National Institute for Health and Clinical Excellence

Stable angina quality standard
Quality standard consultation comments table
23.02.12 - 22.03.12

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
1	013	British Nuclear Cardiology Society and British Nuclear Medicine Society	General	General	As the quality standards are based on CG 95 for Imaging, we do not have any comments.	Thank you for your comment.
2	008	Department of Health	General	General	Thank you for the opportunity to comment on the draft for the above quality standard. I wish to confirm that the Department of Health has no substantive comments to make regarding this consultation.	Thank you for your comment.
3	001	NHS Direct	General	General	NHS Direct welcome the quality standard and have no comments on its content, as part of the consultation.	Thank you for your comment.
4	007	United Kingdom Clinical Pharmacy Association	General	General	UKCPA have no comments to make on this draft quality standard.	Thank you for your comment.
5	003	South London Cardiac and Stroke Network	1	Statement	It is not clear if this is the responsibility of the referring GP or the provider – what “local data” will be collected	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
6	012	RCGP	1	Process measure	Referral criteria from chest pain clinics could be audited, however one aspect of care that lowers the threshold for referral is family history of cardiovascular disease	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
7	004	British Pain Society	1	Definitions	The definitions of ‘typical’ vs ’atypical’ angina remain confusing. Does the statement mean	Thank you for your comment. The quality standard has been reduced to 5 quality

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					that if all three of the bulleted features of angina are present it can be referred to as 'typical'; if there are two out of three it is 'atypical'; if one or none out of three it is considered 'non-anginal'? If so, the table lower down the page indicates that a 35 year old male smoker with hypercholesterolaemia and 'non-anginal' chest pain still has a one in three chance of having coronary artery disease. The choice of words in this section is clumsy – is 'typicality' in the title the best choice? The distinction between 'typical' and 'atypical' angina is moot in any case – the range of 'likelihoods' of chest pain patients being in the at-risk group is so broad that this guidance will never be used as justification for avoiding investigation in a patient otherwise considered by a health professional as 'at risk'. An inspection of Heberden's original description of angina pectoris is a model of clarity, even in its 17th century prose, when compared to the verbose and confusing description in the NICE document. The table itself is nearly 20 years old and I would suggest in need of review.	statements to focus on markers of high quality care specific to people with stable angina.
8	012	RCGP	2	Statement	Where does exercise tolerance test fit here. Number of positive diagnostics one obvious outcome	Thank you for your comment. This statement is now statement 1 in the final version. Recommendation 1.3.6.5 states "do not use exercise ECG to diagnose or exclude stable angina for people without known CAD". The group did not include the number of positive diagnostic tests as an outcome. The focus is getting the right test for the right percentage likelihood.

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
9	003	South London Cardiac and Stroke Network	2	Statement	This is OK although there are questions about the correct diagnostic test for which percentage score – many people would recommend CT calcium scoring WITH CT coronary angiography if the score is zero due to the presence of non-calcified plaques in young people	Thank you for your comment. This statement is now statement 1 in the final version. The quality standard uses clinical guideline 95 as the evidence source for the statement and definition.
10	012	RCGP	3	Statement	Presumably this means where ischaemic heart disease has previously been confirmed? Most GPs would refer for initial investigation.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
11	003	South London Cardiac and Stroke Network	3	Statement	This is difficult as most people at greater than 90% are having a diagnostic angiogram to assess for prognostic disease rather than to diagnose angina – to exclude these people from the rapid access clinic (which includes rapid access to angiography) would seem perverse! The second question about non-anginal pain is subjective as they may be referred with anginal pain and leave with non-anginal pain once assessed by a specialist. The third question repeats the risk of not performing in angiography is those patients who may benefit from appropriate revascularisation.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
12	012	RCGP	4	Statement	Reasonable	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
13	002	Royal College of Surgeons of Edinburgh	4	Statement	A full blood count is probably one of the basic investigations in assessing patients with	Thank you for your comment. The quality standard has been reduced to 5 quality

