National Institute for Health and Care Excellence

Hypertension in pregnancy

Quality Standard Consultation Comments Table

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.	Response Please respond to each comment
013	Action on Pre-eclampsia	Briefing paper		The report has highlighted the lack of patient experience evidence and we think that there is a serious need for far more research into this aspect of care. It can be (and in some cases it is being) integrated into clinical research in women with hypertensive disorders of pregnancy. However this area of research has also been removed in recent funding applications on the basis of cost.	Thank you for your comment. The NICE Quality Standards programme is unable to make research recommendations. The topic expert group prioritised the areas of care they felt were most important for women with hypertension in pregnancy, based on the development sources listed.
013	Action on Pre-eclampsia	Briefing paper		May we request that the statement “the GDG felt that despite the exclusion if IUGR in the evidence..... there were no strong grounds for offering birth before 34 weeks in women with pre-eclampsia simply on the basis of poor fetal growth” be rephrased if this document is to be made public. It implies that poor fetal growth is not something that requires a change in management. Remove the word “simply” and add “although action/ increased monitoring is required” or similar.	Thank you for your comment. The briefing paper is published at the consultation stage for information and is not a document for consultation. The briefing paper uses evidence from key development sources, in this case the NICE clinical guideline 107.
013	Action on Pre-eclampsia	General: patient experience		Please always consider that from the healthcare professional’s point of view they are managing an urgent medical condition, from the woman’s point of view she is always pregnant and expecting to have a baby however critical her condition. The support that is offered to women who are pregnant and healthy is often not available to women with hypertensive disorders, at a time when they are justifiably even more concerned with the wellbeing of their baby.	Thank you for your comment. The topic expert group recognise the importance of the woman’s experience and that high quality support and information should be provided to her. The quality standard on patient experience should be used alongside this quality standard. This includes a number of quality statements that

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					should address these issues, including statements on respect, communication, opportunities to discuss health beliefs, concerns and preferences. Experience measures are also included in the quality standard where these support measurement (statement 6).
013	Action on Pre-eclampsia	Quality statement 1	Definitions	Please be more specific so women know what to do and when to do it. “Annually told about safe antihypertensives in pregnancy” is current statement. Woman will want to know when she needs to think about her medication (when trying to get pregnant? When confirmed?), who she should contact (GP? Consultant? Midwife?), timelines (hours, days, weeks), potential harm of stopping medication vs. Harm to foetus. Women may panic if they find they are pregnant, and have not switched. Suggest “provide a written plan which is reviewed once a year” and list the information it should contain (or provide a pro forma). Suggested outcome: no of women taking “high risk” treatment (as in QS) at 6 weeks of pregnancy.	Thank you for your comment. The importance of ensuring women are fully informed and supported is recognised. The quality standard should be used alongside the patient experience quality standard, which would enable these issues to be addressed. Statement 5 of the patient experience quality standard states that “Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences”. Statement 6 states “Patients are actively involved in shared decision making and supported by healthcare professionals to make fully informed choices about investigations, treatment and care that reflect what is important to them“. The quality statement is based on recommendations in NICE guideline CG107.
013	Action on Pre-eclampsia	Quality statement 2		In process section suggest list all risk factors. Explain what “integrated” management means (who, when, how) Women at high risk should also be referred to a	Thank you for your comment. Each quality statement relates to a single concept of high quality care. The

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				specialist, not just given aspirin (as recommended in CMACE which highlighted failure of GPs to refer women to specialist services). Suggest this recommendation is explicitly linked. Suggested outcome; % of high risk women developing pre-eclampsia/ preterm pre-eclampsia. This is a clear important QS.	topic expert group prioritised the areas of care they felt were most important for women with hypertension in pregnancy, based on the development sources listed. Please refer to the full clinical guideline for detailed summary of the underpinning evidence base for the clinical recommendations on which the quality standard is based. Specialist input is covered in other statements, such as statement 5. The phrase 'integrated management' is now not included for statement 2. An outcome measure has been added to reflect your suggestion.
013	Action on Pre-eclampsia	Quality statement 4 and 5		What does an "integrated package of care" mean? Remove phrase and specify please (who does it, when, how, what does the woman need to do/ expect, as per table). Suggest the target blood pressure should be linked to the consultant supervisor who is responsible for achieving it. Please also either reiterate, or specifically link to, recommendations/ QS in other NICE guidelines (if available) or PRECOG recommendations, covering accurate measurement of blood pressure and proteinuria. Failure to take measurements appropriately have significant impact on outcomes, as shown in CMACE reports. Suggested outcome QS 3: no of women who need i.v. management for severe hypertension, or ITU admission. As they stand these QS have little value; suggest need to review the management tables to extract specifics.	Thank you for your comment. Following a review of feedback from consultation quality statement 4 now focuses on admission of pregnant women with severe hypertension to hospital for a full assessment from a health care professional trained in the management of hypertensive disorders. Quality statement 5 now focuses on admission of women with a diagnosis of pre-eclampsia to hospital with daily monitoring. All suggestions for additional quality measures were considered by the topic expert group. The quality standard should be read in the context of national and local

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					guidelines on training and competencies. Implementation of this quality standard is based on all healthcare professionals involved in the management of hypertension in pregnancy having sufficient and appropriate training, and competence to deliver the actions and interventions described in the quality standard.
013	Action on Pre-eclampsia	Quality statement 5	(and definitions generally)	Please change the definition of pre-eclampsia given for women from “a serious type of temporary high blood pressure” as the condition is easily misunderstood/ missed by healthcare professionals and women. Very important for women to understand all the potential signs and symptoms, as they are asked to self-monitor. One of the signs of pre-eclampsia can be “a serious type of temporary high blood pressure” but this is only a part of the syndrome. Pre-eclampsia is a serious multi-system disorder of pregnancy which includes pregnancy-induced hypertension as one of its components as well as substantial risks for the fetus. Please see PRECOG/ APEC leaflets for information for women (or we are happy to make further suggestions). Similarly, throughout the document, the use of “gestational hypertension” instead of “new hypertension” to describe the sign does not make it clear that pre-eclampsia is a rapidly changing and unpredictable condition e.g. woman may change rapidly from “gestational hypertension integrated package of care” to “severe pre-eclampsia package of care” within hours; that gestational hypertension as a diagnosis can only be made post partum. Strongly suggest therefore that new hypertension is used instead of gestational hypertension. CMACE highlighted that healthcare professionals sometimes do not react quickly to changes in bp because they do not	Thank you for your comment. This has been considered by our editors and the wording amended. The term ‘gestational hypertension’ is reflective of the underpinning NICE clinical guidance 107 which has been used as a primary development source for the quality standard. A definition has been provided to explain that this is new hypertension presenting after 20 weeks without significant proteinuria (urinary protein:creatinine ratio greater than 30 mg/mmol or a validated 24-hour urine collection result greater than 300 mg protein). Quality statement 3 focuses on blood pressure targets and quality statement 4 focuses on admission of women with severe hypertension to hospital for assessment. These quality statements are intended to support appropriate investigation of changes in blood pressure. The intent of quality statement 4 is for

