

Chronic kidney disease in adults

Quality standard

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Contents

Quality statements	3
Quality statement 1: Identification and monitoring	4
Quality statement.....	4
Rationale	4
Quality measures.....	4
What the quality statement means for different audiences.....	6
Source guidance.....	7
Definitions of terms used in this quality statement	7
Quality statement 2: Blood pressure control	10
Quality statement.....	10
Rationale	10
Quality measures.....	10
What the quality statement means for different audiences.....	12
Source guidance.....	13
Definitions of terms used in this quality statement	13
Quality statement 3: Statins for people with CKD	15
Quality statement.....	15
Rationale	15
Quality measures.....	15
What the quality statement means for different audiences.....	17
Source guidance.....	18
Definitions of terms used in this quality statement	18
Update information	20
About this quality standard	21
Resource impact.....	21
Diversity, equality and language.....	22

This standard is based on NG203 and NG238.

This standard should be read in conjunction with QS72, QS15, QS13, QS66, QS76, QS87, QS100, QS99, QS6 and QS195.

Quality statements

Statement 1 Adults with, or at risk of, chronic kidney disease (CKD) have eGFRcreatinine and albumin:creatinine ratio (ACR) testing at the frequency agreed with their healthcare professional. **[2011, updated 2017]**

Statement 2 Adults with CKD have their blood pressure maintained within the recommended range. **[2011, updated 2017]**

Statement 3 Adults with CKD are offered atorvastatin 20 mg. **[new 2017]**

In 2017, this quality standard was updated, and statements prioritised in 2011 were updated (2011, updated 2017) or replaced (new 2017). For more information, see [update information](#).

The [previous version of the quality standard for chronic kidney disease](#) is available as a pdf.

Quality statement 1: Identification and monitoring

Quality statement

Adults with, or at risk of, chronic kidney disease (CKD) have eGFRcreatinine and albumin:creatinine ratio (ACR) testing at the frequency agreed with their healthcare professional. [2011, updated 2017]

Rationale

Routine monitoring of key markers of kidney function for adults with, or at risk of, CKD will enable earlier diagnosis and early action to reduce the risks of CKD progression, such as cardiovascular disease, end-stage kidney disease and mortality.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local systems that invite adults with, or at risk of, CKD to have eGFRcreatinine and ACR testing.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, through local protocols on appointment reminders.

Process

a) Proportion of adults with CKD who had eGFRcreatinine testing in the past year.

Numerator – the number in the denominator who had eGFRcreatinine testing in the past year.

Denominator – the number of adults with CKD.

Data source: CVD Prevent's indicator CVDP006CKD reports the percentage of people aged 18 and over with GP recorded CKD (G3a to G5), with a record of an eGFR test in the preceding 12 months.

b) Proportion of adults with CKD who had ACR testing at the frequency agreed with their healthcare professional.

Numerator – the number in the denominator who had ACR testing at the frequency agreed with their healthcare professional.

Denominator – the number of adults with CKD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records. NHS Digital's indicator no longer in QOF (INLIQ) CKD004 reports the percentage of patients on the CKD register whose notes have a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 12 months.

c) Proportion of adults at risk of CKD who had eGFRcreatinine testing at the frequency agreed with their healthcare professional.

Numerator – the number in the denominator who had eGFRcreatinine testing at the frequency agreed with their healthcare professional.

Denominator – the number of adults at risk of CKD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records.

d) Proportion of adults at risk of CKD who had ACR testing at the frequency agreed with their healthcare professional.

Numerator – the number in the denominator who had ACR testing at the agreed frequency.

Denominator – the number of adults at risk of CKD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records.

Outcomes

a) Prevalence of undiagnosed CKD.

Data source: NHS Digital's Quality and Outcomes Framework indicator CKD005 reports the prevalence of patients aged 18 or over with CKD with classification of categories G3a to G5 registered at GP practices. Comparing recorded prevalence with expected prevalence estimated using a tool, such as Public Health England's CKD prevalence model, can give an indication of local prevalence of undiagnosed CKD. CVD Prevent's indicator CVDP002CKD reports the percentage of GP registered people aged 18 and over, with 2 low eGFRs with no GP recorded CKD (G3a to G5) and indicator CVDP003CKD reports the percentage of GP registered patents aged 18 and over, where the latest eGFR reading is low with no GP recorded CKD (G3a to G5).

b) Stage of CKD at diagnosis.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records.

What the quality statement means for different audiences

Service providers (such as general practices and secondary care services, including renal, cardiology, diabetes and rheumatology clinics) ensure that systems are in place to identify adults with, or at risk of, CKD, for example, through computerised or manual searching of medical records, and offer an appointment to discuss with them how frequently they should have eGFRcreatinine and ACR testing. They also have systems in place to offer appointments for testing at the agreed frequency.

Healthcare professionals (such as GPs, nephrologists, cardiologists, diabetologists, rheumatologists, nurses and pharmacists) discuss and agree the frequency of eGFRcreatinine and ACR testing with adults who have, or at risk of, CKD and offer testing

at the agreed frequency. They can then agree any appropriate treatment based on the results of testing.