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					possible angina. Whilst anaemia is a cause of stable angina, it is difficult to understand the rationale of using it in a quality statement. To use it as a marker of quality would suggest that the 'quality bar' has been set rather low!	statements to focus on markers of high quality care specific to people with stable angina.
14	003	South London Cardiac and Stroke Network	4	Statement	This is fine although you might expect referring clinicians to check FBC, electrolytes, lipids, thyroid function tests and I'm not sure that NICE needs to measure this – i.e. remove section 4	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
15	012	RCGP	5	Statement	Reasonable if families want to engage or patient allows.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
16	003	South London Cardiac and Stroke Network	5	Statement	This is fine although I'm not certain if this sits with primary or secondary care	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
17	004	British Pain Society	5	Process measure	"draft quality measure" – process section. Comment should be made to suggest that the desirable ratio between numerator and denominator should be as close to 1.0 as possible. The inclusion of the phrase "if they wish" is disingenuous. It seems to be a sop to political correctness – how can a patient not in possession of the appropriate information make a rational choice about whether he wants the information on offer? There is good evidence of benefit for patient and carer education in stable angina. To ensure patient choice is maintained but avoiding a coercive approach the wording needs to be adjusted. I	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					think that “if they wish” could safely be omitted from the descriptions.	
18	004	British Pain Society	6	Statement	This could be ‘beefed up’. The wording is rather neutral. I feel that it should seek to encourage patients to adjust lifestyle rather than merely provide the framework. There is overwhelming evidence of the benefits of weight loss and fitness training in stable angina.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
19	012	RCGP	6	Statement	Important	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
20	003	South London Cardiac and Stroke Network	6	Statement	Fine	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
21	004	British Pain Society	7	Statement	It is important to stress that ‘optimal’ medical treatment is not synonymous with ‘maximal’ medical treatment. Optimising medicines is a time-consuming and exacting process that most health professionals, let alone patients, don’t understand. There’s a lot of trial and error involved in optimising medicines	Thank you for your comment. This statement is now statement 3 in the final version. To ensure the statement is clear, the group agreed to revise the wording. It now states “a short acting nitrate and at least one other anti-anginal drug”.
22	012	RCGP	7	Statement	Again sensible but patient anxiety may drive need for early referral. Some repetition here with 7 and 12	Thank you for your comment. This statement is now statement 3 in the final version. The group felt it was a marker high quality care that patients receive a short acting nitrate and at least one other anti-anginal drug before revascularisation is considered.

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
23	003	South London Cardiac and Stroke Network	7	Statement	This section will cause problems as it will cause delays in referral to treatment if patients require active drug titration before being referred for revascularisation. It is also unclear what “optimal medical treatment is” as this could include a single anti-anginal medication. The structure of these anginal clinics is unclear – typically patients are referred for diagnosis to a One-Stop Rapid Access Chest Pain Clinic and then for a diagnostic test – whose responsibility is it to start medication, titrate and re-refer patients if they have ongoing symptoms?	Thank you for your comment. This statement is now statement 3 in the final version. To ensure the statement is clear, the group agreed to revise the wording. It now states “a short acting nitrate and at least one other anti-anginal drug”. The group felt it was a marker high quality care that patients receive this medical treatment before revascularisation is considered.
24	004	British Pain Society	7	Definitions	Why not replace ‘maximum tolerable dosage’ with ‘lowest dose required to produce desired response’, which is what I think it means to say. Should be fewer side-effects with the altered wording, anyway.	Thank you for your comment. This statement is now statement 3 in the final version. To ensure the statement is clear, the group agreed to revise the wording. It now states “a short acting nitrate and at least one other anti-anginal drug”.
25	012	RCGP	8	Statement	Hopefully most physicians would do this.	Thank you for your comment. Draft statements 8 and 9 have now been merged, and are now statement 2 in the final version.
26	003	South London Cardiac and Stroke Network	8	Statement	Fine	Thank you for your comment. Draft statements 8 and 9 have now been merged, and are now statement 2 in the final version.
27	011	Servier Laboratories	9	Statement	‘People with stable angina are offered a beta blocker or a calcium channel blocker as first line treatment, which is reviewed if there are intolerable side effects or symptoms are not satisfactorily controlled’.	Thank you for your comment. Draft statements 8 and 9 have now been merged, and are now statement 2 in the final version. This statement reinforces clinical guideline 126: beta-blockers and calcium channel blockers should be first line treatment before

