NHS
National Institute for
Health and Clinical Excellence

Hypertension in Pregnancy, Quality Standard Topic Expert Group

Minutes of the TEG3 meeting held on 21st March 2013 at the NICE Manchester Office

Attendees	David Williams (DW, chair), Chloe Bayfield (CB), Anthony Emmerson (AE), Frances Garraghan (FG), Moira Mugglestone (MM), , Jenny Myers (JM), Felicity Plaat (FP), Judy Shakespeare (JS), Jason Waugh (JW) **NICE Staff** Michelle Gilberthorpe (MG), Tony Smith (TS), Paula Prior (PP), Lee Berry (LB) **Observers** Elizabeth Fleming (NICE), Lisa Hinton (Oxford University)
Apologies	Anne Marie Barnard, Lynda Mulhair

Agenda item	Discussions and decisions	Actions
1. Introductions and apologies, minutes of last meeting	DW welcomed the attendees, noted the apologies and reviewed the agenda for the day. The group confirmed that the minutes from the meeting held on 23rd November 2012 were an accurate record.	
Declarations of interest	DW asked the group whether they had any new interests to declare since the last meeting and none were declared.	
2. Review of progress so far and objectives of the day	TS reviewed the progress made on the quality standard (QS) so far. He advised the group that the main objectives of the day were to discuss the results of the consultation and agree the quality statements and associated measures for progression into the final QS. TS reminded the group that the QS should only consist of aspirational statements addressing key areas of quality or variations in care. The group was also reminded that the QS should be as concise as possible and should not include anything that is standard practice. TS reminded the TEG that further changes may be made to the QS after the meeting, including changes from ongoing discussion with the TEG Chair and NICE quality assurance ahead of publication. TS confirmed that the group will have the opportunity to see and comment on the final version of the QS before publication.	
3. Support for commissioners and others using the quality standard	PP outlined the role of the NICE Costing and Commissioning team which would develop a support document for commissioners and other users to accompany the QS. She stated that the purpose of this document is to help commissioners and service providers consider the commissioning implications and potential resource impact of using the QS. PP advised the group that they may need to provide input during its development, and that they will have the opportunity to comment on the document. PP asked the group to contact her if they have any questions or would like to contribute.	TEG members to contact PP if they would like to contribute to the commissioning document.

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4. Presentation and discussion of consultation feedback	MG gave a brief overview of the consultation comments received. There had been positive feedback and suggestions for amendments to the QS. MG advised the group that they would consider statement-specific comments received from the consultation as they discussed each statement. MG noted that responses to comments received from registered stakeholders will be published on the NICE website alongside the final quality standard.	
5. Presentation, discussion and agreement of final statements	MG presented each of the statements and the responses to them from the stakeholders. The group discussed each statement and the feedback in turn. The group suggested an introductory separate page of definitions. **Statement 1 - Women of childbearing potential with treated chronic hypertension are given information at each annual review about safe antihypertensive treatment during pregnancy.** The group agreed to remove 'chronic' and use 'pre-existing' as chronic is only used when it refers to pregnancy and this statement is aimed at pre-pregnancy advice. They considered whether this should be included at every annual review, and agreed that the statement should say 'annually'. It was considered whether this was covered by statement 5 of the patient experience (PE) quality standard; however the TEG agreed that while statement 5 of the PE QS covered general information this was a specific issue for hypertension in pregnancy and a statement was required. The TEG agreed to keep this statement as they felt it was important given that certain drugs are teratogenic. **Revised statement - Women of childbearing potential with treated hypertension are given information annually about safe antihypertensive treatment during pregnancy** **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.**	MG to consider presentation of definitions in final QS.

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	The TEG agreed this was an important statement. They discussed the wording and agreed to change 'prescribed' to 'advised to take' to be in line with the guideline, and also to recognise that aspirin may be purchased over the counter. The group advised that there were no contraindications to continuing after 37 weeks and therefore to change this to 'until birth' to be in line with the guideline. **Revised statement - Pregnant women at increased risk of pre-eclampsia at the booking appointment are advised to take 75 mg of aspirin daily from 12 weeks until birth** **Statement 3 - Pregnant women with chronic hypertension have a blood pressure target set at below 150/100mmHg if they have uncomplicated hypertension or below 140/90mmHg if they have target organ damage.** The TEG agreed a rewording to include 'hypertension in pregnancy' to would cover all types of hypertensive disorder including chronic hypertension, gestational hypertension and pre-eclampsia. The group agreed this was an important statement and was referring to the actual aspirational target levels, not individual measurement. The statement would not cover methods of measuring blood pressure. **Revised statement - Women with hypertension in pregnancy have a blood pressure target set below 150/100mmHg or, if they have end organ damage, below 140/90mmHg** **Statement 4 - Women with gestational hypertension receive an integrated package of antenatal care.** The TEG agreed that this should not be included in the final QS. Gestational hypertension is mainly benign and it was agreed that no specific element of the care plan justified a QS statement. **Statement 5 - Women with pre-eclampsia receive an integrated package of antenatal care.** The group considered feedback from stakeholders asking what was covered by the care package. The group agreed that the most	