Commissioners ensure that they commission services in which adults with, or at risk of, CKD have eGFRcreatinine and ACR testing at the frequency agreed with their healthcare professional. They might do this by checking that services have systems in place to identify adults with, or at risk of, CKD and offer appointments to discuss and agree the frequency of eGFRcreatinine and ACR testing.

Adults who have, or may be at risk of, CKD discuss and agree with their healthcare professional how often they should have tests to check how well their kidneys are working. They are offered blood and urine tests at the agreed frequency to find out if their CKD is worsening (progressing), or if they have kidney problems. The blood test is at least once a year for adults with CKD. People with CKD are offered information and education relevant to the cause of kidney disease, how advanced it is, any complications they may have and the chances of it getting worse, to help fully understand and make informed choices about treatment. They are also able to get psychological support if needed – for example, support groups, counselling or support from a specialist nurse.

Source guidance

Chronic kidney disease: assessment and management. NICE guideline NG203 (2021), recommendations 1.1.20, 1.1.21, 1.3.1 and 1.3.4

Definitions of terms used in this quality statement

Adults with CKD

CKD is defined as abnormalities of kidney function or structure present for more than 3 months, with implications for health. This includes:

- all people with markers of kidney damage, including albuminuria (ACR more than 3 mg/mmol), urine sediment abnormalities, electrolyte and other abnormalities due to tubular disorders, abnormalities detected by histology, structural abnormalities detected by imaging or a history of kidney transplantation
- people with a glomerular filtration rate (GFR) of less than 60 ml/min/1.73 m² on at least

2 occasions separated by a period of at least 90 days (with or without markers of kidney damage).

[[NICE's guideline on chronic kidney disease](#), terms used in this guideline]

Adults at risk of CKD

Adults with any of the following risk factors:

- diabetes
- hypertension
- previous episode of acute kidney injury
- cardiovascular disease (ischaemic heart disease, chronic heart failure, peripheral vascular disease or cerebral vascular disease)
- structural renal tract disease, recurrent renal calculi or prostatic hypertrophy
- multisystem diseases with potential kidney involvement – for example, systemic lupus erythematosus
- gout
- family history of end-stage renal disease (GFR category G5) or hereditary kidney disease
- incidental detection of haematuria or proteinuria
- medicines that can adversely affect kidney function, such as calcineurin inhibitors (for example, cyclosporin or tacrolimus), lithium or non-steroidal anti-inflammatory drugs (NSAIDs).

[[NICE's guideline on chronic kidney disease](#), recommendations 1.1.20 and 1.1.21, and expert opinion]

eGFRcreatinine testing

A blood test that estimates glomerular filtration rate (GFR) by measuring serum creatinine. It is used as an estimate of kidney function to identify kidney disease and monitor CKD progression. Clinical laboratories should use the Chronic Kidney Disease Epidemiology

Collaboration (CKD-EPI) creatinine equation to estimate GFRcreatinine, using creatinine assays with calibration traceable to standardised reference material. [Adapted from [NICE's guideline on chronic kidney disease](#), recommendation 1.1.2]

Albumin:creatinine ratio (ACR) testing

A test used to detect and identify protein in the urine, which is a sign of kidney disease, and can be used to assess progression of CKD. [Adapted from [NICE's guideline on chronic kidney disease](#), recommendation 1.1.12, and full guideline]

At the frequency agreed with their healthcare professional

The frequency of monitoring should be discussed and agreed by the person and their healthcare professional. [Table 2 in NICE's guideline on chronic kidney disease](#) should be used to guide the frequency of GFR monitoring. Adults with CKD should be seen at least annually and adults at risk of CKD can be seen annually or less often for monitoring of eGFR. ACR does not need to be measured every time eGFR is measured, except when evaluating response to a treatment targeted at reducing proteinuria. Frequency of monitoring is determined by the stability of kidney function and the ACR level, and tailored to the individual according to:

- the underlying cause of CKD
- the rate of decline in eGFR or increase in ACR (but be aware that CKD progression is often non-linear)
- other risk factors, including heart failure, diabetes and hypertension
- changes to their treatment (such as renin–angiotensin–aldosterone system [RAAS] antagonists, NSAIDs and diuretics)
- intercurrent illness (for example, acute kidney injury)
- whether they have chosen conservative management of CKD.

[Adapted from [NICE's guideline on chronic kidney disease](#), recommendations 1.3.1 and 1.3.4, and full guideline]

Quality statement 2: Blood pressure control

Quality statement

Adults with chronic kidney disease (CKD) have their blood pressure maintained within the recommended range. [2011, updated 2017]

Rationale

People with CKD are at a higher risk of high blood pressure. Maintaining blood pressure within a target range reduces the risk of cardiovascular disease, CKD progression and mortality.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local systems to identify and invite adults with CKD to have a blood pressure reading.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, through local protocols on appointment reminders.

b) Evidence of the availability of equipment to take a blood pressure reading from adults with CKD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, local protocols and service

specifications.

