Clinical Effectiveness
South East London
Southwark

South East London Integrated Care System

NHS

Hypertension

A guide for Lambeth General Practice

Key messages

1. Check blood pressure *at every opportunity* (and do a pulse check)
2. Life-style changes can prevent/reduce need for medication
3. Check for complications and do a QRISK
4. Optimise BP management and aim for NICE blood pressure targets
5. Encourage adherence to life-style 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 Lambeth?

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[1]

- **Risk reduction:** Every 10 mmHg reduction in systolic BP reduces risk of major CV events by 20%[1]
- **Under-treated:** 28% of Lambeth patients <80 years, with hypertension, have a BP >140/90mmHg[2]
- Under-diagnosed: Around 28000 Lambeth residents have BP>140/90 but no diagnosis of hypertension[3]
- Health inequalities: Lambeth data shows that patients in most deprived quintile and Black African and Black Caribbean patients are the most likely to have poor BP control[3]

In Lambeth, if we reduce the average systolic BP in people with hypertension by 10 mmHg, in one year, we could prevent[1]:

- **65** people from having a stroke
- **48** people from developing heart failure
- **61** people from developing IHD
- **196** deaths

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

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Confirm hypertension diagnosis using ABPM/HBPM and stratify CV risk [4,5]

Clinic BP **<140/90mmHg**

Clinic BP **Systolic ≥ 140-179mmHg OR Diastolic ≥ 90-119mmHg**

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

ABPM/HBPM **≥ 135/85mmHg** (Stage 1 Hypertension)

ABPM/HBPM **≥ 150/95mmHg** (Stage 2 Hypertension)

Clinic BP **Systolic ≥ 180mmHg OR Diastolic ≥ 120mmHg** (Severe Hypertension)

Urgent (same day) GP review

Complications? (see page 4)

No → **Repeat clinic BP within 7 days (or urgent ABPM/HBPM) and treat accordingly**

Yes → **Consider treating BP without ABPM/HBPM result**

Worrying symptoms? → **999/A&E**

Offer Life-style Advice

Assess for complications + CV risk (QRISK3 preferred)
(See Page 4)

If <60 yrs + QRISK <10% → ***'Consider'* starting BP treatment**

If >80 yrs + BP >150/90 mmHg → ***'Consider'* starting BP treatment**

If <80 yrs and ≥1 of: QRISK ≥10% DM/CKD/LVH/CVD renal disease/ hypertensive eye disease → ***'Discuss'* starting *BP treatment****

***Start* BP Treatment ***
Use clinical judgment in frailty/multi-morbidity

QRISK (to assess 10-year CV risk)

≤10%
No statin

≥10%
Address modifiable risk factors first, then consider initiating or optimising statin if still >10%[6]

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 (at least annually or more frequently when clinically indicated)
(BP/blood tests/ACR/urine dip/life-style and medication review)

See page 4 for notes on:

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

***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 for evidence on:

- Lifestyle advice

Hypertension diagnosis: additional information

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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 ≥ 20mmHg from sitting to standing), or age ≥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 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 + do a **QRISK**

- **Examination:** BMI, waist circumference, fundoscopy/optometry review, CV exam
- **Tests:** renal profile, lipids, FBC, HbA1c, TFT, ACR, urinalysis for haematuria + ECG
- **Record:** smoking status, physical activity level, alcohol intake, family history [use Ardens BP EMIS Template]

Corrected eGFR in black people of African or Caribbean Family origin[6]
Latest NICE CKD guidance (August 2021) does not recommend adjusting the estimation of glomerular filtration rate (GFR) in people of African-Caribbean or African family background

Assessing Cardiovascular (CV) risk: QRISK

- Currently there is a link to QRISK3 calculator via the Ardens template; **if unavailable use QRISK2**
- It may help some people with these conditions to make an informed choice on whether to take a statin. The calculated CV risk is an estimate. Clinical judgement is required to adjust for factors that the risk calculator does not take into account

QRISK & CKD/CVD

- 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** eg Cushing's, Conn's*
- **If <40 years + BP ≥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.[4]
- 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, palpitations, headache, pallor, abdo pain, excess sweating

Immediate: 999 or A&E

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

Impact of life-style changes on BP[7]

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	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.[5] Average BP reduction (systolic) from one anti-hypertensive drug= 12.5-15.5mmHg.[8] The effects of implementing lifestyle modifications are dose and time dependent, and could be greater for some individuals.[7] In the study used, stress management's impact on BP was variable.[7]

