

# Hypertension

## A guide for Bexley General Practice

### Key messages

1. Check blood pressure *at every opportunity* (and do a pulse check)
2. Lifestyle changes are key to reducing CV risk and lowering blood pressure
3. Check for complications and do a QRISK2 or 3
4. Optimise BP management (lifestyle + medication) and aim for NICE BP targets
5. Encourage adherence to lifestyle and medication, review at least annually

Always work within your knowledge and competency

October 2021 (review October 2023, or earlier if indicated)

# Why focus on BP in Bexley?

Hypertension is a risk factor for having worse outcomes from Covid-19.

Treatment of high BP significantly reduces risk of stroke, IHD, heart failure and all cause mortality<sup>1</sup>

- **Risk reduction:** Every 10 mmHg reduction in systolic BP reduces risk of major CV events by 20%<sup>1</sup>
- **Under-treated:** 45% of Bexley patients <80 years, with hypertension, have a BP >140/90mmHg<sup>2</sup>
- **Under-diagnosed:** 22,650 people remain undiagnosed (prevalence= 13.3% vs. expected= 22.4%)<sup>1</sup>

In Bexley, if we reduce the average systolic BP in people with hypertension by 10 mmHg, in one year, we could prevent<sup>1</sup>:

- **68** people from having a stroke
- **54** people from developing heart failure
- **95** people from developing IHD
- **173** deaths

# Hypertension diagnosis and assessment, including for people with Type 2 diabetes (T2DM)\*

Confirm hypertension diagnosis (using ABPM/HBPM) and stratify CV risk<sup>3,4</sup>

Clinic BP  
<140/90mmHg

Clinic BP  
Systolic 140-179mmHg or Diastolic 90-119 mmHg

Clinic BP  
Systolic  $\geq 180$ mmHg or Diastolic  $\geq 120$ mmHg  
Severe Hypertension

Confirm diagnosis, request bloods/ACR + check for complications  
Do ABPM/HBPM

Urgent (same day) GP review

Target organ damage?

Worrying symptoms?

No

Yes

Repeat clinic BP  
within 7 days  
(or urgent  
ABPM/HBPM) and  
treat accordingly

Consider treating  
BP without  
ABPM/  
HBPM result

999/A&E

ABPM/HBPM  
 $\geq 135/85$ mmHg  
Stage 1 Hypertension

ABPM/HBPM  
 $\geq 150/95$ mmHg  
Stage 2 Hypertension

Offer lifestyle advice

Assess for complications + CV risk (QRISK2 or 3)  
(See page 4)

If <60 yrs +  
QRISK2 or  
3 <10%

If >80 yrs +  
BP >150/90  
mmHg

If <80 yrs and  $\geq 1$  of:  
QRISK2 or 3  $\geq 10\%$   
diabetes/renal disease/  
hypertensive eye  
disease/CKD/LVH or  
CVD

'Consider' starting  
BP treatment

'Discuss' starting  
BP treatment\*

Start BP Treatment\*

\*Use clinical judgment in frailty/multi-morbidity

See page 4 for  
notes on:

- Confirming diagnosis with ABPM/HBPM
- When to do postural BPs?
- How to assess for complications?
- QRISK2 or 3 & CKD/CVD
- What are worrying symptoms?
- When to refer to a specialist?

See page 5 for  
evidence on

- Lifestyle advice

\*New NICE  
guidance: T2DM

Diagnostic thresholds and treatment targets for BP in people with T2DM are **now the same as hypertension alone**, unless there is co-existent CKD (see page 5)

QRISK2 or 3 (to assess 10-year CV risk)

$\leq 10\%$   
No statin

$\geq 10\%$   
Address modifiable risk factors first, then consider initiating or optimising statin if still >10%

BP every 5 years, or annually if near to 140/90mmHg (use clinical judgement), or if target organ damage/T2DM (see Traffic Light page within SELIMOC hypertension guidance 2021 for primary care)

Get BP under control and add to hypertension register

BP review (recommended at least annually, or more frequently when clinically indicated)  
(BP/blood tests/ACR/lifestyle and medication review)

## Diagnosing hypertension

### How to measure BP when considering a diagnosis of hypertension:

- Measure blood pressure in both arms, if difference >15 mmHg, repeat measurements
- If difference in readings between arms remains >15 mmHg on the second measurement, measure subsequent blood pressures in the arm with the higher reading (note this on EMIS)

