Fairer Health for All Fellowship Cohort 1:
Optional Template – Interim and Final report

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Project details

Project Name	Take Heart, Take Part (Healthy Hearts)
Fellowship Dates	*February 2024 - January 2025*

Summary/Abstract – FINAL REPORT

The summary / abstract provides the reader with an overview of all covered in the project report. Even though a summary is placed at the beginning of a project report, you can only write it once your entire report is complete.

Introduction	The Take Heart, Take Part project (THTP) aimed to address cardiovascular health inequalities within the Black African and Caribbean (BAC) community in North Manchester. By developing culturally tailored healthcare interventions, the project sought to enhance hypertension management, increase awareness of cardiovascular disease (CVD) risks, and strengthen relationships between healthcare providers and the community. Key outcomes include increased community engagement, improved communication skills among healthcare professionals, and the creation of sustainable educational resources.

	The Healthy Hearts project, to which this project was linked, was initiated to tackle the pressing issue of cardiovascular disease, which remains a leading cause of premature death and health inequalities in Greater Manchester. The THTP project specifically focused on the BAC community, a population disproportionately affected by CVD and healthcare disparities. Data highlighted that 1 in 4 deaths in the region are attributable to CVD, necessitating urgent intervention. The project was driven by the need to develop culturally relevant healthcare initiatives that resonate with the BAC community, bridging gaps in communication and access to care.
Central aim of your project	The project aimed to reduce cardiovascular health inequalities by: • Improving healthcare delivery and communication tailored to the BAC community. • Enhancing hypertension diagnosis and management. • Increasing community engagement and trust in healthcare services. • Developing educational resources to sustain long-term health improvements.
Methodology, results, conclusion	**Methodology:** The project employed a multi-faceted approach involving: 1. **Mutual Learning Events:** Interactive sessions for healthcare professionals and BAC community members to exchange knowledge and experiences. 2. **Clinician Training:** Development of culturally sensitive training modules to enhance communication and improve hypertension care pathways. 3. **Community Outreach:** Monthly events in local community spaces to promote health checks and deliver education on CVD prevention.

	4. **Curriculum and Resource Development:** Co-creation of a health curriculum and educational materials with input from BAC leaders. 5. **Data-Driven Targeting:** Use of GM Tableau data to identify high-risk populations and inform outreach strategies. **Due to pressures in relation to staffing (loss of outreach worker available) and winter pressures within primary care (limiting staff availability for learning events) alterations have been made to the planned approaches above, which will be detailed below.** **Summary of outcomes** • Established trust and engagement within the BAC community, resulting in greater participation in health initiatives. • Enhanced clinician understanding of cultural barriers to healthcare, leading to more inclusive practices. • Improved hypertension awareness, with community members actively participating in blood pressure monitoring and health education sessions. • Development of a resource bank of culturally relevant educational materials, ensuring ongoing community access to health information. Had we been successful in applying for funding to continue our work (through training a community outreach worker or working alongside peer lay members to deliver BP checks and healthcare advice in community settings – a possibility identified through collaboration with our health development coordinators) our project would have met more planned objectives. We are also pleased to report that our work extended to promoting health more generally at community events, running a 'hula hoop and healthcare advice' stand at a family fun day and engaging with vaccine hesitant parents to listen to concerns at a recent MMR focused Stay and Play

	event. In addition, we have established links with local school the Manchester Communication Academy who were keen to run BP checks as part of a health event, and whose students may be willing to assist in extending available BAC specific video resources on healthcare messaging. **Conclusion:** The Healthy Hearts project successfully addressed key healthcare disparities within the BAC community by fostering trust, enhancing clinician communication skills, and creating sustainable educational resources. The project has laid a foundation for long-term health improvements and ongoing collaboration between healthcare providers and the community. Future actions include expanding outreach, integrating digital health tools, and maintaining continuous professional development to ensure sustained impact.

Restating Original Ambition:
The Healthy Hearts project set out to improve healthcare delivery and outcomes among the Black African and Caribbean (BAC) community in North Manchester. The focus was on addressing health inequalities, particularly in cardiovascular disease (CVD) management, through culturally tailored communication, targeted outreach, and enhanced community engagement.

Central Aim:
To reduce the disproportionate burden of cardiovascular disease within the BAC community by improving access to hypertension management, increasing awareness around CVD risk factors, and fostering trust between healthcare providers and the community.

Key Themes:

1. **Community Engagement and Trust Building:**
   Establishing reciprocal relationships between healthcare providers and the BAC community to promote culturally appropriate health interventions. This was done through mutual learning events, outreach sessions, and collaboration with BAC community leaders.

2. **Hypertension Pathways Overhaul:**
   Targeting undiagnosed and unmanaged hypertension within the BAC population by enhancing clinician training, optimising patient pathways, and promoting regular blood pressure checks.

3. **Outreach and Health Curriculum Development:**
   Creating culturally relevant health education materials and resources to raise awareness of hypertension, diabetes, and cholesterol, tailored specifically for the BAC population. This involved co-designing a health curriculum and developing a sustainable resource bank.

4. **Data-Driven Targeting:**
   Utilising GM Tableau data and patient records to identify high-need areas and populations, ensuring outreach efforts were precise and effective.

Summary of Work Done:
Over the course of the project, the Healthy Hearts initiative conducted a series of activities aimed at bridging the gap between the BAC community and healthcare services. Key actions included:

- **Mutual Learning Events:** Delivered workshops and interactive sessions, fostering two-way learning between healthcare professionals and BAC community members.
- **Clinician Training:** Developed and implemented culturally relevant training modules to improve healthcare communication and address barriers to hypertension management.
- **Community Outreach:** Organised monthly outreach sessions in local community spaces, including barbershops and restaurants, increasing accessibility to healthcare services.
- **Curriculum Development:** Co-designed a health education curriculum with BAC leaders, focusing on CVD prevention and healthy lifestyle choices.
- **Resource Bank:** Created a repository of educational materials, including videos and pamphlets, to support ongoing health education initiatives.

- **Hypertension Pathway Overhaul:** Identified and engaged with BAC patients at risk of hypertension through targeted data analysis and outreach, resulting in increased blood pressure monitoring and follow-up care.

Summary of Thoughts:
Overall, the project has made significant strides in addressing healthcare inequalities within the BAC community. The initiative underscored the importance of culturally relevant healthcare delivery and the power of community-led interventions. While the project encountered challenges such as resource limitations and historical mistrust of healthcare providers, the collaborative approach fostered strong community relationships and laid the foundation for sustainable health improvements.

Learning Outcomes:

- **Healthcare Providers:** Gained greater insight into the unique barriers faced by the BAC community in accessing healthcare and managing CVD.
- **Community Members:** Reported increased awareness of hypertension risks, with a noticeable shift in trust towards local healthcare providers.
- **Collaborative Networks:** Strengthened partnerships between Valentine Medical Centre (VMC), Nurturing Foundations, and local organisations, enhancing cross-sector collaboration for future health initiatives.

Future Actions and Sustainability:
To sustain and expand the impact of the Healthy Hearts project, the following actions are recommended:

1. **Continuous Professional Development:**
   Ongoing cultural competency training for healthcare professionals, ensuring healthcare messaging remains relevant and responsive to the BAC community's evolving needs.
2. **Digital Health Tools and Outreach:**
   Leverage telemedicine, mobile health applications, and social media to expand outreach and engagement, addressing digital exclusion where necessary.

3. **Feedback Loops and Curriculum Updates:**
   Establish structured feedback mechanisms after every outreach session and community event to refine and enhance educational materials.

4. **Strengthened Partnerships:**
   Broaden collaboration with schools, faith-based organisations, and local businesses to embed health education within trusted community spaces.

5. **Funding and Volunteer Networks:**
   Pursue long-term funding streams and develop a volunteer base to support ongoing outreach and resource development.

6. **Monitoring and Evaluation (M&E):**
   Implement robust M&E frameworks to track progress, measure community impact, and adjust strategies based on real-time data.

Conclusion:
The Healthy Hearts project marks a pivotal step in reducing cardiovascular health inequalities among the BAC community in North Manchester. By prioritising culturally sensitive interventions and fostering community trust, the project has laid the groundwork for long-term health improvements. Sustained effort, collaboration, and innovation will be critical to ensuring the continued success and expansion of this initiative.

Introduction: Purpose and Overview of the Project Brief –FINAL REPORT

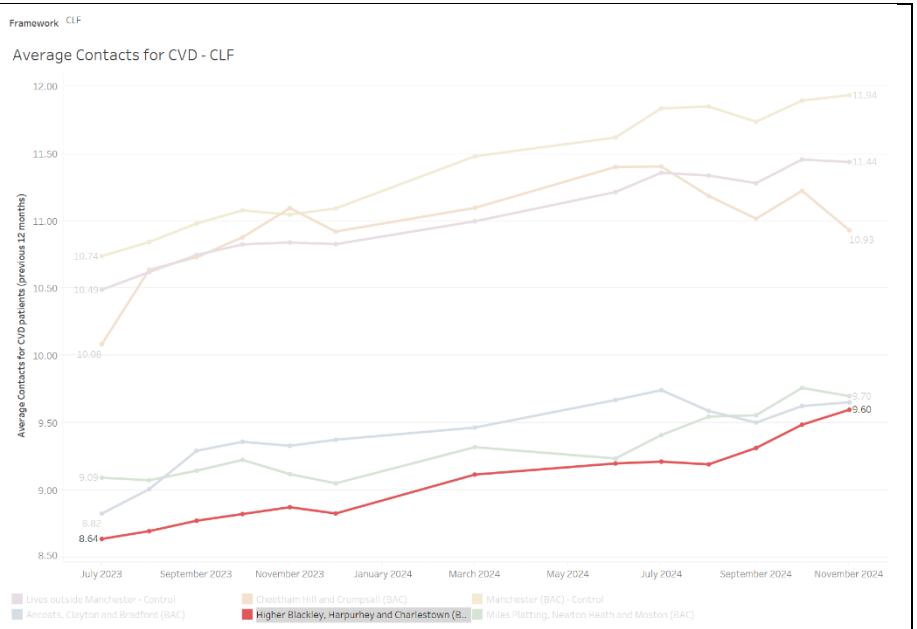
Provide background, context, and an outline for your chosen project

Problem the idea is seeking to solve or address (if any) and population group	Reducing CVD risk is the biggest way we can improve life expectancy in the next 10 years. It is the leading cause of health inequalities AND premature death in Greater Manchester (GM). 1 in every 4 deaths in GM will be due to CVD. CORE20PLUS5, NHS England's initiative to address inequalities, states we must find and manage people with high BP and high cholesterol and reduce smoking rates, in order to do so.

	Cardiovascular risk factors such as hypertension are more prevalent in the black British, African, Caribbean (BAC) population, and our BAC community are more likely to experience significant morbidity and mortality as a result of cardiovascular events. This is a group vulnerable to healthcare inequalities and traditional models of providing care may not be working to address their specific needs. The cost associated with cardiovascular disease is high both in terms of healthcare (£7.4bn) but also economic costs (£15.8bn). The time to act is now, and by mapping areas of specific high cardiovascular need in our North Manchester community, we can target interventions to make maximum impact. **A note on ethnic differences in health in Greater Manchester** Health disparities among ethnic groups in Greater Manchester reflect broader national trends, with significant variations in disease prevalence, access to healthcare, and social determinants of health. **Cardiovascular Disease and Stroke** Ethnic minorities face higher risks of cardiovascular diseases. For example, Black individuals are 1.5 to 2.5 times more likely to experience strokes compared to White individuals. Furthermore, the onset of heart failure occurs six years earlier for South Asians and nine years earlier for Black individuals compared to their White counterparts. Similarly, strokes tend to occur about ten years earlier in Black African, Caribbean, and South Asian groups. These differences are influenced by both biological and socio-economic factors. **Obesity and Diabetes** Obesity rates are disproportionately high among Black adults in Greater Manchester, with 67.5% categorized as overweight or

	obese—the highest among all ethnic groups. Additionally, South Asian groups are up to six times more likely to develop diabetes, while Black groups face a threefold increased risk. These disparities often stem from higher levels of deprivation, which are more prevalent among ethnic minority households. **Access to Healthcare** Ethnic minority communities often encounter barriers to accessing healthcare, including reduced GP availability, insufficient cultural competence among healthcare staff, and inadequate interpretation services. Digital access to services has introduced further challenges, as many tools are not available in first languages, compounding difficulties for those with disabilities or long-term conditions. **Demographic Shifts and Data Limitations** The 2021 census revealed rapid growth in Greater Manchester's ethnic minority population, driven largely by younger demographics. The Black population, for instance, grew by 81% between 2011 and 2021, with significant increases in African sub-groups. Despite these changes, health data at the Greater Manchester level often relies on national datasets due to insufficient local ethnic breakdowns. Addressing this gap is critical for tailoring services to the region's diverse population. **Socio-Economic Impact on Health** Ethnic minority groups in Greater Manchester are more likely to live in deprived areas, exacerbating health inequalities. These communities experienced disproportionate negative impacts during the Covid-19 pandemic, including delayed care, reduced access to healthcare services, and a lack of tailored information. Such systemic inequities highlight the need for better representation, improved cultural competence in services, and enhanced ethnicity recording in health data.

	References 1. Chaturvedi, N., Ethnic Differences in Cardiovascular Disease. *Heart*, 2003, 89(6): 681-686. 2. Lawson, C.A., et al., Risk Factors for Heart Failure: 20-Year Population-Based Trends by Sex, Socio-Economic Status, and Ethnicity. *Circ Heart Fail*, 2020, 13(2): e006472. 3. Wang, Y., Rudd, A.G., & Wolfe, C.D., Age and Ethnic Disparities in Incidence of Stroke Over Time: The South London Stroke Register. *Stroke*, 2013, 44(12): 3298-3304. 4. Greater Manchester Combined Authority. *Greater Manchester Strategy: Ethnicity Evidence Baseline*, June 2022. 5. Greater Manchester Combined Authority. *Census 2021 Briefing: Ethnicity*. 6. Healthwatch Tameside. *Access to and Experiences of Health Care by Ethnic Minorities Report*, April 2024. **A note on health care costs:** Data from the CV Need dashboard suggests rising numbers of contacts occurring with those with CVD even across the period from July to November 2024 within the PCN linked to this project. Prevention work could reduce these costs overtime.

	
Key assumptions and interdependencies	This project's success was contingent on building successful working relationships with local community led organisations and groups. This took place through our unique collaboration – bringing together the healthy neighbourhood team, representatives from organisations such as BeWell, myself as a GP and link person to Valentine Medical Centre (VMC), and the VCSE sector (Nurturing Foundations) Its progress is also dependent on funding linked to the Healthy Hearts programme which allows for the delivery of health advice sessions and creation of monthly outreach events. A successful eight week programme promoting ways to create a healthy lifestyle and ways to manage CVD risk factors has been developed, based on feedback from the BAC community.

	Building relationships between the BAC community and primary health care services is a work in progress though progress has been made, as gathered through qualitative feedback from community members. In future, the Nurturing Foundations team plan on Using GM data sets and applying these to the VMC patient population. They also hope to undertake targeted outreach and community drop in events are planned in high uses spaces such as barbers and local restaurants.
What is the overall purpose of this project? Aims?	This project aimed to improve healthcare delivery and ideally healthcare outcomes, particularly among the Black African and Caribbean (BAC) community, by enhancing communication, outreach, and management of key health conditions like hypertension. It sough to engage the BAC community in a culturally relevant and inclusive way, build trust, and ensure that community members receive the support they need to manage their health effectively. The project was structured into two key strands: **<u>VMC (Valentine Medical Centre) Strand:</u>** Training in Healthcare Communication: Using community feedback, this part of the project focused on delivering targeted training to healthcare professionals, enhancing their ability to deliver healthcare messages more effectively to the BAC community. This involved mutual learning events, culturally relevant training and community feedback integration into practice.