Which BP target? Aim for and maintain at NICE BP targets (or below)[5, 9, 10, 11]

Which condition?	Which cohort within the condition?	NICE Clinic BP Target	QOF BP Targets[12] 2023/2024
		• Use clinical judgment in frailty/multi-morbidity • **Corresponding targets for ABPM/HBPM are 5mmHg lower than for clinic BPs**	
Hypertension, including Type 2 Diabetes (but with no CKD)	Age <80yrs	**≤140/90mmHg** (ABPM/HBPM ≤ 135/85mmHg)	QOF now in line with NICE
	Age ≥80yrs	**≤150/90mmHg** (ABPM/HBPM ≤ 145/85mmHg)	
Diabetes	Type 2 Diabetes	**Same as hypertension if no CKD**	If no moderate/severe frailty: ≤140/80mmHg (ABPM/HBPM ≤ 135/85), but use clinical judgement in Type 1 DM as NICE targets much lower than QOF
	Type 1 Diabetes + no albuminuria	**≤135/85mmHg**	
	Type 1 Diabetes + albuminuria or ≥ 2 features of metabolic syndrome	**≤130/80mmHg**	
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)**	
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 (if with severe bilateral carotid stenosis: systolic BP 140-150mmHg)	**Same as hypertension, if no CKD**	

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.

Hypertension treatment[4,5]

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

Optimise medication to most effective tolerated dose, and check adherence at each step, before stepping up

	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 **or** 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/thiazide-like diuretic**		**CCB + ACE 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 Heart Failure guide

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

Hypertension in Chronic Kidney Disease[6] (CKD stages 3-5 i.e. eGFR <60ml/min)	
ACR <30 mg/mmol	Follow BP algorithm
ACR ≥30 mg/mmol	1st line: ACEI or ARB, then follow BP algorithm

Women with pre-existing hypertension contemplating pregnancy[13]

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**

Hypertension: preferred medication[4, 5, 9, 14, 15, 16]

	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	1st Line: Ramipril	2.5mg OD (1.25mg OD in frail/elderly patients)	2.5-10mg OD	- For people of **Black African or African-Caribbean family origin, use ARB** instead of ACEI (as increased risk of angioedema with ACEI) - Check baseline renal profile (Na/K/Cr/eGfr). Hyperkalaemia may occur, therefore close monitoring of potassium is required. Re-check renal profile within 2 weeks of initiation or dose increase and then at least annually - **Titrate ACEI/ARB up at 2-4 weekly intervals to achieve optimal BP control** - Initiation/Dose titrations: If serum creatinine increases by >20% (or eGFR falls by >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 <5.5mmol - **ACEI/ARB dose should be optimised before the addition of a second agent** - Side-effects: Symptomatic hypotension can occur on first dosing – suggest to take at night. Dry cough with ACEI, consider switch to ARB - **Caution:** Do not combine an ACEI and an ARB to treat hypertension - **For diabetic nephropathy ARB of choice**: losartan and irbesartan
	2nd 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	
	Candesartan	8mg OD	8mg-32mg OD	
CCBs	Amlodipine	5mg OD	5-10mg OD	- Increase after 2-4 weeks to maximum dose of 10mg OD - **Caution:** Interacts with simvastatin – consider switching to atorvastatin - Step 1: If amlodipine causes ankle oedema, consider using a thiazide-like diuretic instead of a CCB - **CI:** Unstable angina, aortic stenosis - Side effects include flushing and headaches at initiation; swollen ankles especially at higher doses
Thiazide -like diuretics	Indapamide (IR)	2.5mg OD	2.5mg OD	- Check baseline renal profile, then after 2 weeks, then at least annually. If potassium <3.5mmol/L or eGFR <25ml/min, stop indapamide and seek specialist advice
Aldosterone antagonist	Spironolactone	25mg OD	25mg OD	- Step 4: Spironolactone is the preferred diuretic at step 4 (NICE) but is an unlicensed indication in resistant hypertension (BNF). Consider only if potassium ≤4.5mmol/L (caution in reduced eGFR <30ml/min, as increased risk of hyperkalaemia). Monitor Na/K/renal function within 1 month and repeat 6 monthly thereafter[4] - If K >4.5mmol/L it should be stopped
α-B	Doxazosin (IR)	1mg OD	2-16mg OD (or BD dosing when dose >8mg/day)	- Consider at Step 4 if potassium ≥4.5mmol/L. Initial dose of 1mg usually increased after 1-2 weeks to 2mg OD - At doses above 8mg/day, consider split dosing from OD to BD to reduce BP variation - **Caution:** Initial dose postural hypotension, avoid in elderly as orthostatic hypotension risk[4]
β-B	Atenolol	25mg OD	25-50mg OD	- Consider at Step 4 if potassium ≥ 4.5mmol/L. - 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 - **Particular caution in T2DM: symptoms of hypoglycaemia may be masked** - **Caution:** 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 - **CI:** Asthma, 2nd/3rd degree AV block, severe PAD
	Bisoprolol	5-10mg OD	5-20mg OD	
	Related Drugs			
S	Atorvastatin	20mg OD	20-80mg OD	- Please see SELMOC guideline on lipid management: medicines optimisation pathways (Sept 2021) - Primary prevention 20mg, secondary prevention 40-80mg (alternative is rosuvastatin)