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				understand that the high blood pressure associated with pre-eclampsia is not the same as the high blood pressure of chronic hypertension.	all women with severe hypertension in pregnancy to be admitted for full assessment which should provide clarity about the type of hypertension. The quality statement is based on evidence based recommendations from NICE clinical guideline 107.
013	Action on Pre-eclampsia	Quality statement 6		Please quantify the meaning of the words "**indications** from any previous pregnancy and "**timely**" fetal US. Suggestion that the specifics are linked to the new RCOG guideline on SGA (when available) which has specific recommendations for chronic hypertension, previous pre-eclampsia and new hypertension/ pre-eclampsia. It would be beneficial to share details with this group so that consistent recs/ QS can be developed. Suggestion re timescale: suggestions available on request for pre-eclampsia, isolated new hypertension, and chronic hypertension.	Thank you for your comment. The topic expert group have refined the quality standard following feedback from consultation. The quality statement on fetal monitoring has been removed
013	Action on Pre-eclampsia	Quality statement 7		This statement requires that a plan is devised with input from a consultant defining the thresholds for elective birth. The issues in CMACE show that a consultant specialist with expertise and the right training should be available for advice (to "update the care plan") throughout this time, not just to develop an initial plan. Everyone involved in the care should understand the unpredictable nature of the condition. Measure could be timescale within which advice from a consultant specialist is obtained, and acted apon. Suggested outcome: ITU admission?	Thank you for your comment. The statement has been refined in view of consultation feedback. Definitions for the quality statement on a consultant-led plan have been amended. References to elective birth before 34 weeks in women with pre-eclampsia have been removed. Definitions for the quality statement on a consultant-led plan have been amended. The definitions state that delivery should be according to the most up to date version of the plan. The intent of the statement is for a

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					consultant obstetric-led plan to be developed with multi-disciplinary input as well as input from the woman. This is to enable early input from the consultant obstetrician and to ensure identification of other professionals required to provide input. A rationale has been added for the statement which highlights that the plan should be updated as needed. The definition of the plan states that birth should be according to the most up-to-date version of the plan. All suggestions for additional outcome measures were considered by the topic expert group.
013	Action on Pre-eclampsia	Quality statement 8		As for statement 7, the issue is to define who cares for the woman and the input into care within level 2, and throughout the period. Also please specify what level 2 critical care is i.e. delivery suite? We understand that it is necessary to quantify the statements, but “severe pre-eclampsia with complications” is a narrow definition and women may be missed. Also need to specify whether the time frame refers to transfer from another level of care within a hospital, or includes identification in the community. Suggested outcomes: death, ITU admission	Thank you for your comment. Following feedback from consultation this statement has been removed. Other quality statements are intended to support identification and management, including quality statement 4 on assessment of severe hypertension, quality statement 5 on admission of women with pre-eclampsia and quality statement 6 on early consultant input.
013	Action on Pre-eclampsia	Quality statement 9	(and general)	GP notification. Suggest that women could also be given a letter on discharge to take to their GP as well as a letter/ email directly to the GP. This would be an opportunity for the bp to be taken, and post-natal management of bp to be discussed. As a general point there is some concern that women with chronic conditions who become pregnant suffer	Thank you for your comment. The topic expert group have amended the wording of the quality statement to say ‘Women who have had hypertension in pregnancy have a plan for ongoing antihypertensive management included in their postnatal

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				from the relative exclusion of GPs from maternity care, which may be required for pre-pregnancy and post-natal support and advice as recommended in QS 1,2 and 9.	care plan, which is communicated to their GP when they are transferred to community care after the birth'. The intent of the statement is that the woman's GP would receive all relevant information about the woman's condition and its ongoing management.
013	Action on Pre-eclampsia	Quality statement 10	(and general issue re. patient experience)	Discuss future related risks at 6-8 week review: although it is relevant that a woman is informed of the future related risks, this must be done within an integrated package of post-natal care when a woman has experienced a hypertensive disorder of pregnancy. Before she is told of her future risk, she needs to understand what has happened to her and her baby during the pregnancy and have the opportunity to explain her experiences (see below re research). At 6-8 weeks she should be given the details (who, how) so she can get advice and information when it is appropriate for her. A leaflet, in various languages, should be given to her, so she and her family can refer to it later. At this time she will probably have a young baby to care for, who may be premature, in SCBU or have died. She may be physically recovering from a Caesarian section, and mentally recovering from a major illness. Also please specify who is responsible for the review i.e. obstetrician, GP, other? Significant issue as this covers all women with new hypertension.	Thank you for your comment. This quality statement has been refined in view of consultation comments. It now reads 'Women who have had gestational hypertension or pre-eclampsia discuss future pregnancy and lifetime cardiovascular risks during a medical review at their 6–8 week postnatal medical check'. The definitions section of this quality statement now stipulates that this would be carried out by a GP or an appropriately trained midwife). The quality standard should be used alongisde the patient experience quality standard. This includes quality statements which would ensure that women are fully informed and able to understand their condition and ongoing support, and to be involved in agreeing their care.
002	British Cardiac Society	General	Intro	Hypertension in pregnancy has been divided into chronic HT or that which develops in the second half pregnancy. Later in the guidelines (page 7) there is a comment that the definition of chronic HT is that which is present at the booking visit or before 20 weeks. This group will include newly diagnosed women not previously know to be have hypertension as many	Thank you for your comment. The definition of chronic hypertension and references to it have been amended for clarification. The introductory text has been updated to reflect your suggestion.

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				women do not attend their GPs until they are pregnant. The opening sentence is confusing for primary care as they will see newly diagnosed women before 20 weeks not as having “chronic hypertension” and may therefore not consider her eligible for the guidelines. Could the opening sentence and others related to it read “Hypertension in pregnancy may occur in women with pre-existing chronic hypertension (including those newly diagnosed at booking or before 20 weeks gestation) or may develop for the first time during the second half of pregnancy”.	Definitions have been aligned to the underpinning NICE guidance.
002	British Cardiac Society	General		A number of patients with pre-existing chronic hypertension on treatment present to obstetrics / cardiology because of dizzy spells / blackouts due to the fact that their requirements for anti-hypertensives have reduced in the first trimester. This is predominantly due to the physiological changes in pregnancy combined with an overlying hyperemesis. Rarely, women are given advice about if and when to reduce their drugs in early pregnancy and I wonder whether this guideline would look at that.	Thank you for your comment. The topic expert group prioritised the areas of care they felt were most important for women with hypertension in pregnancy, based on the development sources listed, predominantly NICE clinical guideline 107. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on care of women with hypertension in pregnancy and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the topic expert group who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective

