



INFORMATION BOOKLET

Hypertension as a Long-Term Condition in UK Health and Social Care

A critical examination of management, policy and person-centered care

Programme: MSc Public Health and Social Care in Practice

Module: Community Care and Management of Longer-term Conditions

Module Code: LCHS7003

Assignment Title: Component 1- Information Booklet of Long-term Condition Management

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Target Audience: Health and social care professionals and commissioners in the UK

Diseases: Hypertension

Submission Date: 17 July 2026

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Introduction

Definition of Hypertension

Hypertension, also known as high blood pressure, is a chronic heart disease that is marked by the chronically high blood pressure in the arteries (Goorani, Zangene and Imig, 2024). National Institute for Health and Care Excellence (NICE) notes that hypertension is commonly diagnosed with clinic blood pressure of 140/90 mmHg and above, which is verified with the help of ambulatory blood pressure monitoring (ABPM) or home blood pressure monitoring (HBPM) (NICE, 2023). The long-term effects of high blood pressure cause damage to blood vessels and other vital body organs, which pose a high level of risk of cardiovascular diseases, stroke, chronic kidney disease and heart failure. Hypertension being a disease that is not manifested in clear symptoms has been commonly referred to as the silent killer.

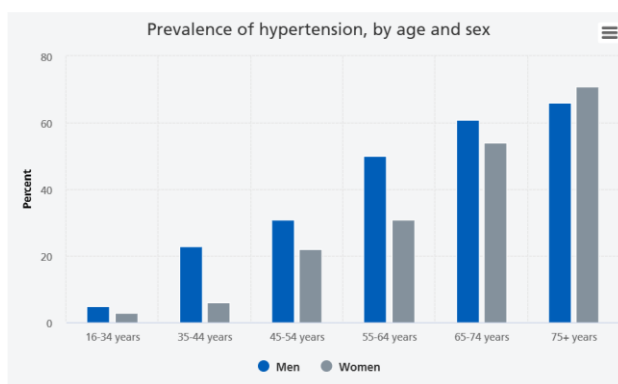


Figure 1: Prevalence of hypertension, by age and sex

Source: (<https://digital.nhs.uk/>, 2023; Toua, 2021; 2026b)

Why Hypertension is a Major Long-Term Condition

One of the most widespread and avoidable long-term conditions globally and one of the biggest challenges to the population health is hypertension. It is estimated by the World Health Organization (WHO, 2023) that around 1.28 billion adults aged 30-79 years across the world live with hypertension, with nearly 46% of them ignorant of their condition. Moreover, merely 42 percent of hypertensive people are diagnosed and treatable, and only 21 percent are able to have proper blood pressure levels (Vito, 2025). Hypertension is one of the most prevalent causes of cardiovascular morbidity, premature death and health care spending in the United Kingdom, and approximately 14.4 million adults in the country are estimated to have this condition (Ayre, 2024).

Purpose of the Booklet

The purpose of this information booklet is to give an evidence-based summary of hypertension to health and social care professionals. It looks at the commonality, causes and risk factors of hypertension, assesses the physical, psychological and social effects and summarizes the existing evidence-

based management approaches in existence within the NHS.

Understanding Hypertension

Definition and Classification

Hypertension is a long-term health disorder involving continuously high blood pressure in the arteries, which cause a strain on the heart and damage blood vessels during the years (Alhazmi, 2024). Blood pressure is divided into Stage 1 hypertension (140/90-159/99 mmHg), Stage 2 hypertension ($\geq 160/100$ mmHg), and Severe hypertension ($\geq 180/120$ mmHg), which is to be evaluated by a clinician urgently (Guirguis-Blake et al., 2021).

