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NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

QUALITY AND OUTCOMES FRAMEWORK (QOF) INDICATOR DEVELOPMENT PROGRAMME

Consultation report on piloted indicator(s)

QOF indicator area: Hypertension: target organ damage

Consultation period: 06/01/2014 – 03/02/2014

Potential output: Recommendations for NICE Menu

Contents

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Introduction

This report provides a summary of the responses received from the recent consultation on potential new indicators for inclusion in the NICE menu. The Committee is also provided with the full consultation comments in appendix A of this paper.

The Committee is asked to consider the results of the consultation alongside the pilot reports produced by the National Collaborating Centre for Indicator Development and cost effectiveness analysis by York Health Economics Consortium where available.

Indicator(s) included in the consultation

ID	Indicator	Evidence source
IND-2	The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of urinary albumin: creatinine ratio test in the three months before or after the date of entry to the hypertension register	NICE clinical guideline 127: Hypertension - Clinical management of primary hypertension in adults (2012)
IND-3	The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of a test for haematuria in the three months before or after the date of entry to the hypertension register.	NICE clinical guideline 127: Hypertension - Clinical management of primary hypertension in adults (2012)
IND-4	The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of a 12 lead ECG performed in the three months before or after the date of entry to the hypertension register.	NICE clinical guideline 127: Hypertension - Clinical management of primary hypertension in adults (2012)

A summary of comments relating to the specific questions below is provided following the summary of responses to the standard consultation questions:

- Do you think the indicators in piloting will provide an adequate assessment of target organ damage?

- Which of the indicators relating to hypertension, do stakeholders feel are the highest priority for the QOF?

Overarching comments on the indicators

Overall stakeholders acknowledged the value in assessing target organ damage in people with hypertension. NHS England commented on the

availability of tests and noted that the ability to diagnose target organ damage in primary care may be limited.

In relation to the first indicator (IND-2), stakeholders were mostly in favour of tests for urinary albumin: creatinine ratio (ACR), adding that this should be supplemented by additional information from other tests such as estimated glomerular filtration rate (eGFR) and serum creatinine.

In relation to the second indicator (IND-3), the British Renal Society and the British Hypertension Society questioned the utility of haematuria testing in people with hypertension.

In relation to the third indicator (IND-4), the availability of 12-lead electrocardiogram (ECG) in primary care and the ability for primary care staff to interpret ECG results were considered to be the main barriers to implementation.

Some stakeholders suggested additional tests for target organ damage: renal function, eGFR, retinopathy and other risk factors such as dyslipidaemia. One stakeholder suggested the development of a composite indicator, similar to that developed for diabetes, assessing routine investigations in people with hypertension.

Considerations for Advisory Committee

The specific issues that the Advisory Committee is asked to consider when making recommendations on which indicators should be published on the NICE menu for the QOF are stated below.

These issues are also addressed in the indicator development reports which will include suggestions for possible amendments to how the indicators should be specified following piloting and public consultation.

The Advisory Committee is asked to consider:

- Whether the indicators do provide an adequate assessment of target organ damage
- Whether a composite indicator should be considered?

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Summary of responses: comments by indicator (IND-2)

> *The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of urinary albumin: creatinine ratio test in the three months before or after the date of entry to the hypertension register.*

Stakeholders, including the British Renal Society, Care Quality Commission, British Hypertension Society and British Cardiovascular Society welcomed this potential new QOF indicator for hypertension. The British Cardiovascular Society commented that the ACR test is one of the main tests for target organ damage and is required to determine the need for medication in stage one hypertension. It was added that ACR tests are straightforward and already routinely provided in primary care for people with diabetes. The British Hypertension Society commented that the ACR test is inexpensive and gives a valuable measure of glomerular function. NHS England and NHS Employers felt this was a reasonable and achievable indicator given ACR laboratory tests are readily available to practices.

The General Practitioners Committee (GPC) of the British Medical Association (BMA) commented that the indicator risks micromanaging the diagnostic process for hypertension and that the timeframes specified may be difficult to achieve where diagnosis is made during a long hospital stay.