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					care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.
002	British Cardiac Society	Quality Statement 1		The statement outlines clear guidelines on what to advise a women about the safety of ACE/ARBs and thiazides when planning a pregnancy. Data shows us that up to one third of pregnancies are un-planned and therefore a statement about the advice to give a woman whom conceives on the drugs would be beneficial.	Thank you for your comment. The TEG recognised that a proportion of pregnancies are unplanned. The intent of quality statement 1 is that all women with potential to conceive would be given information about safe drugs during pregnancy and could further discuss this with their clinician prior to pregnancy. However, the statement focuses on advising all women of child bearing potential. It does not specify those planning a pregnancy and it is envisaged that providing this information would enable women who did conceive to seek further advice.
002	British Cardiac Society	Quality statement 2	Definitions	The last sentence in this section states “pre-eclampsia is new hypertension presenting after 20 weeks with significant proteinuria”. I would suggest that the word significant is quantified ie 2+ or > protein on dipstick or PCR >50 for example.	Thank you for your comment. A quantification of proteinuria has been added from NICE clinical guideline 107.
002	British Cardiac Society	Quality Statement 3		Following on from my comment with regards to newly diagnosed patients at booking ie chronic HT, these women will have had no assessment of either cause of HT ie primary or secondary nor will they have had assessment for end organ damage. Would it be useful to define a target for what is expected of the newly diagnosed women at booking or are the stakeholders happy for investigations to be delayed until after delivery.	Thank you for your comment. The topic expert group prioritised the areas of care they felt were most important for women with hypertension in pregnancy, based on the development sources listed, predominantly NICE clinical guideline 107. It remains important that other evidence based guidance recommendations continue to be implemented.

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					Quality statement 4 includes a full assessment of women with severe hypertension in pregnancy. This may consider secondary hypertension.
002	British Cardiac Society	Quality statement 6		As a cardiologist I am not qualified to comment about the timing of ultrasound	Thank you. The topic expert group have revised the statement based on consultation feedback.
002	British Cardiac Society	Quality statement 8		Personally I feel that women with severe pre-eclampsia with complications should be transferred and managed in critical care immediately which means practically within one hour of diagnosis rather than two. These women can deteriorate quickly and with midwives and obstetricians increasingly sub-specialising early due to “run through training” there is increasing chance that these women will not receive the appropriate medical care required for safe outcomes.	Thank you for your comment. Following feedback from consultation this statement has been removed. Other quality statements are intended to support identification and management, including quality statement 4 on assessment of severe hypertension, quality statement 5 on admission of women with pre-eclampsia and quality statement 6 on early consultant input.
007	British Hypertension Society	General		The guidelines are lengthy and excessively repetitive. There is insufficient information on BP measurement and the role of ambulatory or home BP measurement. Most obstetricians and GPs have received no training on BP measurement. A single raised BP reading on a nervous patient, taken by a harassed, busy obstetrician can be misleading. The guidelines provide a "target" BP but provide insufficient information on how to achieve the target. There is insufficient information on the value, or otherwise of salt restriction The endorsement of labetolol, which is basically a beta-blocker, seems in appropriate, particularly as labetolol	Thank you for your comment. Following feedback from consultation, the topic expert reduced the number of quality statements at their final meeting in order to produce a set of concise statements. The topic expert group prioritised the areas of care they felt were most important and measurable for women with hypertension in pregnancy, based on the development sources listed, predominantly NICE clinical guideline 107. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based

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				is hardly ever used in non-pregnancy situations. The danger is that the valid sections of this guideline will be lost in a plethora of words and implementation will therefore be less likely.	guideline recommendations continue to be implemented, including recommendations relating to blood pressure monitoring and lowering of blood pressure. The guideline contains a recommendation that salt restriction during pregnancy should not be recommended solely to prevent gestational hypertension or pre-eclampsia. Labetalol is licensed for the treatment of hypertension, including during pregnancy and is recommended in NICE guideline 107; however it is no longer specifically referenced in the quality standard. The quality standard should be read in the context of national and local guidelines on training and competencies. All health and social care professionals involved in assessing, caring for and treating women at risk of or with hypertension in pregnancy should be sufficiently and appropriately trained and competent to deliver the actions and interventions described in the quality standard.
007	British Hypertension Society	Guideline recs 1.2.1.3 Guideline recs		We are puzzled by the comments about chlorothiazide. There is no reference to such a contraindication with chlorothiazide in the BNF, ABPI Compendium of Drugs or the definitive text on adverse drug interactions, Meyler's Side Effects of Drugs. Professor G McInnes (Senior BHS Member) authored the chapter on diuretics in that volume for more than a decade, until about 10 years ago. Very few people take this drug	Thank you for your comment. The quality statements are based on evidence-based recommendations from national accredited guidance, i.e. the NICE 107 clinical guideline. This includes evidence-based recommendations about advice on the

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		1.1.2 clinical effectiveness evidence		which may no longer be available in the UK. Does the author of this section mean "thiazide or thiazide-like diuretics"? Because of haemodynamic and metabolic effects, such drugs are not advised in gestational hypertension. However, the best evidence (a major meta-analysis by Rory Collins many years ago) suggests no harm in pregnant women with chronic hypertension.	safety of antihypertensive drugs in pregnancy, including chlorothiazide. Quality standards do not seek to reassess or redefine the evidence base. Please refer to the full clinical guideline for detailed summary of the underpinning evidence base for the clinical recommendations on which the quality standard is based.
007	British Hypertension Society	Quality statement 10		Standard 10. Who is going to give this advice at the anti-natal visit?	Thank you for your comment. The definitions section of this quality statement now stipulates that this would be carried out by a GP or an appropriately trained midwife).
001	British Maternal & Fetal Medicine Society	General	Overall	Statements1,2,3,4,5,6, 8 and 9 are the most important	Thank you for your comment.
001	British Maternal & Fetal Medicine Society	Quality statement 1	Definitions	Definition of chronic hypertension discusses that it should be diagnosed prior to 20 weeks. As this statement is regarding "pre-pregnancy advice" then it is only with regard to those diagnosed prior to pregnancy?	Thank you for your comment. The definition of chronic hypertension and the wording used in this statement have been amended for clarification.
001	British Maternal & Fetal Medicine Society	Quality statement 2		Guideline refers to stopping aspirin "at birth". There is not really an evidence-based consensus on this issue? Why does the quality statement refer to stopping at 37 weeks? If this is because "some clinicians" (personal view) stop at 37 (and this is thought to be acceptable) continuing to birth should not be considered unacceptable.	Thank you for your comment. The topic expert group have refined this quality statement following feedback from consultation. The statement now reads '…until birth'.
001	British Maternal & Fetal Medicine Society	Quality statement 2		Data source needs to include those with 2 moderate risk factors as part of the denominator	Thank you for your comment. The denominator includes 'women at increased risk'. The definition provided of 'at increased risk' states that women are at an increased risk of pre-