### When to measure standing + sitting BP?

- In DM, postural hypotension (systolic drop  $\geq$  20mmHg from sitting to standing), or age  $\geq$  80yrs
- If significant drop/symptoms of postural hypotension, **review medication and treat to BP target based on standing BP**

- **Ambulatory BP monitoring (ABPM)**  
Ensure sufficient readings - minimum 14 readings during waking hours  
Use daytime average BP for diagnosis
- **Home BP monitoring (HBPM)**  
Ensure a validated (and calibrated) BP machine is being used and advise to record two BP readings every morning and evening every day, for at least 4 days (ideally 7)  
In practice, disregard the first day's readings and take an average of the remaining readings

## Assessing complications

**Look for complications** (target organ damage - i.e. check eyes - fundoscopy, dip urine, CV exam) + do a **QRISK2 or 3**

- **Tests:** renal profile, lipids, FBC, HbA1c, TFT, ACR, urinalysis for haematuria + ECG + fundoscopy
- **Record:** smoking status, physical activity level, alcohol intake, BMI, [waist circumference], family history [use Arden's BP EMIS Template]

### Corrected eGFR in Black people of African or Caribbean Family origin?

Latest NICE CKD guidance (August 2021) **does not recommend** adjusting the estimation of glomerular filtration rate (eGFR) in people of African-Caribbean or African family background

## Assessing Cardiovascular (CV) risk: QRISK 2 or 3

- Currently a QRISK 2 calculator is integrated into EMIS. Practices with Ardens may have access to QRISK 3, which is a more inclusive risk score and can also be found online [here](#)
- The calculated CV risk is an estimate. Clinical judgement is required to adjust for factors that the risk calculator does not take into account, but it may help people to make an informed choice on whether to take a statin (and discuss risk reduction using the 'heart-age' calculation)

## QRISK 2 or 3 & exclusions

- QRISK 3 is a more advanced risk calculator than QRISK 2 as it has additional inclusions such as CKD 3-5, severe mental illness and rheumatological conditions.
- QRISK 2/3 are CVD risk estimate calculators only, and therefore **clinical judgment must be used**. For example, people considered high risk of CVD should already be on/offered lipid management treatment (such as those with type 1 diabetes, CKD 3-5, existing CVD/previous Stroke/TIA, familial hypercholesterolaemia and people aged >85 yr).

## When to refer a patient?

### Suspect secondary causes OR patient <40 years?

- If you suspect **secondary causes** in a patient of **any age** e.g. Cushing's, Conn's\*
- If **<40 years + BP  $\geq$  140/90mmHg + no evidence of CVD, renal/hypertensive eye disease or diabetes**. The 10-year CV risk can underestimate the lifetime risk of CV events in this cohort.<sup>3</sup>
- In patients of **African or Caribbean family origin, primary hypertension can present earlier, if in doubt, consider A&G to discuss need for referral**

Refer to specialist clinic for investigation

### Worrying symptoms?

- **Life-threatening symptoms** - new onset confusion, chest pain, HF, AKI
- **Accelerated hypertension** - retinal haemorrhage, papilloedema
- **Suspected phaeochromocytoma** - labile or postural hypotension, headache, palpitations, pallor, abdo pain, excessive sweating

Immediate: 999 or A&E

\*Other conditions which can cause hypertension include: Connective tissue disorders: scleroderma, systemic lupus erythematosus, polyarteritis nodosa, retroperitoneal fibrosis, obstructive sleep apnoea

## Impact of lifestyle changes on BP<sup>6</sup>

Action	Recommendation	Approx. systolic BP reduction
Reduced weight	Maintain healthy body weight	5-20mmHg/10kg loss
DASH diet	Consume a diet rich in fruits, vegetables, low-fat dairy with reduced saturated and total fat	8-14mmHg
Reduced salt intake	Reduced dietary sodium intake ( <u>≤1 teaspoon/day</u> )	2-8mmHg
Increased exercise	Regular aerobic physical activity (at least 30 min/day, most days of the week)	4-9mmHg
Reduced alcohol intake	Below or equal to 14 units/week	2-4mmHg

