhaler technique (video)
- Spacer advice
- Exacerbation management advice
- Repeat CAT test at 4 weeks and escalate to GP/Nurse if red or amber

### Low risk
- Health Care Assistant
- Check medication compliance - regular inhaler usage. Signpost to education (video)
- Spacer advice
- Lifestyle info/ stress management/ exercise
- Smoking Cessation advice
- Exacerbation management advice
- Signpost to British Lung Foundation and other resources

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**Digital Support Tools to support patient self-management**

MyCOPD app offering patient information & education, inhaler technique, online pulmonary rehab classes, smoking cessation support, self-management plan.

Overview of COPD – diagnosis, treatment, and managing flare ups: [www.blf.org.uk/support-for-you/copd](http://www.blf.org.uk/support-for-you/copd)

Step-by-step guidance on physical activity: [https://movingmedicine.ac.uk/disease/copd/#start](https://movingmedicine.ac.uk/disease/copd/#start)
Type 2 Diabetes
Long Term Condition Pathway: Type 2 Diabetes

1 Identify & stratify

<table>
<thead>
<tr>
<th>Search criteria</th>
<th>Demographics</th>
<th>Social Determinants</th>
<th>Biochemical Markers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-Morbidity*</td>
<td>Age</td>
<td>Falls history</td>
<td>eGFR</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td></td>
<td>Housebound</td>
<td>HBA1c</td>
</tr>
<tr>
<td>BMI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Multifactorial Risk Stratification Tool produces a composite risk score
Version currently set out for EMIS with System One to follow

- High risk
- Medium risk
- Low risk

*Specific codes for frailty, foot disease and retinopathy will be added in version 2
### Long Term Condition Pathway: Type 2 Diabetes

#### Manage

<table>
<thead>
<tr>
<th>Staff type to contact</th>
<th>Intervention</th>
<th>Healthcare Assistants</th>
<th><strong>High risk</strong></th>
<th><strong>Medium risk</strong></th>
<th><strong>Low risk</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GP/Diabetes Specialist/ Nurse</strong></td>
<td><strong>Medication:</strong></td>
<td>adherence, titrate as appropriate</td>
<td><strong>Monitory</strong></td>
<td>Blood sugar control, Lipids/lipid lowering therapy, BP and proteinuria</td>
<td><strong>Education (inc online tools):</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Review &amp; Discuss Red flags:</strong></td>
<td>Vision: floaters/flashing lights, Feet/skin: pressure areas; virtual skin integrity check</td>
<td><strong>Review &amp; Discuss Red flags:</strong></td>
<td>Vision: floaters/flashing lights, Feet/skin: pressure areas; virtual skin integrity check</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Signposting and Escalation, Diabetes community + secondary care team/advice</td>
<td></td>
<td>Signposting and Escalation</td>
<td><strong>Recall &amp; Code</strong></td>
</tr>
</tbody>
</table>
Expert input
UCLPartners tested the Primary Care LTC approach with patient and public representatives via a virtual engagement session.

<table>
<thead>
<tr>
<th>Communication</th>
<th>Patients were concerned about not having regular communication with their usual GP but would be happy to hear from someone who was confident and consistent in their messaging &amp; who had access to their existing health information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic approach</td>
<td>Support offered needs to consider more than just the specific condition the individual is calling about but take into account and be responsive to the person's wider mental and physical wellbeing.</td>
</tr>
<tr>
<td>Trust</td>
<td>Patients raised concerns of fraud or breach of confidentiality when being contacted. They also wanted to have a single number/ named person to call if they needed support urgently.</td>
</tr>
</tbody>
</table>
Training and support package

**Search**
- Search tools
- Pre recorded webinar as to how to use the searches
- Online Q&A to troubleshoot challenges with delivery of the search tools

**Workforce training and capacity building**
- **Protocols** for contacting low, medium and high risk patient groups
- **HCA virtual training package**:
  - How to use the protocols
  - Basic introduction to specific long term conditions
  - Practical training e.g. inhaler technique, peak flow
  - Health Coaching
- **Clinical Pharmacist/ specialist nurse virtual training package**
  - Specialist information on each condition
  - Health coaching
- *can be adapted for different staff types

**Digital Support Tools**
- Evidenced-based, clinically selected digital tools identified to support with each pathway
- Implementation toolkits/ training as required
Thank you

For more information please contact:

Matt.kearney@uclpartners.com
Laura.boyd@uclpartners.com

www.uclpartners.com
@uclpartners
Post COVID-19 Recovery:
Hypertension and Heart Failure

