Clinical Effectiveness
South East London

Our Healthier South East London
Integrated Care System

NHS

Hypertension

A guide for Lewisham General Practice

Key messages

1. Check blood pressure *at every opportunity* (and do a pulse check)
2. Lifestyle changes *are key* to reducing cardiovascular (CV) risk and lowering blood pressure (BP)
3. Check for target organ damage and use a QRISK assessment tool
4. Optimise BP management with lifestyle and medication changes
5. Aim for NICE BP targets and review BP at least annually

Always work within your knowledge and competency

June 2023 (review June 2025, or earlier if indicated)

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Why focus on BP in Lewisham?

Treatment of high BP significantly reduces risk of stroke, ischaemic heart disease, heart failure, diabetic complications and all cause mortality[1]

- **Risk reduction**: Every 10mmHg reduction in systolic BP reduces risk of major CV events by 20%[1]
- **Under-treated:** In Lewisham, **1 in 3** patients under 80 and **1 in 5** patients over 80, with hypertension, have uncontrolled BP
- **Under-diagnosed:** Of the population estimated to have hypertension in Lewisham, **44%** (27,586) remain undiagnosed[2]
- **Variation**: In Lewisham, the achievement of GP practices managing to control their patients' blood pressure varies by 21%[2]
- **Health Inequalities:** 48% of patients on the hypertension register who have uncontrolled blood pressure are of Black family origin[3]

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

50 people from developing **heart failure**

63 people from having a **stroke**

67 people from developing **ischaemic heart disease**

208 **deaths**

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BP measurement, assessment and targets[4]

How to measure BP

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 (document which arm on EMIS)

When to measure standing + sitting BP?

- In Diabetes Mellitus (DM), suspected postural hypotension, or age ≥ 80yrs
- Measure BP with the patient standing for at least 1 min before measurement - if systolic drop ≥ 20mmHg or symptoms of postural hypotension, **review medication and treat to BP target based on standing BP**

Ambulatory BP monitoring (ABPM) and Home BP monitoring (HBPM)

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 target organ damage

- **Target organ damage: damage to organs such as the heart, brain, kidneys and eyes.**
- **Examination:** check eyes (fundoscopy), urine dipstick (for blood), CV exam
- **Tests:** full blood count (FBC), renal profile, lipid profile (cholesterol), HbA1c, thyroid function test (TFT), urine albumin creatinine ratio (ACR), and 12 lead ECG
- **Record:** smoking status, physical activity level, alcohol intake, BMI, [waist circumference], family history (use Ardens Template)
- **Corrected eGFR** The latest NICE CKD guideline **does not recommend** adjusting the eGFR in people of Black African or African-Caribbean family origin[5]

Assessing Cardiovascular (CV) risk: QRISK2 or QRISK3?

- The QRISK2/3 score estimates the risk of a patient developing CVD over the next 10 years
- Currently a QRISK2 'calculator' is integrated into EMIS, however a link to a more inclusive CV risk score QRISK3 can be found here (and in the Ardens hypertension template)
- For several conditions QRISK2 will underestimate people's risk e.g. severe mental illness and rheumatological conditions.
- QRISK 2/3 are CVD risk estimate calculators, and **therefore clinical judgment must be used**. For example, people considered high risk of CVD (such as Type 1DM, CKD 3-5, lipid disorders, existing CVD, previous stroke/TIA or people ≥ 85 years) should already be on/offered lipid modification therapy (do consider factors that may make treatment inappropriate such as frailty, polypharmacy, life expectancy)
- Follow SEL ICS guideline on lipid management[6] on how to action QRISK2/3 scores ≥ 10%

Which BP target? Aim for and maintain at NICE BP targets (or below)[4, 7, 8, 9]

Which condition?	Which cohort within the condition?	NICE Clinic BP Target	QOF BP Targets[10] 2023/24
		Use clinical judgment in frailty/multi-morbidity Note: corresponding targets for ABPM/HBPM are 5mmHg lower than clinic BPs	
Hypertension, including Type 2 Diabetes (but with no CKD)	Age <80yrs	**≤140/90mmHg**	≤140/90mmHg
	Age ≥80yrs	**≤150/90mmHg**	≤150/90mmHg
Diabetes	Type 2 Diabetes	**Same as hypertension if no CKD**	≤140/90mmHg
	Type 1 Diabetes + no albuminuria	**≤135/85mmHg**	
	Type 1 Diabetes + albuminuria or ≥ 2 features of metabolic syndrome	**≤130/80mmHg**	
CKD (chronic kidney disease)	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)**	
	Age ≥80yrs, irrespective of ACR value	**≤150/90mmHg**	
Ischaemic heart disease (IHD)/ Peripheral arterial disease (PAD) or TIA/Stroke	History of IHD/PAD	**Same as hypertension, if no CKD**	No QOF target for PAD, but for IHD/TIA/Stroke based on age i.e. <80yrs ≤140/90mmHg ≥80yrs ≤150/90mmHg
	History of TIA/Stroke	**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[4] (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.**