Note: In addition, discourage consumption of excessive caffeine or caffeine-rich products.<sup>4</sup> Average BP reduction (systolic) from one anti-hypertensive drug= 12.5-15.5mmHg.<sup>7</sup> The effects of implementing lifestyle modifications are dose and time dependent, and could be greater for some individuals.<sup>6</sup> In the study used, stress management's impact on BP was variable.<sup>6</sup>

## Which BP target? Aim for and maintain at NICE BP targets (or below)<sup>4, 5, 8, 9</sup>

Which condition?	Which cohort within the condition?	NICE Clinic BP Targets	QOF BP Targets <sup>14</sup> 2023/24
		Note: Corresponding targets for ABPM/HBPM are 5mmHg lower than clinic BPs	
		Use clinical judgment in frailty/multi-morbidity	
Hypertension only	Age <80yrs	≤140/90mmHg (ABPM/HBPM ≤135/85)	QOF now in line with NICE
	Age ≥80yrs	≤150/90mmHg (ABPM/HBPM ≤145/85)	
Hypertension and diabetes	Type 2 Diabetes	Same as hypertension, if no CKD	If no moderate/severe frailty: ≤140/90mmHg (ABPM/HBPM ≤135/85), but use clinical judgement in Type 1 as NICE targets much lower to QOF
	Type 1 Diabetes + no albuminuria	≤135/85mmHg	
	Type 1 Diabetes + albuminuria or ≥ 2 features of metabolic syndrome	≤130/80mmHg	
Hypertension and IHD/PAD or TIA/Stroke	History of IHD/PAD	Same as hypertension, if no CKD	No QOF target for PAD, but for rest, based on age i.e. <80yrs ≤140/90mmHg (ABPM/HBPM ≤135/85) ≥80yrs ≤150/90mmHg (ABPM/HBPM ≤145/85)
	History of TIA/Stroke	Same as hypertension, if no CKD	
Hypertension and CKD	ACR <70mg/mmol	<140/90mmHg (systolic range = 120-139mmHg)	No QOF target
	ACR ≥70mg/mmol or co-existent Diabetes	<130/80mmHg (systolic range = 120-129mmHg)	

Note: For people ≥80 years with hypertension and T2DM, CKD, PAD, CVD or TIA/Stroke, individual NICE guidance on these areas offers no age-specific BP targets for this cohort. However, NICE Hypertension guidelines (as mentioned above) do suggest a target of ≤150/90 mmHg for those ≥80 years with hypertension, but with frailty/multi-morbidity, use clinical judgement.

For CVD patients, consider first-line treatment according to co-morbidities

Hypertension with type 2 Diabetes  
(any age or family origin)

Hypertension without type 2 diabetes

Age <55 years and not of Black African or African-Caribbean family origin

Age ≥ 55 years

Black African or African-Caribbean family origin  
(any age)

Step 1

ACEI or ARB\*

ramipril/lisinopril or losartan

CCB

[or thiazide-like diuretic if CCB related oedema, or if heart failure\*\*]

amlodipine (or indapamide)

Step 2

ACEI or ARB\* + CCB or thiazide-like diuretic

CCB

+ ACEI or ARB\* or thiazide-like diuretic

Step 3

ACEI or ARB\* + CCB + thiazide-like diuretic

If uncontrolled on optimal doses, regard as Resistant hypertension. Repeat ABPM/HBPM, assess for postural hypotension, discuss adherence

Step 4

Consider further diuretic with low-dose spironolactone if potassium ≤4.5mmol/L and good renal function. If potassium >4.5 mmol/L and/or reduced renal function, prescribe alpha-blocker (doxazosin) or beta-blocker (atenolol/bisoprolol) and/or consider seeking specialist advice

\*For people of Black African or African-Caribbean family origin, use ARB instead of ACEI (as increased risk of angioedema with ACEI)

\*\* If hypertension in context of heart failure, please see CES Heart Failure guide

Hypertension in Chronic Kidney Disease<sup>9</sup>  
(CKD stages 3-5 i.e. eGFR <60ml/min)

ACR <30 mg/mmol Follow BP algorithm

ACR ≥30 mg/mmol 1<sup>st</sup> line: ACEI or ARB, then follow BP algorithm

Women with pre-existing hypertension contemplating pregnancy<sup>10</sup>

Refer to specialist pre-conception counselling (page 9)