Helen Williams
Consultant Pharmacist for CVD
Hypertension and Heart Failure Pathway in progress – available on the LTC webpage in the coming weeks
Thank you

For more information please contact

Helen Williams  helen.williams11@nhs.net

Consultant Pharmacist for CVD
Community of Practice Poll

We would appreciate if you take a minute to complete the poll – results to be shared at the end of the session.
Pharmacist Led Hypertension Review Project

Rita Shah, Project Pharmacist

Sagal Hashi, Joint Formulary Pharmacist
Aims and Objectives

Aim
To review and improve blood pressure in black patients (African or Afro-Caribbean origin) with uncontrolled hypertension (>140/90mmHg) through pharmacist led hypertension clinics.

Objectives
➢ Review and optimise antihypertensive medication
➢ Provide advice on lifestyle and nutrition
➢ Identify and understand reasons for poor adherence to antihypertensive medication
Method

Practice Support Pharmacists (PSPs) were tasked with setting up hypertension review clinics to review Black (African or Afro-Caribbean origin) patients with uncontrolled blood pressure.

<table>
<thead>
<tr>
<th>Search Criteria</th>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusion criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black (African or Afro-Caribbean origin) patients</td>
<td>Dementia</td>
<td></td>
</tr>
<tr>
<td>18 years of age or over</td>
<td>Palliative care patients</td>
<td></td>
</tr>
<tr>
<td>Last 2 blood pressure readings &gt; 140/90mmHg (in last 12 months)</td>
<td>Pregnant patients</td>
<td></td>
</tr>
<tr>
<td>Patients on one or more antihypertensive</td>
<td>Patients referred to CVD specialist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients recently diagnosed with hypertension (in last 6 months)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients with renal disease</td>
<td></td>
</tr>
</tbody>
</table>
Process for Hypertension Review Consultations

**Step 1**
Organise Hypertension Clinics
- Inform practices of hypertension review project.
- Undertake searches and identify **10 patients** for review.
- PSP to liaise with reception staff to book in 30 minute consultations.

**Step 2**
Initial Hypertension Review Clinic
- PSP to review patients in the hypertension clinic.
- PSP to meet with the GP for a debrief following each clinic.
- PSP to record changes made onto EMIS and complete the data collection form.

**Step 3**
Follow Up Clinic at 3 months
- PSP to follow up the patient in clinic after 3 months and follow the hypertension protocol.
- PSP to meet with the GP for a debrief following each appointment.
- PSP to record changes made onto EMIS and complete the data collection form.

**Step 4**
Follow Up at 6 months
- PSP to follow up the outcomes for each patient with the GP at 6 months.
- PSP to complete and submit the final data collection form.
- Data to be analysed and a formal evaluation of the hypertension project to be completed.
Pharmacist Led Consultation

**Initiating the consultation**

**Gathering information**
(using ICEF, TED, golden minute)

**Physical assessment**
Taking blood pressure and pulse

**Explanation and planning**
Suitable options for improving blood pressure control, including medication and improvements to lifestyle

**Closing the session**
Checking patient’s understanding
Providing a safety net
Follow up

Based on Calgary-Cambridge consultation framework
Number of Consultations

426 patients identified for a hypertension review

Initial hypertension consultation
253 patients were reviewed

Follow up consultation
117 patients were reviewed

60 patients not invited for follow up

168 patients were not reviewed

76 patients were not reviewed
The results showed that 91% of patients reviewed were either overweight (28%) or obese (63%).
# Adherence to antihypertensives

<table>
<thead>
<tr>
<th>Level of adherence to antihypertensive medication</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient takes medication as prescribed</td>
<td>132 (52%)</td>
</tr>
<tr>
<td>Patient takes antihypertensive most of the time</td>
<td>34 (13%)</td>
</tr>
<tr>
<td>Patient takes antihypertensive some of the time</td>
<td>37 (15%)</td>
</tr>
<tr>
<td>Patients has stopped one or more antihypertensives</td>
<td>41 (16%)</td>
</tr>
<tr>
<td>Patient not taking medication at the correct dose/frequency</td>
<td>9 (4%)</td>
</tr>
<tr>
<td>Total</td>
<td>253</td>
</tr>
</tbody>
</table>
Results

117 patients were reviewed for an initial and follow up consultation.

