NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE indicator validity assessment

Indicator IND235

The percentage of patients on the CKD register and with an albumin to creatinine ratio (ACR) of less than 70 mg/mmol, without moderate or severe frailty, in whom the last blood pressure reading (measured in the preceding 12 months) is less than 135/85 mmHg if using ambulatory or home monitoring, or less than 140/90 mmHg if monitored in clinic.

Importance

Considerations	Assessment
NHS England referred chronic kidney disease (CKD) as a topic for exploring possible indicators. There is a single indicator for CKD in the current 2021/2022 QOF. CKD is recognised as a risk factor for other conditions such as cardiovascular disease and identification and management of CKD has been included in data collection for the CVD Prevent audit.	The indicator reflects a specific priority area identified by NHS England.
No data identified. This area is based on the indicator advisory committee and stakeholder's knowledge.	The indicator relates to an area where there is assumed variation in practice. The indicator is proposed to address under-treatment.
Chronic kidney disease (CKD) is a long-term condition characterised by abnormal function or structure (or both). Optimal blood pressure control can slow progression of CKD and reduce the risk of cardiovascular disease. A focus on people without moderate or severe frailty allows for an individualised management approach that adjusts care according to frailty status. The General Medical Service (GMS) contract requires practices to use an appropriate tool (such as the electronic frailty index) to identity moderate and severe frailty in patients 65 years and over. It also requires secondary validation.	The indicator will lead to a meaningful improvement in patient outcomes.

Evidence base

Considerations	Assessment
NICE's guideline on chronic kidney disease (2021), recommendation 1.6.1. In adults with CKD and an ACR under 70 mg/mmol, aim for a clinic systolic blood pressure	The indicator is derived from a high-quality evidence base.

below 140 mmHg (target range 120 to 139 mmHg) and a clinic diastolic blood pressure below 90 mmHg. NICE's guideline on hypertension in adults (2019, last updated 2022) recommendations 1.4.10, 1.4.18,1.4.20 and 1.4.22. 1.4.10 Discuss starting antihypertensive drug treatment, in addition to lifestyle advice, with adults aged under 80 with persistent stage 1 hypertension who have 1 or more of the following: • target organ damage • established cardiovascular disease • renal disease • diabetes • an estimated 10-year risk of cardiovascular disease of 10% or more. Use clinical judgement for people with frailty or multimorbidity (see also NICE's guideline on multimorbidity). 1.4.18 Consider ABPM or HBPM, in addition to clinic blood pressure measurements, for people with hypertension identified as having a white-coat effect or masked hypertension (in which clinic and non-clinic blood pressure results are conflicting). Be aware that the corresponding measurements for ABPM and HBPM are 5 mmHg lower than for clinic measurements (see recommendation 1.2.8 for diagnostic thresholds). 1.4.20 For adults with hypertension aged under 80, reduce clinic blood pressure to below 140/90 mmHg and ensure that it is maintained below that level. 1.4.22 When using ABPM or HBPM to monitor the response to treatment in adults with hypertension, use the average blood pressure level taken during the person's usual waking hours (see recommendations 1.2.6 and 1.2.7). Reduce blood pressure and ensure that it is maintained: • below 135/85 mmHg for adults aged under 80 • below 145/85 mmHg for adults aged 80 and over. Use clinical judgement for people with frailty or multimorbidity (see also NICE's guideline on multimorbidity).	The indicator aligns with the evidence base.

Specification

Considerations	Assessment

Numerator: The number of patients in the denominator whose last blood pressure reading (measured in the preceding 12 months) is less than 135/85 mmHg if using ambulatory or home monitoring, or less than140/90 mmHg if monitored in clinic. Denominator: The number of patients on the CKD register and with an albumin to creatinine ratio (ACR) of less than 70 mg/mmol, without moderate or severe frailty. Exclusions: None Personalised care adjustments or exception reporting should be considered to account for situations where the patient declines, does not attend or if the blood pressure target is not appropriate.	The indicator has defined components necessary to construct the indicator, including numerator, denominator and exclusions.
The indicator would be appropriate to assess performance at individual general practice level. To be classified as suitable for use in QOF, there should be an average minimum population of more than 20 patients per practice eligible for inclusion in the denominator prior to application of personalised care adjustments. Piloting data showed an estimated 151 patients for an average practice with 10,000 patients (67.3% of people on the CKD register had an ACR less than 70 mg/mmol, and 33.8% of these were clinically coded for moderate or severe frailty).	The indicator does outline minimum numbers of patients needed to be confident in the assessment of variation.

Feasibility

Considerations	Assessment
Data can be collected from GP systems using SNOMED coding.	The indicator is repeatable.
NHS Digital suggest the following clusters can be used: CKD_COD MODFRAIL_COD SEVFRAIL_COD APCR_COD BP_COD BPEX_COD A similar logic is seen in QOF, INLIQ and CVD Prevent.	The indicator is measuring what it is designed to measure. The indicator uses existing data fields.

Acceptability

Considerations	Assessment
Stakeholders note the need to exclude people on maximally tolerated therapy or where treatment may not	The indicator assesses performance that is

be indicated. Personalised care adjustments could be used in these circumstances.	attributable to or within the control of the audience
Data can be extracted and used to compare practice within the GP practice or with other GP practices.	The results of the indicator can be used to improve practice

Risk

Considerations	Assessment
Stakeholders and feedback from piloting showed concern that frailty may not be coded well in primary care and may not reflect clinical status. The indicator advisory committee noted that the General Medical Service Contract requires practices to use an appropriate tool (such as the electronic frailty index) to identity moderate and severe frailty in patients 65 years and over. It also requires secondary validation. Stakeholders and feedback from piloting noted low uptake of urine ACR measurement. CVD Prevent audit (2022) showed that an annual urine ACR test was recorded in 24.6% of people with CKD. An existing NICE menu indicator NM109 measures the number of people on the CKD register with a record of a urine ACR test in the preceding 12 months, this indicator has data collected as part of the indicators no longer in QOF (INLIQ) dataset (CKD 004) and is suitable for inclusion in QOF.	The indicator has an acceptable risk of unintended consequences.

NICE indicator advisory committee recommendation

The NICE indicator advisory committee approved this indicator for publication on the menu. They advised that care should be given when using coding for moderate frailty.