National Institute for Health and Clinical Excellence

Quality Standards Hypertension in Pregnancy

Minutes of the TEG 2 meeting held on 23rd November at the NICE offices in Manchester

Attendees	**Topic Expert Group Members** David Williams (DW), Moira Mugglestone (MM), Jason Waugh (JW), Jenny Myers (JM), Judy Shakespeare (JS), Anne Marie Barnard (AMB), Chloe Bayfield (CB), Frances Garraghan (FG), Felicity Plaat (FP), Anthony Emmerson (AE), Lynda Mulhair (LM) **NICE Staff** Michelle Gilberthorpe (MG), Tony Smith (TS), Tim Stokes (TSt), Lisa Nicholls (LN) **External Attendees** Azim Lakhani (AL) (Head of Clinical Analysis Research and Development, Health and Social Care Information Centre)

Agenda item	Discussions and decisions	Actions
1. Welcome, introductions and plan for the day	DW welcomed the attendees, noted the apologies and outlined the agenda for the day. The group reviewed the minutes from the TEG 1 meeting held on 21st August. Group agreed as accurate recording.	
2. Declaration of Interest	DW asked the group whether they had any new interests to declare since the last meeting.	TEG to send any new declarations to LN
3. Objectives of the meeting	DW outlined the objective for the day: to discuss and agree the wording of the draft quality statements and measures, which will go out to consultation. DW explained that the group was tasked with developing a small number of key evidence-based statements that focus on high quality care and identify critical markers of challenging but achievable care to drive up quality.	
4. Review of process for developing the quality standard	TS reviewed the process for developing the quality standard (QS) and core principles for development, including their purpose to pick out only critical markers for improvement. He emphasised the need for clear, focused, measurable quality statements and reminded the group that the statements must be aspirational but achievable. It was also stated that the statements need to be in plain English. TS noted the quality standard will be informed by recommendations from accredited guidance only and should focus on quality improvement. He also asked the group to highlight any equality issues relating to each statement to the NICE team during the meeting as part of the ongoing equality impact assessment for the quality standard. TS also mentioned that this topic would cover more than one population (chronic hypertension, gestational hypertension and pre-eclampsia) across the pathway and had the potential for women to move between populations. MG reiterated that the objective of this meeting was to decide which statements should be progressed for consultation, and the wording and	

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	intent of these statements. MG gave an overview and re-cap to date and said the briefing paper would be the main document for today. MG presented the areas of care agreed at the first TEG meeting for potential draft statements and discussed the provisional prioritisation of recommendations. MG reminded the group of the key development sources agreed for consideration in the provisional prioritisation of recommendations. MG reminded the TEG that each statement or concept should be person - focused. MG confirmed that the TEG would have opportunity to comment on the draft version of the QS prior to consultation.	
5. Draft quality statements (QS) and quality measures (QM) • Presentation • Discussion • Agreement	There followed a review of draft quality statements to agree the intent of the statements, and to consider the wording of proposed statements in line with evidence from clinical guidelines. **Draft Quality Statement 1: 'Women with chronic hypertension [of child bearing age] who are being treated with antihypertensive drugs are given information about safe antihypertensive treatment in pregnancy before they become pregnant.** Discussion included how to specify the population, and the setting and frequency for the provision of information. A revision of the wording was agreed (subject to alignment with other QS statements by the NICE team). The TEG agreed to remove 'before they become pregnant' as not all pregnancies were planned and they felt women should be given this advice at each annual review to keep them informed. **Revised Draft Quality Statement 1: 'Women with chronic**	MG to update statement wording. MG to define child bearing age in definitions. Check with wording of Epilepsy QS 10 and Diabetes QS7 which refers to child bearing age.

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	hypertension of child bearing age who are being treated with antihypertensive drugs are given information at each annual review about safe antihypertensive treatment in pregnancy'.	
	Draft Quality Statement 2: 'Pregnant women at risk of pre-eclampsia with chronic hypertension should have their proteinuria estimated at each antenatal care appointment in a secondary care setting using an automated reagent-strip reading device or a spot urinary protein:creatinine ratio'. The TEG agreed the intent of this statement was around the identification of women who are at high risk of pre-eclampsia, and that it should focus on blood pressure and proteinuria testing, rather than the method or the clinical setting. It was agreed the measure should include the number of appointments in the denominator rather than the number of women. The method of testing should be included in the definitions section. Subject to confirmation of underlying evidence, a revision of the wording was agreed: **Revised Draft Quality Statement 2: 'All pregnant women should have their blood pressure measured and proteinuria estimated at each antenatal contact'.**	MG to update wording of statement. NICE to check if can include 'all women' in statement. Check guideline supports including blood pressure check as well as proteinuria.
	Draft Quality Statement 3: 'Pregnant women with chronic hypertension are targeted to a blood pressure of below 150/100mmHg if they have uncomplicated chronic hypertension, or below 140/90mmHg if they have target organ damage secondary to chronic hypertension; The TEG agreed that target blood pressure was important for all women with hypertensive disorders of pregnancy (not just chronic hypertension). It was agreed to include the lower BP range in the revised statement to reflect the guideline recommendation.	MG to update statement wording.