The change in blood pressure was recorded for 114 patients:

• 66 (56.4%) patients had a reduction in systolic blood pressure
• 44 (37.6%) patients had an increase in systolic blood pressure
• 4 (3.4%) patients had no change in systolic blood pressure
## Reduction in systolic bp

<table>
<thead>
<tr>
<th>Reduction in Systolic Blood Pressure</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10 mmHg</td>
<td>26</td>
</tr>
<tr>
<td>11-20 mmHg</td>
<td>11</td>
</tr>
<tr>
<td>21-30 mmHg</td>
<td>16</td>
</tr>
<tr>
<td>31-40 mmHg</td>
<td>7</td>
</tr>
<tr>
<td>41-50 mmHg</td>
<td>4</td>
</tr>
<tr>
<td>51-60 mmHg</td>
<td>1</td>
</tr>
<tr>
<td>121- 130 mmHg</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>66</strong></td>
</tr>
</tbody>
</table>
## Reduction in systolic and diastolic bp

<table>
<thead>
<tr>
<th>Stage of hypertension at initial consultation</th>
<th>Stage of hypertension at follow up consultation</th>
<th>No. Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stages 3</td>
<td>Stage 3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Stage 2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Stage 1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>&lt;140/90mmHg</td>
<td>1</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Stage 2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Stage 1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>&lt;140/90mmHg</td>
<td>14</td>
</tr>
<tr>
<td>Stage 1</td>
<td>Stage 1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>&lt;140/90mmHg</td>
<td>18</td>
</tr>
<tr>
<td>&lt;140/90mmHg</td>
<td>&lt;140/90mmHg</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Total</strong></td>
<td><strong>56</strong></td>
</tr>
</tbody>
</table>
Reasons for reduction in bp

Reasons for Blood Pressure Reduction

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence improved</td>
<td>36</td>
</tr>
<tr>
<td>Dose antihypertensive increased</td>
<td>12</td>
</tr>
<tr>
<td>Antihypertensive added or changed</td>
<td>6</td>
</tr>
<tr>
<td>Weight Loss</td>
<td>4</td>
</tr>
</tbody>
</table>
## Increase in systolic blood pressure

<table>
<thead>
<tr>
<th>Level of adherence to antihypertensive medication</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10 mmHg</td>
<td>24</td>
</tr>
<tr>
<td>11-20 mmHg</td>
<td>12</td>
</tr>
<tr>
<td>21-30 mmHg</td>
<td>5</td>
</tr>
<tr>
<td>41-50 mmHg</td>
<td>1</td>
</tr>
<tr>
<td>51-60 mmHg</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>
## Increase in systolic blood pressure

<table>
<thead>
<tr>
<th>Reason for increase in systolic blood pressure</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence remains poor</td>
<td>13 (54%)</td>
</tr>
<tr>
<td>Patient does not want to increase the dose or add any antihypertensive medicines</td>
<td>3 (12.5%)</td>
</tr>
<tr>
<td>Inaccurate reading as patients rushed to clinic or felt anxious</td>
<td>2 (8.3%)</td>
</tr>
<tr>
<td>PSP recommendation to initiate calcium channel blocker not actioned</td>
<td>2 (4.2%)</td>
</tr>
<tr>
<td>Patient referred by PSP to GP due to low pulse and feeling dizzy (diagnosed with heart block)</td>
<td>1 (4.2%)</td>
</tr>
<tr>
<td>Complex patient (Cushing’s Syndrome)</td>
<td>1 (4.2%)</td>
</tr>
<tr>
<td>Could not afford medicines</td>
<td>1 (4.2%)</td>
</tr>
<tr>
<td>Difficulty communicating with patient</td>
<td>1 (4.2%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>
Recommendations

• Evaluate the impact of including regular adherence checks in hypertension clinic consultations run by practice pharmacists and other healthcare professionals.

• Involve community pharmacists to work with practices to support adherence checks.

• Undertake another hypertension review project to include all patient groups with uncontrolled blood pressure.

• Undertake a qualitative patient survey to gain an insight into the patient’s perspective about their condition, treatment and value of the consultation.

• Trial group consultations for hypertensive patients with uncontrolled blood pressure who are resistant to taking medication. This approach could be used to target adherence and help to motivate patients to lose weight, eat healthily, reduce alcohol consumption and promote smoking cessation.
Thank you

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Questions
Official Launch on the 3rd June for Asthma and COPD

Next to follow will be Diabetes, Hypertension and Heart Failure - Launch date TBC

Future event: Community of Practice June 2020
Thank you

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