Summary of responses: comments by indicator (IND-3)

> *The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of a test for haematuria in the three months before or after the date of entry to the hypertension register.*

The British Renal Society and British Hypertension Society questioned the utility of identifying people with haematuria and a normal ACR as a QOF indicator. They commented that haematuria is a late sign of hypertensive renal disease and more often relates to renal, bladder or genitourinary problems rather than hypertension. The British Cardiovascular Society commented that although haematuria is a less specific test for renal damage this is straightforward and would be an achievable indicator.

Stakeholders warned of potential increased referrals to urology services. The British Cardiovascular Society highlighted that detection of asymptomatic microscopic haematuria may lead to a rise in the number of two-week

referrals to haematuria clinics for further investigation. It was suggested that the views of urological surgeons should be taken into account before this indicator is accepted into the OQF.

NHS England and NHS Employers felt that this indicator is reasonable and achievable but that QOF guidance would need state which test is appropriate i.e. stick test or microscopy. They also commented that urinalysis would need clarification as to the threshold which indicates organ damage.

The GPC of the BMA considered that the prevalence of haematuria of left ventricular hypertrophy in people with a new diagnosis of hypertension is too small in general practice to make this indicator suitable for inclusion in the QOF. One stakeholder also highlighted that activity occurring in the final three months of the QOF year results in automatic success when dealing with new diagnosis. It was highlighted that this would therefore need to be a cross year indicator and commented that this can be confusing for practices, particularly when the business rules do not reflect the indicator wording.

Summary of responses: comments by indicator (IND-4)

> *The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of a 12 lead ECG performed in the three months before or after the date of entry to the hypertension register.*

Stakeholders including the British Heart Foundation considered that the availability of 12 lead ECG in primary care and interpretation of results may be a barrier to implementation. It was felt that this indicator could be susceptible to variation in practice depending on the skills and expertise of the primary care staff. The British Heart Foundation commented that variability in care is likely and that care is needed to ensure normal findings from ECGs are not over investigated but abnormal findings from ECGs are correctly identified. Other stakeholders including the Royal College of Nursing, British Cardiovascular Society and British Hypertension Society considered that 12-lead ECG is an important test in all people with hypertension, stating that only a minority of practices would not have the ability to perform and interpret ECGs. It was felt that where equipment and training may be a barrier to implementation commissioners should be responsible for providing this since this should be basic practice.

NHS England and NHS Employers felt that the threshold which would indicate organ damage requires clarification.

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The GPC of the BMA considered that the prevalence of left ventricular hypertrophy detected by ECG in people with a new diagnosis of hypertension too small in general practice to make this indicator suitable for inclusion in the QOF.

The British Renal Society were unsure how ECG findings would affect management in people without clinical evidence of cardiac dysfunction, commenting that evidence supporting current treatment thresholds is not influenced by the presence or absence of left ventricular hypertrophy. It was suggested that QOF guidance should provide detail as to how GPs manage people on identifying left ventricular hypertrophy.

Indicator specific question(s) and responses

The QOF Advisory Committee recommended that indicators to assess target organ damage focus on tests used in primary care for renal damage and electrocardiographs. Stakeholders were therefore asked:

Do you think the indicators in piloting will provide an adequate assessment of target organ damage?

Stakeholders made the following comments in relation to this question:

- NHS England and NHS Employers considered that ability to diagnose target organ damage in primary care limited.
- The British Heart Foundation felt that the three tests included in this indicator set would identify patients with renal damage and ventricular hypertrophy but not assess renal function, eGFR, retinopathy and other risk factors such as dyslipidaemia.
- The National Kidney Federation consider that a measure of eGFR to ascertain kidney function as well as ACR is imperative for safe prescribing, to determine the use of hypertensive drugs and assessing risk from chronic kidney disease (CKD) and Acute Kidney Injury.
- The British Renal Society felt that tests of renal function (serum creatinine) should be included for hypertension as they are for diabetes as haematuria and proteinuria are considered to be evidence of end organ damage from hypertension. It was suggested that an extended list of tests would be best practice and should be included.
- One stakeholder suggested that an assessment of target organ damage should also include body mass index and waist

circumference since hypertension is often related to excessive body fat and weight accumulation. Stakeholders commented that excessive body fat often underlies the pathology of many non-communicable diseases and that weight loss is a common feature of disease management for a number of conditions including type 2 diabetes, cardiovascular disease and hypertension.

