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 – Ambulatory blood pressure monitoring
Consultation period: 07/01/2013 – 04/02/2013
Potential output: Recommendations for NICE Menu

Indicator(s) included in the consultation

1. The percentage of patients with a new diagnosis of hypertension after 1 April 2014 whose diagnosis was confirmed following ABPM.

Summary of responses: general comments on indicator(s)

A number of stakeholders, including the British Heart Foundation, welcomed the inclusion of this proposed new QOF indicator, commenting that ambulatory blood pressure monitoring (ABPM) is the best method for confirming a diagnosis of hypertension, and is in line with NICE clinical guideline 127.

A number stakeholders noted that implementation of this indicator could be problematic for practices where ABPM equipment is not currently available.

Some stakeholders highlighted that NICE clinical guideline 127 allows for either ABPM or home blood pressure monitoring (HBPM) for diagnosing hypertension, and suggested that this indicator should allow for HBPM because this is more likely to be available in general practice. One stakeholder also noted that the indicator does not state the time window in which the diagnosis must be confirmed and that this should be made clear.

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:

- Should HBPM be included as an acceptable alternative to ABPM for achieving this indicator?

Summary of responses: comments by indicator

1. The percentage of patients with a new diagnosis of hypertension after 1 April 2014 whose diagnosis was confirmed following ABPM.

A number of stakeholders, including the British Heart Foundation, welcomed the inclusion of this proposed new QOF indicator, commenting that ambulatory blood pressure monitoring (ABPM) is the best method for confirming a diagnosis of hypertension, and is in line with NICE clinical guideline 127.

The most common theme from stakeholders was the variation in the availability of ABPM equipment which is not routinely available in all GP practices. Stakeholders expressed concerns over the cost associated with providing and maintaining ABPM equipment, and commented that there may be delays in diagnosis where access to ABPM is limited. Stakeholders considered that a potential unintended consequence of this indicator could be increased referrals to secondary care and that cost effectiveness analysis should take this into account.

Some stakeholders stated that if practices needed to refer people to secondary care in order to achieve the indicator this could have a negative impact on certain groups, for example, people with low incomes, the elderly and people with disabilities who may rely on public transport. One stakeholder also reported that some secondary care providers only fit monitors for 24 hours and on weekdays, which may require people to take time off work. It was suggested that in such cases HBPM may provide a more acceptable and representative measure of blood pressure. Stakeholders also noted that using ABPM requires compliance by people fitted with the device and this may be a barrier to implementation.

A number of stakeholders added that HBPM should be included as an acceptable alternative to diagnose hypertension because this is more widely available and in line with NICE clinical guideline 127. It was noted that provision of HBPM would allow for people who cannot tolerate or find it impractical to have ABPM e.g. people who work shifts, to have their diagnosis confirmed. Stakeholders also felt that there needs to be a clear definition of ‘does not tolerate ABPM’. In terms of the technical specifications stakeholders thought it would be useful to understand how a diagnosis using HBPM would

be dealt with and if this would be covered using exclusions or exception reporting.

One UK supplier of cardiovascular and diagnostic instrumentation commented that the price of ABPM monitors has fallen since August 2011 and that potential savings in inappropriate drugs prescribing may increase the cost effectiveness of ABPM.

NHS Employers and the General Practitioners Committee (GPC) of the British Medical Association suggested a need to move away from cumulative indicators and proposed making this a 'reset indicator' which states 'in the preceding X months'.

Stakeholders, including NHS Employers and the GPC, commented that QOF guidance would need to make clear the time period over which blood pressure should be measured using ABPM[1], and explain how to interpret varying results i.e. where diastolic pressure is elevated but not systolic. It was commented that simply referencing the NICE clinical guideline would not be sufficient because this is lengthy and complex. One stakeholder also noted that the indicator does not state the time window in which the diagnosis must be confirmed and that this should be made clear.

Stakeholders commented that the current QOF guidance supporting indicator BP001 recommends the use of ABPM to confirm diagnosis of hypertension and queried if this indicator would be in addition to or a replacement of BP001. The Royal College of General Practitioners (RCGP), NHS Employers and the GPC queried if other QOF indicators for blood pressure monitoring would require ABPM, and commented that this would be a fundamental change to practice with considerable workload and resource implications. NHS Employers suggested that it may be appropriate first to introduce the use of ABPM via the Clinical Commissioning Group Outcomes Indicator Set (CCG OIS) in England to ensure that the skills and equipment are in place before incentivising the use of ABPM via the QOF.

Stakeholders highlighted the need to train practice staff on how to use ABPM, and the potential workload implications from having to describe how the machine works, interpreting results, and recalling individuals to explain results and discuss treatment options. Stakeholders suggested that if the points allocation for this indicator was not reflective of the potential workload, this may act as a disincentive to diagnose hypertension, thereby reducing the

[1] Recommendation 1.2.9 from the NICE hypertension guideline states: When using ABPM to confirm a diagnosis of hypertension, ensure that at least two measurements per hour are taken during the person's usual waking hours (for example, between 08:00 and 22:00).Use the average value of at least 14 measurements taken during the person's usual waking hours to confirm a diagnosis of hypertension.

effective treatment of hypertension. One stakeholder also commented that consideration would need to be given to infection control.

The RCGP noted that NICE clinical guideline 127 guidance recommends offering antihypertensive drug treatment to people aged under 80 years with stage 1 hypertension who have a 10 year cardiovascular risk equivalent to 20% or greater. It was suggested that since ABPM readings tend to be lower than the clinic blood pressure readings from which risk scores using Framingham and QRISK are calculated, 10 year cardiovascular risk is likely to be falsely low using ABPM readings resulting in fewer people receiving treatment. A footnote to the NICE recommendation on cardiovascular risk assessment[2] states that “clinic blood pressure measurements must be used in the calculation of cardiovascular risk”.

One stakeholder suggested that waiting for a diagnosis using ABPM in those people with very high blood pressure would be contrary to NICE guidelines. It was suggested that people with a clinic blood pressure of greater than 180/110 should be excluded because NICE guidance recommends same day specialist referral for people with accelerated hypertension (blood pressure usually higher than 180/110 mmHg with signs of papilloedema and/or retinal haemorrhage)[3].

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[2] NICE CG127 recommendation 1.3.2: Estimate cardiovascular risk in line with the recommendations on Identification and assessment of CVD risk in 'Lipid modification' (NICE clinical guideline 67)[4]

[3] NICE CG127 Recommendation 1.2.11 Refer the person to specialist care the same day if they have: i)accelerated hypertension, that is, blood pressure usually higher than 180/110 mmHg with signs of papilloedema and/or retinal haemorrhage or ii) suspected phaeochromocytoma (labile or postural hypotension, headache, palpitations, pallor and diaphoresis)