AKI SICK DAY RULES[17] When patients have any of the following: **Vomiting, diarrhoea, or general dehydration** due to intercurrent illness,. Advise 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). Link to information for patients.

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

Hypertension review (at least annual)

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	Tasks/Activity	Who?	Where?	Tools/Support
Review planning at practice level	**Call/recall planning**: Use 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 (pharmacist/nurse/ GP)	In practice or remotely via EMIS	EMIS searches e.g. EZ Analytics and Ardens searches
Pre-patient review	**Contact patient to:** 1. **Arrange bloods (renal function, FBC, lipids, HbA1c) & urine ACR** 2. **Arrange BP measurement** (in practice/machine at home), at least annually	HCA/ Nurse	In practice/at home/ at pharmacy	AccuRx text messages Consider E-Consult which has a BP review page or the Doctaly Assist hypertension flow on WhatsApp BP@Home if available
Patient review	1. **Concerns + screen for symptoms/complications related to hypertension and hypotension (dizziness/nausea/weakness/confusion, BP <90/60mmHg)** 2. **Review BP trend and Pulse check** 3. **Review investigations**: blood + urine ACR results 4. **Re-calculate QRISK** (if appropriate) 5. **Discuss risk-reduction + life-style**: in context of QRISK (BMI, smoking, alcohol, diet, activity) & COVID 6. **Mind + Body**: consider screening for mental health conditions 7. **Medication review**: concerns, side-effects, compliance, adherence, ensure renal function satisfactory and adjust medications if needed. Note that some drugs/substances can cause hypertension*	Pharmacist/GP/ Nurse	Remote or F2F	EMIS templates e.g. Ardens Hypertension template (for correct coding, annual review, medication review & Vital 5** recording) Brief-interventions around lifestyle
	8. **Self-management/Shared decision-making**	GP/ Nurse or Social prescriber, Care Navigator & Patient		Self-management resources - send links via AccuRx: British Heart Foundation resources • Understanding your BP • 6 tips for reducing BP • BP and COVID-19 • Online Community for patients • Online programme about BP for patients
Follow-up	9. Review BP **monthly** until it is at target	GP/ Nurse/HCA		

*Drugs/other substances that can cause hypertension, include[5]
- combined oral contraceptives, corticosteroids, NSAIDs, sympathomimetics
- venlafaxine
- cyclosporine
- liquorice (present in some herbal medicines)
- alcohol, substances of abuse including cocaine

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

Lambeth Patient Support

Patient resources

- **Practice social prescribing link worker or health and wellbeing coach**
- Blood Pressure UK: **Patient information leaflets translated into 32 languages**
- Black and Asian people are being invited to attend a **dedicated wellness clinic** to help detect long-term health conditions
- Lambeth health and wellbeing **information and support** (smoking, healthy eating and physical activity)
- **NHS Digital Weight Management** 12-week online behavioural and lifestyle programme
- NHS Better Health **free tools and support** to kickstart your health (weight, smoking, activity, alcohol)
- **Lambeth Early Intervention Prevention Service (LEIPS)** refer via DXS
- Silverfit **physical activity for older people**
- Your Healthier You **(Diabetes prevention)** refer via DXS
- Local activity finders: **getactive** and https://www.gomammoth.co.uk/
- Walking for health **Lambeth Community Health Walking Scheme**
- Lowering your blood pressure with **DASH diet**
- **Local Community Pharmacy Blood pressure check service**

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

Lambeth Clinical Support

Urgent telephone advice- Consultant connect: Cardiology at GSTT/KCH by telephone or via App

Virtual hypertension clinics- These are available for practices to organise via the community hypertension clinics (see below)

Community hypertension clinic- Referral criteria on form (see DXS). Can also provide hypertension drug related advice via email: gst-tr.KHPCommunityCVD@nhs.net