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					eclampsia if they have one high risk factor or more than one moderate risk factor for pre-eclampsia.
001	British Maternal & Fetal Medicine Society	Quality statement 3		Blood pressure rising is an indication to increase treatment. By setting the quality statement gives no allowance for progression of disease. It may be better to look at response to any blood pressure reading above 150/100 (140/90 with end organ damage). Thus, "Was medication changed if the blood pressure was over the target range?"	Thank you for your comment. The topic expert group prioritised the areas of care they felt were most important for women with hypertension in pregnancy, based on the development sources listed, predominantly NICE clinical guideline 107. The topic expert group were grateful for suggested metric to measure blood pressure, however they agreed the focus of the quality statement should be on ensuring that a target BP is the aim; the ways of meeting the BP target are not the focus of the statement. It remains important, however, that other evidence based guidance recommendations continue to be implemented, including lowering of blood pressure and ongoing blood pressure monitoring.
001	British Maternal & Fetal Medicine Society	Quality statement 4		The phrase "integrated care package" is not a familiar one to clinicians. Clinical guideline is a more familiar phrase.	Thank you for your comment. Following a review of feedback from consultation quality statement 4 now focuses on admission of pregnant women with severe hypertension to hospital for a full assessment from a health care professional trained in the management of hypertensive disorders.
001	British Maternal & Fetal Medicine Society	Quality statement 5		As for statement 4	Thank you for your comment. Following a review of feedback from consultation quality statement 5 now

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					focuses on admission of women with a diagnosis of pre-eclampsia to hospital with daily monitoring.
001	British Maternal & Fetal Medicine Society	Quality statement 6		We would suggest more specific timing of ultrasound scans? Women with chronic hypertension should have 2 scans between 28 and 34 weeks ? Women with diagnosis of PIH should have scan within 2 weeks of diagnosis Women with Severe PIH or PET (with plan of conservative management) should be scanned within 72 hours	Thank you for your comment. The topic expert group have refined the quality standard following feedback from consultation. The quality statement on fetal monitoring has been removed.
001	British Maternal & Fetal Medicine Society	Quality statement 7		This statement could be qualified by defining the cases as those with PET diagnosed <37 weeks as there is general agreement that in those diagnosed after 37 weeks need delivery. Our 'expert' panel were split as to whether this should be discussed with consultant prior to induction. On balance, we feel that this is good practice.	Thank you for your comment. The statement has been refined in view of consultation feedback. Definitions for the quality statement on a consultant-led plan have been amended. References to elective birth before 34 weeks in women with pre-eclampsia have been removed.
001	British Maternal & Fetal Medicine Society	Quality statement 8		Evidence of track and trigger charts would be better described as use of a MEOWS chart or equivalent for all antenatal or postnatal women with a diagnosis of PET	Thank you for your comment. Following feedback from consultation this statement has been removed. Other quality statements are intended to support identification and management, including quality statement 4 on assessment of severe hypertension, quality statement 5 on admission of women with pre-eclampsia and quality statement 6 on early consultant input.
001	British Maternal & Fetal Medicine Society	Quality statement 8		Women with complications should be reviewed by a senior obstetrician (ST3 or above) within 2 hours and managed or moved to area where the nursing /midwifery ratio is 1:2 or better (including labour ward and obstetric HDU) within 2 hours	Thank you for your comment. Following feedback from consultation this statement has been removed. Other quality statements are intended to support identification and management,

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					including quality statement 4 on assessment of severe hypertension, quality statement 5 on admission of women with pre-eclampsia and quality statement 6 on early consultant input.
001	British Maternal & Fetal Medicine Society	Quality statement 10		There is too much detail as to what is required at the postnatal follow up. Although it would be excellent if all women with PET got such a complete follow up in terms of advice about their long term risks of hypertension, this is not currently happening (most GPs are unaware and secondary care is not resourced to provide this care). Requiring some kind of follow up at six-eight weeks is at least a start. There is currently no evidence that giving advice about future health will improve outcomes (though we are aware of the risks). Is there any evidence that giving women with gestational diabetes either delays the onset of type 2 diabetes or the complications?	Thank you for your comment. This quality statement has been refined in view of consultation comments. It now reads 'Women who have had gestational hypertension or pre-eclampsia discuss future pregnancy and lifetime cardiovascular risks during a medical review at their 6–8 week postnatal medical check'. The topic expert group felt that it was important for women to have an understanding of their condition and its potential future impact. A rationale has now been provided for this statement which highlights the risk of women developing high blood pressure and an increase in lifetime cardiovascular risk. The topic expert group consider that increased surveillance in this group may lead to earlier intervention, usually with antihypertensives, with likely benefits for the woman.
008	National Childbirth Trust	General		We welcome the introduction of a quality standard that aims to improve the care of women with hypertension in pregnancy.	Thank you for your comment.
008	National Childbirth Trust	Quality statement 1	Definitions	This quality statement says "Women of childbearing potential with treated chronic hypertension are given information at each annual review about safe antihypertensive treatment during pregnancy".	Thank you for your comment. The definition of chronic hypertension and the wording used in this statement have been amended for clarification.

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				The definition of chronic hypertension given is "hypertension that is present at the booking visit or before 20 weeks or if the women is already taking antihypertensive medication when referred to maternity services". As this quality statement relates to women who are not pregnant, this definition of chronic hypertension does not make sense: it should relate to women who are not pregnant.	
008	National Childbirth Trust	Quality statement 2	Source clinical guideline	This quality statement says "Pregnant women at increased risk of pre-eclampsia at the booking appointment are prescribed 75mg of aspirin to take daily from 12 weeks until 37 weeks". Section 1.1. of the NICE clinical guideline CG 107 is the source clinical guideline reference given for this quality statement. This says "Advise women with more than one moderate risk factor for pre-eclampsia to take 75 mg of aspirin daily from 12 weeks until the birth of the baby". We recommend that this quality statement is amended to (additional text underlined) "Pregnant women at increased risk of pre-eclampsia at the booking appointment are <u>advised about the benefits and any risks of taking aspirin during their pregnancy and</u> prescribed 75mg of aspirin to take daily from 12 weeks until 37 weeks". We feel that this amended statement better reflects the sense of the source clinical guideline reference, as well as the essential requirement to ensure that women are appropriately informed about medication given to them during pregnancy so that they can make a truly informed decision about whether to take it.	Thank you for your comment. The topic expert group have refined this quality statement following feedback from consultation. The statement now reads '…until birth'. The importance of informed decision making is recognised. The quality standard should be used in conjunction with the patient experience quality standard. Statement 5 of the patient experience quality standard states that "Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences". Statement 6 states "Patients are actively involved in shared decision making and supported by healthcare professionals to make fully informed choices about investigations, treatment and care that reflect what is important to them".
008	National Childbirth Trust	Quality	Definitions	This quality statement says "Women with a hypertensive disorder of pregnancy or indications from	Thank you for your comment.