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Hypertension diagnosis[4,11]

Clinic BP
Systolic ≤ 140 mmHg AND
Diastolic ≤ 90 mmHg

Normal

Offer lifestyle advice

BP every 5 years, or annually if near to 140/90 mmHg (use clinical judgement) or increased CV risk (p.3)

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

Confirm diagnosis with ABPM/HBPM
check for target organ damage (p.3)

ABPM/HBPM
Systolic 135 - 149 mmHg AND Diastolic 85 - 94 mmHg

Stage 1 Hypertension

ABPM/HBPM
Systolic 150 - 179 mmHg AND Diastolic 95 - 119 mmHg

Stage 2 Hypertension

Clinic BP
Systolic ≥ 180mmHg OR
Diastolic ≥ 120mmHg
Urgent (same day) GP review

Severe Hypertension

Target organ damage? (p.3)

No

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

Yes

Consider treating BP without ABPM/ HBPM result

Worrying symptoms? (p.6)

999/A&E

Offer lifestyle advice (p.7) and assess for target organ damage (p.3)

If <60 yrs and QRISK2/3 <10%

If >80 yrs and BP >150/90 mmHg

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

Offer lifestyle advice and *'consider'* starting BP treatment

Offer lifestyle advice and *'discuss'* starting BP treatment

Offer lifestyle advice and *start* BP treatment
Use clinical judgment in frailty/multi-morbidity

Assess 10-year CV risk using QRISK2/3 (p.3)

If QRISK2/3 ≤10%
No lipid modification treatment*

If QRISK2/3 ≥10%
Address modifiable risk factors first, then consider lipid modification treatment if still >10%

*if total cholesterol >7.5mmol/l consider familial hypercholesterolaemia

Achieve BP control (in line with NICE guidance p.4) **and add to hypertension register with 'Essential Hypertension' code**

BP review at least annually (or more frequently when clinically indicated)
Check BP, give lifestyle advice, arrange blood tests/urine dipstick and review medication (p. 7,10)

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Hypertension management[4]

When to refer a patient?

Suspected secondary cause OR patient < 40 years

- **Secondary causes of hypertension in a patient of any age** e.g. Cushing's syndrome, Conn's Syndrome, obstructive sleep apnoea, scleroderma, lupus, polyarteritis nodosa, retroperitoneal fibrosis
- **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[11]
- **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, heart failure (HF), acute kidney injury (AKI)
- **Accelerated hypertension -** retinal haemorrhage, papilloedema
- **Suspected phaeochromocytoma –** labile or postural hypotension, headache, palpitations, pallor (pale skin), abdominal pain, excessive sweating

Immediate: 999 or A&E

Secondary/Tertiary care support

Urgent telephone advice: Consultant connect - Ambulatory Care UHL, Cardiology, Elderly Care UHL, Renal Medicine
Non-urgent advice: eRS 'Advice & Guidance' - Depending on the context: Hypertension clinic (GSTT), CKD clinic (GSTT), Diabetic medicine (GSTT/KCH), Obstetric medicine (GSTT), Pregnancy in Hypertension clinic (GSTT)

Available specialist clinics Refer via eRS as below.
These forms are available on DXS: 'Lewisham and Greenwich cardiology', 'Hypertension clinic GSTT', 'SEL Nephrology'

- **Resistant** hypertension (on 3/4 meds, one of which is a diuretic) → Hypertension clinic (GSTT) or Cardiology clinic (LGT)
- Hypertension in people **<40 years** → → Hypertension clinic (GSTT) or Cardiology clinic (LGT)
- Hypertension with **suspected secondary cause** → → Hypertension clinic (GSTT) or Cardiology clinic (LGT)
- Hypertension **with renal impairment** → General nephrology (LGT/GSTT/KCH)
- Hypertension **with diabetes** → Diabetic medicine (LGT/GSTT/KCH)