Blood Pressure Stages

Blood Pressure Category	Systolic mm Hg (upper #)		Diastolic mm Hg (lower #)
Low blood pressure (Hypotension)	less than 80	or	less than 60
Normal	80-120	and	60-80
Prehypertension	120-139	or	80-89
High Blood Pressure (Hypertension Stage 1)	140-159	or	90-99
High Blood Pressure (Hypertension Stage 2)	160 or higher	or	100 or higher
High Blood Pressure Crisis (Seek Emergency Care)	higher than 180	or	higher than 110

Source : (Toua, 2021; 2026b)

Types (Primary and Secondary)

About 90-95 percent of hypertension is primary (essential) hypertension, which progresses over time and has no single identifiable cause and is closely related to genetic predisposition, old age and lifestyle (Evbayekha et al., 2022). The others 5-10 percent are secondary hypertension, which is caused by conditions that can be identified like chronic kidney disease, endocrine problems, as well as obstructive sleep apnea or some drugs. It is crucial to determine any secondary causes because the treatment of the underlying condition can reverse or ameliorate hypertension.

Pathophysiology

Hypertension occurs as a result of interplay of heightened peripheral vascular resistance, hyperactivity of reninangiotensinaldosterone system (RAAS), hyper-stimulation of sympathetic nervous system and endothelial dysfunction (F et al., 2022). Chronic hypertension facilitates stiffening of the arteries, vascular remodeling and left ventricular hypertrophy, which gradually adds to strokes, coronary artery disease, heart failure and chronic kidney disease chances.

Signs and Symptoms

Hypertension is often silent and hence it is known as a silent killer. Symptoms when present can be described as the presence of

persistent headaches, dizziness, blurred vision,
chest pains, palpitations, fatigue and shortness
of breath.

Burden of Disease

Global Prevalence (WHO Statistics)

One of the most important non-communicable diseases (NCDs) burden on a global scale is hypertension (World Health Organization, 2023). The World Health Organization (WHO, 2023) estimates that there are 1.28 billion adults aged 30-79 years with hypertension in the world, of whom about two-thirds are living in low- and middle-income nations (Cheraghi et al., 2025).

UK Prevalence (NHS, UKHSA and NICE)

NHS England estimates that approximately 14.4 million adults are hypertensive, which constitutes one in every three adults yet many are undiagnosed (Graham et al., 2025). It causes more than half of heart attacks and strokes and the early diagnosis and proper management are the priority of the NHS Long Term Plan and NICE guideline NG136.

Economic Burden on the NHS

Hypertension poses a significant economic burden on NHS in terms of primary care consultations, long-term medication, hospital admissions and treatment of avoidable complications such as stroke, heart failure and chronic kidney disease. CVDs alone cost the NHS more than 10 billion a year, and

hypertension is one of the most significant risk factors that increase healthcare expenses that are modifiable (Waterall, 2018).

Mortality and Morbidity

Hypertension is a major cause of premature morbidity and mortality that is uncontrolled. It significantly raises the chances of stroke, myocardial infarction, heart failure, atrial fibrillation, chronic kidney disease and vascular dementia (Waterall, 2018).

Risk Factors and Causes

Non-Modifiable Factors

There are a number of risk factors of hypertension that are not changeable. One of the strongest determinants is the advancement of age because the arteries become stiffer with a decreased vascular elasticity as time passes. The elderly that are 60 years old and older are also more prone to contracting high blood pressure (Debie Anggraini, 2023; Waterall, 2018). The risk is high in case of a family history of hypertension, as inherited genetic factors affect blood pressure regulation. Also, male sex is linked with increased prevalence of hypertension under the age of 65 whereas it increases significantly in women after menopause due to hormonal alterations

(Connelly, Currie and Delles, 2022). Susceptibility is also determined by ethnicity, wherein people of African and South Asian descent are more susceptible and at risk of having complications associated with hypertension (Ho et al., 2022).

Modifiable Factors

These include obesity, physical inactivity, high level of dietary salt intake, tobacco smoking, bad alcoholism and untamed psychological stress. The World Health Organization indicates that millions of cardiovascular events worldwide every year would be prevented by decreasing salt intake to less than 5 g per day (World Health Organization, 2025).

Lifestyle Contributors

Unhealthy lifestyle is a major cause of high blood pressure. High levels of processed foods, saturated fats and refined sugars, sedentary living, poor sleep and chronic stress, are conducive to weight gain, endothelial dysfunction and high vascular resistance, which enhance the progression of hypertension.