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		statement 6		any previous pregnancy receive timely fetal ultrasound assessment". There is, however, no definition given of the phrases "hypertensive disorder of pregnancy" and "indications from any previous pregnancy". Clear and unambiguous definitions should be given for both these phrases to ensure that all women who require additional ultrasound monitoring receive it.	The topic expert group have refined the quality standard following feedback from consultation. The quality statement on fetal monitoring has been removed.
008	National Childbirth Trust	Quality statement 6	Question 5	You asked "Do stakeholders think that a timescale from diagnosis to fetal ultrasound assessment should be applied to process measure b" and "If so, can stakeholders suggest what the timescale from diagnosis to fetal ultrasound assessment should be?". We think that it is always appropriate to indicate a timescale for investigations and that such timescales should be clearly and unambiguously stated. This is so that this information can be given to women who will then be reassured that the investigation should occur before a given date and empowered to seek advice should it not have been done. We recommend that timescales are based on the best available relevant evidence or expert advice if no such evidence exists.	Thank you for your comment. The topic expert group have refined the quality standard following feedback from consultation. The quality statement on fetal monitoring has been removed.
008	National Childbirth Trust	Quality statement 7	Definitions	This quality statement says "Women with pre-eclampsia have their babies delivered according to an agreed consultant obstetrician-led plan for the timing and mode of delivery". The definitions section says "Consultant obstetric staff should document in the woman's notes the maternal (biochemical, haematological and clinical) and fetal thresholds for elective birth before 34 weeks in women with pre-eclampsia". There is no gestation limit included in the quality	Thank you for your comment. The statement has been refined in view of consultation feedback. Definitions for the quality statement on a consultant-led plan have been amended. References to elective birth before 34 weeks in women with pre-eclampsia have been removed.

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				statement. The definitions section, therefore, seems to lack a description of what happens after 34 weeks. Given the current wording of the quality statement, the definitions section should also clearly indicate that consultant obstetric staff should document the plan for deciding after 34 weeks, as well as before 34 weeks, how and when the baby should be delivered. If instead the intention was that this quality statement should only apply to elective deliveries before 34 weeks, this should be clearly set out in the quality statement, for example (amended text underlined) "Women with pre-eclampsia <u>who give birth to their babies electively before 34 weeks should do so</u> according to an agreed consultant obstetrician-led plan for the timing and mode of <u>birth</u>". Please note that we would prefer the use of "give birth to their babies" and "birth", respectively, rather than "have their babies delivered" and "delivery".	
008	National Childbirth Trust	Quality statement 8	Question 6	This quality statement says "Women who have severe pre-eclampsia with complications have their conditions managed in level 2 critical care within 2 hours of identification". You asked "Do stakeholders think that 'with 2 hours' is an appropriate timescale for women with severe pre-eclampsia with complications to be managed in critical care?". We recommend that timescales are based on the best available relevant evidence or expert advice if no such evidence exists. Whatever the final timescale should be, we recommend adding the underlined text to the statement to stress that the earliest critical care possible is preferable and that the timescale given is the latest deadline for receiving that care, rather than it being the time when critical care is recommended to begin (additional text underlined): "Women who have	Thank you for your comment. Following feedback from consultation this statement has been removed. Other quality statements are intended to support identification and management, including quality statement 4 on assessment of severe hypertension, quality statement 5 on admission of women with pre-eclampsia and quality statement 6 on early consultant input.

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				severe pre-eclampsia with complications have their conditions managed in level 2 critical care as soon as possible but at the latest within 2 hours of identification"	
008	National Childbirth Trust	Quality statement 9	Audience descriptors and definitions	This quality statement says "Women who have had a hypertensive disorder of pregnancy have information about their condition sent to their primary care clinician when they are transferred to community care after the birth". Women are often given letters when they are discharged from secondary care to give to their primary care providers. This may mean that women in certain circumstances, for example with more chaotic lifestyles, may be less likely to remember to deliver those letters. The descriptions of what this statement means for each audience and its definitions do not clearly set out what "sent" means, for example given to the women to give to her primary care provider or independently posted or both. We recommend that consideration is given as to how the information should be sent to the primary care provider to ensure that it actually arrives with them and that it arrives in a timely fashion and that this is clearly and unambiguously set out.	Thank you for your comment. The topic expert group have amended the wording of the quality statement to say 'Women who have had hypertension in pregnancy have a plan for ongoing antihypertensive management included in their postnatal care plan, which is communicated to their GP when they are transferred to community care after the birth'. The definitions section sets out what should be included in the information that is communicated, including information about the woman's condition and a plan for ongoing management.
014	Royal College of General Practitioners	General		This document shows a lot of discussion and work.	Thank you for your comment.
014	Royal College of General Practitioners	Quality statement 6		Under 6 it should be foetal ultrasounds as several are needed to assess foetal growth.	Thank you for your comment. The topic expert group have refined the quality standard following feedback from consultation. The quality statement on fetal monitoring has been removed
014	Royal College of General Practitioners	Quality statement 8		I would like the 2hrs for dealing with severe pre-eclampsia to be reduced, but I guess those in the know had to make it workable.	Thank you for your comment. Following feedback from consultation

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					this statement has been removed. Other quality statements are intended to support identification and management, including quality statement 4 on assessment of severe hypertension, quality statement 5 on admission of women with pre-eclampsia and quality statement 6 on early consultant input.
014	Royal College of General Practitioners	Quality statement 9		Under 9 it should be General Practice not primary care clinician, as it is often the team making sure standards are complied with!	Thank you for your comment. The topic expert group have amended the wording of the quality statement to say 'Women who have had hypertension in pregnancy have a plan for ongoing antihypertensive management included in their postnatal care plan, which is communicated to their GP when they are transferred to community care after the birth'.
011	Royal College of Nursing	General		The draft quality standards seem appropriate.	Thank you for your comment.
011	Royal College of Nursing	Quality statement 6	Question 5	A week seems a reasonable time, however, this might not be practical to provide due to the lack of sonographers in some areas, particularly in London. It might also be a challenge to meet this standard particularly over holiday periods such as Easter and Christmas when routine clinics are often not available.	Thank you for your comment. The topic expert group have refined the quality standard following feedback from consultation. The quality statement on fetal monitoring has been removed
011	Royal College of Nursing	Quality statement 8	Question 6	Yes, we would agree	Thank you.
009	Royal College of Obstetricians and Gynaecologists	General		In regards to the focus on Aspirin which as far as I know is no longer recommended for Prevention. UptoDate article from Jan 2013 is: 'Results from large trials of at risk women ‹ In contrast to the above findings from initial small studies in selected women at	Thank you for your comment. The introduction to the quality standard has been updated based on your comment to include reference to eclampsia.