Specialist clinics- Request **advice and guidance** or referral to specialist clinics via eRS to: Hypertension clinic (GSTT/KCH), Pre-conception counselling clinic (GSTT), Pregnancy in Hypertension clinic (GSTT), Obstetric Medicine clinic (GSTT) – for pregnant women with multiple co-morbidities, [CKD clinic (GSTT), Diabetic medicine (GSTT/KCH)]

Data: SELICB Hypertension Dashboard is available to practices. Watch this webinar for more information and contact 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[1] and these individuals have higher risk of stroke due to hypertension, associated with worse outcomes[2]. 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[3]. The drivers for these inequalities include overcrowded housing, higher levels of deprivation, unemployment, barriers to education attainment and racism[2,4].

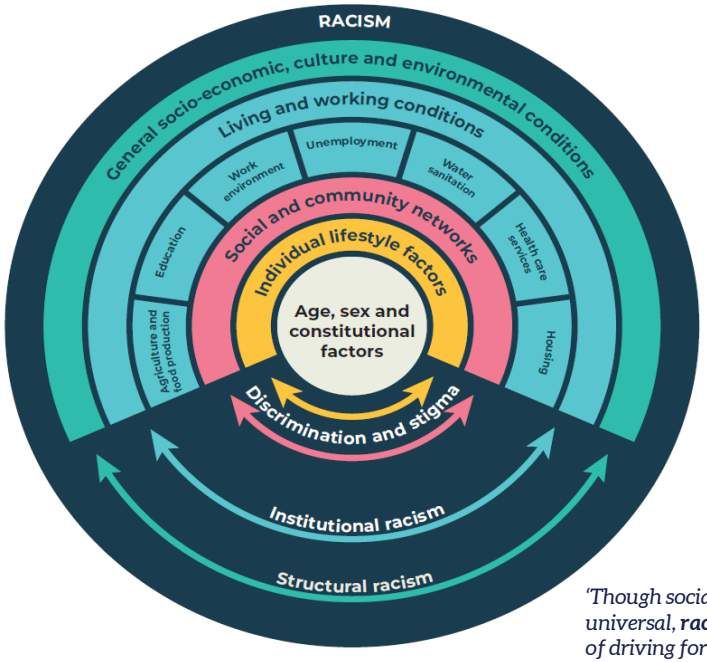
What people have told us [5]

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.'*[4,5]

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[6].

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[2, 8]. 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[1].
- 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[9].
- Patents prefer face-to-face care, especially for a new diagnosis of hypertension[9].
- Encourage self-care and engagement for example home BP monitors and out of hours drop-in GP attendance for BP testing[9].

References

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Pages 2 – 9

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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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Abbreviations

α-B – Alpha-blocker

ABPM –Ambulatory blood pressure monitoring

ACEI– Angiotensin converting enzyme inhibitor

ACR – Albumin-creatinine ratio

A&G – Advice & Guidance

AKI – Acute kidney injury

ARB- Angiotensin II receptor blocker

β-B – Beta-blocker

BD – Twice daily dosing

BMI – Body mass index

BP – Blood pressure

CCB – Calcium channel blocker

CI - Contraindication

CKD – Chronic kidney disease

Cr – Serum creatinine

CV - Cardiovascular

CVD – Cardiovascular disease

DASH diet – Dietary approaches to stop hypertension diet

DXS – Point-of-care tool for EMIS Web

ECG – Electrocardiogram (12-lead)

eGFR – Estimated glomerular filtration rate

eRS – Electronic referral system

FBC – Full blood count

GSTT – Guy's & St Thomas' NHS Trust

HF – Heart failure

K – Serum potassium

KCH – King's College Hospital NHS Trust

HbA1c – Haemoglobin A1c

HBPM – Home blood pressure monitoring

IHD – Ischaemic heart disease

IR – Immediate release

LVH – Left ventricular hypertrophy

Na – Serum sodium

NSAID – Non-steroidal anti-inflammatory drug

OD – Once daily (dosing)

PAD – Peripheral arterial disease

QOF – Quality and outcomes framework (contract)

QRISK- an algorithm that predicts 10-year CVD risk. QRISK3 is available on EMIS via Ardens or online

Renal profile – this includes serum sodium/potassium/creatinine/eGFR

S- Statin

SELAPC – South East London Area Prescribing Committee

TFT – Thyroid function blood tests

TIA-Transient ischaemic attack

T2DM – Type-2 diabetes

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Clinical Effectiveness
South East London

South East London
Integrated Care System

NHS

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

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