Comorbidities

Hypertension is often comorbid with such chronic diseases as type 2 diabetes mellitus, chronic kidney disease, dyslipidemia, obstructive sleep apnea and obesity (Moke,

Demaki and Daubry, 2023). These comorbidities enhance the risk of cardiovascular disease, complicate disease and have worse clinical outcomes, requiring multidisciplinary and person-centered long-term care.

Impact of Hypertension

Physical Impact

The physical effects of hypertension are severe and can occur when the blood pressure is not under control over certain time. Long-term high blood pressure harms the blood vessels, organs, and puts individuals at risk of stroke, heart attack, heart failure, chronic kidney disease, peripheral arterial disease and blindness. Fatigue, lower exercise tolerance and decreased physical functioning may also be experienced by patients negatively influencing their quality of life.

Psychological Impact

Hypertension can be a very psychologically disrupting condition to live with. Patients can develop anxiety, stress, depression and fear of lifelong use of medication, the development of the disease, and potential severe complications like stroke or heart attack.

Social Impact

High blood pressure may adversely affect working, social life and economic condition. Regular visits to medical facilities, drug expenses and decreased work efficiency can restrict everyday life and augment financial strains. Social interactions and general wellbeing might also be influenced by lifestyle changes such as diet, smoking and alcohol reduction.

Impact on Family and Careers

Close relatives and informal careers are significant to facilitate medication adherence, healthy lifestyle changes and periodic health checkups (Maha Alkhaldi, Lindsey and Richardson, 2025). Nonetheless, the emotional stress, financial strain and caregiver burden of caregiving can arise especially in instances where hypertension comes with complications such as stroke, heart failure or chronic kidney disease.

Diagnosis

Blood Pressure Measurement

Diagnosis of hypertension can only be accurately diagnosed by measuring the blood pressure using standardized measurements in a clinical setting. National Institute of Health and Care Excellence (NICE) suggests that blood

pressure measurement should be done in both arms during the first time and then use the arm with the higher reading to measure it again (Gregory, 2025). A second reading should be carried out in case the clinic blood pressure is 140/90 mmHg or greater and third reading should be carried out in case there is a significant difference.

Ambulatory Blood Pressure Monitoring (ABPM)

ABPM is regarded as the gold standard of diagnosis of hypertension. Patients are equipped with a portable monitor that they carry over the course of 24 hours to monitor the blood pressure changes automatically every 15-30 minutes during the day and 30-60 minutes at night to achieve a detailed evaluation of the blood pressure variability and minimise the impact of the white-coat effect (Konstantinidis et al., 2022). According to NICE, hypertension is confirmed when the daytime average ABPM is $\geq 135/85$ mmHg (Hermida et al., 2021; Konstantinidis et al., 2022).

Home Blood Pressure Monitoring (HBPM)

HBPM is suggested where ABPM is not available or not applicable. The patients take two blood pressure readings in the morning and evening at least four days (preferably seven days) and drop the initial day results and

average the rest (Hermida et al., 2021; Konstantinidis et al., 2022). HBPM has been demonstrated to enhance long-term blood pressure control, increase self-management and enhance patient engagement.

Diagnostic Thresholds

Stage 1 hypertension is defined by clinic blood pressure of 140/90-159/99 mmHg and ABPM/HBPM of 135/85-149/94 mmHg (NICE Guideline NG136) (McGurgan et al., 2022). Stage 2 hypertension is characterized by clinic blood pressure of 160/100 mmHg or higher with an average of ABPM/HBPM of 150/95 mmHg or higher and severe hypertension is characterized by a clinic blood pressure of 180/120 mmHg or higher (Rosen, 2024).

Evidence-Based Treatment in the UK (NHS)

Lifestyle Modification

The NHS and NICE Guideline NG136 suggest that lifestyle change should be the initial intervention in all hypertension patients. There is evidence that healthier behaviors have the potential to lower systolic blood pressure by 5-20 mmHg, depending on the interventions

involved, and also decreasing the risk of cardiovascular disease. P

Weight Management, Salt Reduction and Exercise

A Body Mass Index (BMI) of 18.524.9 kg/m² is linked to a substantial drops in blood pressure, and a 1 mmHg loss in systolic blood pressure related to every kilogram of weight loss (Rosen, 2024; Yang et al., 2023). NICE also advises to consume not more than 6 g/day of salt, whereas the World Health Organization suggests not more than 5 g/day, which lessens the risk of CVD. Adults ought to engage in moderate-intensity aerobic workouts that last at least 150 minutes a week and may lower systolic blood pressure by about 5-8 mmHg and enhance cardiovascular fitness.