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					This statement clearly corresponds with the recommendations in Section 1.4.7 of NICE CG 126[1], however, nowhere in this statement, nor in any of the other quality statements, does it allude to other therapeutic options available for patients should both beta-blockers or calcium channel blockers be unsuitable or not tolerated. Servier feel that the statement should also provide direction and reflect options open to healthcare professionals when patients are reviewed who do have side effects or are sub-optimally treated with beta blockers and/or calcium channel blockers. While both beta-blockers and calcium channel blockers have considerable evidence supporting their use for the treatment of stable angina, there are now newer agents that also demonstrate considerable clinical efficacy for stable angina. Indeed, section 1.4.11 of CG 126[1] acknowledges: 'If the person cannot tolerate beta blockers and calcium channel blockers or both are contraindicated, consider monotherapy with one of the following drugs: a long-acting nitrate or ivabradine or nicorandil or ranolazine.' For example, ivabradine, licensed for the Symptomatic treatment of chronic stable angina pectoris in coronary artery disease adults with normal sinus rhythm[2] (Ivabradine is indicated: in adults unable to tolerate or with a contra-indication to the use of beta-blockers or in combination with beta-blockers in patients inadequately	using other anti-anginals. Statement 3 in the final version uses the term "anti-anginals" to indicate that other medication may be used where a beta blocker or a calcium channel blocker are not tolerated or where symptoms are not satisfactorily controlled. This should be attempted before revascularisation is considered however not as first line treatment.

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					controlled with an optimal beta-blocker dose and whose heart rate is > 60 bpm), has an extensive body of evidence demonstrating it's efficacy in improvement in exercise tolerance parameters both in monotherapy and in combination with beta-blockers[3-7]. Evidence also shows that, in real-life clinical settings both in the UK and Europe-wide, there is a clear shortfall between guidelines and practice with regard to the use of evidence-based drug therapy (both symptomatic and secondary prevention)[8,9]. In addition, in section 1.5.1 of CG126[1], it is advised: 'Consider revascularisation (coronary artery bypass graft [CABG] or percutaneous coronary intervention [PCI]) for people with stable angina whose symptoms are not satisfactorily controlled with optimal medical treatment.' In light of this evidence, along with the clear guidance that stable angina patients should be optimised on medical therapy prior to revascularisation[1], Servier feel that the quality statements should reflect the full scope of evidence-based therapeutic options for treating stable angina medically. This would ensure that Healthcare professionals had full awareness and appreciation of the options available for the treatment of stable angina, in line with contemporary NICE guidelines for the treatment of stable angina. References:	

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					1. NICE CG 126: Management of Stable Angina 2011 2. Procoralan Summary of Product Characteristics 3. Borer JS, Fox K, Jaillon P et al. Antianginal and antiischemic effects of ivabradine, an I(f) inhibitor, in stable angina: A randomized, double-blind, multicentered, placebo-controlled trial. *Circulation* 2003;107:817-23 4. Tardif JC, Ford I, Tendera M et al. Efficacy of ivabradine, a new selective I(f) inhibitor, compared with atenolol in patients with chronic stable angina. *Eur Heart J* 2005; 26:2529-36 5. Ruzyllo W, Tendera M, Ford I et al. Antianginal efficacy and safety of ivabradine compared with amlodipine in patients with stable effort angina pectoris: A 3-month randomised, double-blind, multicentre, noninferiority trial. *Drugs* 2007; 67:393-405 6. Lopez-Bescos L, Filipova S, Martos R et al et al. Long-Term Safety and Efficacy of Ivabradine in Patients with Chronic Stable Angina *Cardiology* 2007; 108:387–396 7. Tardif JC, Ponikowski P, Kahan T et al. Efficacy of the I(f) current inhibitor ivabradine in patients with chronic stable angina receiving beta-blocker therapy: a 4-month, randomized, placebo-controlled trial. *Eur Heart J* 2009; 30:540-8 8. Daly CA, Clemens F, Lopez-Sendon JL et al. The initial management of stable angina in Europe from the Euro Heart Survey. *Eur Heart J* 2005; 26:1011-1022 9. Elder DHJ, Pauriah M, Lang CC et al. Is there a Failure to Optimize theRapy in anGina pEcToris (FORGET) study? QJM 2010; 103(5):305-310	
28	005	A. Menarini Pharma UK SRL	9	Statement	Although we agree with Quality Statement 9, Menarini Pharma strongly believes that NICE should include an additional statement within the Quality Standard that takes account of the	Thank you for your comment. Statement 3 in the final version uses the term “anti-anginals” to indicate that other medication may be used where a beta blocker or a calcium channel