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	Subject to alignment with the guidance, including confirmation of the lower limit from the clinical guideline a revision of the wording was agreed: The TEG did not feel that the type of monitoring (clinic, ABPM etc) needed to be specified. **Revised Draft Quality Statement 3: 'Pregnant women with hypertension should have a documented target blood pressure range of between 130/80 - 150/100mmHg if they have uncomplicated hypertension, or below 140/90mmHg if they have target organ damage'.**	
	Draft Quality Statement 4: Pregnant women at high risk of pre-eclampsia at the booking appointment are offered a prescription of 75 mg of aspirin to take daily from 12 weeks until at least 36 weeks **OR** **Pregnant women with more than one moderate risk factor for pre eclampsia (at the booking appointment) are offered a prescription of 75 mg of aspirin to take daily from 12 weeks until at least 36 weeks.** Discussion was based around the fact that the use of aspirin for high risk of pre-eclampsia is included in the antenatal care quality standard. The TEG questioned whether all increased risk groups were sufficiently captured under the antenatal care 'high risk' statement. The TEG agreed that it would prefer the statement to cover women who have more than one moderate risk factor. The TEG discussed combing both statements but decided to amend the second option. The TEG agreed to capture those at increased risk, including one high	MG to amend statement wording. NICE to consider issues around proposed statement in relation to the statement in the antenatal care QS.

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	risk factor or more than one moderate risk factor ('at increased risk' to be defined). **Revised Draft Statement 4: Pregnant women at increased risk of pre-eclampsia at the booking appointment are offered a prescription of 75 mg of aspirin to take daily from 12 weeks until at least 36 weeks.**	
	Draft Quality Statement 5: **'Women with gestational hypertension are offered a (documented) integrated package of care covering admission to hospital, treatment, measurement of blood pressure, testing for proteinuria and blood tests'.** The TEG agreed that the intent of this statement was on making sure that clinical teams were offering the right care at specific stages. The emphasis was on the delivery of care, not the documenting of care delivery (therefore 'documented' was removed in the revised wording). The TEG asked the NICE team to define integrated package of antenatal care and include NICE guidance table in the measures/ definitions. The TEG discussed merging statements 5 and 6 (since both refer to packages of care) but because they cover different populations, and are described separately in the clinical guideline, the TEG agreed they should be progressed as separate draft quality standards for consultation. The revised wording agreed was: **Revised Draft Quality Statement 5: 'Women with gestational hypertension are offered an integrated package of antenatal care in accordance with NICE guidance'.**	MG to update statement. Define integrated package of antenatal care and include NICE guidance table in measures/ definitions.
	Draft Quality Statement 6: 'Women with pre-eclampsia are offered a (documented) integrated package of care covering admission to hospital, treatment, measurement of blood pressure, testing for proteinuria and blood tests'.	MG to update statement 6 to reflect revised statement 5.

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	Discussion on drafting a statement about packages of care was similar to statement 5. The revised wording agreed was: **Revised Draft Quality Statement 6: 'Women with pre-eclampsia are offered an integrated package of antenatal care in accordance with NICE guidance'.**	
	Draft Quality Statement 7: 'Pregnant women assessed to be at high risk of severe gestational hypertension or pre-eclampsia are offered ultrasound fetal growth and amniotic fluid volume assessment and umbilical artery doppler velocimetry starting at between 28 and 30 weeks, or at least 2 weeks before previous gestational age of onset if earlier than 28 weeks, which is repeated 4 weeks later'. The TEG agreed that the intent was to draft a statement on fetal health associated with the risk of pre-eclampsia. The TEG felt the statement should be simplified, with methods of assessment covered in definitions. Indication for assessments earlier than 28 weeks would also be covered in definitions. The TEG proposed the following revised wording, with 'increased risk of pre-eclampsia' to be defined in a manner consistent with previous statements: **Revised Draft Quality Statement 7: 'Pregnant women at increased risk of pre-eclampsia are offered a fetal ultrasound assessment starting at between 28 and 30 weeks or earlier if indicated'.**	MG to update statement wording. Define fetal ultrasound assessment, indications for assessment before 28 weeks, and 'increased risk of pre-eclampsia'.
	Draft Quality Statement 8: 'Women with pre-eclampsia have consultant obstetrician-defined thresholds documented in their notes for the timing [and mode] of delivery based on maternal and fetal thresholds of clinical, biochemical and haematological parameters'. The TEG agreed to change the heading of this statement from 'intrapartum care' to 'planning for delivery'. The TEG felt the key concept for this statement was having a plan in	MG to change heading of statement and wording of statement. Add type of plan