- The British Heart Foundation felt there may be merit in testing a composite indicator similar to that developed for diabetes which assesses integration of routine investigations in people with hypertension. It was suggested that a composite indicator could include tests for urine protein and blood, urine albumin:creatinine ratio, renal function, blood glucose, lipid profile, ECG and fundoscopy for retinopathy.
- The British Cardiovascular Society however felt that primary care should only focus on renal damage and ECG evidence of left ventricular hypertension and primary prevention risk assessments. They did not agree that fundoscopy be included noting evidence suggesting this is not achievable in primary care[1].
- HEART UK supported including an assessment of a full lipid profile and documentation of CVD risk in all people with hypertension (with relevant exclusions) rather than just newly diagnosed patients.

Stakeholders were also asked:

Which of the indicators relating to hypertension, do stakeholders feel are the highest priority for the QOF?

Stakeholders made the following comments in relation to this question:

- The British Heart Foundation and PHE Midlands and East Regional Team considered all the hypertension indicators important for the QOF. PHE Midlands and East Regional Team felt that focussing on one indicator may lead to indicators of equal importance for good hypertension management being ignored. They suggested all indicators ensuring people receive evidence based care are important. The British Heart Foundation commented that a composite indicator would give a range of indicators equal precedence.

[1] Van den Born B, Hulsman C, Hoekstra J. Value of routine fundoscopy in patients with hypertension: systematic review. BMJ 2005;331:73-6

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- Alcohol Concern, Lundbeck Ltd and one CCG felt that indicators 5 and 6 (alcohol) were highest priority for the QOF. It was noted that around1.6million people (one in 20 adults) in England are dependent on alcohol with millions more drinking at unsafe levels costing the NHS £3.5 billion per year. Lundbeck Ltd commented that in 2011/12 there were around 1.2 million alcohol-related hospital admissions in England, representing a 135% increase since 2002/03 and that harmful alcohol misuse is the 2nd top risk factor for early death in the Chief Medical Officer's Annual Report. It was commented that incentivising better identification of people at risk of alcohol-related harms and providing information and advice, as well as onward referral where appropriate, represents a significant opportunity to improve alcohol-related health outcomes.
- NHS England and NHS Employers, and the National Kidney Federation considered indicators 2, 3 and 4 (all indicators for target organ damage) the highest priority for the QOF.
- The Royal College of Nursing, British Renal Society and Healthwatch Bucks considered indicator 2 (ACR test for target organ damage) the highest priority for the QOF. ACR testing but not as a one off test, Should be annually in those at risk of organ damage The British Renal Society commented that a raised ACR is a strong marker of increased CV risk as well as end-organ damage and that a one-off test is inadequate. They commented that ACR tests are the most sensitive for identifying early vascular damage from hypertension and provide a means of monitoring progression.
- Unity Health YORK felt indicators 2 and 3 (ACR and haematuria tests for target organ damage) the highest priority for the QOF.
- The British Cardiovascular Society and British Hypertension Society considered indicators 2 and 4 (ACR and 12 lead ECG tests for target organ damage) the highest priority for the QOF.
- Two practices considered indicators 3 and 4 (haematuria and 12 lead ECG tests for target organ damage) the highest priority for the QOF.
- One practice considered indicator 4 (12 lead ECG test for target organ damage) the highest priority for the QOF.
- The GPC of the BMA commented that they did not support the inclusion of any of the new hypertension indicators.