	Hypertension Pathways Overhaul: A new pathway was developed to overhaul hypertension care, reaching out to those who may have undiagnosed or unmanaged hypertension. It encouraged clinicians to make every interaction with patients count, focusing on medication optimisation and patient education and activation, so individuals understand their health numbers and risks. **<u>Outreach Strand:</u>** Health Curriculum Development: The project provided support to create an appropriate health curriculum tailored to the local BAC population's needs. The team will attend training delivery sessions, offering support, improving visibility, and building relationships. A resource bank (including videos) will also be developed to support future training replication. The Targeted Outreach Using Data portion of the project was affected by staffing changes. The team had planned to use GM Tableau CV Need data to identify areas of high need and conduct monthly outreach in community spaces. This was to include working alongside the Nurturing Foundations worker, undertaking asset mapping, and sharing local community offers with both community members and primary care professionals. This aspect of the project was not able to progress.
Opportunities and Challenges?	**<u>Opportunities:</u>** **Culturally Tailored Healthcare Delivery:** By incorporating community feedback and mutual learning events, this project can tailor healthcare delivery to meet the specific needs and preferences of the BAC population. This creates an opportunity

	to improve trust, engagement, and the overall effectiveness of healthcare interventions. **Improved Hypertension Management:** Targeting hypertension through outreach and proactive engagement offers a significant opportunity to reduce undiagnosed or poorly managed cases, thus preventing complications such as heart disease and stroke in a vulnerable population. **Enhanced Community Engagement:** With monthly outreach activities in areas of high need, the project can foster deeper connections between healthcare providers and the community. This allows for continuous learning, collaboration, and responsiveness to the evolving needs of the community. **Sustainable Training and Resources:** Developing a resource bank, including videos explaining healthcare access, can offer long-term benefits. These resources can be reused and adapted for future training sessions, creating sustainability and reducing the need for constant resource development. **Data-Driven Decision Making:** The use of GM Tableau CV Need data allows for precise targeting of outreach efforts, ensuring that resources are directed where they are most needed and where they are likely to deliver most benefit. This data-driven approach enhances the efficiency of the project's outreach initiatives. **Partnership and Cross-Sector Collaboration:** Collaborating with MLCO and other community organizations presents an opportunity to leverage existing expertise and resources, enhancing the project's effectiveness and reach.

	<u>Challenges:</u> **Engaging the BAC Community:** While the project aims to build trust, healthcare initiatives aimed at minority communities can face barriers such as historical mistrust, language differences, and cultural stigmas around certain health conditions. Overcoming these requires sustained engagement and sensitive communication. **Sustaining Feedback Loops:** Continuously incorporating community feedback into healthcare practices may be logistically challenging. Ensuring that the feedback received is not only collected but also leads to meaningful changes and is communicated back to the community could be complex. **Clinician Engagement and Training Impact:** Getting clinicians to fully engage with the training and make every interaction count in terms of hypertension management may be difficult. Busy clinic schedules, resource constraints, and potential resistance to change in practice can limit the impact of training. **Resource and Time Constraints:** Developing a robust resource bank and organising monthly outreach activities require significant time, personnel, and financial resources. There may be a risk of resource strain, especially if the project expands or faces unforeseen challenges. Longevity is a key concern. **Access to Accurate Data:** The use of GM Tableau data is essential for targeted outreach, but data accuracy, completeness, and timeliness may be a challenge. Inaccurate data could result in outreach efforts being misdirected. If the primary care record is being used, we are already aware of

	issues around recording of demographic information, such as ethnicity, and a lack of connectedness to other population health data sources which can be a challenge. **Consistency in Curriculum Development and Delivery:** Ensuring that the health curriculum developed remains relevant and effective over time requires ongoing evaluation and updates. Additionally, building long-term relationships and visibility among BAC community members will require a consistent presence, which could be difficult if there is staff turnover or shifts in priorities. **<u>Conclusion:</u>** This project holds significant potential for improving health outcomes among the BAC community by creating culturally tailored interventions and strengthening community-healthcare relationships. However, it will require careful planning, sufficient resources, and ongoing collaboration to overcome challenges related to community engagement, clinician buy-in, and resource management.
Brief description of methodology used.	The methodology for this project is designed to systematically address the health disparities in the Black African and Caribbean (BAC) community by enhancing healthcare communication, management of hypertension, and community outreach. It involves a mix of qualitative and quantitative approaches, leveraging community feedback, data-driven outreach, and collaboration with healthcare professionals and community organisations. **1. VMC (Valentine Medical Centre) Strand** **a. Training in Culturally Appropriate Healthcare Communication:** **Step 1: Needs Assessment and Community Engagement**

	• **Method**: Conduct focus groups, surveys, and interviews with BAC community members to gather qualitative data on the effectiveness of current healthcare communication. • **Objective**: Identify key gaps in how healthcare messages are delivered and perceived in the BAC community. • **Tools**: Structured questionnaires, qualitative interviews (undertaken by Nurturing Foundations), and MLCO resources for gathering feedback. **Step 2: Design of Culturally Relevant Training** • **Method**: Co-design training modules with input from the MLCO and BAC community leaders. This includes culturally appropriate communication techniques, language use, and addressing potential breakdowns in successful healthcare messaging. • **Objective**: Equip healthcare professionals with the skills needed to deliver tailored healthcare messages to the BAC community. • **Tools**: Curriculum development based on community input, collaboration with subject matter experts. **Step 3: Mutual Learning Events** • **Method**: Organise workshops where healthcare professionals and community representatives can engage in reciprocal learning sessions. This will allow healthcare workers to learn from the lived experiences of the BAC community, while also sharing best medical practice and up to date knowledge on key healthcare issues. • **Objective**: Foster mutual understanding and ensure that the training addresses real-world issues. • **Tools**: Workshops, role-playing activities, interactive discussions. **Step 4: Implementation and Continuous Feedback** • **Method**: Deliver the training and integrate feedback loops to allow for continuous improvement.

	• **Objective**: Ensure that healthcare professionals apply the training effectively and that changes in practice are communicated back to the community. • **Tools**: Post-training surveys, focus groups with BAC community members to assess changes in practice.
	b. Hypertension Pathways Overhaul **Step 1: Data Collection and Patient Identification** • **Method**: Use electronic medical records and GM CV Need Tableau data to identify community members with undiagnosed or unmanaged hypertension. • **Objective**: Target high-risk individuals for early intervention. • **Tools**: Data analytics, collaboration with local primary care networks to access patient data. **Step 2: Outreach and Education Campaign** • **Method**: Engage community health workers and local organisations to disseminate educational material on hypertension management in culturally appropriate ways. • **Objective**: Improve awareness of hypertension risks, encourage regular blood pressure monitoring, and empower the community to 'know their numbers.' • **Tools**: Leaflets, community events, hypertension awareness programs in community centres. **Step 3: Clinician Training and Hypertension Pathway Optimisation** • **Method**: Provide additional training to clinicians, focusing on the management of hypertension, medication optimisation, and how to make every patient contact count for hypertension management. • **Objective**: Ensure that clinicians are proactive in diagnosing and managing hypertension in the BAC population. • **Tools**: Evidence-based training materials, protocols for hypertension management, audit of patient outcomes.

	Step 4: Monitoring and Evaluation • **Method**: Track hypertension management outcomes using patient follow-up data, audit, CV Need tableau data. • **Objective**: Measure the effectiveness of pathway changes and ensure long-term improvement in hypertension management. • **Tools**: GM Tableau data, patient and staff satisfaction surveys, blood pressure monitoring logs.
	2. Outreach Strand **a. Health Curriculum Development** **Step 1: Needs Assessment** • **Method**: Collaborate with local health experts, BAC community leaders, and educators to assess the health education needs of the community. • **Objective**: Design a curriculum that addresses specific health concerns (e.g., hypertension, diabetes) prevalent in the BAC population. • **Tools**: Focus groups, community surveys, literature review on health disparities and PCN level population data reports. **Step 2: Curriculum Design and Development** • **Method**: Develop educational materials and lesson plans that reflect the health concerns and cultural values of the BAC community. • **Objective**: Ensure the curriculum is relevant, culturally sensitive, and accessible to the community. • **Tools**: Multimedia resources (e.g., videos), pamphlets, culturally adapted health messages. **Step 3: Delivery of Training Sessions** • **Method**: Attend and support the delivery of health education sessions, offering hands-on support to trainers and building relationships with community participants.

	• **Objective**: Improve visibility of healthcare services and establish trust with the community. • **Tools**: Interactive workshops, community health events, feedback surveys to measure impact. **Step 4: Resource Bank Development** • **Method**: Create a repository of educational resources (e.g., videos, brochures) that can be reused in future training sessions. • **Objective**: Ensure sustainability of the training and enable other organisations to replicate the approach. • **Tools**: Video production, online resource repository, guides on accessing healthcare

Logic Model for BAC Healthcare Project

Project Elements	Inputs	Activities	Outputs	Short-Term Outcomes	Impacts
1. VMC Strand – Training in Healthcare Communication	- Funding - MLCO (Manchester Local Care Organisation) support - BAC community leaders - Healthcare	- Conduct needs assessment (focus groups, surveys, interviews) - Co-design culturally relevant training - Organise mutual learning events	- Training modules - Mutual learning events held - Post-training feedback collected	- Improved healthcare communication - Healthcare workers are more culturally aware and responsive to BAC needs	- Increased trust in healthcare services among BAC community - Improved health outcomes due to effective healthcare messaging

Project Elements	Inputs	Activities	Outputs	Short-Term Outcomes	Impacts
	professionals - Feedback tools	- Provide training for healthcare professionals			
2. VMC Strand – Hypertension Pathways Overhaul	- GM Tableau data - Patient records - Clinicians -Community workers	- Identify undiagnosed/unmanaged hypertension cases using data - Launch targeted outreach campaign - Train clinicians in optimised hypertension pathways	- Hypertension outreach events - Educational materials disseminated - Clinician training delivered	- Increased diagnosis and management of hypertension - More BAC community members 'know their numbers'	- Reduction in hypertension-related health disparities - Long-term improvement in BAC community health outcomes
3. Outreach Strand – Health Curriculum Development	- Local health experts - BAC community leaders - Educators - Multimedia resources	- Conduct needs assessment - Develop and design health curriculum - Deliver training sessions - Develop a resource bank	- Health curriculum materials - Training sessions delivered - Resource bank created	- Improved visibility of healthcare services - BAC community has access to culturally relevant health education	- Sustainable health education programs - Improved long-term health literacy and outcomes in the BAC community
4. Outreach Strand – Targeted Outreach Using Data	- GM Tableau data - Community spaces - Community health workers	- Map high-need areas using GM Tableau data - Conduct monthly outreach - Asset mapping	- Monthly outreach events held - Community resources	- Enhanced community-healthcare connections - Increased community awareness of available resources	- Increased utilisation of appropriate healthcare services - Greater BAC community

Project Elements	Inputs	Activities	Outputs	Short-Term Outcomes	Impacts
	- Nurturing Foundations worker	- Share community offers with primary care	shared - Asset maps developed		engagement in preventive health programs

Explanation of the Logic Model Components:

1. **Inputs**: These are the resources needed to implement the project. They include funding, staff, BAC community involvement, and data sources like GM Tableau.
2. **Activities**: The specific actions carried out, such as needs assessments, co-designing culturally relevant training, holding workshops, and conducting outreach events.
3. **Outputs**: Tangible deliverables from activities like training modules, mutual learning events, educational materials, and outreach sessions.
4. **Short-Term Outcomes**: These reflect the immediate effects, such as improved communication, better hypertension management, and enhanced community engagement.
5. **Long-Term Outcomes**: The broader impacts the project aims to achieve over time, such as improved health outcomes for the BAC community, sustainable healthcare education, and increased trust in healthcare systems.

B

Body of the report – INTERIM REPORT & FINAL REPORT

This section provides the detail of your work analysis, data, and graphics.

Provide the evidence and theory behind your project	Greater Manchester has higher rates of heart disease, stroke, and related conditions compared to other regions in the UK. Public Health England has shown that Greater Manchester residents have a higher-than-average risk of developing cardiovascular diseases.Many deaths due to cardiovascular diseases occur in people under the age of 75. Manchester Health and Care Commissioning data reveals that CVD contributes significantly to premature mortality in the region, with a stark gap in life expectancy compared to the national average. Evidence from community-based screening programs in Greater Manchester, such as NHS Health Checks and targeted CVD risk assessments, shows a measurable impact of early detection and prevention. Public health interventions such as smoking cessation programs, weight management initiatives, and physical activity promotion have been particularly successful in reducing risk factors like smoking and obesity. For example, the Greater Manchester Tobacco Control Programme has been instrumental in reducing smoking rates, a leading cause of CVD. Using CV need GM tableau and PCN population reports, we can see that the practice area covered by VMC reflects a higher than GM and England averages for risk factors such as smoking, and hypertension. The practice's BAC patients number around 2000 (20%) and alongside the above data, provides compelling evidence for action.
Explain your key findings, results,	

	Interim findings: **<u>VMC strand:</u>** **<u>FINDINGS:</u>** • **Gaps Identified**: Communication barriers due to cultural differences, lack of visibility or accessibility of healthcare team members, and complex medical language and lack of time were identified as key issues. • **Community Insight**: Around 40% of participants expressed a preference for healthcare messages or simple checks to be delivered through trusted community leaders or in familiar community settings, as opposed to formal clinical environments. This was often due to a mismatch of who was delivering the message in clinical settings as per findings in the 2022 the Race Equality report ie situations such as where a white middle class younger female is discussing prostate issues with older BAC community member, leading to disengagement. **Next steps/notes:** Data to inform the design of culturally relevant communication training modules, addressing identified gaps. Modules to include strategies for building trust, understanding cultural perspectives on healthcare, and using plain language or culturally relevant resources (such as the modified eatwell plate). BAC community leaders will help refine the content to ensure cultural sensitivity. **<u>Step 2: Design of Culturally Relevant Training</u>** Method: Co-designed training modules with input from MLCO and BAC community leaders, focusing on culturally appropriate communication techniques, addressing mistrust, and improving language use.

	Objective: Equip healthcare professionals with the necessary skills to deliver tailored healthcare messages to the BAC community. Tools: Curriculum development based on community input, collaboration with subject matter experts. Findings: Please see Appendix on questionnaire findings from VMC staff. Initial training delivered with input from Nurturing Foundation team. Further training via podcast to be produced and shared, with repeat of staff qualitative measure. Professional Feedback: aim is for Healthcare professionals to find the curriculum to be insightful and for 85% to say they felt better prepared to communicate with BAC patients. **Step 3: Mutual Learning Events** Method: Organise workshops for reciprocal learning between healthcare professionals and BAC community members, combining lived experiences with medical best practice. Objective: Foster mutual understanding and ensure that the training addresses real-world healthcare issues. Tools: Workshops, role-playing activities, and interactive discussions. Findings: Mutual learning event took place at local community hub where professionals and patients could share their current views on improving CVD management. Stress, especially in relation to the cost of living crisis, and in the context of pressures to support family abroad financially, was raised as a kay factor in their ability to reduce risk factors and manage hypertension. This could then be factored into the healthy advice sessions. All attendees

	reported mutual respect and 75% satisfaction with the opportunity to engage with a healthcare professional. Feedback was also gathered from BAC patients informally during consulting indicating increased trust and positive experiences with the FhFA GP with comments given around feeling heard, and feeling able to discuss their experiences with medication more easily. The feedback from GPs was that many patients already seemed really engaged with their health, and a sense perhaps of there still being some 'missing' groups we aren't reaching. More time and open questioning to be given during consultations especially around medication and understanding of hypertension. Next Steps: Expand these workshops and include follow-up sessions to ensure the learning continues to be applied. **Step 4: Implementation and Continuous Feedback** Method: Delivered training and integrated feedback loops through post-training surveys and focus groups with BAC community members to assess changes in practice. Objective: Ensure that healthcare professionals apply the training effectively and that community feedback leads to continuous improvement. Tools: Post-training surveys, focus groups, and performance reviews. Findings: Unfortunately qualitative data gathered by Nurturing Foundations not shared so not able to use this to structure service improvement approaches, but we were guided by mutual learning

	events and our own qualitative data. We aim to repeat staff questionnaires following a further scheduled session in February. A future aim will be to collect evidence of improved healthcare communication, with 70% of BAC community members noting better understanding and clarity during healthcare interactions. Continuous Feedback remains a work in progress - Feedback loops will be shown to be effective, ie healthcare workers requesting further training based on self identified needs, or mutual learning sessions with community members to deepen understanding. We already have 6 team members keen to continue learning via podcast! Next Steps: Continue with periodic training updates and maintain the feedback system to track communication improvements. **2. VMC Strand: Hypertension Pathways Overhaul** Step 1: Data Collection and Patient Identification Method: Used electronic medical records and GM CV Need Tableau data to identify BAC community members with undiagnosed or unmanaged hypertension. Objective: Target high-risk individuals for early intervention. Tools: Data analytics and collaboration with local primary care networks. Findings: See below for figures. Undiagnosed Cases: Aim will be to connect with 15% of BAC patients identified as having undiagnosed or unmanaged hypertension and record an up to date reading and management plan. Data will allow for precise targeting of outreach efforts,

	ensuring high-risk individuals are prioritised. This aim was achieved. **<u>Cases At VMC breakdown: Using CV Need and emis audit data</u>** 2 had a BP >180/120 – now 1. 12 had a BP >160/110 – now 2, but this increase is linked to case review. 4 are having ongoing medication adjustment and require repeat measures. 10 have never had check – now 2. 46 had no BP recorded in the last 18 months – now 7 4 have a clinical condition such as previous stroke, chronic kidney disease with a urinary proten level of >70 and a clinic BP above target >130/80. Now 0 still need a reading. 16 have a clinical condition such as previous stroke, chronic kidney disease with a urinary proten level of <70 and a clinic BP above target >130/80 – 2 still need a reading. 88 are under 80 years of age with a clinical BP of >140/90. Now 2 still need a reading. Interestingly those with the highest CV Need risk scores have 'not stated' as ethnicity which could reflect length of time since being seen in practice, or reduced engagement in providing information when prompted, or that this is a potentially a transient population, or don't have smart phones if being prompted to add this data. Next Steps: Continue refining data use and expand to more comprehensive health data integration. **Step 2: Outreach and Education Campaign**

	Method: Engaged community health workers and local organisations to disseminate hypertension management materials in culturally appropriate ways. Objective: Raise awareness of hypertension risks and encourage blood pressure monitoring. Tools: Leaflets, community events, and hypertension awareness programs. Findings: Please note that to date, we do not have access to Nurturing Foundations data forms to examine pledging to improve BP and CVD risk factors. From my participation, I spoke with 5 patients who pledged to review their BP with their GP and 3 who were motivated to discuss medication options. Please also note, there was no available outreach worker to support dissemination in a more hyperlocal, targeted way. However we plan to work with Winning Hearts & Minds fieldworkers and local peer health connectors to offer checks at events and in high need local areas, and to connect with their point of care testing offer. Previous aims: Community Engagement: Aim of awareness events is to find participants reporting they were more informed about hypertension risks and that educational material tailored to the community was well-received, with 65% of participants pledging to regularly monitor their blood pressure. Outreach: Aim is that among those populations who require more support to connect with healthcare, that 40% have had contact with their GP service and have newly recorded data around their

	health and lifestyle as well as an up to date blood pressure reading. Next Steps: Sustain awareness efforts and integrate digital health tools for continuous engagement. **Step 3: Clinician Training and Hypertension Pathway Optimisation** Method: Provided additional training to clinicians on hypertension management, optimising pathways, and maximising patient contact for hypertension care. Objective: Proactively diagnose and manage hypertension in BAC patients. Tools: Evidence-based training materials, patient management protocols, and regular audits. Findings: Questionnaire due to be repeated following further review in February. Training Success: Aim is for a reported 40% increase in confidence in managing hypertension among BAC patients. Improved Patient Outcomes: Preliminary audits to show a 10% improvement in blood pressure control among previously unmanaged patients. This has now increased further – please see above for data on unmanaged patients. Next Steps: Conduct follow-up audits to track long-term impact and continue refining hypertension management pathways.