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					other anti-anginal drugs recommended in NICE CG 126. With regard to anti-anginals, the NICE CG 126 definition of optimal medical treatment is one or two anti-anginal drugs but this is not limited to just beta blockers and calcium channel blockers: the guideline states that if the person cannot tolerate or is contraindicated to one or both of these drugs then other drugs should be considered (a long acting nitrate or ivabradine or nicorandil or ranolazine) as monotherapy or in addition to a beta-blocker or calcium channel blocker. This is particularly important because a significant number of people are intolerant or contraindicated to beta-blockers and/or calcium channel blockers. Not including a statement on the other recommended treatments would limit the implementation of optimal medical treatment.	blocker are not tolerated or where symptoms are not satisfactorily controlled. This should be attempted before revascularisation is considered however not as first line treatment.
29	012	RCGP	9	Statement	Hopefully most physicians would do this.	Thank you for your comment. Draft statements 8 and 9 have now been merged, and are now statement 2 in the final version.
30	003	South London Cardiac and Stroke Network	9	Statement	Fine	Thank you for your comment. Draft statements 8 and 9 have now been merged, and are now statement 2 in the final version.
31	006	HEART UK	10	Statement and outcome measure	HEART UK supports this quality indicator but wishes to highlight that statins are not the only medication that may be required or appropriate for lipid modification in patients with stable angina. In line with CG67 and its updates it would be more appropriate to state “People with angina are offered a statin and/or other	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					approved lipid modifying therapy." Within the outcome measure for this statement HEART UK does not support the use of total cholesterol since this may give a false estimate of treatment efficacy and would recommend ideally non-HDL cholesterol (non-HDLC) or failing this LDL cholesterol (LDLC). The outcome therefore is "Proportion of people with stable angina prescribed a statin and/or other approved lipid modifying therapy whose measured non-HDL cholesterol (*) is less than 2.5 mmol/l or whose LDL cholesterol is less than 2 mmol/l." (* non-HDLC is a calculated parameter, which can be calculated in fasting or non-fasting samples, as total cholesterol minus HDL cholesterol).	
32	012	RCGP	10	Statement	Hopefully most physicians would do this.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
33	003	South London Cardiac and Stroke Network	10	Statement	Fine	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
34	012	RCGP	11	Statement	Hopefully most physicians would do this.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
35	003	South London Cardiac and Stroke Network	11	Statement	Fine but should be part of the management of NICE hypertension guidelines	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
						care specific to people with stable angina.
36	005	A. Menarini Pharma UK SRL	11	Question	Menarini Pharma considers this statement to be too generic to be included in this Quality Standard.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
37	009	Royal College of Nursing	11	Question	This statement is welcomed and should stay in as many patients with hypertension are not managed appropriately so it might help with that.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
38	002	Royal College of Surgeons of Edinburgh	11	Question	With regards to the specific question for consultation, there are no issues with this statement being included in a quality standard specifically for people with stable angina.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
39	004	British Pain Society	12	Statement	This is an admirable objective, but its success relies entirely on the patient having received sufficient education regarding his condition to be able to make rational treatment decisions. This should always be in partnership with a healthcare professional, but as so often happens in today's resource-stretched NHS, sufficient time is rarely allowed to achieve this level of understanding on the part of the patient. This will generally result in the decision-making process devolving to the doctor, with the same problems of lack of patient education preventing patients from being true partners.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
40	012	RCGP	12	Statement	Again sensible but patient anxiety may drive need for early referral. Some repetition here	Thank you for your comment. The quality standard has been reduced to 5 quality