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Appendix A consultation comments

General comments

Indicator no.	Stakeholder organisation	Type of comment	Comment
IND-2-3	Corbett Medical Practice	General comments	This would add extra burden and so it would need to be clear is the evidence for this consensus only or based on real patient outcomes
IND-2	National Kidney Federation	General comments	To be read in conjunction with eGFR and serum Creatinine results and NICE Guidance on CKD
IND-2	British Renal Society	General comments	Agree
IND-2	Care Quality Commission	General comments	We support the proposed hypertension indicators.
IND-2-3	Unity Health, YORK	General comments	As CKD lead I would strongly support this The unintended consequences include confusion about positive findings and then we need to tie in education about the relevance of this finding This is a risk marker enabling us to target treatment There will be no adverse impacts This should be routine but urine testing is often missed There should be no barriers to this
IND-2-4	HEARTUK	General comments	With regard to hypertension in QOF, HEART UK would be strongly supportive of including an assessment of a full lipid profile and documentation of CVD risk (using an agreed risk assessment tool) in all hypertensive patients (excluding those with pre-existing CHD, diabetes,

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			stroke/transient ischaemic attack (TIA), peripheral arterial disease (PAD), hypertension and already treated with or known to be intolerant of statins), rather than just newly diagnosed patients.
IND-3-4	Forest Health Care GP surgery	General comments	Good indicator.
IND-3	British Renal Society	General comments	Not convinced of the utility of identifying people with haematuria and a normal ACR. An unintended consequence may be increased referral to urology services
IND-4	Corbett Medical Practice	General comments	This would seem reasonable
IND-4	Unity Health, YORK	General comments	The major barrier is the presence of 12 lead ECG and the interpretation of the results Patients will need to come back and practices will need systems in place to deliver this However it reflects good practice and we need to reduce the barriers
IND-4	Individual stakeholder	General comments	I feel a 12 lead ECG is of little value in this scenario and if it is felt we need to be doing anything to screen for cardiac end organ damage at the point of diagnosis then an ECHOCARDIOGRAM would be more worthwhile.
IND-2-4	Newark and Sherwood CCG	Response to questions 1-4	Agree
IND-4	Wye Valley NHS Trust and Herefordshire & Worcestershire Diabetic	General comments	Diabetic eye screening should be a qof indicator and GPs should be encouraged to submit all patients with diabetes for screening Hypertension can worsen retinopathy so detection and treatment is important

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	Eye Screening Programme		
IND-4	Boehringer Ingelheim	General comments	A pulse check in hypertension for Asian women may be a more realistic and empathetic intervention than undressing for an ECG. In addition this will most likely improve presentations as well as adherence as it will remove the need for another appointment. .

Response to questions 1-4

1. Do you think there are any barriers to the implementation of the care described by any of these indicators?

2. Do you think there are potential unintended consequences to the implementation of any of these indicators?

3. Do you think there is potential for differential impact (in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation), if so please state whether this is adverse or positive and for which group?

4. If you think any of these indicators may have an adverse impact in different groups in the community, can you suggest any guidance on adaptation to the delivery of the indicator to different groups which might reduce health inequalities?

Indicator no.	Stakeholder organisation	Type of comment	Comment
IND-2	General Practitioners Committee, British Medical Association	Response to questions 1-4	This is micromanaging the diagnostic process, but also the timelines may be difficult to achieve if the diagnosis is made during a long hospital stay. We therefore do not support to inclusion of this indicator.
IND-2	Forest Health Care GP surgery	Response to questions 1-4	Is there good evidence that this is beneficial if eGFR normal and urine dip test negative for protein (this allows single test for protein and blood. Adding ACR means 2 samples usually)?justified.
IND-2	Royal College of Nursing	Response to	Barriers: accuracy of records; accessibility to data and documentation

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		questions 1-4	
IND-2	British Heart Foundation	Response to questions 1-4	We do not see any barriers to the implementation of indicators 2, 3 and 4. However, we suggest that there may be merit in developing and testing a composite set of indicators, in much the same way that NICE has done for diabetes. The routine set of investigations for patients with hypertension include: • Urine dip stick for protein and blood • Urine albumin:creatinine ration • Renal function • Blood glucose • Lipid profile • ECG • Fundoscopy for retinopathy. A composite indicator could be developed and piloted include all the above tests, as an integrated assessment of the patient with hypertension.
IND-2	The British Cardiovascular Society	Response to questions 1-4	The Hypertension Quality Standards 2013 require commissioners to achieve certain standards. This is one of the tests for target organ damage, which is required to differentiate the need for treatment with medication in stage one hypertension. Urinary albumin: creatinine ratio tests are straightforward and are already delivered in primary care for diabetics. We would therefore support this as an indicator.
IND-2	NHS England and NHS Employers	Response to questions 1-4	Reasonable and achievable assuming from a lab perspective ACR is readily available to all GPs - Wording consistency (incl. date format – "1 April to 31 March") - Assume this will be a cross year indicator to pick up patients diagnosed in the last three months?