Drugs to avoid at conception/in pregnancy include: ACEI/ARB/thiazide or thiazide-like diuretic (increased risk of congenital abnormalities)

NICE guidelines:

Stop ACEI/ARBs and change medication (preferably within 2 working days of notification of pregnancy). Offer alternatives:

- Labetalol if no CI e.g. asthma, nifedipine or methyldopa. Can also remain on amlodipine – GSTT Obstetric Medicine advice
- Target BP ≤ 135/85 mmHg
- Offer aspirin 75-150mg OD from week 12 of pregnancy

Refer to Hypertension in Pregnancy clinic (GSTT) ASAP

	Drug	Starting dose	Daily Range	Notes (These are not extensive, please refer to the latest BNF for further information, especially titration increments, cautions and contraindications)
ACEIs	1 <sup>st</sup> Line: Ramipril	2.5mg OD (1.25mg OD in frail/elderly patients)	2.5-10mg OD	<ul style="list-style-type: none"><li>- For <b>people of Black African or African-Caribbean family origin</b>, use <b>ARB</b> instead of ACEI (as increased risk of angioedema with ACEI)</li><li>- Check baseline renal profile (Na/K/Cr/eGfr). Hyperkalaemia may occur, therefore close monitoring of serum potassium is required</li><li>- Re-check renal profile within 2 weeks of initiation, or dose increase and then at least annually</li></ul>
	2 <sup>nd</sup> line: Lisinopril	10mg OD	10-80mg OD (usual maintenance dose 20mg OD for hypertension)	
ARBs	Losartan	50mg OD (25mg OD if >75yrs old)	50-100mg OD	<ul style="list-style-type: none"><li>- <b>Titrate ACEI/ARB up at 2-4 weekly intervals to achieve optimal BP control</b></li><li>- Initiation/Dose titrations: If serum creatinine increases by &gt;20% (or eGFR falls by &gt;15%) – stop ACEI and seek specialist advice. ACEI dose should only be increased if serum creatinine increases by less than 20% (or eGFR falls by less than 15%) after each dose titration, and potassium &lt;5.5mmol</li><li>- <b>ACEI/ARB dose should be optimised before the addition of a second agent</b></li><li>- Side-effects: Symptomatic hypotension can occur on first dosing – suggest to take at night. Dry cough with ACEI, consider switch to ARB</li><li>- <b>Caution:</b> Do not combine an ACEI and an ARB to treat hypertension</li><li>- <b>For diabetic nephropathy ARB of choice:</b> losartan and irbesartan<sup>3</sup></li></ul>
	Candesartan	8mg OD	8mg-32mg OD	
CCBs	Amlodipine	5mg OD	5-10mg OD	<ul style="list-style-type: none"><li>- Increase after 2-4 weeks to maximum dose of 10mg OD</li><li>- <b>Caution:</b> Interacts with simvastatin – consider switching to atorvastatin</li><li>- Step 1: If amlodipine causes ankle oedema, consider using a thiazide-like diuretic instead of a CCB</li><li>- <b>CI:</b> Unstable angina, aortic stenosis</li><li>- Side effects include flushing and headaches at initiation; swollen ankles especially at higher doses</li></ul>
Thiazide-like diuretics	Indapamide (IR)	2.5mg OD	2.5mg OD	<ul style="list-style-type: none"><li>- Check baseline renal profile, then after 2 weeks, then at least annually. If potassium &lt;3.5mmol/L or eGFR &lt;25ml/min, stop indapamide and seek specialist advice</li></ul>
Aldosterone antagonist	Spironolactone	25mg OD	25mg OD	<ul style="list-style-type: none"><li>- Step 4: Spironolactone is the preferred diuretic at step 4 (NICE), but is an unlicensed indication in resistant hypertension (BNF)</li><li>- Consider only if <b>potassium ≤4.5mmol/L</b> (caution in reduced eGFR &lt;30ml/min, as increased risk of hyperkalaemia). Monitor Na/K/renal function within 1 month and repeat 6 monthly thereafter<sup>3</sup></li><li>- If K&gt;4.5mmol/L should be stopped.</li></ul>
α-B	Doxazosin (IR)	1mg OD	2-16mg OD (or BD dosing when dose >8mg/day)	<ul style="list-style-type: none"><li>- Consider at Step 4 if potassium ≥. 4.5mmol/L. Initial dose of 1mg usually increased after 1-2 weeks to 2mg OD</li><li>- At doses above 8mg/day, consider split dosing from OD to BD to reduce BP variation</li><li>- <b>Caution:</b> Initial dose postural hypotension, avoid in elderly as orthostatic hypotension risk<sup>3</sup></li></ul>
β-B	Atenolol	25mg OD	25-50mg OD	<ul style="list-style-type: none"><li>- Consider at Step 4 if potassium ≥ 4.5mmol/L.</li><li>- Beta blockers may be considered in younger people and in those with an intolerance/CI to ACEI or ARBs, women of childbearing potential, co-existent anxiety/tachycardia/heart failure</li><li>- <b>Particular caution in T2DM: symptoms of hypoglycaemia may be masked</b></li><li>- <b>Caution:</b> Increased risk of diabetes when beta-blocker is prescribed with a thiazide diuretic. Beta-blockers can cause bradycardia if combined with certain CCBs e.g., verapamil/diltiazem</li><li>- <b>CI:</b> Asthma, 2<sup>nd</sup>/3<sup>rd</sup> degree AV block, severe PAD</li></ul>
	Bisoprolol	5-10mg OD	5-20mg OD	
Related Drugs				
S	Atorvastatin	20mg OD	20-80mg OD	<ul style="list-style-type: none"><li>- <u>Please see SEL IMOC guideline on lipid management: medicine optimisation pathways (Sept 2021)</u></li><li>- Primary prevention 20mg, secondary prevention 40-80mg (alternative is rosuvastatin)</li></ul>