	<u>3. Outreach Strand: Health Curriculum Development</u> **Step 1: Needs Assessment** Method: Collaborated with local health experts, BAC community leaders, and educators to assess the community's health education needs. Objective: Design a health curriculum that addresses the prevalent health concerns of the BAC community. Tools: Focus groups, community surveys, and a literature review on health disparities. Identified Needs: Hypertension, cholesterol and diabetes were highlighted as key concerns. Participants requested practical advice on managing these conditions. The need for more visual and interactive learning tools was strongly expressed. The opportunity to engage with health care professionals was sought. Findings: Nurturing foundations report consistent engagement over the course of 8 weeks. They have gathered questionnaire data but have not shared this. Data gathered by questionnaires and informal engagement with community members shaped the health curriculum that was delivered. **Step 2: Curriculum Design and Development** Method: Developed educational materials and lesson plans reflecting BAC health concerns and cultural values in conjunction with Nurturing Foundations. Objective: Ensure curriculum relevance, cultural sensitivity, and accessibility. Tools: Multimedia resources, pamphlets, and culturally adapted health messages.

	Findings: As above – NF have oversight over data gathered but have yet to share this. Cultural Sensitivity – the aim is for the curriculum to be praised for its relevance and accessibility, particularly through the use of videos and real-life scenarios and for participants to find the content clear and easy to follow. **Step 3: Delivery of Training Sessions** Method: Supported delivery of health education sessions while building relationships with community participants. Objective: Improve healthcare visibility and trust within the BAC community. Tools: Interactive workshops, community health events, and feedback surveys. Findings: As above – data not yet shared by NF. The hope is to achieve greater reported connection or knowledge of healthcare services and increased confidence in self management. Next Steps: Continue delivering sessions and expand community engagement strategies. Roll out planned to 2 other areas in coming months. **Step 4: Resource Bank Development** Method: Create a repository of educational resources that can be reused in future sessions. Objective: Ensure sustainability and replicability of the approach. Tools: Video production, online resource repository, and healthcare guides.

	Findings: An online resource bank has been created around the BAC community and CVD. However, hosting beyond the NHS is difficult and has attached cost, and we as yet have no means to calculate page views from the wider community. In house, all VMC members have signed up to access it. Sustainability: The resource bank ensures long-term access to healthcare education for the BAC community. Next Steps: Continue to update the repository with new materials based on community feedback.
Describe achievements, changes and difference made, impact	Key Metrics – please see above for improvements in care numbers. Community Outreach Events: • Manchester Community Academy Staff Wellbeing event: 28 checks, 2 new cases stage 1 hypertension for further checks, 2 known stage 2 hypertension needing GP review as raised readings, one due a statin/cholesterol check also. • Community Family Fun & Health event - 18 BP checks were made.3 signposted to their GP due to elevated readings (Lindsey) 5 were signposted to GP/local pharmacy (BeWell – Suraj) 10 normal readings.

	• Co produced healthy advice sessions – BP checks at 2 initial events. Additional events attended / other outcomes achieved: • MMR/Smear event @ Harpurhey Sure Start centre: spoke with local mums about looking after their health and children's health – able to signpost one mum with persistent hypertension to further review and care. Links made with A Visit From The Stork allowing us to support new mums with early essentials, parenting support and advice on finances (Cost of living issues identified as key factor in stress linked to raised BP by community members) • MMR Stay and Play event: established links with local exercise providers MorrisoHealth allowing us to add to our resource kit for patient signposting.
Provide any recommendations	*Do you have any recommendations? What do you think should happen next? Who, what, when, why and how?* 1. **Sustaining Culturally Relevant Healthcare Communication (VMC Strand)**: ○ **Recommendation**: Establish ongoing professional development programmes to regularly update healthcare providers on cultural competency, integrating continuous learning modules that evolve with the community's needs. Collaborate with the BAC community to refresh training materials regularly and incorporate new healthcare challenges. ○ **Rationale**: Healthcare communication needs to adapt over time, especially as the demographics and healthcare challenges of the BAC community may shift. Continuous engagement will ensure

	healthcare workers remain responsive to these changes. 2. **Expand the Reach of Hypertension Management Programs (VMC Strand)**: ○ **Recommendation**: Leverage digital health platforms (e.g., apps, telemedicine) to extend the hypertension management efforts, particularly for patients who are hard to reach in person. Offer BAC-specific health campaigns via social media to enhance hypertension awareness. ○ **Rationale**: Reaching all undiagnosed or unmanaged hypertension patients may be challenging solely through physical outreach, especially with limited resources. Digital tools offer scalable options for maintaining patient engagement, monitoring, and education but have to factor in the risk of digital exclusion. 3. **Regular Feedback Loops for Ongoing Curriculum Improvement (Outreach Strand)**: ○ **Recommendation**: Implement a structured feedback mechanism after every training session and community engagement event to continuously refine the health curriculum. Engage local BAC health professionals in the periodic review of content. ○ **Rationale**: Health curricula can become outdated or disconnected from current community needs. By collecting regular feedback and involving community members in curriculum revisions, the project will maintain relevance and cultural resonance. 4. **Enhance Data-Driven Outreach with Community-Led Insights (Outreach Strand)**:

	○ **Recommendation**: Combine GM Tableau data with community-driven insights by conducting regular community-led focus groups to identify less quantifiable needs. Use community members as outreach ambassadors to extend the project's reach. ○ **Rationale**: While data can identify high-need areas, local insights from community members often capture more nuanced, hidden barriers to healthcare access. A hybrid approach of data and community leadership will make outreach more effective. 5. **Strengthen Collaboration Across Sectors**: ○ **Recommendation**: Build stronger partnerships with local schools, faith-based organizations, and BAC-owned businesses to broaden the scope of outreach efforts and reinforce healthcare education through community institutions. ○ **Rationale**: Broadening partnerships will help embed health messages more deeply in the community's everyday life, increasing trust and reach. Schools and faith-based groups, for instance, are trusted spaces that can facilitate healthcare education in more informal, relatable settings. 6. **Establish Long-Term Funding and Resource Plans**: ○ **Recommendation**: Seek multi-year funding options and government grants to ensure the sustainability of outreach, training, and hypertension management / CVD reduction programmes. Develop a volunteer network to sustain outreach efforts – which will also require a costed approach.

	○ **Rationale**: Long-term outcomes, such as improved trust and health literacy, will require sustained efforts. Securing continuous funding and expanding community involvement through volunteers will mitigate the risk of project fragmentation due to resource constraints. 7. **Monitor and Evaluate Impact with a Continuous Learning Approach**: ○ **Recommendation**: Introduce a robust monitoring and evaluation (M&E) framework that regularly assesses both qualitative and quantitative outcomes. Incorporate this M&E process into all project activities to track real-time progress and make agile adjustments. This could be done in collaboration with wider GM population health teams and PCNs. ○ **Rationale**: Continuous learning through real-time monitoring will allow the project to identify gaps or opportunities early, enabling quick adjustments to strategies and increasing the likelihood of achieving long-term goals.

Conclusion – FINAL REPORT

This section brings the entire project report together, summarising your argument and why it is significant.

Restate original ambition	***FINAL REPORT: HEALTHY HEARTS PROJECT*** ***Restating Original Ambition:*** *The Healthy Hearts project set out to improve healthcare delivery and outcomes among the Black African and Caribbean (BAC) community in North Manchester. The focus was on addressing health inequalities, particularly in cardiovascular*

	disease (CVD) management, through culturally tailored communication, targeted outreach, and enhanced community engagement. ***Central Aim:*** *To reduce the disproportionate burden of cardiovascular disease within the BAC community by improving access to hypertension management, increasing awareness around CVD risk factors, and fostering trust between healthcare providers and the community.* ***Key Themes:*** 1. ***Community Engagement and Trust Building:*** *Establishing reciprocal relationships between healthcare providers and the BAC community to promote culturally appropriate health interventions. This was done through mutual learning events, outreach sessions, and collaboration with BAC community leaders.* 2. ***Hypertension Pathways Overhaul:*** *Targeting undiagnosed and unmanaged hypertension within the BAC population by enhancing clinician training, optimising patient pathways, and promoting regular blood pressure checks.* 3. ***Outreach and Health Curriculum Development:*** *Creating culturally relevant health education materials and resources to raise awareness of hypertension, diabetes, and cholesterol, tailored specifically for the BAC population. This involved co-designing a health curriculum and developing a sustainable resource bank.* 4. ***Data-Driven Targeting:*** *Utilising GM Tableau data and patient records to identify high-need areas and populations, ensuring outreach efforts were precise and effective.* ***Summary of Thoughts:*** *Overall, the project has made significant strides in addressing*

	healthcare inequalities within the BAC community. The initiative underscored the importance of culturally relevant healthcare delivery and the power of community-led interventions. While the project encountered challenges such as resource limitations and historical mistrust of healthcare providers, the collaborative approach fostered strong community relationships and laid the foundation for sustainable health improvements. ***Learning Outcomes:*** • ***Healthcare Providers:*** *Gained greater insight into the unique barriers faced by the BAC community in accessing healthcare and managing CVD.* • ***Community Members:*** *Reported increased awareness of hypertension risks, with a noticeable shift in trust towards local healthcare providers.* • ***Collaborative Networks:*** *Strengthened partnerships between Valentine Medical Centre (VMC), Nurturing Foundations, and local organisations, enhancing cross-sector collaboration for future health initiatives.* ***Future Actions and Sustainability:*** *To sustain and expand the impact of the Healthy Hearts project, the following actions are recommended:* 1. ***Continuous Professional Development:*** *Ongoing cultural competency training for healthcare professionals, ensuring healthcare messaging remains relevant and responsive to the BAC community's evolving needs.* 2. ***Digital Health Tools and Outreach:*** *Leverage telemedicine, mobile health applications, and social media to expand outreach and engagement, addressing digital exclusion where necessary.* 3. ***Feedback Loops and Curriculum Updates:*** *Establish structured feedback mechanisms after every*

	outreach session and community event to refine and enhance educational materials. 4. ***Strengthened Partnerships:*** *Broaden collaboration with schools, faith-based organisations, and local businesses to embed health education within trusted community spaces.* 5. ***Funding and Volunteer Networks:*** *Pursue long-term funding streams and develop a volunteer base to support ongoing outreach and resource development.* 6. ***Monitoring and Evaluation (M&E):*** *Implement robust M&E frameworks to track progress, measure community impact, and adjust strategies based on real-time data.* ***Conclusion:*** *The Healthy Hearts project marks a pivotal step in reducing cardiovascular health inequalities among the BAC community in North Manchester. By prioritising culturally sensitive interventions and fostering community trust, the project has laid the groundwork for long-term health improvements. Sustained effort, collaboration, and innovation will be critical to ensuring the continued success and expansion of this initiative.*

Appendix 1:

Cases At VMC breakdown: Using CV Need dashboard data

2 had a BP >180/120 – now 1.

12 had a BP >160/110 – now 2, but this increase is linked to case review. 4 are having ongoing medication adjustment and require repeat measures.

10 have never had check – now 2.

46 had no BP recorded in the last 18 months – now 7

4 have a clinical condition such as previous stroke, chronic kidney disease with a urinary proten level of >70 and a clinic BP above target >130/80. Now 0 still need a reading.

16 have a clinical condition such as previous stroke, chronic kidney disease with a urinary proten level of <70 and a clinic BP above target >130/80 – 2 still need a reading.

88 are under 80 years of age with a clinical BP of >140/90. Now 2 still need a reading.

Interestingly those with the highest CV Need risk scores have 'not stated' as ethnicity which could reflect length of time since being seen in practice, or reduced engagement in providing information when prompted, or that this is a potentially a transient population, or don't have smart phones if being prompted to add this data.

As shown by CV Need we have increased prevalence, which may be linked to our outreach work and/or an increase in an at risk population locally (we know our BAC patient numbers are growing)

Community Outreach Events:

- Manchester Community Academy Staff Wellbeing event: 28 checks, 2 new cases stage 1 hypertension for further checks, 2 known stage 2 hypertension needing GP review as raised readings, one due a statin/cholesterol check also.
- Community Family Fun & Health event - 18 BP checks were made.3 signposted to their GP due to elevated readings (Lindsey) 5 were signposted to GP/local pharmacy (BeWell – Suraj) 10 normal readings.
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Additional events attended / other outcomes achieved:

- MMR/Smear event @ Harpurhey Sure Start centre: spoke with local mums about looking after their health and children's health – able to signpost one mum with persistent hypertension to further review and care. Links made with A Visit From The Stork allowing us to

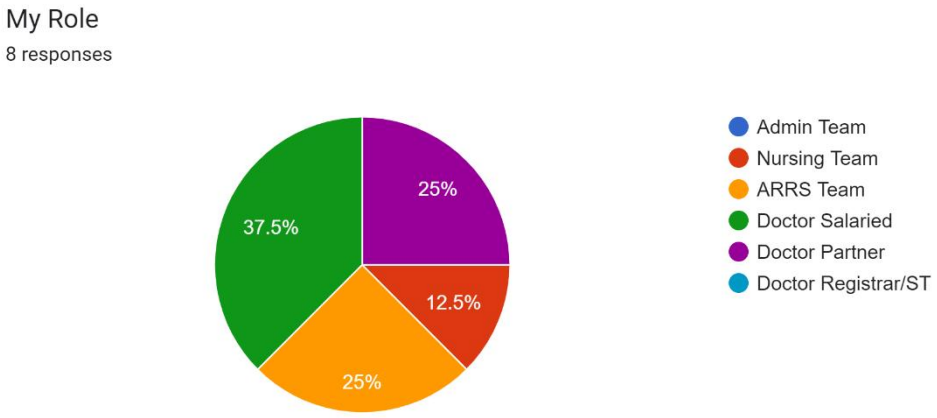
support new mums with early essentials, parenting support and advice on finances (Cost of living issues identified as key factor in stress linked to raised BP by community members)

- MMR Stay and Play event: established links with local exercise providers MorrisoHealth allowing us to add to our resource kit for patient signposting.