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	important part of this care plan was to admit to hospital until birth. The group felt this would ensure that all the other parts of the care plan would be delivered. It was felt this would also improve accurate diagnosis and would be aspirational. **Revised statement - Women with confirmed pre-eclampsia are admitted to hospital until birth** **Statement 6 - Women with a hypertensive disorder of pregnancy or indications from any previous pregnancy receive timely fetal ultrasound assessment.** The group agreed to remove this statement because it mostly reflects current practice. **Statement 7 - Women with pre-eclampsia have their babies delivered according to an agreed consultant obstetrician-led plan for the timing and mode of delivery.** The TEG agreed to reword the statement to ensure it was clear that the plan was flexible and based on agreement with the pregnant woman and from the wider clinical team including the consultant obstetrician. The group also agreed to remove 'babies delivered' to ensure flexibility in planning for women's needs. The TEG agreed that early consultant obstetrician involvement in planning the mode and timing of delivery is an important part of care for women with pre-eclampsia, **Revised statement - Women with confirmed pre-eclampsia have an agreed consultant obstetrician-led plan for the timing and mode of delivery** **Statement 8 - Women who have severe pre-eclampsia with complications have their condition managed in level 2 critical care within 2 hours of identification.** The TEG felt this was a very important concept, but agreed that specifying a timescale could be dangerous as in some cases immediate critical care is essential. They noted that level 2 critical	

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	care wasn't a place, but a combination of interventions based upon individual women's needs. The TEG discussed several options in relation to this area and felt that pregnant women with severe hypertension should be admitted and receive a full assessment, from which any specific needs would be covered. The TEG agreed it was important to specify that this should be delivered by a health care professional trained in the management of hypertensive disorders. **Revised statement - Pregnant women with severe hypertension are admitted for a full assessment by a health care professional trained in the management of hypertensive disorders** **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.** The group agreed this concept was over and above statement 12 of the PE quality standard. They agreed that this was a significant area for improvement as postnatal care of hypertension is very poor, and women who have had a hypertensive disorder of pregnancy are at high risk of stroke. The group felt that this should be a specific statement within the hypertension in pregnancy quality standard, beyond the draft statement on care planning within the postnatal quality standard recently consulted on. The group agreed that this should specify general practitioners, and more broadly the community team; this to be defined within the definitions section to include community midwives and health visitors. **Revised statement - Women who have had a hypertensive disorder of pregnancy have a plan for ongoing antihypertensive management communicated to their general practitioner when they are transferred to community care after the birth** **Statement 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.** The TEG agreed that this quality statement should be retained within	

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	the standard and discussed which risks should be referred to. They agreed the focus was future risks of pregnancy and lifetime cardiovascular risk. The TEG agreed that this needed to be a medical review at 6-8 weeks, but this could be carried out by an appropriately trained midwife. **Revised statement - Women who have had gestational hypertension or pre-eclampsia have a discussion about future pregnancy and lifetime cardiovascular risk, and how to reduce them, at a 6–8 week postnatal medical review**	
8. Summary of final statements	MG presented a summary of the revised statements to the TEG. The TEG discussed these further and rearranged the order of the statements. MG reminded the TEG that further work would take place to develop and refine the quality statements following the meeting.	
9. Equality impact assessment	MG advised the group that an equalities impact assessment would be completed, for the following reasons: • To confirm that equality issues identified have been considered and appropriately addressed. • To ensure that the outputs do not discriminate against any of the equality groups • To highlight planned action relevant to equality • To highlight areas where statements may promote equality. The TEG was asked to highlight any potential equalities issues. It was flagged that some women may not wish to be admitted to hospital and this may relate to a specific equality characteristic; this will be explored further and addressed in the EQIA.	TEG to flag and equality issues with the technical team
10. Next steps	LB outlined the next steps, including key dates in the QS development process. He advised the dates for the group to review the amended standard and advised of the next meeting for indicator development.	
11. AOB	DW thanked the group for their hard work and closed the meeting.	