**AKI SICK DAY RULES<sup>15</sup>** When patients have any of the following: **Vomiting, diarrhoea, or general dehydration due to intercurrent illness**, Advice to **STOP** taking the medicines listed below (restart after feeling well/after 24-48hrs of eating and drinking normally): • **ACE Inhibitors, ARBs, Diuretics, Metformin, NSAIDs, Sulfonylureas, SGLT2 inhibitors (e.g. Empagliflozin)**

This guidance is aligned to SEL IMOC Hypertension 2021 guidance for Primary Care)



Hypertension review (at least annual)

	Tasks/Activity	Who?	Where?	Tools/Support
<b>Review planning at practice level</b>	<b>Call/recall planning:</b> Use Arden's/CE Bexley searches to help determine who to invite for review first e.g. BP >160/100mmHg recorded in the last year vs. those that are well controlled.	Admin colleague with clinician support (GP nurse/GP)	In practice or remotely via EMIS	Arden's/CE Bexley searches
<b>Pre-patient review</b>	<b>Contact patient to:</b> 1. <b>Arrange bloods</b> (renal function, FBC, lipids, HbA1c) & urine ACR  2. <b>Arrange BP measurement + pulse check</b> (in practice/ <u>machine at home</u> ), at least annually	HCA/GP Nurse	Remote or F2F  In practice/at home	AccuRx text messages  Consider E-consult which has a BP review page or the Doctaly Assist Hypertension flow on WhatsApp
<b>Patient review</b>	1. <b>Concerns + screen for symptoms/complications related to:</b> <ul style="list-style-type: none"> <li>Hypertension</li> <li>Hypotension (dizziness/nausea/weakness/confusion, BP &lt;90/60mmHg)</li> </ul> 2. <b>Review BP trend</b> 3. <b>Review investigations:</b> blood + urine ACR results 4. <b>Re-calculate QRISK2 or 3</b> (if appropriate)  5. <b>Discuss risk-reduction + lifestyle:</b> in context of QRISK2 or 3 (BMI, smoking, alcohol, diet, activity) & COVID 6. <b>Mind + Body:</b> consider <u>screening for mental health conditions</u>  7. <b>Medication review:</b> concerns, side-effects, compliance, <u>adherence</u> , ensure renal function satisfactory and adjust medications if needed. Note that some drugs/substances can cause hypertension*  8. <b>Self-management/Shared-decision making</b>  9. <b>Follow-up plans:</b> <u>review BP monthly until it is at target</u>	GP/GP Nurse/GP pharmacist           GP/GP Nurse/GP Pharmacist or Social prescriber, Care Navigator & Patient    GP/GP Nurse/GP pharmacist/HCA	Remote or F2F	Arden's template (for correct coding, annual review, medication review & Vital 5** recording)  <u>Brief-interventions</u> around lifestyle          Self-management resources - send links via AccuRx: British Heart Foundation resources <ul style="list-style-type: none"> <li><u>Understanding your BP</u></li> <li><u>6 tips for reducing BP</u></li> <li><u>BP and COVID-19</u></li> <li><u>Online Community</u> for patients</li> <li><u>Online programme about BP for patients</u></li> </ul>