Appendix 2: Questionnaire

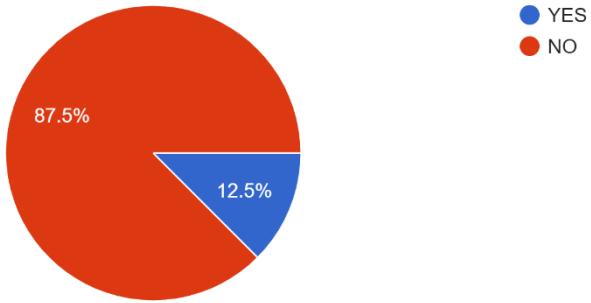
This guided the staff training at VMC. We plan to repeat this questionnaire following a planned second teaching session & podcast produced jointly with Nurturing Foundations due to take place in February 2025.

Initial Survey Findings:



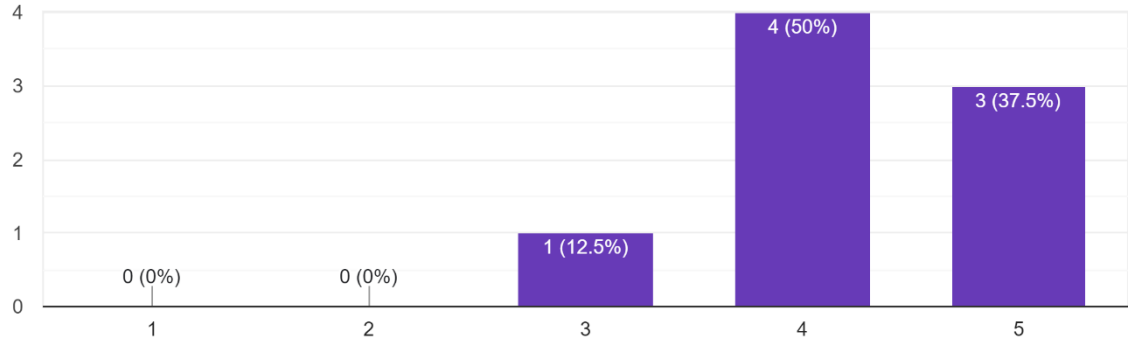
Have you received formal training on cultural competence / delivering culturally relevant or appropriate health care information for our black British, African, Caribbean (BAC) patients?

8 responses



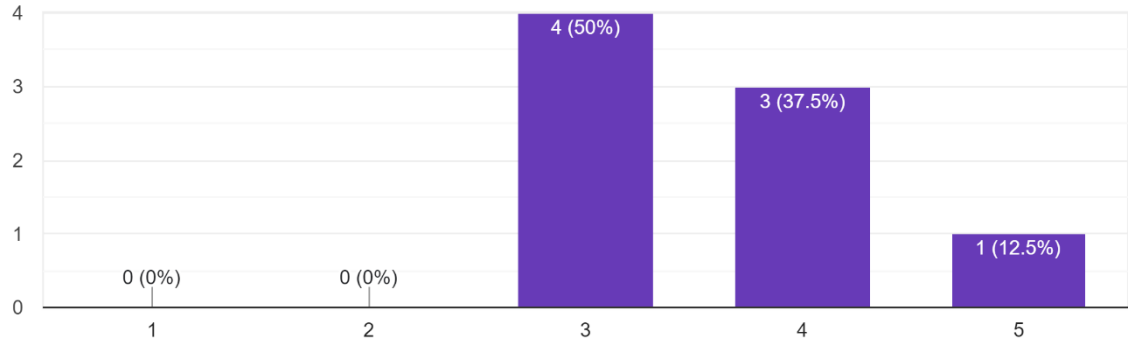
Hypertension Knowledge check: I know and apply national guidance on hypertension.

8 responses



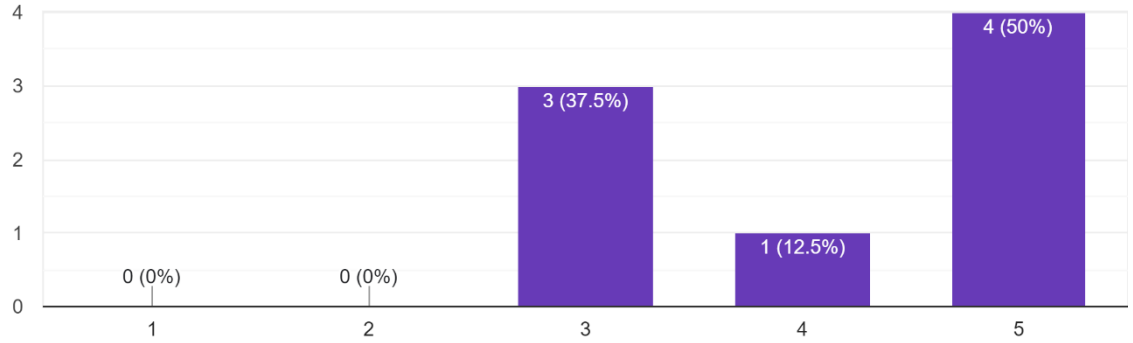
I know and apply local GM guidance and understand the standards for 2024 on hypertension (multimorbidity reivews which include hypertension medication review and coding in emis)

8 responses



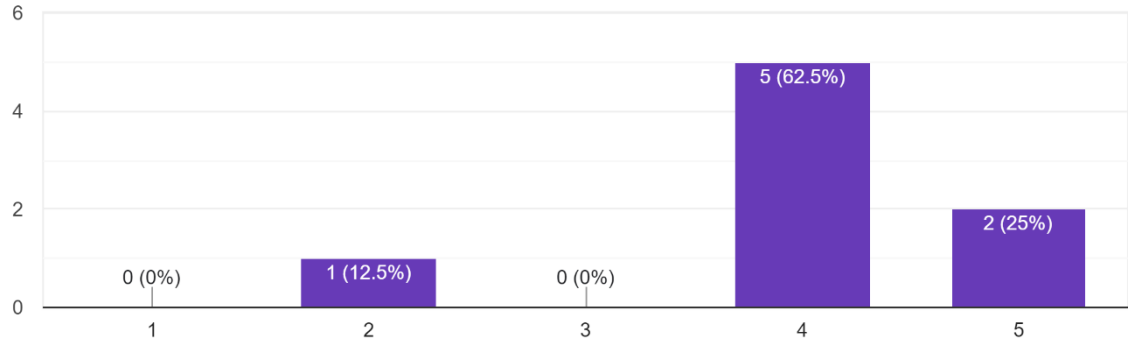
I always check compliance with medication and discuss any side effects or concerns.

8 responses



How confident are you? I know how the pathways for hypertension management work within Valentine Medical Centre (from identifying hyperte...eeded, to following up and scheduling reviews etc)

8 responses

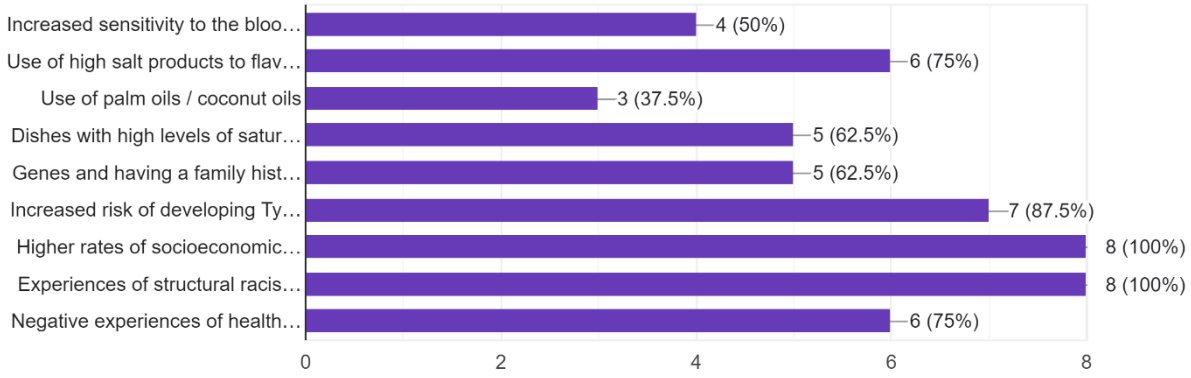


Suggestions: please add any ideas below on ways to improve how we manage the processes around hypertension (or just flag any issues / bits that work well!)1 response

use the bp machine in w room more, use of home readings - average to be worked out bu clinicians

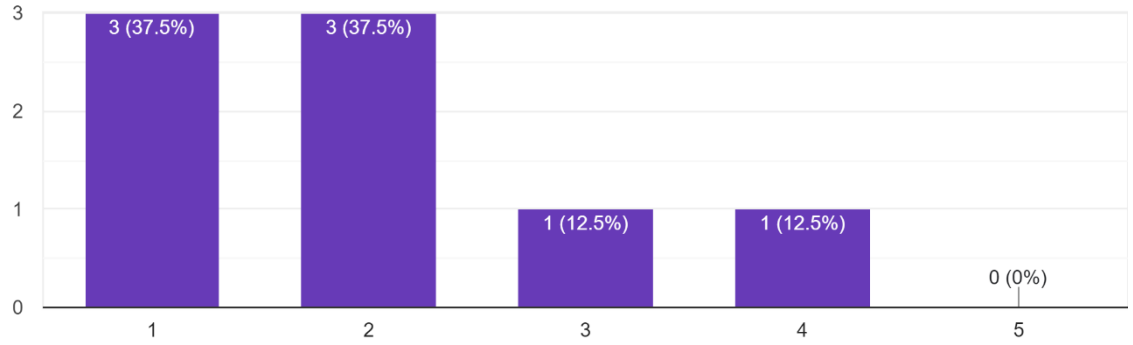
KNOWLEDGE: What are the risk factors for hypertension in the Black African Caribbean (BAC community?) Tick all that apply.

8 responses



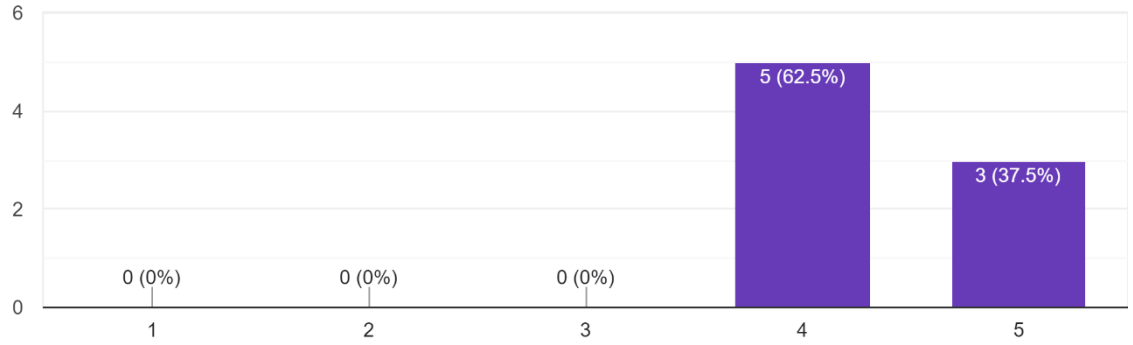
KNOWLEDGE: How familiar are you with the concepts of 'cultural humility' or 'cultural competence' when providing care to patients?

8 responses



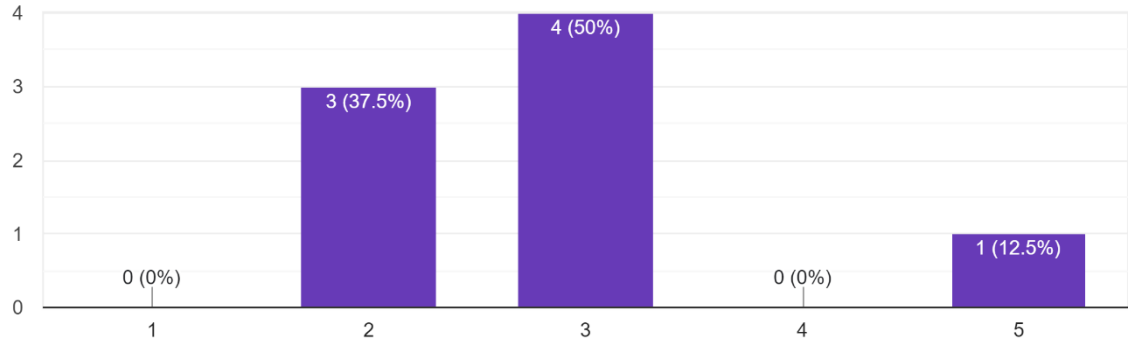
ATTITUDES: How important do you think cultural competence is in managing hypertension in Black African and Caribbean patients?

8 responses



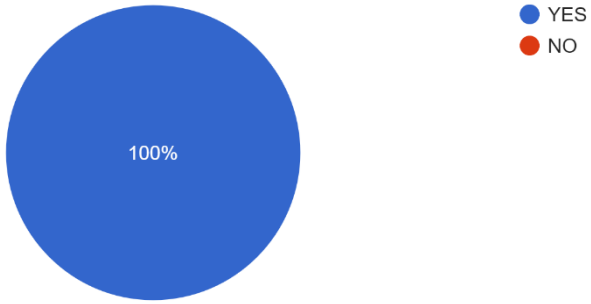
ATTITUDES: How comfortable are you discussing culturally specific dietary and lifestyle changes with Black African and Caribbean patients?

8 responses



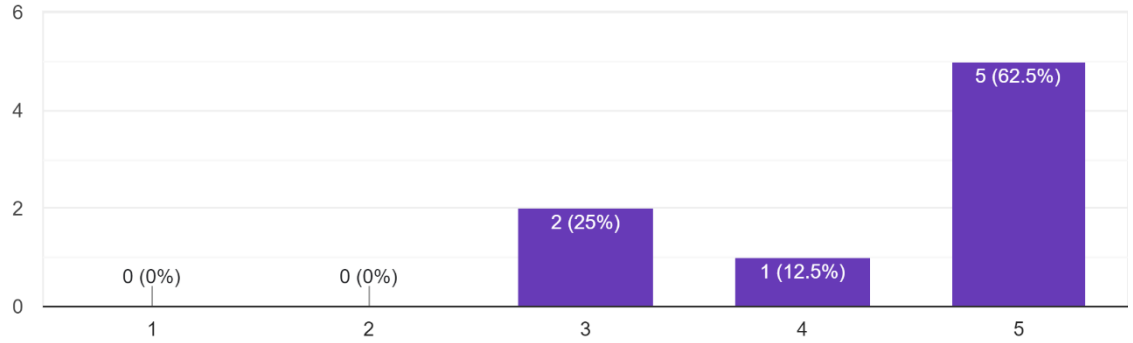
ATTITUDES: Do you believe traditional remedies and different health beliefs should be addressed in hypertension consultations?

8 responses



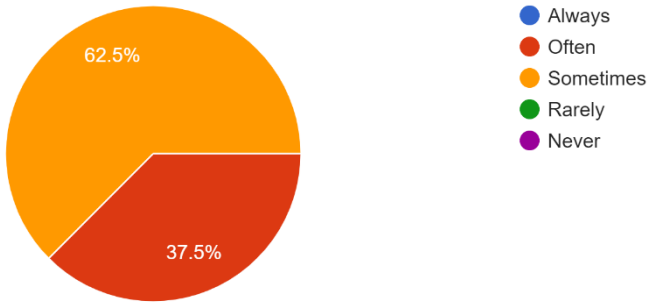
ATTITUDES: How open are you to learning from patients about their cultural practices?

8 responses



SKILLS: How often do you assess the cultural context of a patient's lifestyle when providing hypertension advice?

8 responses

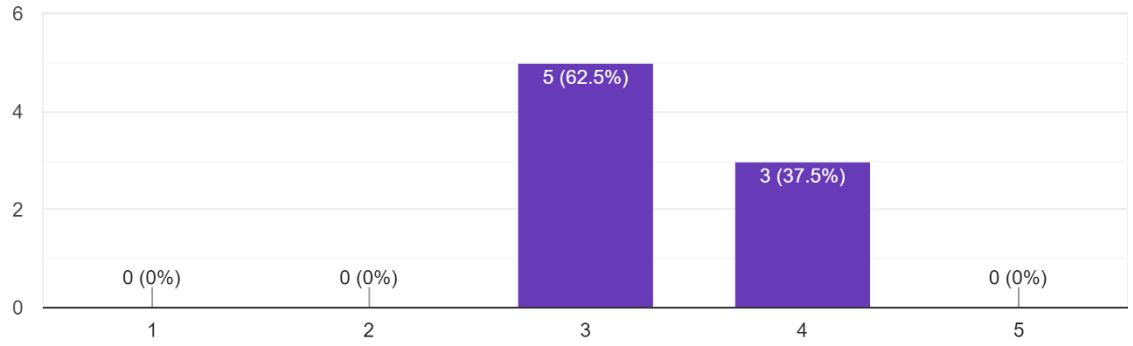


SKILLS: Can you provide examples of culturally relevant communication strategies you've used to discuss hypertension?
2 responses

discussions around animal produscts in med , fasting- use of

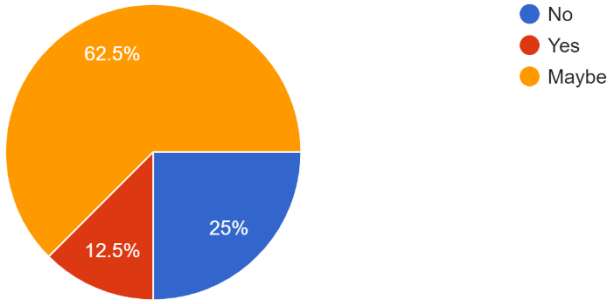
Ask open questions about diet and compliance with medication.