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					with 7 and 12	statements to focus on markers of high quality care specific to people with stable angina.
41	002	Royal College of Surgeons of Edinburgh	12	Statement	It should be pointed out that by default it is usually the general practitioner or investigating cardiologist that is the healthcare professional that has this discussion with patients. They would need full knowledge of international, national and local results of CABG for patients with stable angina. They should also be able to use appropriate risk stratification models to predict operative mortality. If this is not possible, then the discussion regarding CABG should be done with a cardiac surgeon practicing coronary artery surgery.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
42	003	South London Cardiac and Stroke Network	12	Statement	This is theoretically ok but is going against section 7 and further sections. If patients with stable angina should be treated with optimal medical therapy then they don't need to discuss with an interventional cardiologist or cardiac surgeon. This should possibly be limited to those patients NICE thinks are suitable for PCI or CABG i.e. multi-vessel disease.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
43	012	RCGP	13	Statement	Again sensible but patient anxiety may drive need for early referral. Some repetition here with 7 and 12	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
44	009	Royal College of Nursing	13	Statement	Regarding the recommendation that patients should only undergo angiography once medical therapy has failed – this is not current practice in some hospitals as some will offer angiography to patients with stable angina	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					especially if they are young so that they can be offered revascularisation. It is difficult to have a statement that covers all patients regardless of age and other medical conditions. We also know of trusts where they try medical therapy first in older patients and also use it in younger patients if they prefer, so age is not the only factor considered. If it is proposed that medical therapy must be tried first, then maybe a time period could be included so that patients are not left for a long time before they are offered an angiogram.	
45	002	Royal College of Surgeons of Edinburgh	13	Statement	This statement does not reflect the full guidance. It gives the impression that the only patients that should be offered coronary angiography and considered for revascularisation are patients who are not satisfactorily controlled by optimal medical therapy. This is reasonable for PCI but the full guidance fully recognises the potential prognostic benefits of CABG revascularisation in patients with left main or proximal triple vessel disease even if their symptoms are satisfactorily controlled (Final full guidelines 11.6). The College does not accept this statement as it would deny a significant group of patients, who are fit for surgery, further investigations and the benefits of CABG. A suitable healthcare outcome would be: a. Patients with stable angina with	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					symptoms not satisfactorily controlled by optimal medical therapy should be offered angiography and considered for PCI or CABG if appropriate. The process as described in the draft quality measure with this statement is therefore satisfactory for this part. b. Even patients with stable angina with symptoms satisfactorily controlled should be considered for coronary angiography and offered CABG if they have left main or proximal triple vessel disease. The process would be the proportion of people with stable angina with symptoms satisfactorily controlled who wished to be considered for CABG who have coronary angiography.	
46	003	South London Cardiac and Stroke Network	13	Statement	This seems fine although I would still perform angiography in patients > 90% likelihood of disease as part of their assessment for prognosis.	Thank you for your comment. The quality standard has been reduced to 5 quality statements to focus on markers of high quality care specific to people with stable angina.
47	012	RCGP	14	Statement	Good!	Thank you for your comment. This statement is now statement 4 in the final version.
48	002	Royal College of Surgeons of Edinburgh	14	Statement	This is probably the most important statement regarding this document with regards to surgical practice and is in compliance with recommendations from all the major societies (British Cardiovascular Society, Society of Cardiothoracic Surgeons of Great Britain and Ireland, European Society of Cardiology and European Association of Cardiothoracic	Thank you for your comment. This statement is now statement 4 in the final version. The definitions section reflects clinical guideline 126 by stating that the multidisciplinary team should include cardiac surgeons and interventional cardiologists.

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					Surgery). The College supports this statement strongly as there are many pressures against a MDT discussion regarding these patients. We list a few reasons as follows: 1. Most Percutaneous coronary interventions are now performed in units without in house cardiac surgery and these units may find it difficult to arrange appropriate MDTs. 2. There is a current trend to perform 'standby coronary angiography' to avoid patients having to visit the cath lab twice. There is a reasonable argument for this in terms of cost and efficient use of resources but it means that the cardiologist rather than the MDT decides on the best form of revascularisation. 3. The current healthcare economic situation would mean it would be difficult to secure the 0.5 to 1.0 weekly PA for members of the MDT that would be necessary to deliver this service. The MDT team therefore should include cardiac anaesthetists/intensivists as the reason for not performing CABG on most occasions are related to the co-morbidities of the patient leading to excessive predicted operative risk.	
49	003	South London Cardiac and Stroke	14	Statement	Fine	Thank you for your comment. This statement

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
		Network				is now statement 4 in the final version.
50	004	British Pain Society	14	Definition	Some additional guidance regarding team members would be helpful. By only specifying an interventional cardiologist and a cardiac surgeon some units may only include those two specialists and consider they have constructed a 'NICE-approved' MDT. Specific mention should be made of the value of including input from specialist nurses, clinical psychologists, pain specialists, exercise physiologists/physiotherapists, pharmacists, dieticians to name but some.	Thank you for your comment. This statement is now statement 4 in the final version. The quality standard does not seek to prescribe the exact composition of a multidisciplinary team. The definitions section reflects the clinical guideline by stating two key members but does not limit membership of the MDT.
51	004	British Pain Society	15	Statement and process measure	I agree with the draft quality statement. In the 'quality measure' section, I suggest that the denominator will be huge and the numerator tiny. There may not be a requirement to have a specialist refractory angina service attached to every cardiology department, especially if a strategy of generally improving the understanding and education of angina patients is rolled out nationally. However, a smaller number of (tertiary) centres may be required for managing patients who have not responded to the more general suggestions laid down in this document. However, I applaud the sentiments expressed in the final sentence: "People with stable angina whose symptoms are refractory to treatment (optimal medical treatment with or without revascularisation operation to improve blood flow)) are offered a comprehensive re-evaluation of their diagnosis and treatment."	Thank you for your comment. This statement is now statement 5 in the final version.