\*Drugs/other substances that can cause hypertension, include<sup>4</sup>

- combined oral contraceptives, corticosteroids, NSAIDs, sympathomimetics
- venlafaxine
- cyclosporine

- erythropoietin
- leflunomide
- liquorice (present in some herbal medicines)
- alcohol, substances of abuse including cocaine

**\*\*Vital 5:** Hypertension, smoking, BMI, alcohol intake and mental health.



## Bexley Patient Support

### Patient resources

- **Check your blood pressure reading - NHS** ([www.nhs.uk](http://www.nhs.uk))
- **Blood pressure information for patients (translated) and 'Loving your heart: a South Asian guide to controlling your BP'**
- **Bexley Healthy Eating, Healthy Preventions:** <https://www.bexley.gov.uk/about-council/jobs-and-careers/employee-well-being/healthy-eating-healthy-preventions>
- **Bexley Get Help Managing Your Weight:** <https://www.bexley.gov.uk/health-and-wellbeing/get-help-managing-your-weight>
- **London Borough of Bexley Adult Weight Management Service Referral form** (search 'weight management' on DXS)
- **British Heart Foundation: Preventing Heart Disease (resources for patients):** <https://www.bhf.org.uk/heart-health/preventing-heart-disease>
- **British Heart Foundation: How to reduce your blood pressure 6 top tips (see page 8 for more):** <https://www.bhf.org.uk/information-support/heart-matters-magazine/research/blood-pressure/blood-pressure-tips#:~:text=Unless%20your%20doctor%20tells%20you,should%20be%20below%20130%20%2F%2080>
- **Bexley Stop Smoking:** <http://www.smokefreebexley.co.uk/home>
- **(Active) Pharmacies providing Blood Pressure Checking Service and local SELGP Surgeries (May 2022) - Google My Maps**

### Shared resources

NICE has produced a document on shared decision making in the context of hypertension and it can be found at:

<https://www.nice.org.uk/about/nice-communities/nice-and-the-public/making-decisions-about-your-care>

## Bexley Clinical Support

**Urgent telephone advice** - Consultant connect: Cardiology GSTT/LGT on the Consultant Connect app

**Non-urgent 'Advice & Guidance'** - Depending on the context: Hypertension clinic (GSTT), CKD clinic (GSTT), Diabetic medicine (GSTT/KCH), Obstetric medicine (GSTT), Pregnancy in Hypertension clinic (GSTT)

**Community hypertension clinics (combined with lipids) led by GSTT pharmacists** - referral by completing referral form on DXS. Search 'hypertension referral'. Once completed e-mail to [gst-tr.KHPCommunityCVD@nhs.net](mailto:gst-tr.KHPCommunityCVD@nhs.net). Contact may be in form of virtual, telephone or F2F.

**Specialist clinics** - Refer via eRS to: Obstetrics>'Maternal medicine' for Pre-conception counselling clinic (GSTT), **Pregnancy in Hypertension clinic (GSTT)**, or more general Obstetric Medicine clinic (GSTT) - for pregnant women with multiple co-morbidities, [CKD clinic (GSTT/KCH), Diabetic medicine (GSTT/KCH)]

**Hypertension data:** SELICB Hypertension Dashboard is available to practices. Watch this [webinar](#) for more information and contact [bi@selondonics.nhs.uk](mailto:bi@selondonics.nhs.uk) for access

# Health Inequalities in Hypertension

## Our population - South East London (SEL)

The Black African and Black Caribbean population in SEL has greater prevalence of hypertension than any other ethnic group<sup>1</sup> and these individuals have higher risk of stroke due to hypertension, associated with worse outcomes<sup>2</sup>. In South London, these patients are more likely to have **hypertension and diabetes and be approx. 10 years younger when presenting with acute stroke** compared to White ethnicity stroke patients<sup>3</sup>. The drivers for these inequalities include overcrowded housing, higher levels of deprivation, unemployment, barriers to education attainment and racism<sup>2,4</sup>.