SKILLS: How confident are you in navigating potential language or communication barriers with Black African and Caribbean patients?
8 responses



PRACTICE: Do you incorporate cultural dietary practices AND/OR physical exercise advice that aligns with cultural norms into your recommendations for hypertension management?

8 responses

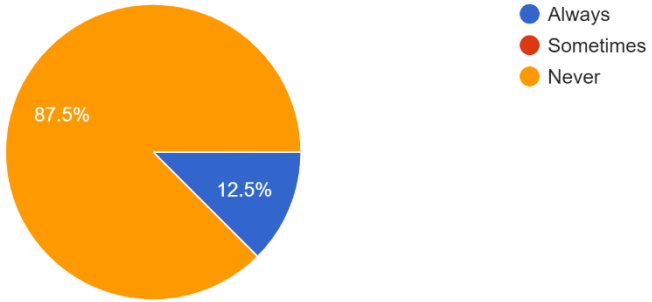


PRACTICE: How frequently do you engage with family members or caregivers in discussions about hypertension management?

8 responses

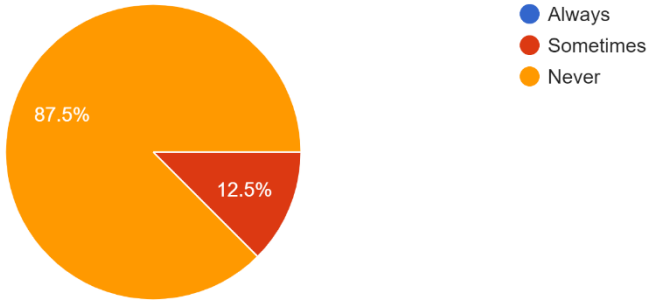
PRACTICE: How often do you provide educational materials tailored to Black African and Caribbean communities?

8 responses



PRACTICE: Do you refer patients to culturally relevant community resources or support groups for hypertension?

8 responses



OPPORTUNITIES: What challenges have you faced when providing hypertension education to Black African and Caribbean patients?3 responses

i dont know what groups are available , sometimes navigating internet to find info / leaflets isnt easy

Time!

Lack of compliance

OPPORTUNITIES: What resources or training would help you feel more competent in this area?5 responses

anything!

Training - what's on offer locally, how to connect better with people, how they might need to hear or understand explanations and how symptoms might be described

Seminar

Any training available and patient information leaflets

Info about local groups or online patient info with cultural reference

OPPORTUNITIES: Are there any gaps in your current practice that you think could be addressed to improve cultural relevance?

5 responses

diet - i only know what patients have told me - ive no proper knowledge of traditional foods - eg i know bits - like about high carbs in afro caribean diet , use of salt and high meat intake - use of ghee in some Asian foods

Not knowing much about specific cultural beliefs about invisible conditions like hypertension and how to describe it or use stories/info to connect with people.

Yes - how hypertension affects afrocarribeans

Engagement

Community services for hypertension

AND FINALLY (!!)

What suggestions do you have for improving culturally sensitive hypertension care for Black African and Caribbean patients @VMC?

4 responses

to be open and understanding , to not be scared to ask questions and show an interest in beliefs and ideas

Have easy templates to share info and utd info on local resources

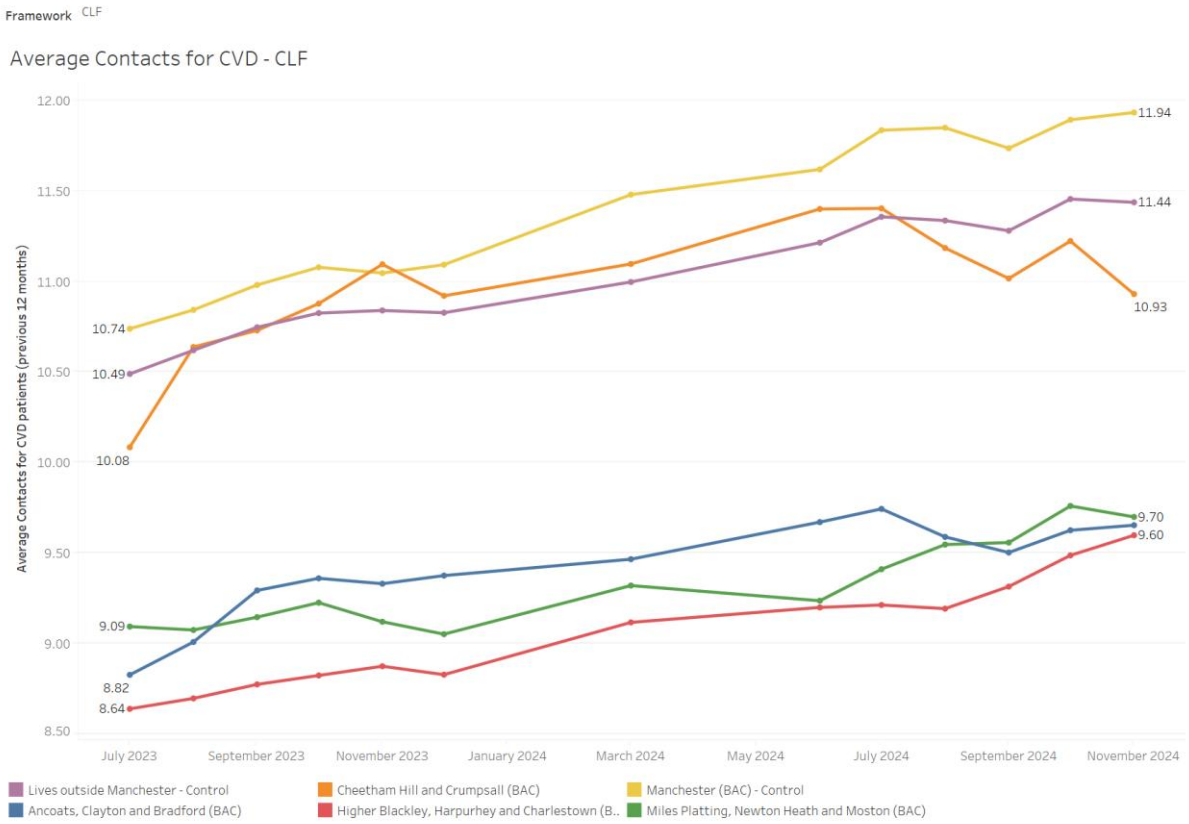
Incorporation of targeted patient information leaflets. More time to discuss and explore any issues.

Improving awareness of cultural variation among staff

Appendix 3

CV Need data:

The rising cost of CVD in terms of patient contacts by PCN: Our PCN in RED



NB: Filtered by ethnicity to include BAC, Mixed, unknown

Prevalence - Summary, trend in time and breakdown

Condition
Hypertension

Breakdown - X Axis
Ethnicity Category

Cover Sheet

Prevalence (Trend)

Prevalence (Variation)

CVNeed (Single)

CVNeed (High Priority)

CVNeed (Dem & Total)

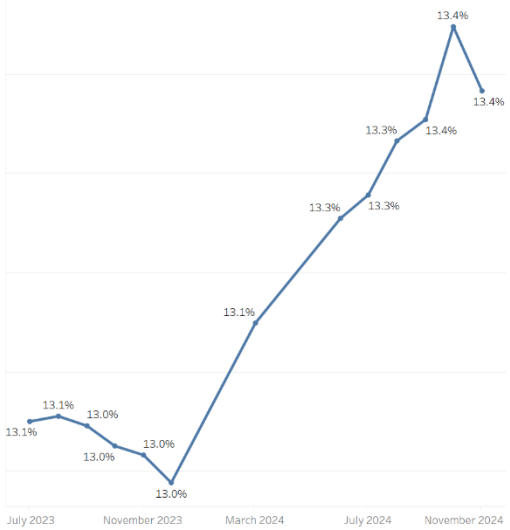
CVNeed (Variation)

Hypertension Pathway

Show description

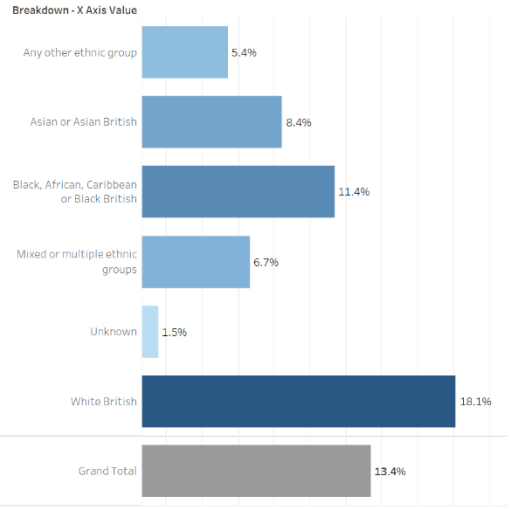
Show filter

Hypertension Prevalence trend in time

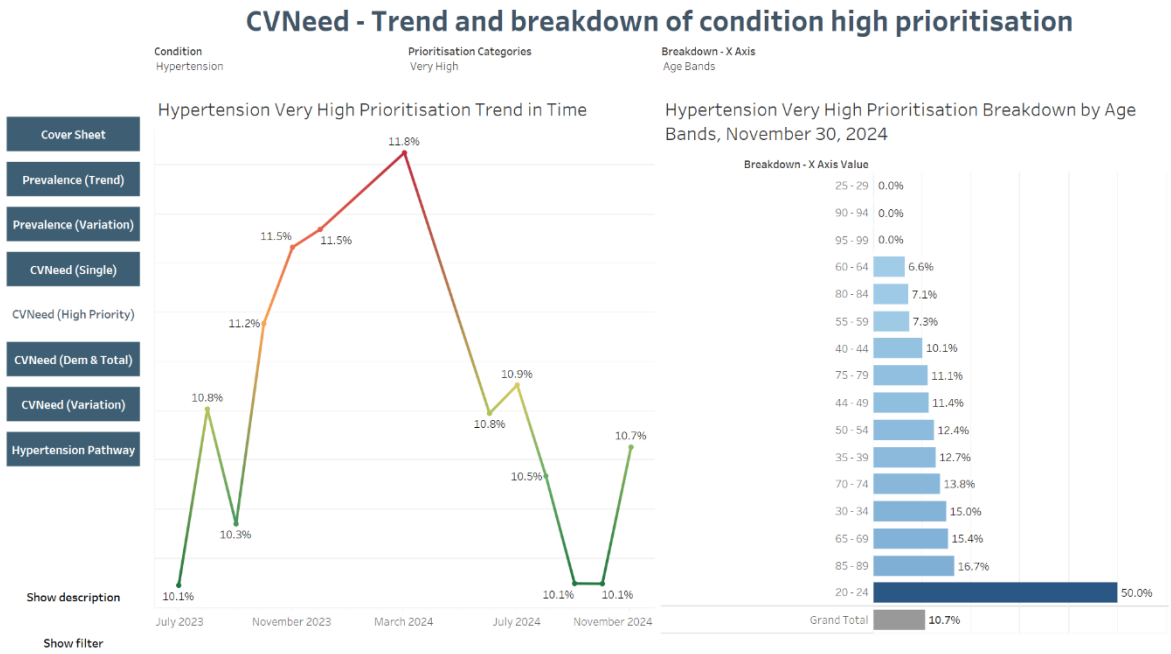


Hypertension Prevalence by Ethnicity Category, November 30, 2024

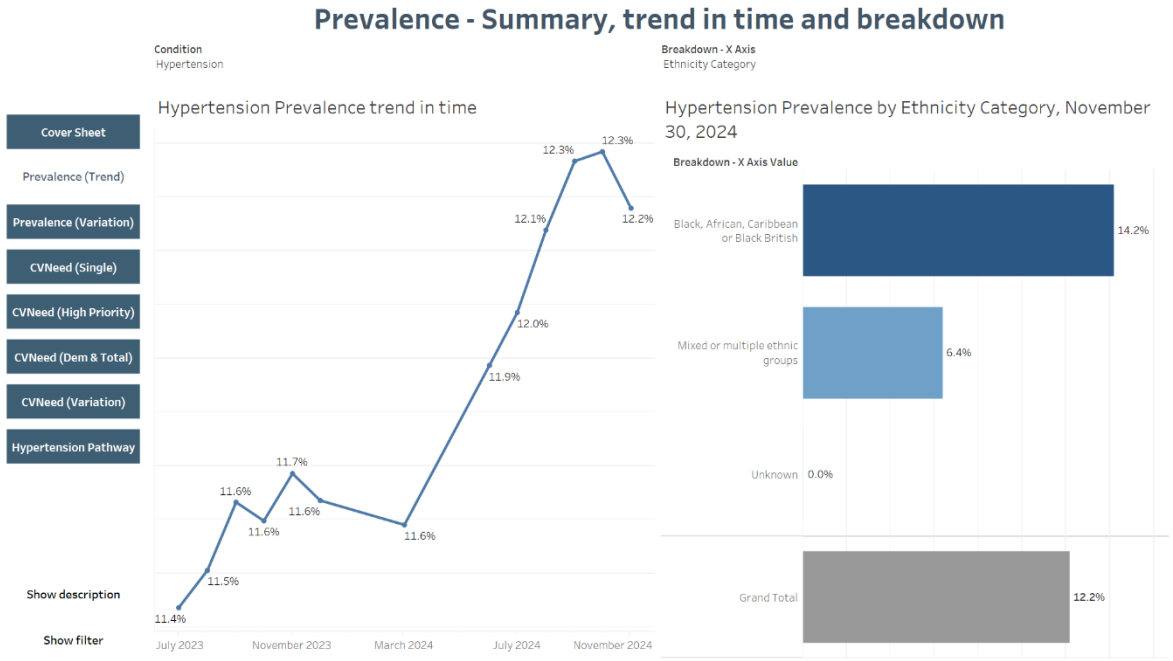
Breakdown - X Axis Value



High need / high prioritisation = no recent BPs, or high BPs as per UCL classification:



Note the split by age - the above may indicate young people with one off high readings and reduced engagement with healthcare at this life stage.



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The Future: Areas of need and future potential reach:

The red area of high CV need next to North Manchester General Hospital: LSOA11NM Manchester 006C contains 219 patients with an average CV need score of 2.7443

The red area of high CV need below Boggart Hole Clough: LSOA11NM Manchester 007A Contains 101 patients with an average CV need score of 2.8064

The amber area below Blakely Golf Club: LSOA11NM Manchester 003G Contains 100 patients with an average CV need score of 2.460

Table of patient numbers and CV need by Ethnicity from May 2024:

Ethnic Group	**CV Need Score**	**No of Patients at VMC in this group**	**Notes**
Any other ethnic group	2.4	24	Medium risk
Asian or Asian British	2.85	120	Medium risk
Black, African, Caribbean or Black British	3.25	204	High
Mixed or multiple ethnic groups	3.88	36	High – nearly v high (above 4)
Unknown	2.15	135	Medium risk
		TOTAL: 519	

White British	2.36	2329	Medium risk
		TOTAL: 2848	

Whilst I can't yet confirm exactly where our patients from BAC communities live, as the hot map only gives info on average CV need in that area, and a total number of patients, given the higher risk CV scores in our communities of interest, it's likely there is some overlap with our 'red' areas.

A note on CV need score: CV Need score: is a score 'created' by GM CVD lead Aseem and data expert, Matt. It is based on research of indicators looked at by UCL in London. The UCL team looked at 'proactive care categories' for certain diseases, to see who would benefit most from input. It's designed as a clinician focused tool, so for practices they can see how and where to prioritise and target an offer to address unmet need. It can also be used as a benchmark for how practices/areas are doing. It is NOT a measure of absolute risk (ie...risk of a person developing a disease over a time period) but is a little like a 'numbers needed to treat' figure in that you can see who might give you the biggest return on your investment (the investment here being a care intervention or 'treatment') as we know that those with higher risk scores, like those who do not exercise at all, get the greatest benefit when there are positive changes. In other words, CV Need score gives us a weighting, and we can see who will benefit most from a clinical intervention/approach to improving health.

Hypertension:

You can also look at CV need scoring specifically for Hypertension. This tells us at VMC **there are 251 patients** with a score above 1, indicating medium to high risk (they may have a high BP or no BP at all recently taken) 44 of these patients have an ethnicity marked as BAC, unknown or declined to provide/not stated.