Smoking Cessation and Alcohol Reduction

Even though sustained hypertension is not directly caused by smoking, it is a major risk factor leading to coronary heart disease, stroke and peripheral vascular disease. NHS Stop Smoking Services are behavioral support and pharmacological therapies to enhance the quit rates. Alcohol use cannot be more than 14 units in a week, which are taken over a number of days since taking a lot of alcohol is a contributing factor to high blood pressure and cardiovascular diseases.

Drug Therapy and Regular Monitoring

In cases of the inadequacy of lifestyle interventions, NICE NG136 promotes the use of antihypertensive drugs, depending on the age and ethnicity (National Institute for Health and Care Excellence (NICE), 2023). Angiotensin-Converting Enzyme (ACE) or Angiotensin II Receptor Blockers (ARBs) in adults below age 55 years, and Calcium Channel Blockers (CCBs) in adults aged 55 or older and African or Caribbean descent are the first-line treatments (National Kidney Foundation, 2023). When blood pressure is not regulated, CCBs, ACE inhibitors/ARBs and thiazide-like diuretics are combined in the treatment (Strauss, Hall and Narkiewicz, 2021).

Social Care, 2026). Adults aged 40-74 years through the NHS Health Check Programme are regularly screened to detect hypertension and other cardiovascular risk factors at an early stage before they complicate. By treating people earlier, particularly with evidence-based interventions, personalized risk assessment and by 2029 preventing over 150,000 heart attacks, strokes and cases of dementia, the NHS is set to achieve this (Raleigh, Jefferies and Wellings, 2022).

Models and Frameworks

[UK Model](#)

NHS Long Term Plan

The current NHS Long Term Plan (2019) has stated cardiovascular disease (CVD) prevention as a national priority and hypertension is among the risk factors that most significantly contribute to premature death and are modifiable (Department of Health and