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	place and having a senior person responsible. The statement could be simplified, with reference to thresholds and parameters moved to definitions if required. The TEG agreed that the statement should recognise a pregnant woman's involvement in planning her delivery, by referring to an 'agreed' plan. The TEG agreed the obstetrician-led plan should involve the MDT and the pregnant woman. Measures should refer to the most up to date plan. The revised wording agreed was: **Revised Draft Quality Statement 8: 'Women with pre-eclampsia should have their babies delivered according to an agreed consultant obstetrician-led plan for the timing and mode of delivery'.**	in measures. Include reference to MDT in definition/ Measures.
	Draft Quality Statement 9: 'Women with severe hypertension or severe pre-eclampsia who are having their condition managed in a critical care setting and have, [or previously have had] an eclamptic fit, should be offered intravenous magnesium sulphate'. The TEG considered that a quality statement should be included about critical care of pre-eclampsia. They felt a statement should focus on triggers for early warning, perhaps drawing on guidance around critically ill adults. The TEG asked NICE to draft a revised statement to focus on the immediate treatment (within 2-3 hours) of critically ill women, (identified through 'track and trigger'), managed by an MDT (to include a consultant obstetrician and consultant obstetric anaesthetist). The TEG emphasised that the level of critical care was the key quality	NICE to draft a revised statement and discuss with DW. Definitions to cover identification / triggers and MDT

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	issue for the statement, rather than the actual care setting. **Revised Draft Quality Statement 9: *To be worded by NICE team and agreed with the TEG***	
	Draft Quality Statement 10: 'Women with gestational hypertension or pre-eclampsia who have given birth and are being transferred to community care have the risk of developing high blood pressure and its complications in later life communicated to them and their primary care clinician'. TEG felt the key quality issue was to inform GPs about patients having had a hypertensive disorder of pregnancy to support post natal management after hospital discharge. The TEG agreed to define 'after birth' in the definitions'. The TEG felt 'Information about their condition' should include risks of developing high blood pressure and its complications in later life, which will be defined in the definitions section. The revised wording agreed was: **Revised Draft Quality Statement 10: '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 birth'.**	MG to update statement wording. Define 'after birth' in definitions. Define 'Information about their condition'. In definitions.

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	Draft Quality Statement 11: 'Women who have had gestational hypertension or pre-eclampsia are advised about their risks of developing gestational hypertension or pre-eclampsia in a future pregnancy'. The TEG agreed to change the wording 'from advised about risks' to 'offered a discussion'. The TEG proposed revisions to this statement, adding 'how to mitigate risks', and specifying when the advice should be given (at '6 week postnatal review'). The revised agreed wording was: **Revised Draft Quality Statement 11: 'Women who have had gestational hypertension or pre-eclampsia are offered a discussion of future related risks, and how to mitigate them, at the 6 week postnatal review '.**	MG to update statement wording. Define 'future related risks' in definitions section.
6. Other guideline recommendations potentially suitable for QS development	The TEG agreed that recommendations**.** 1.10.1.1, 1.5.3.8 and1.4.3.5 from CG127 should be considered for revised draft statement 10. The NICE technical team agreed to consider additional potential guidance for revised statement 9.	MG to action
7. Consultation on the draft QS	MG outlined the consultation process and advised the group that only registered stakeholders can comment on the draft QS. Organisations can express an interest to register as a stakeholder. MG explained the process around endorsement partners.	
8. Next steps and AOB	MG outlined the next steps, including key dates in the QS development process, and asked the group to hold time in their diaries to comment during the relevant periods. DW thanked the group and closed the meeting.	