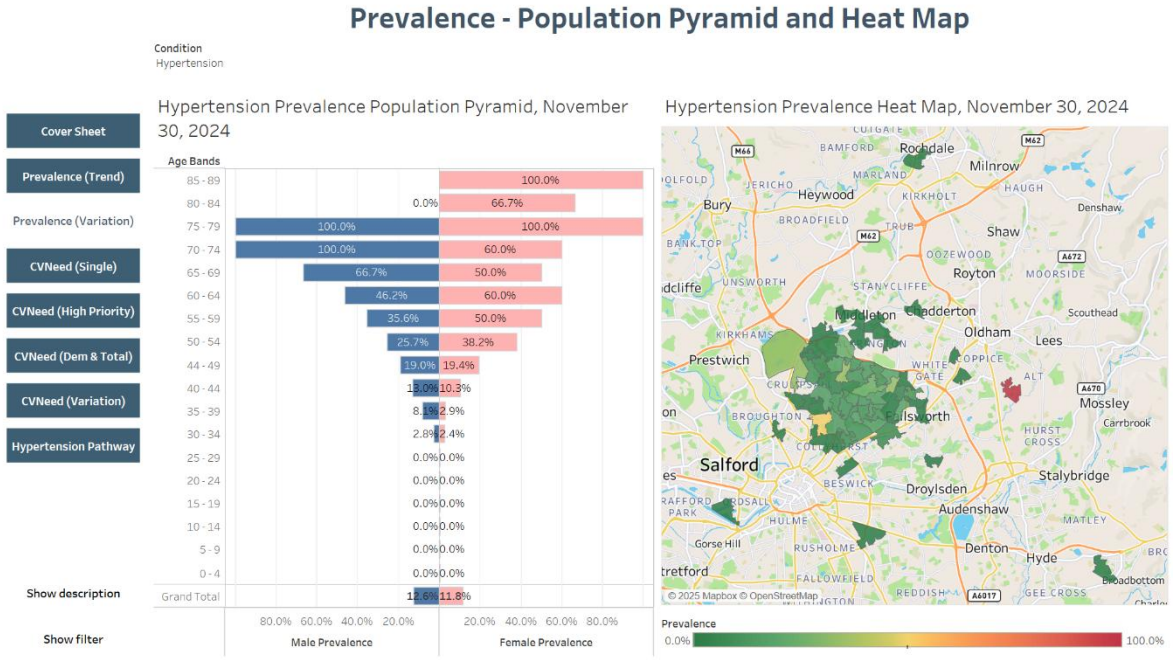
Prevalence:

BAC: 13.3% (147 numerator, over 1102 denominator – ie the no of people who have developed the disease, over the total no of people in our population of interest)

Multiple ethnic groups: 6.2% (19 over 307)

Unknown ethnicity: 0.5% (9 over 1793)

Of note prevalence is higher for women in the working age categories of 44-65 and again, we must wonder about missing cases amongst working age males from a mixed or BAC ethnic background.



CV Need data:

Prevalence - Summary, trend in time and breakdown

Condition
Hypertension

Breakdown - X Axis
Ethnicity Category

Cover Sheet

Prevalence (Trend)

Prevalence (Variation)

CVNeed (Single)

CVNeed (High Priority)

CVNeed (Dem & Total)

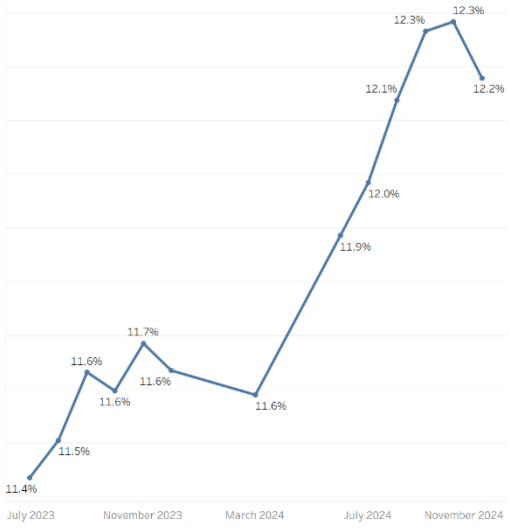
CVNeed (Variation)

Hypertension Pathway

Show description

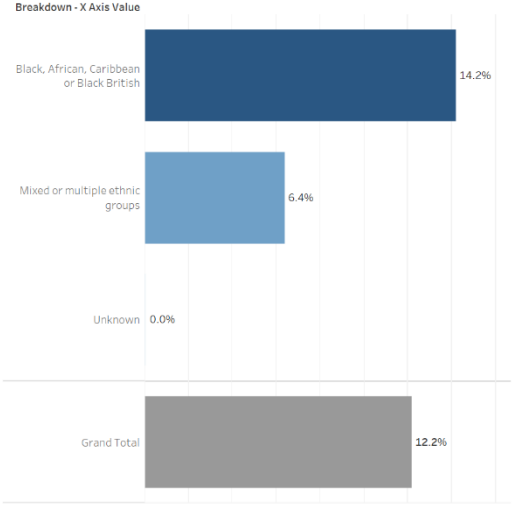
Show filter

Hypertension Prevalence trend in time



Hypertension Prevalence by Ethnicity Category, November 30, 2024

Breakdown - X Axis Value



CVNeed - Trend and breakdown of condition high prioritisation

Condition
Hypertension

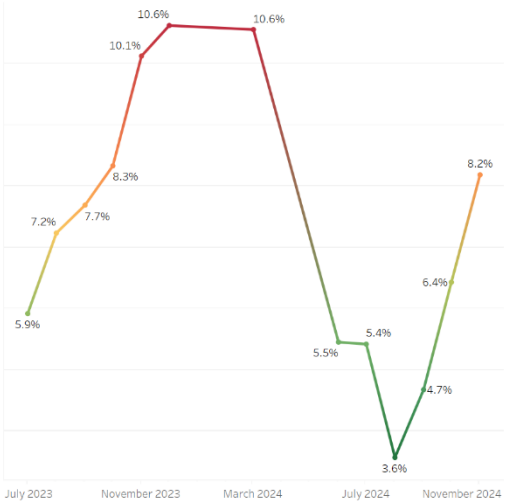
Prioritisation Categories
Very High

Breakdown - X Axis
Ethnicity Category

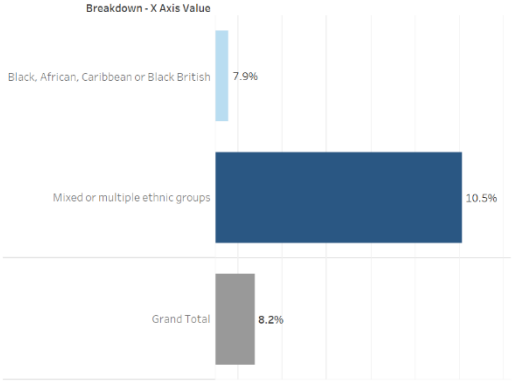
Cover Sheet
Prevalence (Trend)
Prevalence (Variation)
CVNeed (Single)
CVNeed (High Priority)
CVNeed (Dem & Total)
CVNeed (Variation)
Hypertension Pathway

Show description
Show filter

Hypertension Very High Prioritisation Trend in Time



Hypertension Very High Prioritisation Breakdown by Ethnicity Category, November 30, 2024



Hypertension Pathway

Actions for Hypertension patients based on Medication Pathway, November 30, 2024

Cover Sheet

Prevalence (Trend)

Prevalence (Variation)

CVNeed (Single)

CVNeed (High Priority)

CVNeed (Dem & Total)

CVNeed (Variation)

Hypertension Pathway

Show description

Show filter

Hypertension Risk	No action	Reading required		Medication action		Drug resistant	TBC	Grand Total
	No action, hypertension treated to target	Blood pressure reading more than 12 months old	Repeat blood pressure after recent medication change	Start new medication	Increase dosage of existing medication	Resistant to Drugs (one or more contraindicated)	No suggestions, patient has heart failure	
1 Clinic BP >= 180/120 mmHg			100.0% (1)					100.0% (1)
2 Clinic BP >= 160/110 mmHg		15.4% (2)	30.8% (4)	23.1% (3)	23.1% (3)		7.7% (1)	100.0% (13)
3 No BP reading in the last 18 months		100.0% (7)						100.0% (7)
4b NTTT: Stroke / TIA / CKD and ACR >= 70 mg/mol, Clinic BP > 130/80 mmHg				75.0% (3)	25.0% (1)			100.0% (4)
4c NTTT: CKD and ACR < 70 mg/mol, Clinic BP > 140/90 mmHg			50.0% (1)	50.0% (1)				100.0% (2)
4d NTTT: Age < 80, Clinic BP > 140/90 mmHg		9.7% (3)	32.3% (10)	38.7% (12)	16.1% (5)	3.2% (1)		100.0% (31)
5a TTT: Age >= 80, Clinic BP <= 150/90 mmHg	100.0% (3)							100.0% (3)
5b TTT: Stroke / TIA / CKD and ACR >= 70 mg/mol, Clinic BP <= 130/80 mmHg	100.0% (2)							100.0% (2)
5c TTT: CKD and ACR < 70 mg/mol, Clinic BP <= 140/90 mmHg	88.9% (16)	11.1% (2)						100.0% (18)
5d TTT: Age < 80, Clinic BP <= 140/90 mmHg	97.8% (88)	2.2% (2)						100.0% (90)
Grand Total	**63.7% (109)**	**9.4% (16)**	**9.4% (16)**	**11.1% (19)**	**5.3% (9)**	**0.6% (1)**	**0.6% (1)**	100.0% (171)

Prevalence - Summary, trend in time and breakdown

Condition
Hypertension

Breakdown - X Axis
Ethnicity Category

Cover Sheet

Prevalence (Trend)

Prevalence (Variation)

CVNeed (Single)

CVNeed (High Priority)

CVNeed (Dem & Total)

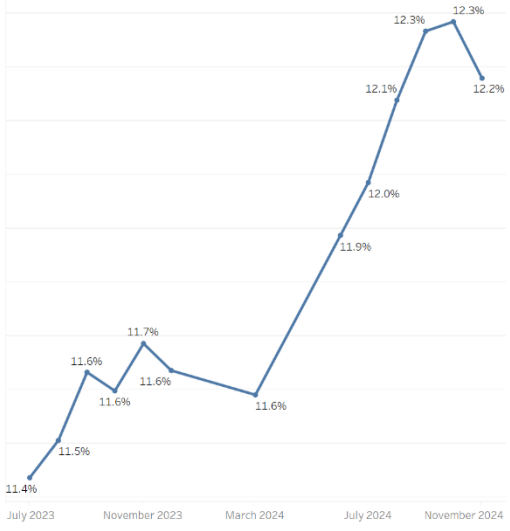
CVNeed (Variation)

Hypertension Pathway

Show description

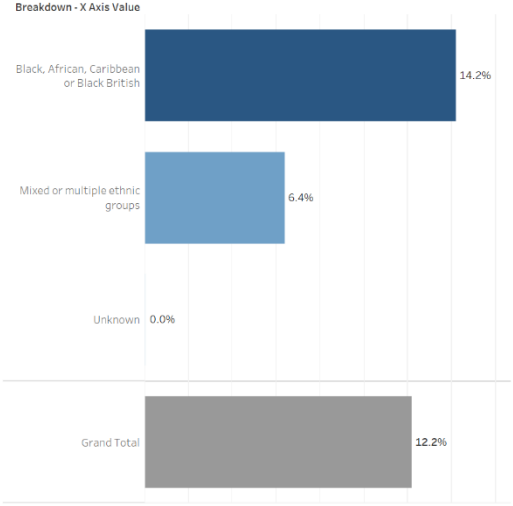
Show filter

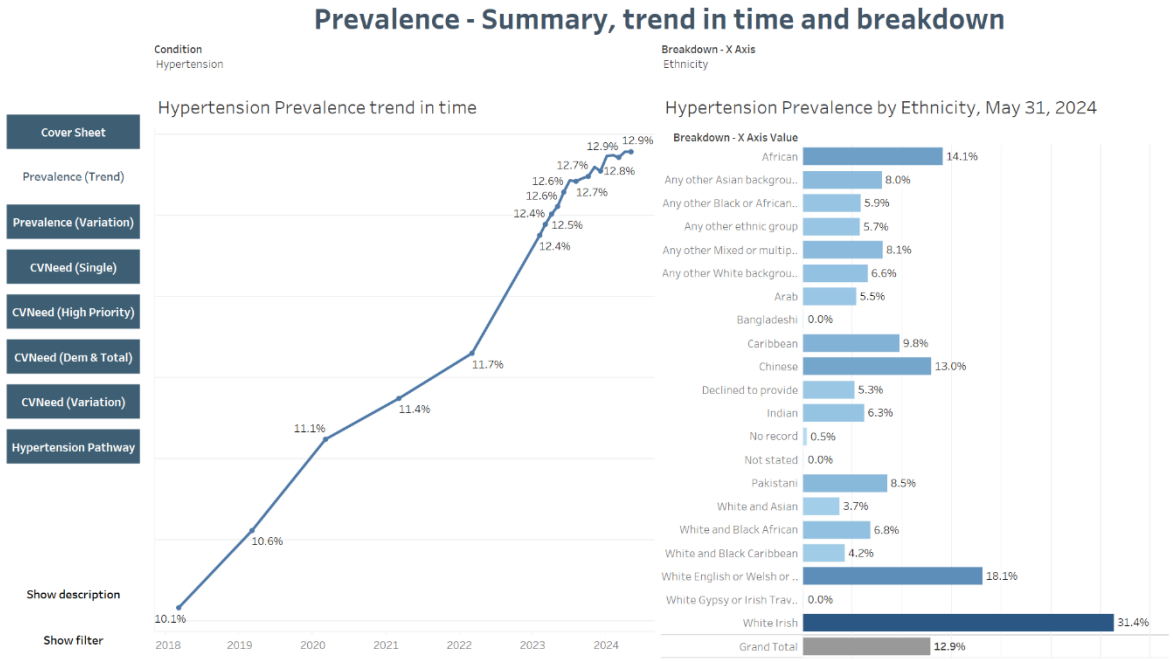
Hypertension Prevalence trend in time



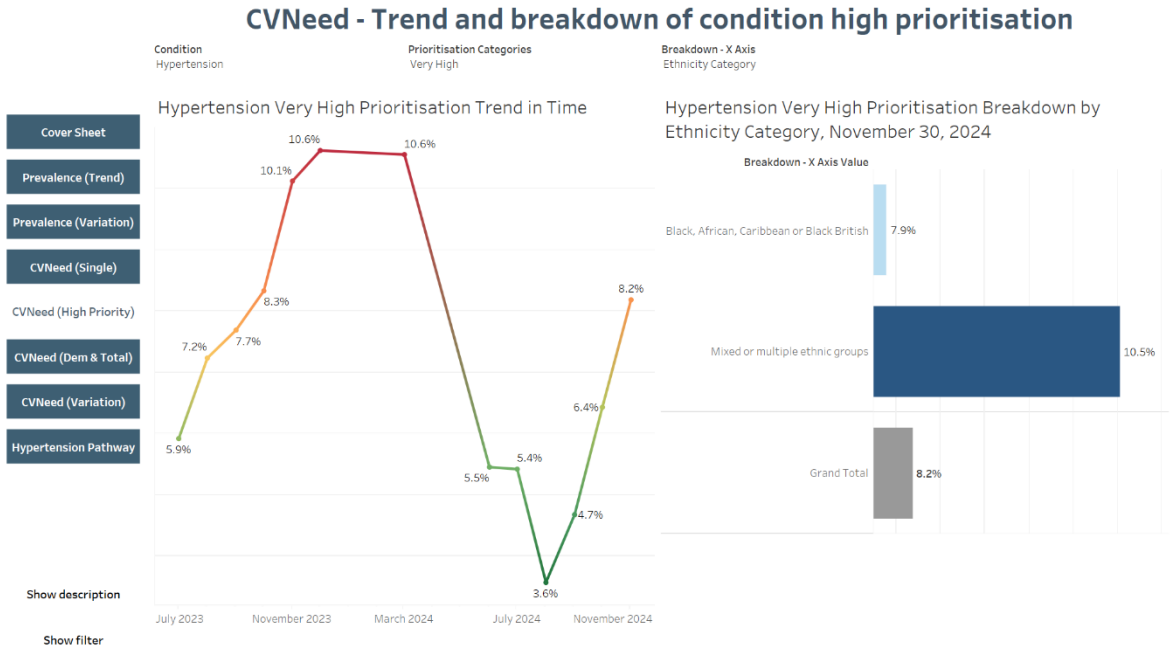
Hypertension Prevalence by Ethnicity Category, November 30, 2024

Breakdown - X Axis Value





NB above screen grab used differing ethnicity filters so direct comparison with November data trickier, but provides a good rationale for focus of project.