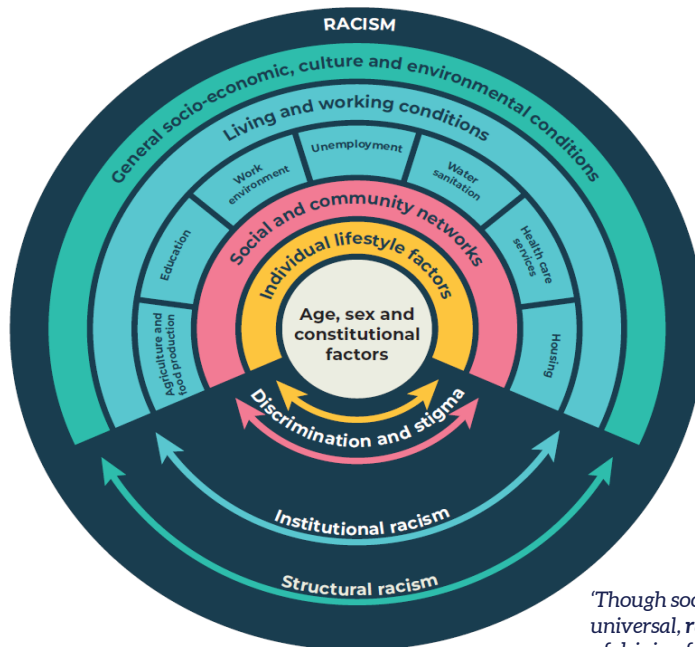
## What people have told us <sup>5</sup>

### Barriers to optimal hypertension detection and management include

**Trust** – lack of trust in health services generally and not trusting individual healthcare professionals

**Access** – difficulties accessing services

## Racism and the wider determinants of health



*‘Though social determinants are universal, racism is one of a range of driving forces that exists in our societies and that acts on these determinants.’<sup>4,5</sup>*

## Racism and the wider determinants of health

### Individual actions

- Acknowledge that patients may have experienced racism in healthcare services.
- Re-establish trust with patient-centred consultations and shared decision making<sup>6</sup>.

### Team and system actions

- Undertake cultural humility training to acknowledge and challenge power imbalances and improve your understanding to support patients in their preferences for their hypertension care<sup>2,8</sup>. There are many cultural awareness courses available, find one that has cultural humility at its core and essential components of self-reflection, understanding the impact of your own culture on others and the intent to neutralise patient-provider power imbalances.
- Access the SEL Hypertension Dashboard to better understand the ethnic mix of your hypertension patients<sup>1</sup>.
- Ardens case-finder searches can identify those patients without their ethnicity coded in your practice, contact your CESEL facilitator for support
- Consider where you offer your service - community-based blood pressure testing and advice, including pharmacies, places of worship and community events, has high acceptability<sup>9</sup>.
- Patients prefer face-to-face care, especially for a new diagnosis of hypertension<sup>9</sup>.
- Encourage self-care and engagement for example home BP monitors and out of hours drop-in GP attendance for BP testing<sup>9</sup>.