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				very high risk, subsequent large trials including both moderate and high risk women did not show a significant reduction in the incidence of preeclampsia with low-dose aspirin <http://www.uptodate.com/contents/aspirin-drug-information?source=see_link> Therapy' Could this guidance please be more specific about specific treatment recommendations And particularly the OP management rather than everyone being admitted and escalated rapidly to HDU? No specific details of intrapartum care e.g. role of Syntometrine or Epidurals just a vague referral to a consultant led approach (this assumes the consultant knows what they are doing) Incidence and MX of Eclampsia not dealt with at all? Surely this is critical quality measure? And its subsequent prevention with MgSO4 Lastly What about the mx of new BP in the Post natal period/Lactation etc?	The quality statements and measures have been refined based on feedback from consultation. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on care of women with hypertension in pregnancy and improved outcomes, and where there is potential to generate measurable indicators. The topic expert group identified the development sources they felt were most relevant to developing the standard, within the framework of the quality standards development process. The quality statements are based on NICE accredited guidance, predominantly NICE clinical guideline 107. NICE clinical guideline 107 includes an evidence based recommendation on aspirin prophylaxis. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. Quality standards do not seek to

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					reassess or redefine the evidence base. Please refer to the full clinical guideline for detailed summary of the underpinning evidence base for the clinical recommendations on which the quality standard is based. Quality statement 7 includes development of a plan for ongoing antihypertensive management to be included in the postnatal care plans of women who have had hypertension in pregnancy. This includes ongoing blood pressure monitoring The quality standard should be used in the context of other quality standards, including the postnatal care quality standard.
009	Royal College of Obstetricians and Gynaecologists	Suggestion for an additional quality statement		We suggest that an additional quality statement should be: 'Clinicians should use an automated reagent-strip reading device or a spot urinary protein:creatinine ratio for estimating proteinuria in hypertensive disorders of pregnancy, in a secondary care setting'. This recommendation is one of the 'key priorities for implementation'.	Thank you for your comment. The topic expert group prioritised the areas of care they felt were most important for women with hypertension in pregnancy, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on care of women with hypertension in pregnancy and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional

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					statements were discussed by the topic expert group who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. It remains important that other evidence-based guideline recommendations continue to be implemented. This quality standard should be read alongside other NICE quality standards. Testing for proteinuria is covered in the quality standard on antenatal care, where quality statement 3 states: "Pregnant women have a complete record of the minimum set of antenatal test results in their hand-held maternity notes". The definitions state blood pressure measurement and proteinuria testing as the first 2 tests for which women should have a complete record of testing at each routine antenatal appointment.
009	Royal College of Obstetricians and Gynaecologists	Quality statement 1		*General* – the statement indicates that the women should be given information about safe antihypertensive treatment during pregnancy at each annual review. We suggest that the statement should clarify if this is given by a GP, practice nurse or physician (or does it not matter)? *Alternative standard on the same theme* – women of childbearing potential with chronic hypertension treated with ACE inhibitors, ARBs or chlorothiazide, who are not planning a pregnancy should be offered adequate and reliable contraception.	Thank you for your comment. The topic expert group did not feel it necessary to specify who should provide this information, as this would be provided by the professional responsible for their annual review. The topic expert group prioritised the areas of care they felt were most important for women with hypertension in pregnancy, based on the development sources listed. Please

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					refer to the full clinical guideline for detailed summary of the underpinning evidence base for the clinical recommendations on which the quality standard is based.
009	Royal College of Obstetricians and Gynaecologists	Quality statement 2		*General* – this is one of the most important quality statements.	Thank you for your comment.
009	Royal College of Obstetricians and Gynaecologists	Quality statement 3		*Okay*	Thank you.
009	Royal College of Obstetricians and Gynaecologists	Quality statement 4		*General* – appropriate standard but determining whether an integrated package of antenatal care has been provided (in line with table 1 in recommendation 1.4.1.3) will be difficult to determine.	Thank you for your comment. Following a review of feedback from consultation quality statement 4 now focuses on admission of pregnant women with severe hypertension to hospital for a full assessment from a health care professional trained in the management of hypertensive disorders.
009	Royal College of Obstetricians and Gynaecologists	Quality statement 5		*General* – appropriate standard but determining whether an integrated package of antenatal care has been provided (in line with table 2 in recommendation 1.5.1.2) will be difficult to determine.	Thank you for your comment. Following a review of feedback from consultation quality statement 5 now focuses on admission of women with a diagnosis of pre-eclampsia to hospital with daily monitoring.
009	Royal College of Obstetricians and Gynaecologists	Quality statement 6		*General* – the quality statement indicates that 'women with a hypertensive disorder of pregnancy or indications from any previous pregnancy receive timely fetal ultrasound assessment'. The term *'indications from any previous pregnancy'* would include women not covered in this guideline (eg women whose baby was growth restricted in a previous pregnancy and who did not have a hypertensive disorder). The RCOG revision of its Green-top Guideline on 'The	Thank you for your comment. The topic expert group have refined the quality standard following feedback from consultation. The quality statement on fetal monitoring has been removed. The topic expert group prioritised the areas of care they felt were most important for women with hypertension

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				Investigation and management of the Small for Gestational Age Fetus' (about to be published on 15 March 2013) provides comprehensive guidance on risk factors for delivery of a SGA or growth restricted infant, and how these risk factors can be applied to the process of recommending serial ultrasound fetal assessment of growth and wellbeing. Chronic hypertension and/or the development of pre-eclampsia/severe pregnancy hypertension (in the current pregnancy) are 'major' risk factors for a SGA neonate and are indications for serial ultrasound fetal assessment. A past history of pre-eclampsia is a 'minor' risk factor for a SGA neonate and by itself does not indicate ultrasound fetal assessment in the third trimester. Suggest the term *'indications from any previous pregnancy'* be removed or made consistent with the revised RCOG guidance on the SGA fetus. *Draft quality measure* – this section is split in to 4 sub-sections: a) = women with chronic hypertension (section 1.6.1 in NICE guideline 107) b) = women with mild or moderate gestational hypertension (section 1.6.2 in NICE guideline 107) c) = women with severe gestational hypertension or pre-eclampsia (section 1.6.3 in NICE guideline 107) d) = women with indications from any previous pregnancy (this relates to section 1.6.4 in NICE clinical guideline 107; *however* in the guideline the heading is 'women at high risk of pre-eclampsia'. The guideline does not mention growth restriction in a previous pregnancy). Being at high risk of pre-eclampsia *per se* is not an indication for serial ultrasound fetal assessment-some of the risk factors for pre-	in pregnancy, based on the development sources listed, predominantly NICE clinical guideline 107. It remains important that other evidence-based guidance recommendations continue to be implemented, including those on fetal monitoring.