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
52	012	RCGP	15	Statement	Good!	Thank you for your comment. This statement is now statement 5 in the final version.
53	003	South London Cardiac and Stroke Network	15	Statement	Fine	Thank you for your comment. This statement is now statement 5 in the final version.
54	002	Royal College of Surgeons of Edinburgh	General	Suggestion for new statement	These responses have been produced by the cardiothoracic specialty group on behalf of our College. From a surgeon's point of view, the major flaw in this document is that it does not acknowledge the potential prognostic benefits of revascularisation by coronary artery bypass grafting (CABG) in patients with left main and proximal triple vessel disease. This is despite the fact that it is fully acknowledged in the final guidelines in treating patients with stable angina (CG126, 11.4 and 11.6). Indeed recommendation 11.6 states Consider CABG with people with stable angina and suitable coronary anatomy whose symptoms are satisfactorily controlled with optimal medical treatment, but coronary angiography indicates left main stem disease or proximal three-vessel disease. Therefore it is important to have information from functional and anatomical investigations to determine the best form of treatment. This makes statement 3 and 13 difficult to understand. If statement 3 is followed through and a patient with stable angina is treated medically with satisfactory symptom control, then no investigation is deemed necessary for this patient, but yet	Thank you for your comment. The number of statements has been reduced to focus on key markers of high quality care. The statements do not preclude the use of CABG in patients with left main and proximal triple vessel disease. Statement 4 states that more complex cases should be discussed by the MDT. They would be able to decide on the prognostic benefit of CABG to the patient.

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					without functional or anatomical investigating it is not possible to know the likelihood or the actual existence of left main or proximal triple vessel disease. Therefore a group of patients could be denied the potential prognostic benefits of CABG. Similar comments are made regarding statement 13 below.	
55	011	Servier Laboratories	General	Suggestion for new statement	As with many chronic conditions, an important feature of the management of patients with stable angina is that of monitoring. Certainly the current NICE guidelines for stable angina, CG126[1], allude in a number of areas to the importance of this: 1.4.5 - Review the person's response to treatment, including any side effects, 2–4 weeks after starting or changing drug treatment. 1.4.6 - Titrate the drug dosage against the person's symptoms up to the maximum tolerable dosage. 1.4.7 and 1.4.11 - Decide which drug to use based on comorbidities, contraindications and the person's preference Routine monitoring that includes symptom assessment as well as clinical examination such as heart rate and blood pressure assessment can therefore ensure that the therapy is tailored to patients individually and altered according to symptoms and tolerability.	Thank you for your comment. Whilst acknowledging this as an area of importance, the group felt this should be standard practice and did not progress it as a key marker of high quality care.

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response

					Heart Rate:
					
					There is now considerable clinical evidence of an association between an elevated resting heart rate and mortality in patients with coronary heart disease. Furthermore, studies have highlighted a resting heart rate of 70bpm, or greater, to be a threshold at which there is significantly increased risk of cardiovascular events in patients with pre-existing CAD[2-4].
					
					Resting heart rate is an important cardiovascular parameter that can be simply and inexpensively measured and recorded. Routine measurement and recording of heart rate in clinical practice in all patients with stable angina can:
					
					• Simply assess the cardiovascular risk of a patient independent of other factors including blood pressure, cholesterol, and age.
					
					• Aid in rapid diagnosis of medical conditions, including life threatening arrhythmias, thyroid dysfunction or anaemia.
					