- **Hypertension and pregnancy:** Patients with hypertension should be referred to the obstetric team at their booking hospital, who will get tertiary support as required
- Hypertension **in patients contemplating pregnancy** → Pre-pregnancy counselling clinic (GSTT)
- Hypertension **in pregnancy** → Cardiology clinic (LGT), Hypertension in Pregnancy clinic (if booked at GSTT) or Antenatal Hypertension Clinic (if booked at KCH)
- Hypertension **for pregnant women with multiple co-morbidities** → Obstetric Medicine clinic (such patients should consider booking at GSTT or KCH)

Lifestyle advice[12]

Lifestyle changes can be more effective than medication on average a standard dose of blood pressure medication reduces systolic blood pressure by approx. 9mmHg[13]
The NHS's **'Making every contact count'** approach, enables the opportunistic delivery of healthy lifestyle information at each consultation. Click here for training.

Action	Recommendation (Any lifestyle changes will reduce BP, set realistic goals with patients)	Approx. systolic BP reduction
Reduced weight	Maintain healthy body weight	5-20mmHg/10kg loss
Healthy diet	DASH diet: consume a diet rich in fruits, vegetables, low-fat dairy with reduced saturated and total fat. More information here Discourage consumption of excessive caffeine or caffeine-rich products	8-14mmHg
Reduced salt intake	Reduce dietary sodium intake to <6 g per day[5] (1 level teaspoon[14]) and it should not be added at the table[14]	2-8mmHg
Increased exercise	Regular aerobic physical activity - 150 min per week of moderate intensity (e.g. brisk walking or cycling), build up from 10 min intervals	4-9mmHg
Reduced alcohol intake	Below or equal to 14 units/week - calculator here[15]	2-4mmHg
Smoking: harm reduction	Stop smoking in one step or reduce gradually with stop smoking services, medication or nicotine replacement therapy BP returns to normal 20 minutes after you stop smoking[16]	Currently no available data

Lewisham Patient Support

- Social prescribing in Lewisham: Via GP practice or self-referral. Community connections Lewisham (CCL) also provide services for adults . They can provide links with local organisations such as cookery clubs, walking/exercise groups
- Lewisham Council diet and exercise advice
- Lewisham Be Active Pass: Free or discounted use of Lewisham leisure centres. Self-service machines available at all Lewisham sites if no internet access available
- Lewisham Healthy Walks
- **Healthwise referral:** Exercise on referral scheme for patients with hypertension – Referral on DXS
- **Slimming world -** Referral on DXS
- **SEL Tier 3 Healthy Weight Programme**– Referrals on DXS
- NHS Better Health: weight, smoking, exercise, alcohol
- Stop smoking services
- **British Heart Foundation: How to reduce your Blood Pressure** 6 Top Tips ; Hypertension and COVID ; Online support group
- Online programme about hypertension for patients
- List of pharmacies providing Blood Pressure Checking Service
- BP Patient information leaflets in different languages

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Hypertension treatment[3,4]

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

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

Offer lifestyle advice (p.7)

Step 1

ACE-I or ARB*

ramipril/lisinopril or losartan

CCB
[or thiazide-like diuretic if CCB related oedema, or if heart failure[17]]

amlodipine (or indapamide)

Step 2

**ACE-I or ARB*
+ CCB/ thiazide-like diuretic**

**CCB+
ACE-I or ARB* / thiazide-like diuretic**

Step 3

ACE-I 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 (p.6)

*For **people of black African or African-Caribbean family origin, use ARB** instead of ACE-I (as increased risk of angioedema with ACE-I)

Hypertension with CKD[9]

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

Hypertension and pregnancy[18]

Patients with pre-existing hypertension contemplating pregnancy

Refer to pre-pregnancy counselling clinic (p.6)

Pregnancy with pre-existing hypertension

Refer to secondary care team at the booking hospital (p.6)

Management:

- **Stop ACE-I/ARBs/thiazide-like diuretics** and change medication (preferably within 2 working days of notification of pregnancy) due to increased risk of congenital abnormalities
- Labetalol if no CI e.g. asthma, nifedipine or methyldopa. Can also remain on amlodipine[19]
- **Target BP ≤ 135/85 mmHg**
- **Offer aspirin 75-150mg OD from week 12 of pregnancy**

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

Hypertension: preferred medication [3,4,6,20,21,22]

Drug Class	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 serum 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[3]
	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 immediate release (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[3] - If K>4.5mmol/L should be stopped.
α-B	Doxazosin immediate release (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[3]
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 SEL IMOC guideline on lipid management: medicines optimisation pathways (Sept 2021) - Primary prevention 20mg, secondary prevention 40-80mg (alternative is rosuvastatin)