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IND-2	British Hypertension Society	Response to questions 1-4	Urinary ACR is an inexpensive and valuable measure of glomerular function. It should be included. No special training required. No barriers.
IND-2-4	Healthwatch Bucks	Response to questions 1-4	See no adverse consequences or impact.
IND-2-4	Dietitians in Obesity Management UK	Response to questions 1-4	We agree with indicators 2, 3 and 4. However we would urge the inclusion of BMI and WC in addition, since hypertension is frequently related to excessive body fat and weight accumulation. In fact we suggest measurement and recording of BMI and WC, with appropriate feedback and action, as an over riding indicator area in its own right, since weight management relates to most of the indicators under consideration. Excessive body fatness underlies the pathology of the most common serious non communicable diseases, and achievement of weight loss is a common feature of disease management for many conditions including type 2 diabetes, cardiovascular disease and hypertension.
IND-3	General Practitioners Committee, British Medical Association	Response to questions 1-4	The prevalence of haematuria of left ventricular hypertrophy in the general practice population at the point of diagnosis of hypertension is too small to make the assessment of these conditions a subject for inclusion in QOF.
IND-3	Whalebridge Practice, Swindon	Response to questions 1-4	There have been problems with this sort of indicator in the past. Briefly a new diagnosis in the final three months of the QOF year cannot fail the indicator (as the three months are not yet up). The solution used in the past has been to cast the net back further (in this case 15 months), accepting success in the last three months but rejecting it from months 15-12. This is complicated and confusing to practices, particularly as it

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			does not reflect the wording of the indicator. At the very least the wording of the indicator should be changed to reflect the actual business rules.
IND-3	Royal College of Nursing	Response to questions 1-4	Barriers: accuracy of records; accessibility to data and documentation
IND-3	The British Cardiovascular Society	Response to questions 1-4	Haematuria is a less specific test for renal damage but again easy to do, so we would feel this is an achievable standard. There is one caveat to consider. The detection of asymptomatic microscopic haematuria may lead to a rise in the number of two-week referrals to haematuria clinics. The yield of cancer detection with microscopic haematuria is much lower than with frank haematuria. This may cause delivery problems for haematuria clinics and the views of the urological surgeons should be taken into account before this indicator is accepted.
IND-3	NHS England and NHS Employers	Response to questions 1-4	Reasonable and achievable. Guidance to cover what test is appropriate i.e. stick test or microscopy. - Wrding consistency - Cross year indicator
IND-3	British Hypertension Society	Response to questions 1-4	Haematuria is not specific for Hypertension. More often relates to renal, bladder or GU problems. Haematuria is a very late sign of hypertensive renal disease. Recommend not included.
IND-4	PHE Midlands and East Regional Team	Response to questions 1-4	Most GPs are likely to have lost their skills in interpreting ECGs and therefore not sure of the value. Moreover, I am not sure that there is sufficient evidence to suggest that ECG is a valid indicator of target organ damage as a consequence of hypertension.

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IND-4	General Practitioners Committee, British Medical Association	Response to questions 1-4	The prevalence of ECG evidence of left ventricular hypertrophy in the general practice population at the point of diagnosis of hypertension is too small to make the assessment of these conditions a subject for inclusion in QOF.
IND-4	Whalebridge Practice, Swindon	Response to questions 1-4	Timings as above.
IND-4	Royal College of Nursing	Response to questions 1-4	Barriers: accuracy of records; accessibility to data and documentation
IND-4	British Heart Foundation	Response to questions 1-4	Interpretation of ECG in primary care is variable and there needs to be care to ensure abnormal ECGs are correctly identified, and patients with normal ECGs are not over investigated. This could be a potential cause for variation in practice, depending on the skills and expertise of the primary care team members.
IND-4	The British Cardiovascular Society	Response to questions 1-4	This is an important test in all patients with hypertension. There will be some, hopefully a minority of practices, who do not have the ability to perform e.c.gs and some GPs who will claim to be unable to interpret e.c.gs. This should not be a barrier to implementing this indicator because in 2015 it should be universally available in primary care and if not, commissioners should be responsible for providing both the equipment and training required. This should be a basic standard of practice.
IND-4	NHS England and NHS Employers	Response to questions 1-4	Agreed subject to clarifying whether practices have the right equipment. - Wording consistency - Cross year indicator