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Appendix 4:

VMC Hypertension pathway

Valentine Medical Centre – HYPERTENSION

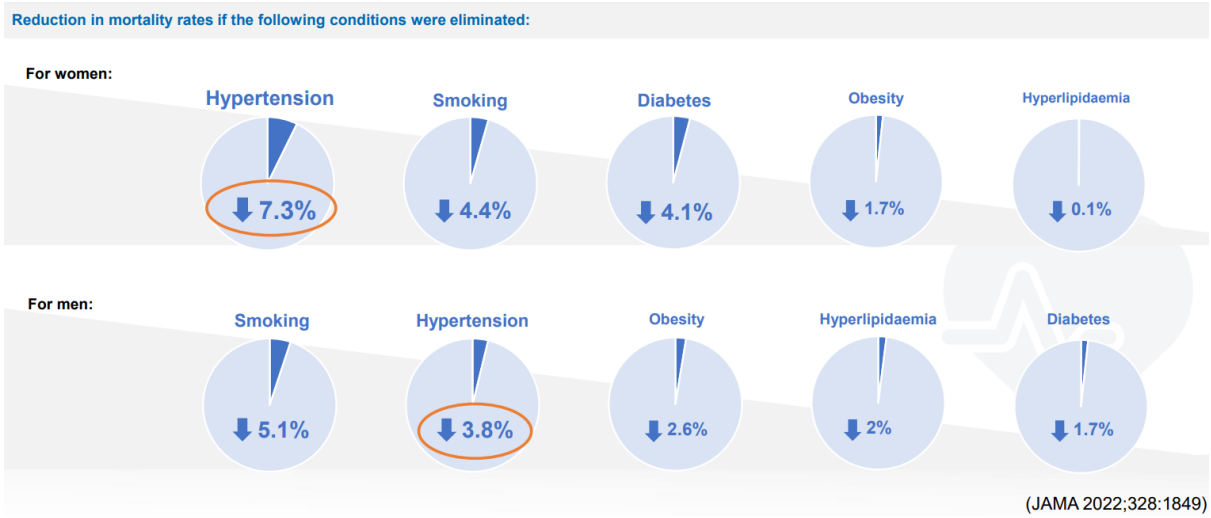
Aims of updating our practice policy :

It's time to talk about hypertension, at practice and PCN level, and with our patients.

• Commit to taking some action.

• Use the resources available to identify patients who may have undiagnosed hypertension, initiate care for newly diagnosed patients, and optimise care for patients already diagnosed.

• The result should be that we move towards the ambition of 77% of patients treated in accordance with NICE guidance, **which will save lives and prevent heart attacks and strokes.**



I'm in it to save lives. But why else does this matter to us?

The agenda for hypertension management is guided by the NHS 10-Year Long Term Plan and incentivised through QOF payments and the PCN DES. It requires collaboration with a system-wide approach to improving hypertension diagnosis and management In addition, hypertension case finding and management, and lipid management are a clinical focus area in the national health inequalities programme CORE20PLUS5

The NHS 10 Year Plan

The ambitions for the management of hypertension in the NHS 10-year plan are:

• Detection: 80% of the expected number of people with hypertension will be

diagnosed by 2029

• Treatment: 80% of the total number of people diagnosed with hypertension

will be treated to target as per NICE guidelines NG136 by 2029. *The

treatment target for hypertension is below 140/90 in people aged under 80,

and below 150/90 in people aged 80 and over (*relating to clinic readings).

NHS National Objectives 2024/25 The national priorities relevant to the CVD agenda are:

• Increase percentage of patients with hypertension treated to NICE guidance to 80% by March 2025, an increase on the 77% target in 23/24. 7

• Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%.

• Continue to address health inequalities and deliver on the Core20PLUS5 approach. CVD is one of the biggest contributors to the life expectancy gap between the most and least deprived population groups. Hypertension case-finding and optimisation and optimal lipid management is one of the 5 focus clinical areas in the Core20PLUS5 approach.

PQRRS:

Hypertension is covered via the PQRRS focus on: Quality- Multimorbidity reviews

- Practices to build on the work to date taking place in relation to multimorbidity reviews to improve the health and wellbeing of people living with Diabetes and Cardiorespiratory disease (Diabetes, CVD and COPD).
- To provide proactive, holistic care for people with diabetes and cardiorespiratory disease, focusing on those who have not had a recent review and those at most risk.
- To undertake a multimorbidity review so patients with long term conditions are attending once for a comprehensive review comprising all aspects of clinical care
- Over the multi-year scheme, to improve clinical outcomes and disease control

Those AT RISK defined as:

Hypertension: UCL Partners at-risk:

• 1 Clinic BP >= 180/120mmHg

• 2a Clinic BP >= 160/100 mmHg

• 2b Clinic BP >= 155/90 mmHg, BAME and CVD Risk

• 2c No BP reading in the last 18 months

Multi-morbidity review elements common across all conditions: • BP • BMI • Cholesterol • HbA1c 13 • Smoking Status • Alcohol • Mental Wellbeing • eFI (age 65 and over)

Patients at risk with Hypertension require: Multi-morbidity elements as defined above and • Medication increased / antihypertensive declined / maximum tolerated dose / adverse reaction

Work flows – The VMC model:

NEW DIAGNOSIS:

GP or Nurse or patient or community pharmacist or outreach workers – identify new hypertensive reading during consultation or at home or via community service.

Diagnosis then required via home BP monitoring / loan of BP monitor – (if able to do BP readings at home, ensure later that coding and added to Home digital BP emis list). Accurx information on home BPs sent, and link to home BP readings link or paper form as preferred. Admin team to manage this step.

Review of home BP findings should be with nurse/PA in first instance to decide best course of action ie review with nurse/PA, GP if complex, urgent review if high/malignant/complex (see UCL partners stratification flow chart below). If no home BPs completed after prompting or reminder sent x 2 and 1 x call by admin team– to send back to GP for review.

Once new diagnosis added to record – this generates a task to book an appointment for ECG, urine dip, ACR as needed.

Nurse team to follow GM hypertension guidance – if feel need to escalate beyond 2 agents, to seek GP review. All medication initially for 1 repeat authorised only, if being started or dose altered to ensure follow up / review.

Key part of management is SELF MANAGEMENT: all patients educated about the target range for blood pressure and its importance, signposted to monitoring resources, and encouraged to self-monitor their blood pressure at home ('know your numbers').

After completion of Hypertension / LTC review – all have medications review slot with GP or pharmacist to ensure medication reauthorised for BP.

Ensure coding of: BP, pulse, weight, other risk factors for CVD, whether patient has access to home monitoring, and information relevant to ensure we optimise care ie ethnicity/language.

KNOWN HYPERTENSION:

Targets Summarised:

Different Targets

Situation	Clinic Target (mmHg)	Home/Average Target (mmHg)
<80 years old	<140/90	<135/85
>80 years old	<150/90	<145/85
CKD and (ACR>70mg/mol) (1)	<130/80	<125/75
Stroke and TIA (2)	<130/80	<125/75

1. NICE CKS CKD Guidelines
2. RCP Stroke Guidelines 2023

1. Regular high risk searches generate patients to contact for multimorbidity review OR patient with known hypertension found to be above target / not currently being issued with meds etc. – appointment should be offered with nurse/PA.
2. Patient review using GM guidance, self management approaches and tailored strategies to support patient.
3. Make use of digital platforms and encourage home BP checks prior to reviews if medication changed/commenced

Greater Manchester Adult Hypertension Medication Pathway

Diagnosis & Assessment : ABPM or Average Home BP (Twice Am and Pm x 4 days)
Titrate every 4 Weeks after BP reassessment
Consider referral to community pharmacy for ABPM where available (tiny.one/cplpservice)

TARGETS Age <80: Home/Average **< 135/85 mmHg** or clinic **< 140/90mmHg**
Age 80+: Home/Average **< 145/85 mmHg** or clinic **< 150/90 mmHg**

Clinic BP ≥ 140/90 mmHg (age <80)
or ≥ 150/90 mmHg (age 80+)

Age < 40 - consider referral and secondary causes

Previous history of raised BP readings including in pregnancy, CKD, TIA, Stroke, Hypertensive retinopathy, sleep apnoea, proteinuria, diabetes, unexplained LVH

Always take each person's clinical and personal situations and preferences into account.
Advise reduction in salt & salty foods, reduce alcohol to < 15 units /week, weight to BMI < 25, DASH diet (tiny.one/dashdiet), exercise for 30+minutes x 3-5/week.
Baseline investigations: Lipids • U&Es • LFTs • TFT • HbA1c • ECG • Urine Dip • ACR

Age < 55 or T2 Diabetes
A
LISINOPRIL 10 mg OM

Clinic BP ≥ 160/110 mmHg OR Home Avg BP ≥ 155/105 mmHg

Age 55+ or Black African or African Caribbean origin
C
AMLODIPINE 5 mg OM

Not at target

A+C

Combine **LISINOPRIL 10mg OM** with **AMLODIPINE 5mg OM**
(combination therapy is approximately 5 x more effective than doubling monotherapy)

Not at target

Consider pre-payment certificates for patients that pay for prescriptions

Not at target

A+C

Increase **LISINOPRIL to 20mg OM**
(See yellow box for monitoring requirements and eGFR change thresholds)

A+C

Increase **AMLODIPINE to 10mg OM**

Not at target

A+C+D

ADD **INDAPAMIDE 2.5mg OM**

A+C+D

Not at target

A+C+D

INCREASE **AMLODIPINE TO 10 mg, LISINOPRIL TO 20mg WITH INDAPAMIDE 2.5mg OM**

Not at target

RESISTANT TO 3 DRUGS
>90% of patients resistant to 3 drugs are not taking them
CHECK CONCORDANCE

Reconsider salt, alcohol, other drugs incl. NSAIDS, Steroids, Additives eg Liquorice, Cancer Therapies; ? Coarctation, Sleep Apnoea, Obesity -
Consider signposting to community pharmacy for New Medication Service (NMS)

FURTHER OPTIONS
K⁺ > 4.6 mmol/L : Doxazosin IR 2-4 mg OD, or Bisoprolol 2.5mg OD
K⁺ < 4.6 mmol/L : Spironolactone 12.5mg OM
or refer for specialist advice

Recheck 6 Months to 1 Year
Once stable

Version 8 April 2023

CKD

CKD (eGFR 25-60 ml/min) and Proteinuria (urine ACR >25mg/mmol):

Without T2DM:
1st Line ACEi/ARB
If ACR then remains > 25 mg/mmol consider **Dapagliflozin[1] 10mg OD**

With T2DM:
Ensure already on appropriate ACE-I/ARB.
If urine ACR 3-30 mg/mmol consider adding **Dapagliflozin[1] 10mg OD**.
If urine ACR >30mg/mmol *offer* **Dapagliflozin[1] 10mg OD**

See CKD guide (coding, calculating kidney failure risk equation, patient information leaflets and more detailed guidance)

CKD and Urine ACR > 70mg/mmol : Aim for clinic BP <130/80 mmHg

A

ACEi/ARB
1st Line: LISINOPRIL[1] 10mg OM
(PERINDOPRIL ERBUMINE[1] 4mg OM)
(Ramipril is shorter acting)
2nd Line: CANDESARTAN[1] 8mg OM
IF ACEI-INDUCED COUGH
(more effective and safer than Losartan)

Check U+E's before starting and 2 weeks after initiation.
If eGFR decreases by less than 25%, do not modify the ACE-i and recheck levels after 1-2 weeks.
If eGFR decreases by more than 25% or creatinine rises by more than 30% : investigate for secondary causes such as dehydration or concurrent medication (eg NSAIDS) if persists despite these measures stop the ACE-i OR reduce dose to previously tolerated (recheck 5-7 days)
Angiotensin-converting enzyme inhibitors | Prescribing information | Hypertension | CKS | NICE

C

Calcium Channel Blocker
1st Line: AMLODIPINE 5mg OM
Amlodipine 5mg gives 80% of the effect of Amlodipine at 10mg
2nd Line: LERCANIDIPINE 10mg OM
If troublesome ankle swelling

D

Diuretic
1st Line: INDAPAMIDE[1] 2.5mg OM

Check U&E's before starting, and at regular intervals, within 2 months and ensure Na+ remains > 130 mmol/l, otherwise STOP
Recheck and, if improved, consider **Bendroflumethiazide[1] 2.5mg OD**

Thiazide-like diuretics | Prescribing information | Hypertension | CKS | NICE

[1] **Medication may require dose adjustment based on co-morbidities (e.g. renal/hepatic impairment) always check the BNF if uncertain. This pathway is not for use with pregnant patients.**

Key Pathway Take home Messages:

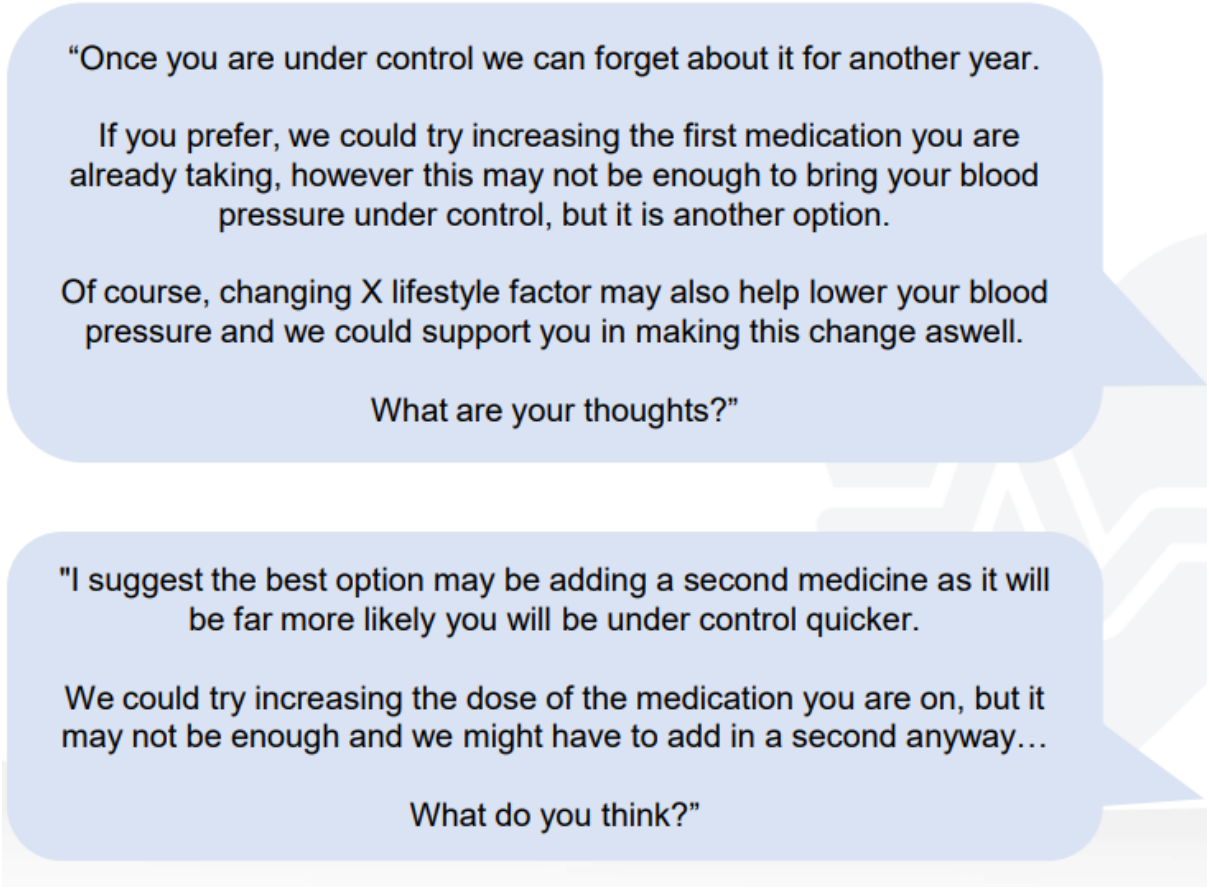
Aim for control, ASAP:

Fewer and quicker titrations to bring blood pressure under control results in a greater proportion of time spent in therapeutic range and better outcomes, while also requiring fewer clinic appointments and number of titrations.

Why go to two agents?