## Pages 1- 9

- 1 British Heart Foundation: How can we do better? NHS Bexley CCG (updated 2018, source data QOF 2016/17, accessed 2017)
- 2 CESEL data analysis (EMIS practices data search) July 2021
- 3 South East London Integrated Medicines Optimisation Committee (SEL IMOC) Hypertension guidance for primary care (April 2021)
- 4 NICE Guideline NG136 Hypertension in adults: Diagnosis and Management, published Aug 2019, updated March 2022 (accessed May 2022)
- 5 NICE Guideline NG17 Type 1 Diabetes in adults: Diagnosis and Management, published Aug 2015, updated Dec 2020, (accessed Jan 2021)
- 6 Simces, ZL, Ross SE & Rabkin, SW, 2012, Diagnosis of hypertension and lifestyle modifications for its management, BCMJ Vol 58(8): 392- 398
- 7 Wu J, Kraja AT, Oberman A, Lewis CE, Ellison RC, Arnett DK, Heiss G, Lalouel JM, Turner ST, Hunt SC, Province MA. A summary of the effects of antihypertensive medications on measured blood pressure. American Journal of Hypertension. 2005 Jul 1;18(7):935-42
- 8 Stroke and TIA. Clinical Knowledge Summaries (NICE), last updated March 2017, (accessed Jan 2021)
- 9 NICE Clinical Guideline NG203 Chronic Kidney Disease: assessment and management, published 25 August 2021, accessed (Sept 2021)
- 10 NICE Clinical guideline NG133 Hypertension in pregnancy: diagnosis and management, published date: June 2019
- 11 British National Formulary, last updated Jan 2021
- 12 SE London Integrated Medicines Optimisation Committee (SELIMOC): Lipid management: medicines optimisation pathways (updated Sept 2021, accessed Oct 2021)
- 13 Consultation correspondence – Southwark CCG's Medicine's Optimisation Team, CVD community clinic Pharmacists, GSTT Cardiology Team, GSTT Obstetric Medicine Team, Bexley MMT, SEL CVD working group
- 14 Quality and Outcomes Framework guidance for 2023/2024
- 15 Acute kidney injury (AKI): use of medicines in people with or at increased risk of AKI [www.nice.org.uk/advice/KTT17/chapter/Evidence-context](http://www.nice.org.uk/advice/KTT17/chapter/Evidence-context)

## Pages 10: 'Health Inequalities in South East London'

Thank you to the [One London Hypertension Pathfinder Project](#) and [Mabadiliko](#) for help developing this resource.

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2. Birmingham City Council, & Lewisham Council Public Health Divisions. (2022). Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)
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$\alpha$ -B – Alpha-blocker	GSTT – Guy's & St Thomas' NHS Trust
ABPM – Ambulatory blood pressure monitoring	HF – Heart failure
ACEI– Angiotensin converting enzyme inhibitor	K – Serum potassium
ACR – Albumin-creatinine ratio	KCH – King's College Hospital NHS Trust
A&G – Advice & Guidance	HbA1c – Haemoglobin A1c
AKI – Acute kidney injury	HBPM – Home blood pressure monitoring
ARB- Angiotensin II receptor blocker	IHD – Ischaemic heart disease
$\beta$ -B – Beta-blocker	IR – Immediate release
BD – Twice daily dosing	LVH – Left ventricular hypertrophy
BMI – Body mass index	Na – Serum sodium
BP – Blood pressure	NSAID – Non-steroidal anti-inflammatory drug
CCB – Calcium channel blocker	OD – Once daily (dosing)
CI – Contraindication	PAD – Peripheral arterial disease
CKD – Chronic kidney disease	QOF – Quality and outcomes framework (contract)
Cr – Serum creatinine	QRISK2 or 3- an algorithm that predicts 10-year CVD risk. QRISK 3 available on Arden's or <a href="https://www.qrisk.org/three/">https://www.qrisk.org/three/</a>
CV – Cardiovascular	Renal profile – this includes serum sodium/potassium/creatinine/eGFR
CVD – Cardiovascular disease	S- Statin
DASH diet – Dietary approaches to stop hypertension diet	SELAPC – South East London Area Prescribing Committee
DXS – Point-of-care tool for EMIS Web	TFT – Thyroid function blood tests
ECG – Electrocardiogram (12-lead)	TIA-Transient ischaemic attack
eGFR – Estimated glomerular filtration rate	T2DM – Type-2 diabetes
eRS – Electronic referral system	
FBC – Full blood count	

### Acknowledgements

CESEL guides are co-developed by SEL primary care clinicians and SEL experts (see below) and are localised to include borough specific pathways and resources. The guides go through a formal approval process including SEL Integrated Medicines Optimisation Committee (IMOC) for the medicines content, a local borough-based Primary Care Leads group and CESEL Steering Group with representation from SELCCG and PCNs, and borough based Medicines Management Teams (MMT).

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**Guide developed by Clinical Effectiveness South East London: Bexley leads**

Contact CESEL at [selccg.clinicaleffectiveness@nhs.net](mailto:selccg.clinicaleffectiveness@nhs.net) and/or visit [https://selondonccg.nhs.uk/covid\\_19/clinical-effectiveness-sel/](https://selondonccg.nhs.uk/covid_19/clinical-effectiveness-sel/)

# Making the right thing to do the easy thing to do.

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