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				eclampsia will justify serial fetal ultrasound assessment (by RCOG revised GTG criteria) whereas others will not. This has the potential to generate a minor degree of conflict between two guidelines and subsequent uncertainty/confusion amongst clinicians. Fully appreciate that the RCOG is not actually published but publication is imminent and the guideline is certainly at the stage where it can be shared with NICE. *Definitions* – we suggest that in this section fetal ultrasound assessment is defined as 'fetal growth and amniotic fluid volume assessment and umbilical artery Doppler velocimetry' to reflect the recommendations in the guideline. *Should a timescale be applied to process measure b)?* – We are not aware of an evidence base for making such a recommendation and hence such a timescale is not suitable as a quality standard. In clinical practice, one aims to obtain an ultrasound within a week of the diagnosis of a hypertensive disorder.	
009	Royal College of Obstetricians and Gynaecologists	Quality statement 7		*General* – the quality statement indicates that women with pre-eclampsia have their babies delivered according to an agreed obstetrician-led plan for the timing and mode of delivery. It is our experience that the decision to arrange delivery in women with pre-eclampsia is based upon many different factors including maternal and fetal wellbeing and the results of various investigations. These factors can change even during the course of a single day. It seems to us that the quality standard is fairly rigid and does not take account of a sometimes rapidly changing situation which may justifiably demand deviation from such an agreed plan. An agreed plan that	Thank you for your comment. The statement has been refined in view of consultation feedback. Definitions for the quality statement on a consultant-led plan have been amended. References to elective birth before 34 weeks in women with pre-eclampsia have been removed. Definitions for the quality statement on a consultant-led plan have been amended. The definitions state that delivery should be according to the most up to date version of the plan.

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				encompasses all reasonable interventions (nature and timing of) would simply read as an exhaustive list of possibilities and not resemble a plan as such. Suggest that the wording of the QS reflects the necessity that such a plan must be fluid rather than rigid. The recommendation in the guideline upon which the quality statement is based (1.5.2.2), relates specifically to elective birth before 34 weeks' in women with pre-eclampsia (this is not reflected in the wording of the QS itself). *Draft quality measure* – the outcome in this quality statement is 'feedback from women who have had pre-eclampsia that they felt sufficiently involved in planning the timing and mode of delivery of their baby'. We are not clear how this relates to the quality statement.	The intent of the statement is for a consultant obstetric-led plan to be developed with multi-disciplinary input as well as input from the woman. This is to enable early input from the consultant obstetrician and to ensure identification of other professionals required to provide input. A rationale has been added for the statement which highlights that the plan should be updated as needed. The definition of the plan states that birth should be according to the most up-to-date version of the plan. The outcome measure reflects involvement of the woman in developing the plan. The rationale clarifies the intent for women to be involved in agreeing their plan.
009	Royal College of Obstetricians and Gynaecologists	Quality statement 8		*General* – the quality statement states 'women who have severe pre-eclampsia with complications have their condition managed in level 2 critical care within 2 hours of identification'. We could find no timescales in the guideline recommendations (1.8.7.1) or in the text of the full guideline (section 10.8, page 178). Whilst we think that 'within 2 hours' would be ideal, this may not be feasible for women initially managed for example in smaller units or in midwifery units in rural and remote locations. We suggest that the wording is changed to '...level 2 critical care *ideally* within 2 hours of identification'. In many such acute situations it may be better to stabilise the woman (ie administer antihypertensive medication and administer magnesium suphate) and then transfer;	Thank you for your comment. Following feedback from consultation this statement has been removed. Other quality statements are intended to support identification and management, including quality statement 4 on assessment of severe hypertension, quality statement 5 on admission of women with pre-eclampsia and quality statement 6 on early consultant input.

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				it could be detrimental to encourage a hastening of transfer prior to stabilisation of the maternal condition which would of course be contrary to the intended consequence of the QS.	
009	Royal College of Obstetricians and Gynaecologists	Quality statement 9		General – we believe that this is one of the most important quality statements (communication issues between primary and secondary care were highlighted in chapter 14 of the 2006 – 2008 Saving Mothers' Lives report). As such we suggest that this quality statement should include a timescale for the communication to happen.	Thank you for your comment. The topic expert group discussed whether a timescale should be added. It was agreed that communication should happen at the time the woman is transferred to community care. The intent is that the information would be communicated effectively without delay.
009	Royal College of Obstetricians and Gynaecologists	Quality statement 10		*General* – this quality statement indicates that women who have had gestational hypertension or pre-eclampsia have a discussion about future related risks, and how to mitigate them at a 6-8 week postnatal medical review. In subsequent sections of this statement, there are good data on future risks of women developing gestational hypertension and pre-eclampsia. We know that these risks can be reduced by prescribing 75mg of aspirin in future pregnancies. However, this quality statement also mentions future related risks, including in the section *'Definitions'*, the increased risk of developing high blood pressure and its complications in later life. We are concerned that at present it is unclear how to mitigate the risks of subsequent cardiovascular and renal disease. In the full version of the clinical guideline, this is discussed at length. The guideline development group found no evidence to support interventions (pharmacological or lifestyle) or to support frequency of follow up (including blood pressure monitoring).	Thank you for your comment. This quality statement has been refined in view of consultation comments. It now reads 'Women who have had gestational hypertension or pre-eclampsia discuss future pregnancy and lifetime cardiovascular risks during a medical review at their 6–8 week postnatal medical check'. The definitions section sets out that women who have had gestational hypertension or pre-eclampsia should be told that these conditions are associated with an increased risk of developing high blood pressure and its complications in later life. A rationale has now been provided for this statement which highlights the risk of women developing high blood pressure and an increase in lifetime cardiovascular risk. The topic expert group consider that increased

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				We therefore suggest that the quality statement should reflect the guideline recommendations: *'Women who have had gestational hypertension or pre-eclampsia have a discussion about the risks of developing a hypertensive complication in a future pregnancy and how to mitigate them, at a 6-8 week postnatal medical review. Women should also be informed that gestational hypertension and pre-eclampsia are associated with an increased risk of developing cardiovascular and renal disease in later life'.*	surveillance for hypertension in this group may lead to earlier intervention, usually with antihypertensives, which is known to reduce the risk of future cardiovascular disease..
010	Royal College of Paediatrics and Child Health	General		Unlike other NICE guidance this document is silent on the importance of supporting breast feeding, and upon being alert to risk factors and requirements to monitor babies after birth.	Thank you for your comment. These are important issues for consideration. The quality standard should be used in the context of other quality standards, including the postnatal care quality standard.
012	Royal College Of Physicians (RCP)	Quality statement 2		Our experts believe that the use of the word 'prescribed' is very limiting and implies that the standard could be failed unless a prescription is issued. However, it would be acceptable (and potentially cheaper) for trusts and GPs to recommend over the counter low dose aspirin. We suggest that the wording is changed to say 'are advised to take or be prescribed'	Thank you for your comment. The wording of the quality statement has been amended.