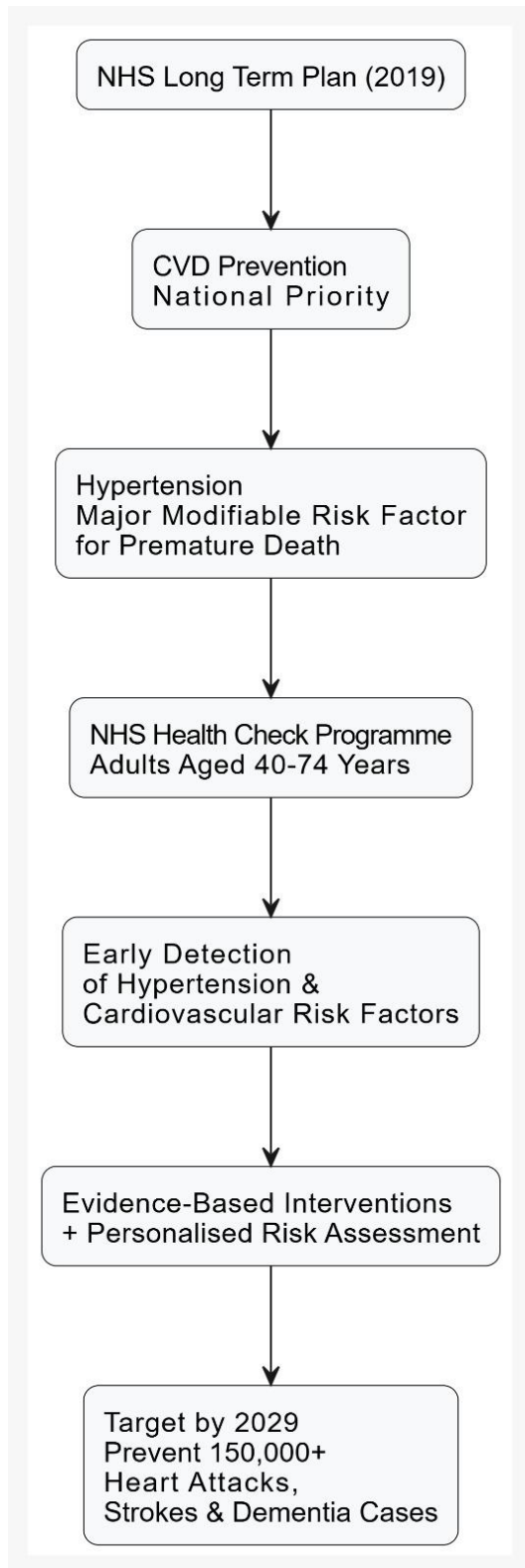


Figure 2: NHS Cardiovascular Prevention Strategy

Source: self-created

Chronic Care Model (CCM) Implementation within NHS Primary Care

NHS primary care has been incorporated with the Chronic Care Model (CCM) to enhance the management of long-term conditions by providing coordinated and person-centred care. In General Practice, multidisciplinary teams (GPs, practice nurses, pharmacists, dietitians and community healthcare professionals) collaborate in the provision of continuous monitoring, medication reviews, and self-management assistance. Structured CCM interventions have been shown to enhance blood pressure management, medication adherence and patient engagement and decrease preventable hospitalization. In England, management of hypertension is mainly done in the primary care by about 90 percent of the population, emphasizing the importance of multidisciplinary services in enhancing long-term outcomes (2026).

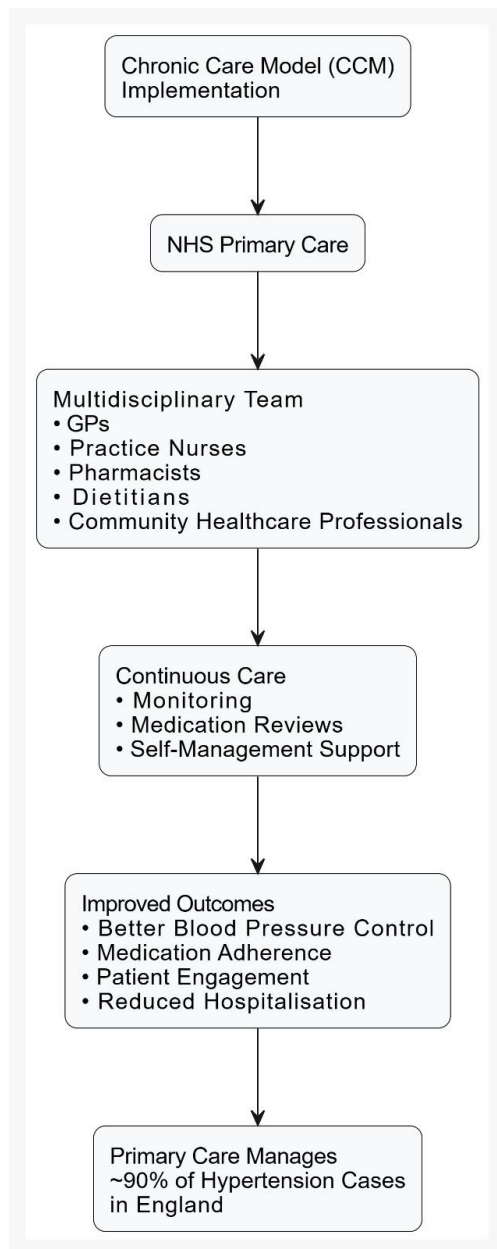


Figure 3: Chronic Care Model (CCM) in NHS Primary Care

Source: self-created

International Model

WHO HEARTS Technical Package

The World Health Organization (WHO) HEARTS Technical Package is an evidence-

based international tool to enhance cardiovascular disease prevention and hypertension management in primary healthcare systems. Applied in more than 40 countries, HEARTS standardizes the diagnosis of hypertension, treatment guidelines and follow-up and enhances equality of access to affordable antihypertensive drugs (Bartelt et al., 2026).