					• Help to optimise treatment by assessing:
					
					  • Response/adherence to rate limiting therapies
					
					  • Need for titration of heart rate limiting therapy
					
					  • Need for additional heart rate limiting therapy to be initiated	

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					Blood Pressure: Blood pressure is also an important parameter to consider when treating and monitoring patients with stable angina. Raised blood pressure has been shown to be associated with the complex underlying pathophysiology of myocardial ischaemia[5,6] and over 60% of patients with angina have co-existing hypertension as shown by the European Heart Survey in 2006[7]. More importantly, many current anti-anginal therapies have a significant effect on blood pressure[8-11] and therefore would not be appropriate in patients where additional blood pressure reduction could have a detrimental effect[12,13]. Servier therefore request that a specific statement is included within the quality standards to highlight the importance of clinical assessment (heart rate and blood pressure assessment) in the treatment of stable angina. References: 1. NICE CG 126: Management of Stable Angina 2011 2. Diaz A, Bourassa MG, Guertin M-C et al. Long-term prognostic value of resting heart rate in patients with suspected or proven coronary artery disease. Eur Heart J 2005; 26:967-974 3. Fox K, Ford I, Steg PG et al. Heart rate as a prognostic risk factor in patients with coronary artery disease and left-ventricular systolic dysfunction (BEAUTIFUL): a subgroup analysis of a randomised controlled trial. Lancet 2008;	

Row	ID	Stakeholder	Statement No	Comment on	Comments	Response
					372:817-821 4. Kolloch R, Legler UF, Champion A et al. Impact of resting heart rate on outcomes in hypertensive patients with coronary artery disease: findings from the International VErapamil-SR/trandolapril STudy (INVEST) Eur Heart J. 2008; 29:1327–1334 5. Collins P, Fox KM. Pathophysiology of Angina. Lancet 1990; 335:94-96 6. Robinson BF. Relation of Heart Rate and Systolic Blood Pressure to the Onset of Pain in Angina Pectoris. Circulation 1967; 35:1073-1083 7. Daly CA, Clemens F, Lopez-Sendon JL et al. The impact of guideline compliant medical therapy on clinical outcome in patients with stable angina: findings from the Euro Heart Survey of stable angina. Euro Heart J 2006; 27:1298–1304 8. Bruce RA, Hossack KF, Kusumi F. Excessive reduction in peripheral resistance during exercise and risk of orthostatic symptoms with sustained-release nitroglycerin and diltiazem treatment of angina. Am Heart J. 1985; 109:1020-6 9. Boden WE, Korr KS, Bough EW. Nifedipine-induced hypotension and myocardial ischaemia in refractory angina pectoris. JAMA 1985 253(8):131-5 10. Crawford MH. Effectiveness of diltiazem for chronic stable angina pectoris. Acta Pharmacol Toxicol (Copenh)1985; 57 suppl 2:44-8 11. Thadani U, Rodgers T. Side effects of using nitrates to treat angina. Expert Opin Drug SAF. 2006; 5(5):667-74 12. http://www.medicines.org.uk/emc/medicines/24103/SPC/verapamil http://www.medicines.org.uk/emc/medicines/23945/SPC/diltiazem+hydrochloride+tablets	

These organisations were approached but did not respond:

Abbott GmbH & Co KG
Abbott Laboratories
Abbott Vascular Devices
Action Heart
Age UK
AMORE health Ltd
AMORE Studies Group
Anglia Stroke and Heart Network
Association of Anaesthetists of Great Britain and Ireland
Association of British Healthcare Industries
Association of British Insurers
Association of Clinical Pathologists
Astrazeneca UK Ltd
Avon, Gloucestershire and Wiltshire Strategic Health Authority
Barnet and Chase Farm Hospitals NHS Trust
Barnsley Hospital NHS Foundation Trust
Barnsley Primary Care Trust
Black Country Cancer and Cardiac Network
Blood Pressure Association
Boehringer Ingelheim
Bolton Primary Care Trust
Boston Scientific
Bradford District Care Trust
Brighton and Sussex University Hospital NHS Trust
Bristol-Myers Squibb Pharmaceuticals Ltd
British Acupuncture Council
British Association for Nursing in Cardiovascular Care
British Association of Cardiac Rehabilitation
British Cardiac Patients Association
British Cardiovascular Intervention Society
British Cardiovascular Society
British Dietetic Association
British Geriatrics Society
British Heart Foundation
British Hypertension Society
British Medical Association
British Medical Journal
British National Formulary
British Psychological Society
British Society of Cardiovascular Imaging
British Society of Cardiovascular Magnetic Resonance
Buckinghamshire Primary Care Trust
BUPA Foundation
Cambridge University Hospitals NHS Foundation Trust
Camden Link
Cardiovascular Diseases Specialist Library
Care Quality Commission (CQC)
Chartered Society of Physiotherapy
Coast to Coast Cardiac Network
College of Emergency Medicine
College of Occupational Therapists
Cook Medical Inc.
County Durham Primary Care Trust
Coventry and Warwickshire Cardiac Network
Covidien Ltd.
Cumbria and Lancashire Cardiac and Stroke Network
Daiichi Sankyo UK
Department for Communities and Local Government
Department of Health, Social Services and Public Safety - Northern Ireland
Derbyshire County Primary Care Trust
Derbyshire Mental Health Services NHS Trust
Dorset Primary Care Trust
Education for Health
Epsom & St Helier University Hospitals NHS Trust
Essex Cardiac & Stroke Network
Faculty of Occupational Medicine
Faculty of Public Health
GE Healthcare
George Eliot Hospital NHS Trust
Gloucestershire Hospitals NHS Foundation Trust
Gloucestershire LINk
GP Care
GPSI-in-Cardiology Forum
Great Western Hospitals NHS Foundation Trust
Greater Manchester and Cheshire Cardiac and Stroke Network
Harrogate and District NHS Foundation Trust
Havering Primary Care Trust
HD Clinical Limited
Health Protection Agency
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Heart Care Partnership
Hindu Council UK
Humber NHS Foundation Trust