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012	Royal College Of Physicians (RCP)	Quality statement 3		This recommendation may need to be ammended when the results of the CHIPS (Control of Hypertension In Pregnancy Study) are published later this year	Thank you for your comment. Publication of an RCT will not automatically trigger the update of a quality standard. A quality standard would be updated if the underpinning guidance was updated. Otherwise, quality standard will be reviewed for update every five years.
012	Royal College Of Physicians (RCP)	Quality statement 5		Receive integrated package of antenatal care. In the event of complications of pre-eclampsia developing, we strongly believe that this statement should include the stipulation that appropriately trained obstetric, medical and anaesthetic specialists are available to advise regarding management.	Thank you for your comment. Following a review of feedback from consultation quality statement 5 now focuses on admission of women with a diagnosis of pre-eclampsia to hospital. This will include daily monitoring of women as part of a package of integrated care, as recommended in NICE clinical guideline 107.
012	Royal College Of Physicians (RCP)	Quality statement 8		As above. In the event of complications of pre-eclampsia developing, we strongly believe that this statement should include the stipulation that appropriately trained obstetric, medical and anaesthetic specialists are available to advise regarding management. Without appropriate expertise (both midwifery and medical) being available there is no point in transferring a woman to a level 2 HDU. With regard to the specific question to stakeholders, we believe that 2 hours is a reasonable target.	Thank you for your comment. Following feedback from consultation this statement has been removed. Other quality statements are intended to support identification and management, including quality statement 4 on assessment of severe hypertension, quality statement 5 on admission of women with pre-eclampsia and quality statement 6 on early consultant input.
006	The Royal College of Anaesthetists	Background		Please note that the Royal College of Anaesthetists can only comment on Draft Statements 7 (Intrapartum Care) and 8 (Critical Care). The rest of the document is not relevant to anaesthesia, critical care or pain management.	Thank you for your comment.
006	The Royal College of Anaesthetists	Quality Statement 7		On this statement our members feel that, due to possible fluctuations in hypertension and coagulability	Thank you for your comment.

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				status associated with the condition, it may be necessary to modify previously agreed modes of pain relief during delivery and/or of anaesthetics used in case of a surgical delivery, and that this should be discussed with the patient. The paragraph on healthcare professionals on page 19, could be rephrased to better represent the need for a multi-specialty approach, including, in particular, anaesthesia and pain management.	The statement has been refined in view of consultation feedback. Definitions for the quality statement on a consultant-led plan have been amended. The definitions state that delivery should be according to the most up to date version of the plan. The intent of the statement is for a consultant obstetric-led plan to be developed with multi-disciplinary input as well as input from the woman. This is to enable early input from the consultant obstetrician and to ensure identification of other professionals required to provide input. The definition has been updated to highlight that input could include from other specialists.
006	The Royal College of Anaesthetists	Quality Statement 8		Members of the Royal College of Anaesthetists are generally very concerned about the 'two hours limit' and think that this is far too long a period of time for initiation of the management of severe pre-eclampsia from identification. They are also concerned about the wording of the statement, which seems to suggest that the management of severe pre-eclampsia can wait up to two hours, until the patient is moved to a critical care unit. Two hours may be acceptable if the condition is managed with appropriate medications immediately after identification and during transfer, or in particular circumstances involving transfers from a home birth location or from an isolated midwifery led unit. Given that many units in labour wards provide level 2 care, the statement could be reworded as follows: "Women who have severe pre-eclampsia with complications have their condition managed in level 2 critical care within an absolute maximum of two hours of identification and initiation of treatment".	Thank you for your comment. Following feedback from consultation this statement has been removed. Other quality statements are intended to support identification and management, including quality statement 4 on assessment of severe hypertension, quality statement 5 on admission of women with pre-eclampsia and quality statement 6 on early consultant input.

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				Some members have pointed out that there does not seem to be any mention of the Maternity Early Obstetric Warning Scoring system (MEOWS) in the document. MEOWS is an indispensible tool to identify potential problems with a woman's clinical condition and should identify mothers with pre-eclampsia before complications occur. This would allow blood pressure control to be instigated from the early stages of labour; consequently the patient should be managed in a suitable area in the maternity unit where provision to level 2 care would be readily available. Some members feel that this is an even more important issue than the debate over the maximum time allowed to get the patient to a level 2 critical care unit, as the use of such a scoring system and consequent warnings would pre-empt the need for a potentially dangerous emergency transfer. Members also expressed concern on the recommendation "Physiological observations should be monitored at least every 12 hours..." on page 22 and believe this to be an entirely inadequate level of monitoring for patients with this condition.	
003	The Royal College of Midwives	General		The RCM consider all the quality statements to be important, however if the number of statements have to be limited, we recommend the following as the most important 1 Women of childbearing potential with treated chronic hypertension are given information at each annual review about safe antihypertensive treatment during pregnancy. 2 Pregnant women at increased risk of pre-eclampsia	Thank you for your comment, which was taken into account by the TEG when producing the final version of the quality standard.

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				at the booking appointment are prescribed 75 mg of aspirin to take daily from 12 weeks until 37 weeks. 3 Pregnant women with chronic hypertension have a blood pressure target set at below150/100mmHg if they have uncomplicated hypertension or below 140/90mmHg if they have target organ damage. 7 Women with pre-eclampsia have their babies delivered according to an agreed consultant obstetrician-led plan for the timing and mode of delivery. 9 Women who have had a hypertensive disorder of pregnancy have information about their condition sent to their primary care clinician when they are transferred to community care after the birth. 10 Women who have had gestational hypertension or pre-eclampsia have a discussion about future related risks, and how to mitigate them at a 6–8 week postnatal medical review	
003	The Royal College of Midwives	General Outcome measures Data source		'Local data collection' is a very unclear option, we think it is important to be more directive about anticipated methods of data collection. Not all maternity units have systems in place that will enable them to use the Maternity Services Secondary Uses Dataset.	Thank you for your comment. Measures associated with quality standard statements are intended for local use or adaptation. Suggested data sources are not definitive sources of data to support quality measures but are examples of existing national data collection which may be relevant, in part at least, to the quality measure. It is expected that local data sources and audits where appropriate will be considered in order to measure the quality statements in full.

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003	The Royal College of Midwives	Quality statement 2		'Pregnant women at increased risk of pre-eclampsia at the booking appointment are prescribed 75 mg of aspirin to take daily from 12 weeks until 37 weeks.' This statement should include the clause 'unless contraindicated'.	Thank you for your comment. This is covered in quality measure b, for which the denominator is the number of pregnant women at increased risk of pre-eclampsia and without contraindications to aspirin at the booking appointment.
003	The Royal College of Midwives	Quality statement 9		'Women who have had a hypertensive disorder of pregnancy have information about their condition sent to their primary care clinician when they are transferred to community care after the birth' This statement should be clearer about which clinician the care is being transferred to. The GP will not be responsible for immediate care, when the woman is transferred, as implied in this description. This will be the responsibility of the community midwife.	Thank you for your comment. The topic expert group have refined the quality statement in view of consultation feedback. The topic expert group considered that it would be important for the general practitioner to be aware of conditions during pregnancy and ongoing antihypertensive management plans.
005	The Royal College of Radiologists	Quality Statement 6		Quality statement 6 includes ultrasound monitoring of fetal growth and well being and as stated is less than we currently do at Birmingham Women's Hospital. This may increase scanning for some departments but if not already provided will improve standards of care.	Thank you for your comment. The topic expert group have refined the quality standard following feedback from consultation. The quality statement on fetal monitoring has been removed.