RCGP Scotland’s response to the Cross-Party Group on Heart Disease and Stroke’s consultation into hypertension

The Royal College of General Practitioners (RCGP) is the professional membership body for family doctors in the UK and overseas. We are committed to improving patient care, clinical standards and GP training. RCGP’s objectives, in concern for care for patients, are to shape the future of general practice, ensure GP education meets the changing needs of primary care throughout the UK, grow and support a strong, engaged membership and to be the voice of the GP.

The College in Scotland came into existence in 1953 (one year after the UK College), when a Scottish Council was created to take forward the College’s interests within the Scottish National Health Service. We currently represent around 5,000 GP members and Associates in Training throughout Scotland. In addition to a base in Edinburgh, the College in Scotland is represented through five regional faculty offices in Edinburgh, Aberdeen, Inverness, Dundee and Glasgow.

RCGP Scotland welcomes the opportunity to respond to the Cross-Party Group on Heart Disease and Stroke’s inquiry into hypertension.

1) Do you have any formal mechanism for assessing medication adherence in patients that do not achieve blood pressure targets?

RCGP Scotland values the patient-doctor relationship and views shared decision making between patient and GP, where appropriate, as vital for this relationship. To this end, we prefer to view effectiveness of medication in the context of concordance rather than adherence by patients.

RCGP Scotland believes that patients who are involved in shared decision making from the start of their treatment will better understand why and how to take their treatment and are more likely to take their prescribed medication as intended. Conversely, we feel that the term adherence implies a paternalistic role for the GP, with patients simply following orders.

Despite being abolished in Scotland in 2016, the previously used Quality Outcome Framework (QOF) has ensured that the majority of GP practices in Scotland have systems in place for call and recall of chronic and disease management clinics for hypertension. These clinics most commonly, but not in all cases, fall under the management of practice nurses or practice pharmacists with these health professionals being able to communicate directly with their patients’ GPs. Such a system helps to ensure that patients’ chronic conditions are monitored effectively, but it cannot guarantee that any prescribed medication is taken as intended by the patient. The existence of such a system and the continuity of care that it brings, affords healthcare professionals with the opportunity to address any issues which may arise, such as optimising drug therapy, with patients. It also, importantly, allows for healthcare professionals to advise patients on any lifestyle measures which they may wish to explore to limit the need for additional medication, such as weight loss, increased levels of exercise and changes to diet.
2) Do you have any examples of good practice to share with regards to treatment of hypertension?

In many instances, the best examples of good practice with regards to treatment of hypertension are those which embed a patient-centred approach. RCGP Scotland recognises the risks that hypertension can bring, particularly in terms of increased risk of strokes and heart attacks, however it is also important to limit over-diagnosis of hypertension. For instance, an example of good practice in general practice would look like a patient with slightly raised blood pressure approaching their GP and being advised to consider increased levels of exercise or to consider making changes to their diet before being prescribed medication. GPs and their teams are well placed to help, encourage and enable such positive interventions, however they have to be supported to do so and recognition must be given to the fact that it is challenging to have these often difficult and more complex conversations within the standard 10-minute consultation period.

Additional examples of good practice include investigations and risk tools used by GPs to fully assess patients in the diagnostic phase. Such tools include Electrocardiograms, the use of blood and urine tests to assess for end-organ damage and also tools such as ASSIGN to assist risk stratification. These tools help clinicians to identify those patients who require medical therapy and those who should trial monitored lifestyle changes in the initial stages.

Examples of good practice with regards to the treatment of hypertension tend to feature the use of 24-hour heart beat monitors or home monitoring, to help avoid over-diagnosis of the condition.

3) Are there examples of innovative technological developments in relation to blood pressure which should be considered by this inquiry?

There are many technological advancements in terms of the measurement of blood pressure which are being used by practices across Scotland. For instance, many practices have blood pressure measuring machines available for use by patients in waiting rooms and other patient areas. However, RCGP Scotland has some concerns over the calibration and standardisation of this technology and these need to be clarified before such devices can be recommended.

We also believe that recognition has to be given to the fact that there is a risk to the continuity of care between GPs and their patients if patients lose all connection with their GP practice to undergo blood pressure monitoring. The trust that is developed between GPs and their patients over time is essential to having frank and honest conversations about a patient’s health care and so to truly developing a patient-centred approach. This approach is vital if GPs are to be able to recommend non-drug interventions to patients experiencing slightly high levels of blood pressure. There is a risk that if technology is over-relied upon, this insight and non-medical intervention could be diluted.
4) **What are your views on whether and how the traditional model of hypertension detection, diagnosis and management could be improved to benefit patient experience and outcomes, improve efficiency and reduce costs to NHS?**

There is a clear move by GP practices and their teams to embrace new technologies to assist in the detection, diagnosis and management of hypertension. However, when considering improvements to the current model, consideration must be given to ensuring that mass treatment and over-medicalisation of hypertension is avoided. For instance, in stage one hypertension (<160/100) high blood pressure could be considered a risk factor rather than a disease. In such cases, advising people into treatment may not be the best course of action. Treating raised blood pressure can reduce the risk of strokes and heart attacks, but only in cases where individuals are experiencing moderate to severe levels of raised blood pressure and for those with a history of Cardiovascular disease. This is evidenced by the Cochrane Review which states, “Antihypertensive drugs used in the treatment of adults (primary prevention) with mild hypertension (systolic BP 140-159 mmHg and/or diastolic BP 90-99 mmHg) have not been shown to reduce mortality or morbidity in RCTs”.

RCGP Scotland recognises the importance of managing hypertension, however we are also cautious that medical solutions are not over-prescribed to manage the disease.

5) **Are there identifiable sub-groups that are likely to benefit the most from new strategies?**

Identifying and understanding the sub-groups that are likely to benefit the most from new strategies in terms of identifying, diagnosing and managing hypertension is important as we recognise that the current evidence is somewhat weak in this area.

In terms of sub-groups that could benefit from more focus, those living in areas of high deprivation, where practices may not have the resources to buy technology such as 24-hour blood pressure monitors, may particularly benefit. Additionally, those patients who are obese or have a family history of cardiovascular disease may benefit particularly from new technologies.

However, we caution that focussing too much on targeting resources to sub-groups may result in dilution of the wider public health message. Efforts must be taken to ensure that any campaigning and public health messages around hypertension take into account the impact of the Inverse Care Law.

**Dr Alasdair Forbes**  
*Deputy Chair (Policy) RCGP Scotland*  
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