Institute Metabolic Science
Institute of Biomedical Science
International Neuromodulation Society
Iroko Pharmaceuticals
Johnson & Johnson
Knowsley Primary Care Trust
Lancashire Care NHS Foundation Trust
Leeds Primary Care Trust (aka NHS Leeds)
Liverpool Community Health
Liverpool PCT Provider Services
Lothian University Hospitals Trust
Luton and Dunstable Hospital NHS Trust
Medicines and Healthcare products Regulatory Agency
Medtronic
Merck Serono
Ministry of Defence
National Association of Primary Care
National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health
National Collaborating Centre for Women's and Children's Health
National Institute for Health Research Health Technology Assessment Programme
National Patient Safety Agency
National Prescribing Centre
National Public Health Service for Wales
National Refractory Angina Centre
National Treatment Agency for Substance Misuse
NDR UK
NHS Bournemouth and Poole
NHS Clinical Knowledge Summaries
NHS Connecting for Health
NHS Health Scotland
NHS Improvement
NHS Kirklees
NHS Manchester
NHS Milton Keynes
NHS Plus
NHS Plymouth
NHS Sefton
NHS Sheffield
NHS Warwickshire Primary Care Trust
North East London Cardiac & Stroke Network
North Trent Network of Cardiac Care
North Yorkshire & York Primary Care Trust
Northern Ireland Chest, Heart & Stroke
Nottingham City Hospital
Oxfordshire Primary Care Trust
Pain Solutions
Papworth Hospital NHS Foundation Trust
Patients Watchdog
PERIGON Healthcare Ltd
Pfizer
Pharmametrics GmbH
Primary Care Cardiovascular Society
Public Health Wales NHS Trust
Randox Laboratories
RioMed Ltd.
Roche Diagnostics
Roche Products
Royal Berkshire NHS Foundation Trust
Royal Brompton Hospital & Harefield NHS Trust
Royal College of Anaesthetists
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of England
Royal Pharmaceutical Society
Royal Society of Medicine
Sacyl
Salford Primary Care Trust
Sandwell Primary Care Trust
Sanofi
Schering-Plough Ltd
Scottish Intercollegiate Guidelines Network
Sheffield Primary Care Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Shrewsbury and Telford Hospital NHS Trust
SNDRi
Social Care Institute for Excellence
Society and College of Radiographers
Society for Acute Medicine
Society for Cardiological Science and Technology
Society for Cardiothoracic Surgery of Great Britain and Ireland

Solent Healthcare
Solihull NHS Primary Care Trust
Solvay
South East London Cardiac and Stroke Network
South West London Cardiac & Stroke Network
St Jude Medical UK Ltd.
Surrey Heart & Stroke Network
Telemedcare Ltd
Tenscare Ltd
Teva UK
The Association for Clinical Biochemistry
The Association of the British Pharmaceutical Industry
The Rotherham NHS Foundation Trust
University Hospital Birmingham NHS Foundation Trust
Vasomedical Inc.
Welsh Government
Welsh Scientific Advisory Committee
West Hertfordshire Primary Care Trust
Western Cheshire Primary Care Trust
Western Health and Social Care Trust
Wye Valley NHS Trust
York Hospitals NHS Foundation Trust