AKI SICK DAY RULES[23] 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)

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

Hypertension management at practice level

The following tasks may be done by practices administrators, social prescribers, care co-ordinators, HCAs, nurses, pharmacists, physicians associates or GPs – depending on practice pathways and staff availability

	Tasks	Tools/Support
1. Maintaining the hypertension register (prevalence improvement)	**Unknown blood pressure**: Identify patients with no blood pressure measurement in the past 5 years (not on the hypertension register)	• EMIS searches e.g. QOF/Ardens
	Uncoded hypertension: Identify patients with a blood pressure ≥ 140/90mmHg who do not have an 'Essential Hypertension' code	
	How to get BP readings	• During consultations • Practice blood pressure pod • Online consultation/ messaging tool • Community Pharmacy • Secondary care sources: Cerner/ LCR/ clinic letters
2. Call/Recall	**Prioritise high risk patients** (e.g. BP> 160/100mmHg, patients of Black African/Caribbean origin)	• EMIS searches e.g. Ardens • Online consultation/ messaging tool • Letter to patient • Telephone call • Opportunistic at reception
	Pre-patient review • Arrange bloods (renal function, lipids, HbA1c and consider FBC as abnormalities may affect HbA1c interpretation) • Arrange BP measurement and pulse check (in practice/machine at home) • Book appointment for annual review	

3. QOF BP review (at least annually)	• **History:** patient concerns + screen for worrying symptoms/target organ damage related to
	  • Hypertension (p.3,6)
	  • Hypotension (dizziness, nausea, weakness, confusion, systolic BP <90, diastolic BP <60)
	• **Review investigations**: BP, blood results (renal function, lipids, HbA1c), urine ACR.
	• **Re-calculate QRISK2/3** (if appropriate)
	• **Discuss risk-reduction and offer lifestyle advice**: BMI, smoking, alcohol, diet, activity & COVID
	• **Mind and body:** consider screening for mental health conditions
	• **Medication review**: concerns, side-effects, compliance, adherence, and adjust medications if renal impairment Note that some drugs/substances can cause hypertension:
	  • Combined oral contraceptives, corticosteroids, NSAIDs, sympathomimetics, venlafaxine, cyclosporine, liquorice (present in some herbal medicines)
	  • Alcohol, substances of abuse including cocaine
	• **Refer to secondary care** if worrying symptoms or target organ damage from hypertension
		In practice consultations
		• F2F or remote consultation using Ardens hypertension template
		• Structured medication review (SMR) with pharmacist
		
		Out of practice consultations
		• Community home visiting teams
		• Out of Hours/Enhanced Access
		• Secondary care
		
		Remote consultations
		• Remote BP monitoring

	Follow-up • Review **BP monthly until it is at target** • If uncontrolled on optimal doses → repeat ABPM/HBPM, assess for postural hypotension, discuss adherence • If resistant hypertension referral to secondary care	As above, prioritise high risk patients using EMIS searches e.g. Ardens

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Contact CESEL at selccg.clinicaleffectiveness@nhs.net and/or click here for our website

Abbreviations and definitions

α-B – Alpha-blocker

ABPM –Ambulatory blood pressure monitoring

ACEI– Angiotensin converting enzyme inhibitor

ACR – Albumin-creatinine ratio. Ideally first-void morning urine sample.

AKI – Acute kidney injury

ARB- Angiotensin II receptor blocker

AccurX – Secure healthcare communication tool that allows interactions between a GP surgery and its patients

Ardens – clinical decision support tool embedded in EMIS that provides templates for long term conditions management

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)

eConsult – Digital triage and remote consultation solution

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

LGT – Lewisham and Greenwich NHS Trust

LVH – Left ventricular hypertrophy

MJog – Mobile messaging app which provides secure communication of health information between a GP surgery and its patients

Na – Serum sodium

NSAID – Non-steroidal anti-inflammatory drug

OD – Once daily dosing

PAD – Peripheral arterial disease

Pod – This is a touchscreen computer connected to a BP monitor that patients can use without clinical supervision

QOF – Quality and outcomes framework (contract)

QRISK- an algorithm that predicts 10-year CVD risk. EMIS is currently using QRISK2 (although QRISK3 was released in 2017)

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

SELAPC – South East London Area Prescribing Committee

TFT – Thyroid function blood tests

TIA-Transient ischaemic attack

T2DM – Type-2 diabetes

UHL – University Hospital Lewisham

CESEL Lewisham – 'Owned by all'

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

June 2023 (review June 2025, or earlier if indicated)