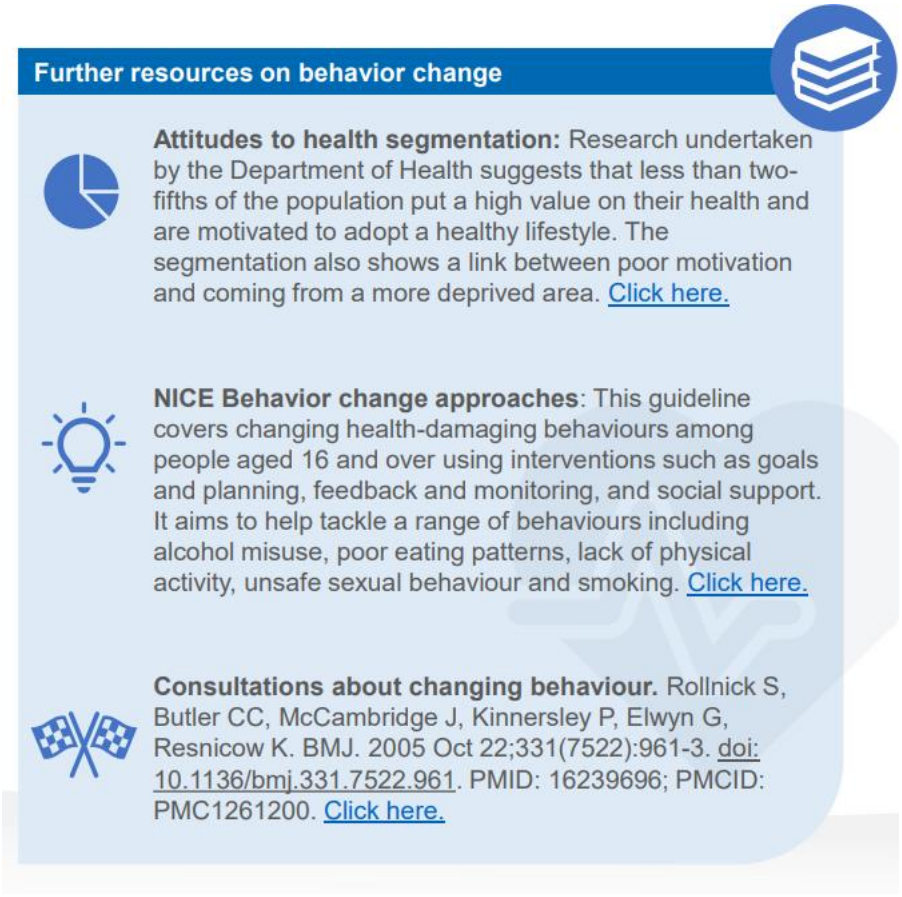
Multiple medications at lower doses are far more effective than fewer medications at higher doses. For instance, it is 5 times more effective to add a second drug at the starting dose than to double the dose of a single medication. Higher doses may increase side effects without a proportional increase in therapeutic effect. (E.g. Amlodipine 5mg gives 80% of the antihypertensive effect of Amlodipine at 10mg, which is far more likely to lead to side effects such as ankle swelling).*

- Offer newly diagnosed people with high BP's (Clinic: >160/110mmHg or Avg >155/105mmHg) two anti-hypertensives at low doses. There is no single anti-hypertensive that will reduce BP by more than 10mmHg. Thus, for those with high BPs it is leading to missed opportunities and ineffective titrations, increasing likelihood of patient disengagement, while ultimately wasting our time and those of our patients.
- Offer those with very high Blood Pressures two medicines at lower doses as this will be far more likely to bring them under control.
- REMEMBER PREPAYMENT CERTIFICATES!



<u>To improve self management:</u>

Why does patient activation matter?



What can we do?

Many people with hypertension may not have a causative lifestyle factor or not be in a change mindset. While the diagnosis of hypertension can be a frightening experience for many, we must ensure **we reframe high blood pressure as positive. We can do something about it** and have many tools and support available to help people bring it under control; ranging from antihypertensives through to lifestyle factors.

Managing high blood pressure is **not about feeling good today, but keeping well going forwards**. Many people have a subconscious bias and over-value immediate gains over long term ones (Present Bias). Thus, preventative consultations can be difficult and require good consultations skills, respecting individuals' autonomies, while empowering and facilitating them to help themselves.

It is of upmost importance we remain non-judgmental and focus on the needs of the individual in context with their social and wider determinants of health

Include these in our consultations:

Self management strategies & links if they are ready for them

Review of side effects of medications and wellbeing more broadly

Review health and cultural beliefs around hypertension

Use cultural competence training to deliver tailored care.

"You have high blood pressure. There are a lot of things we could do including supporting you with X lifestyle changes.

Medication is another important option and will reduce your blood pressure reducing your risk of pain and disability and help you to keep doing whatever is important to you"…

"Your blood pressure is high and it's likely you might need two medications to bring it under control.

It's not your fault that you have high blood pressure and you haven't done anything wrong… as it can often be genetic."…

1

Explicit agenda setting:

A good effective conversation is often topped and tailed by explicit agenda setting, agreeing what issues are most important to discuss today from the patients point of view.

Ideally they would have received a prompt or template to think about this in advance.

To see what additional support might be helpful, considering asking the following at the end of the consultation:

"Thinking about what we have talked about in this consultation, how confident do you feel you will be able to…..?"

2

Taking into account the person's 'activation level':

Patients vary greatly in the knowledge skills and confidence they have in managing their own health and care – we call this their level of activation. These differences significantly affect health outcomes, experience, and costs of health care.

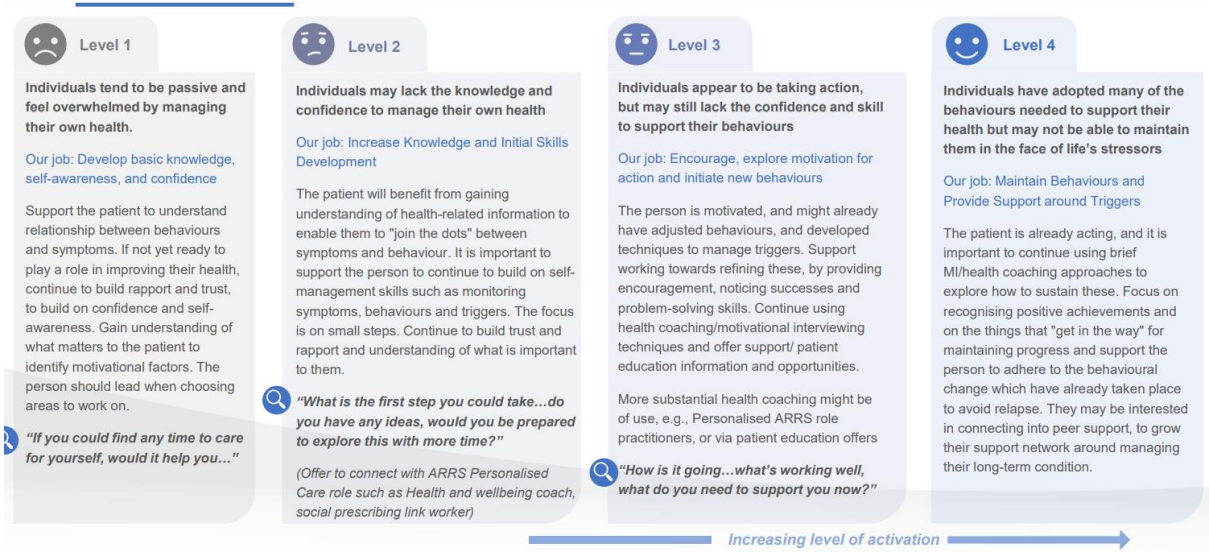
To effectively support a person to better manage their health, lifestyle and behaviour, our conversations and interventions need to be tailored to a person's starting point – meeting a person where they're at.

Useful questions include:

"Please tell me what you already do to look after yourself"

"Are you the kind of person who likes to go away and find out more about their health, or do you prefer it if we give you the answers and arrange things?"

The approach you take from there can then be tailored to that person's starting point.



3

Adopting elements of health coaching and motivational interviewing:

These techniques can be more effective than straight advice giving, because they better engage the patient, can help shift their mindset and build their confidence. Many GPs find it is helpful to skill themselves up in these areas, as well as to utilize the skills of additional colleagues that may be available – such as Health and Wellbeing Coaches, or Social Prescribing Link Workers.

Further resources

- **Dr Ollie Hart unpicks coaching principles** through an Island Metaphor in a 7-minute video. Click here.
- **The Personalised Care Institute** has many free e-learning modules in addition to other resources. Click here.
- **RCGP Person-centred care toolkit**. Click here.
- **Nesta's 'Good Help Bad Help' project** explored the evidence and practicalities underpinning good effective support that enables people to feel hopeful and take action. Click here.

Risk stratification Approach: Using data and searches

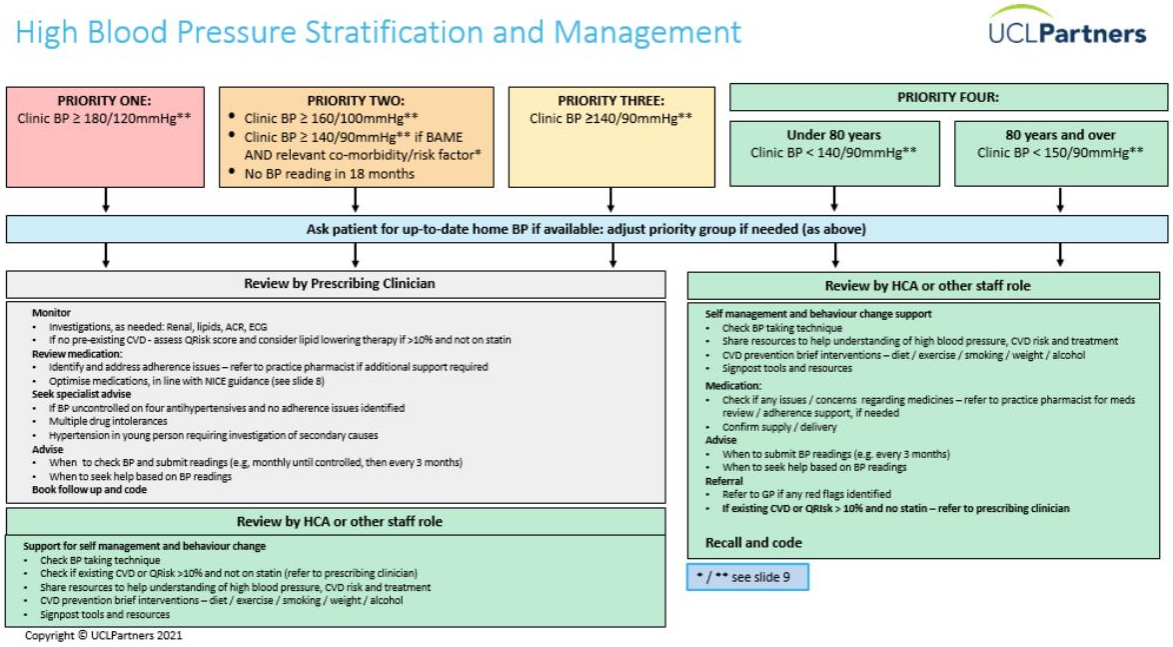
QOF lead for CVD/Hypertension to use a risk stratification approach and CV need dashboard

Benefits of this approach:

– Stratification informs workflow and workforce planning by prioritising and optimising clinical care.

– GP workload can be reduced by utilising the wider workforce to manage different priority groups.

– A shift between priority groups demonstrates clinical impact and helps GPs to meet QOF and other targets. – Prioritisation improves the personalised care offer for patients.



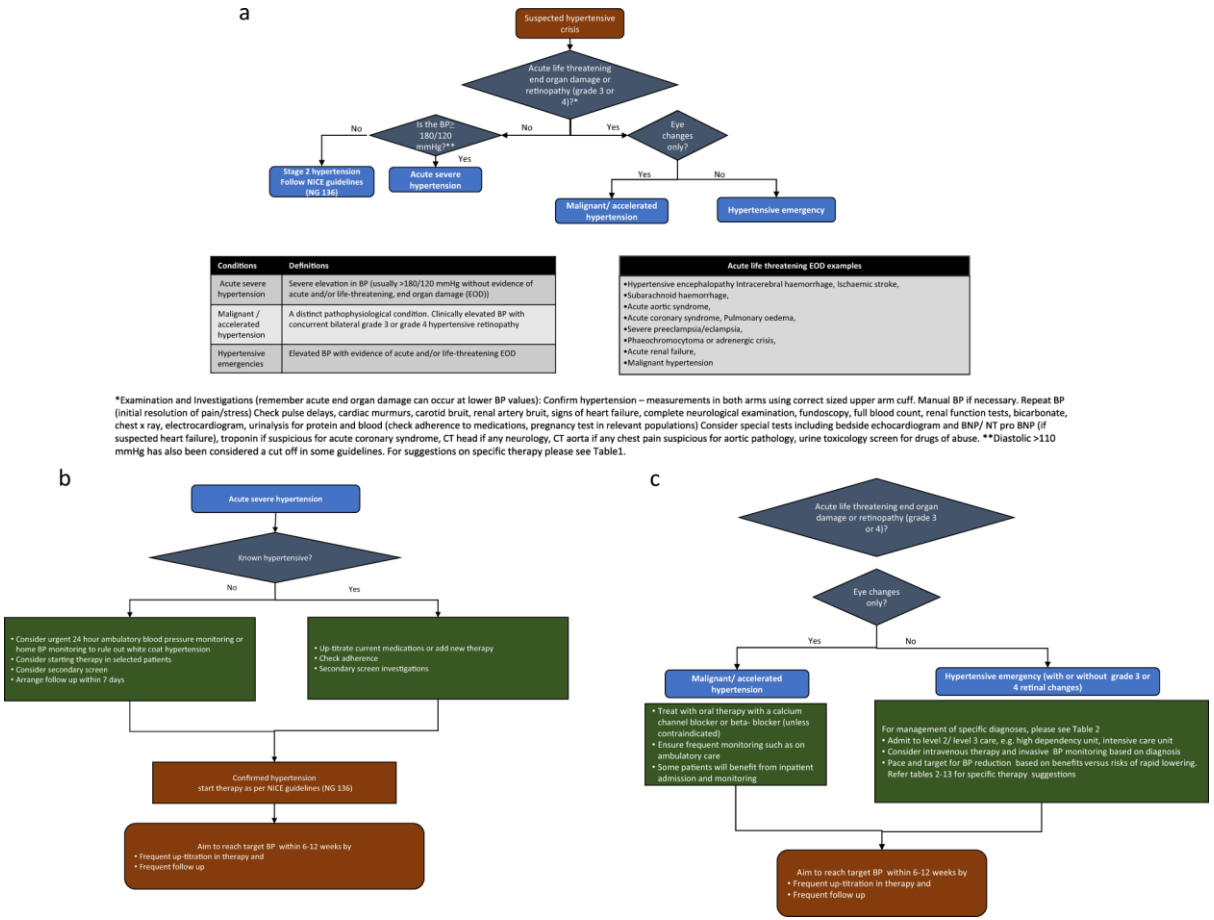
APPENDICES:

APPENDIX A

In an emergency:

Fig. 1: A framework for diagnosis and management of hypertensive emergencies, malignant hypertension (accelerated hypertension), and acute severe hypertension.

From: [Management of hypertensive crisis: British and Irish Hypertension Society Position document]



APPENDIX B:

Resources for patient self-management

A guide about how to manage your blood pressure from Heart UK. https://www.bhf.org.uk/informationsupport/support/manage-your-blood-pressure-at-home

A guide about High Blood Pressure from the Stroke Association.
https://www.stroke.org.uk/sites/default/files/publications/high_blood_pressure_and_stroke_guide.pdf

NHS Diabetes Prevention Programme: the Healthier You programme, a ninemonth, evidence-based lifestyle change programme.
https://www.england.nhs.uk/diabetes/diabetes-prevention/

NHS Digital Weight Management programme: supports adults living with obesity who also have a diagnosis of diabetes, hypertension, or both.
https://www.england.nhs.uk/digital-weight-management/

NHS Type 2 Diabetes Path to Remission Programme: Supports adults who have developed type 2 diabetes within the last 6 years
https://www.england.nhs.uk/diabetes/treatment-care/diabetes-remission/

APPENDIX C:

Dashboards & Data:

QOF:

CVD Prevent: https://www.cvdprevent.nhs.uk/home

CV Need

SHAPE atlas: https://shapeatlas.net/

APPENDIX D:

Guidance:

Behaviour change: https://www.nice.org.uk/guidance/ph49

Consultations about changing behaviour: https://pubmed.ncbi.nlm.nih.gov/16239696/

RCGP long term conditions recovery guidance post Covid pandemic: This guidance, produced by the Royal College of General Practice with input from NHS England, outlines suggestions for how actions might be sequenced during the year (2022/23) to support those at highest risk or those with health inequalities.Though primary care plays a key role in LTC management, this guidance also offers suggested recommendations for system actions to support primary care in LTC recovery.

https://www. aptuk.org/member-news/long-term-conditions-recovery-guidance