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IND-4	British Hypertension Society	Response to questions 1-4	valuable and should be included. Readily available. The ECG machine should have computer diagnosis. No barriers

Response to question 6

6. Indicator 4: The QOF Advisory Committee recommended that indicators to assess target organ damage focus on tests used in primary care for renal damage and electrocardiographs. Do stakeholders consider the indicators in piloting will provide an adequate assessment of target organ damage?

Indicator no.	Stakeholder organisation	Type of comment	Comment
IND-4	Corbett Medical Practice	Question 6	Has the proper research been done?
IND-4	Unity Health, YORK	Question 6	These detect those areas which have the greatest impact on prognosis and treatment along with the knowledge of pre existing CVD and CAD
IND-4	National Kidney Federation	Question 6	The NKF consider that a measure of a patients' eGFR to ascertain kidney function as well as Albumin Creatinine Ratio (ACR) is imperative in terms of future safe prescribing, determining the use of hypertensive drugs, and assessing an individual's risk from CKD and to Acute Kidney Injury. If no baseline exists this first test should be used as such and guidance to re-testing should be followed in accordance with NICE CKD Guidance.
IND-4	Newark and Sherwood CCG	Question 6	Yes mostly but I also think that those existing hypertensives should also have pro-active GP review if their eGFR drops <5 per annum (some would say >3)
IND-4	General Practitioners Committee, British Medical Association	Question 6	See above

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IND-4	Forest Health Care GP surgery	Question 6	Yes
IND-4	Whalebridge Practice, Swindon	Question 6	Whilst this is a reasonable assessment of organ damage there is not a great deal for practices to do with the information.
IND-4	Wye Valley NHS Trust and Herefordshire & Worcestershire Diabetic Eye Screening Programme	Question 6	Tests of renal function and hypertension vital.
IND-4	Royal College of Nursing	Question 6	Yes, this is would help.
IND-4	British Heart Foundation	Question 6	The 3 tests suggested here will identify patients with renal damage and ventricular hypertrophy. They do not assess renal function, eGFR, retinopathy and assess other risk factors such as dyslipidaemia. We feel that this extended list of tests is best practice and should be included in this indicator set.
IND-4	The British Cardiovascular Society	Question 6	Primary care should focus on renal damage and ECG evidence of left ventricular hypertension as well as carrying out a primary prevention risk score. We would not suggest that fundoscopy is included as the evidence is that this would not be achievable in primary care. (Van den Born B, Hulsman C, Hoekstra J. Value of routine fundoscopy in patients with hypertension: systematic review. BMJ 2005;331:73-6). Fundoscopic examination would only be feasible if carried out by trained opticians, optomotrists, opthmologists or via a digital fundus photographic service. It would have to be established through research if this was a feasible or sensible use of resources.

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IND-4	NHS England and NHS Employers	Question 6	Ability to diagnose target organ damage is very limited in primary care. Urinalysis and ECG changes would need clarification as to the threshold which indicates organ damage. Retinal screening via ophthalmoscope would not be reliable and should not be included.
IND-4	British Renal Society	Question 6	In a patient without clinical evidence of cardiac dysfunction, how do the ECG findings affect management? There is ample evidence to support the current treatment thresholds and the presence or absence of LVH do not influence these. There is no suggestion in this document as to how a GP might act differently knowing LVH is present. Maybe we should ask QOF to give some detail on this issue in its "rationale". Haematuria and proteinuria are seen as evidence of end organ damage from hypertension. Why are tests of renal function (serum creatinine) not included for hypertension when they are specifically mentioned for diabetes? These should be included.
IND-4	British Hypertension Society	Question 6	Accurate but incomplete? GPs need further training in competency to be able to complete retinal examination. (See TMC comments and refs)

Response to question 8 Which of the indicators relating to hypertension, do stakeholders feel are the highest priority for the QOF?