The framework includes six elements: Healthy-lifestyle counselling (H), Evidence-based treatment protocols (E), Access to essential medicines and technology (A), Risk-based cardiovascular management (R), Team-based care (T) and Systems for monitoring (S) (Bartelt et al., 2026; WHO, 2020).

UK Health and Social Care Policies

In the NHS Long Term Plan (2019), the prevention and early diagnosis of cardiovascular disease (CVD) is among the priorities, aiming to reduce the number of heart attacks, strokes and cases of dementia by more than 150,000 by 2029 by enhancing the screening of hypertension and supporting it with digital monitoring and personalized care (Magowan, 2021). The NICE Hypertension Guideline (NG136) gives evidence-based guidance on the diagnosis and management of hypertension, and recommends the use of either

Ambulatory Blood Pressure Monitoring (ABPM) or Home Blood Pressure Monitoring (HBPM) to support the diagnosis and suggests age and ethnicity-specific antihypertensive treatment pathways (Shah et al., 2022).

The Quality and Outcomes Framework (QOF) provides financial incentives to the General Practices to keep hypertension registries, annual blood pressure reviews and evidence-based blood pressure goal attainment, to enhance quality and consistency of care (Ho et al., 2025).

Person-Centre Care

The effective management of hypertension relies on person-centered care that has to be integrated so that treatment fits in the preferences, values and clinical needs of a person. Shared decision-making can promote the active involvement of patients and healthcare professionals in the process of choosing lifestyle interventions and antihypertensive drugs, which enhances adherence to treatment and long-term outcomes(2026b).

Patient education on healthy eating, exercise, medication compliance and routine blood pressure checks encourages self-management where patients can be empowered to take charge of their condition. Digital innovations such as the NHS App, Home Blood Pressure

Monitoring (HBPM) and remote consultations allow patients to record blood pressure numbers, order repeat prescriptions, access health records and be in touch with healthcare professionals to facilitate timely interventions and continuity of care (Ho et al., 2025; Wu et al., 2026).

Recommendations

Improve Community Screening

The screening of blood pressure in communities by expanding GP practices, pharmacies, workplaces and mobile health clinics would help in the earlier detection of hypertension. The strategy of expanding the number of adults aged 40-74 years who attend NHS Health Checks will help detect undiagnosed cases and decrease the risk of avoidable cardiovascular problems. High risk and underserved populations should be a priority in outreach programs to enhance early intervention.

Increase Digital Monitoring

There should be increased use of Home Blood Pressure Monitoring (HBPM), remote appointments and NHS app to aid in continuous blood pressure monitoring, medication compliance and prompt clinical evaluation. Digital health technologies may be included in everyday primary care to lower hospital visits

without the necessity, enhance patient engagement, and self-management.

AI-Assisted Risk Prediction

Primary care should include artificial intelligence (AI) to help improve cardiovascular risk assessment. Electronic health records, blood pressure patterns and lifestyle factors can be analysed by AI algorithms to identify people who have a high risk of complications to provide personalized interventions earlier and allocate NHS resources more efficiently.

Better Public Awareness, Health Equity and Patient Education

The national awareness campaigns must focus on the need to check blood pressure on a regular basis, live a healthy lifestyle and treat hypertension early enough since the blood pressure condition does not manifest itself in most cases. Specific measures are needed to resolve the health disparities in communities with socioeconomic disadvantages and ethnic minority groups where the problem of hypertension and its complications are overrepresented.

Conclusion

Hypertension is one of the most common and preventable chronic conditions in the world with an estimated global prevalence of 1.28 billion adults and 14.4 million in the United Kingdom. Regardless of effective treatments, there are a lot of undiagnosed or not well controlled individuals that are at risk of stroke, myocardial infarction, heart failure and chronic kidney disease. It has been shown that early diagnosis, lifestyle changes, evidence-based pharmacological treatment and frequent follow-ups are vital in lessening cardiovascular morbidity and mortality. With the NHS Long Term Plan, NICE Guideline NG136, and person-centered multidisciplinary care, hypertension management can lead to great improvements in patient outcomes.

Further funding in community-level screening, AI-based risk forecasting and community education will empower prevention efforts, decreasing health disparities and making the

NHS more sustainable in the long term and improving the quality of life of people with hypertension.

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