Indicator no.	**Stakeholder organisation**	**Type of comment**	**Comment**
IND-2-6	Unity Health, YORK	Question 8	2 and 3 would be my top priority and easy to achieve
IND-2-6	National Kidney Federation	Question 8	2, 3 and4

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IND-2-6	Newark and Sherwood CCG	Question 8	Alcohol
IND-2-6	PHE Midlands and East Regional Team	Question 8	This does not make sense. Focussing on one will lead to the unintended consequence of ignoring others of equal importance in the context of good management of hypertension. Most local health economies have a variety of services to do with lifestyles to support individuals at high risk and clearly, those with illnesses such as hypertension are within the highest risk group. It is therefore important that the process indicators are based on ensuring patients get all evidence based care.
IND-2-6	Forest Health Care GP surgery	Question 8	3 and 4. Change 2 to urine dip test for protein.
2 & 6	General Practitioners Committee, British Medical Association	Question 8	N/A as we do not support the inclusion of the new hypertension indicators.
IND-2-6	Alcohol Concern	Question 8	It is estimated that 1.6million people in England are dependent on alcohol. Millions more drink at unsafe levels and alcohol currently costs the NHS £3.5 billion per year. Given the rising level of alcohol harms Alcohol Concern feels that indicators 5 and 6 should take the highest priority for the QOF.
IND-2-6	Whalebridge Practice, Swindon	Question 8	Probably ECG and haematuria. It seems a little incongruous that a single mega-diabetes indicator is proposed and lots of separate hypertension indicators.
IND-2-6	Wye Valley NHS Trust and Herefordshire & Worcestershire Diabetic Eye Screening	Question 8	Retinopathy

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	Programme		
IND-2-6	Lundbeck Ltd	Question 8	Harmful alcohol misuse is listed as the 2nd top risk factor for early death within the Chief Medical Officer's Annual Report.Due to the breadth and scale of its associated harms, indicators 5 and 6 should therefore be seen as the highest priority for inclusion within the updated QOF. An estimated 1.6million people in England – one in 20 adults – are dependent on alcohol and many more are damaging their health by drinking at unsafe levels. In 2011/12 there were approximately 1.2 million alcohol-related hospital admissions in England, representing a 135% increase since 2002/03, and alcohol is estimated to cost £21bn per year. Therefore incentivising healthcare services to better identify patients at risk of alcohol-related harms and providing information and advice, as well as onward referral where appropriate, represents a significant opportunity to improve alcohol-related health outcomes.
IND-2-6	Royal College of Nursing	Question 8	Indicator 2
IND-2-6	British Heart Foundation	Question 8	We feel all of indicators 2-6 are important and a composite indicator would give the range of indicators equal precedence.
IND-2-6	The British Cardiovascular Society	Question 8	2 and 4.
IND-2-6	NHS England and NHS Employers	Question 8	Probably 2-4
IND-2-6	British Renal Society	Question 8	ACR testing but not as a one off test, Should be annually in those at risk of organ damage

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			A raised ACR is a strong marker of raised CV risk as well as end-organ damage & a one-off test is inadequate The ACR is the most important. It is the most sensitive test to identify early vascular damage from hypertension and (being quantitative) provides a means of monitoring progression
IND-2-6	British Hypertension Society	Question 8	Indicator 2 ACR Indicator 4 ECG for LVH These should be the highest priority followed by 5,6 and 3 General comments not on the pro forma QOF seem to have by passed much of the Quality Standards, ignoring diagnosis procedures and levels of blood pressure. The new indicators are not patient centric but economic focused to the disadvantage of the patients
IND-2-6	Healthwatch Bucks	Question 8	Indicator 2- target organ damage- is most important. Must also be repeated after appropriate time period to check for changes. Link to individual patient outcomes.