Process

a) Proportion of adults with CKD with an albumin:creatinine ratio (ACR) below 70 mg/mmol whose systolic blood pressure is between 120 mmHg and 139 mmHg and their clinic diastolic blood pressure below 90 mmHg.

Numerator – the number in the denominator whose systolic blood pressure is between 120 mmHg and 139 mmHg and their clinic diastolic blood pressure below 90 mmHg.

Denominator – the number of adults with CKD with an ACR below 70 mg/mmol.

Data source: CVD Prevent's indicator CVDP007CKD reports the percentage of patients aged 18 and over with GP recorded CKD (G3a to G5) with an ACR of less than 70 mg/mmol, in whom the last blood pressure reading (measured in the preceding 12 months) is less than 140/90 mmHg.

b) Proportion of adults with CKD whose systolic blood pressure is between 120 mmHg and 129 mmHg and their clinic diastolic blood pressure below 80 mmHg.

Numerator – the number in the denominator whose systolic blood pressure is between 120 mmHg and 129 mmHg and their clinic diastolic blood pressure below 80 mmHg.

Denominator – the number of adults with CKD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records.

c) Proportion of adults with CKD and an ACR of 70 mg/mmol or more whose systolic blood pressure is between 120 mmHg and 129 mmHg and their clinic diastolic blood pressure below 80 mmHg.

Numerator – the number in the denominator whose systolic blood pressure is between 120 mmHg and 129 mmHg and their clinic diastolic blood pressure below 80 mmHg.

Denominator – the number of adults with CKD and an ACR of 70 mg/mmol or more.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records.

Outcomes

a) Prevalence of cardiovascular disease among people with CKD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records.

b) Incidence of cardiovascular events for people with CKD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records.

c) Cardiovascular mortality rates among people with CKD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records.

d) Incidence of end-stage kidney disease.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records. The [UK Renal Registry](#) annual report includes data on the incidence of kidney replacement therapy.

What the quality statement means for different audiences

Service providers (such as general practices and secondary care services) ensure that systems are in place for adults with CKD to have their blood pressure maintained within the recommended range. This might involve having the equipment to take a blood pressure reading, using clinical IT systems to compare patients to the recommended range when entering a blood pressure reading, or flagging when patients need a blood pressure reading.

Healthcare professionals (such as GPs, nephrologists, nurses and pharmacists) monitor the blood pressure of adults with CKD and are aware of the recommended ranges. They support people to keep their blood pressure within the recommended range, for example, by starting or adjusting treatment, or advising on lifestyle changes.

Commissioners ensure that they commission services in which adults with CKD have their blood pressure maintained within the recommended range. They work with service providers to ensure that adults with CKD are identified, and have a blood pressure reading and any necessary support to maintain it within the recommended range.

Adults with CKD are supported to keep their blood pressure at a healthy level. If it is too high, their healthcare professional might offer medicine, or change the medicine they are taking, or suggest lifestyle changes, to help to control it.

Source guidance

Chronic kidney disease: assessment and management. NICE guideline NG203 (2021), recommendations 1.6.1 and 1.6.2

Definitions of terms used in this quality statement

Adults with CKD

CKD is defined as abnormalities of kidney function or structure present for more than 3 months, with implications for health. This includes:

- people with markers of kidney damage, including albuminuria (ACR more than 3 mg/mmol), urine sediment abnormalities, electrolyte and other abnormalities due to tubular disorders, abnormalities detected by histology, structural abnormalities detected by imaging or a history of kidney transplantation
- people with a glomerular filtration rate (GFR) of less than 60 ml/min/1.73 m² on at least 2 occasions separated by a period of at least 90 days (with or without markers of kidney damage).

[NICE's guideline on chronic kidney disease, terms used in this guideline]

Recommended range

Blood pressure should be monitored and maintained within the following ranges:

- In people with CKD, aim to keep the systolic blood pressure below 140 mmHg (target range 120 mmHg to 139 mmHg) and the clinic diastolic blood pressure below 90 mmHg.
- In people with CKD with an ACR of 70 mg/mmol or more, aim to keep the systolic blood pressure below 130 mmHg (target range 120 mmHg to 129 mmHg) and the clinic diastolic blood pressure below 80 mmHg.

[Adapted from [NICE's guideline on chronic kidney disease](#), recommendations 1.6.1 and 1.6.2]

Quality statement 3: Statins for people with CKD

Quality statement

Adults with chronic kidney disease (CKD) are offered atorvastatin 20 mg. **[new 2017]**

Rationale

There is a higher risk of cardiovascular disease (CVD) in people with CKD. After discussing the risks and benefits of starting statin therapy with a healthcare professional, adults with CKD may choose statin therapy as an appropriate treatment to reduce their risk of first CVD events, or of future CVD events in adults who have already had an event, such as a heart attack or stroke. Statins are a clinically effective treatment for preventing CVD, and reducing the risks associated with CVD, for people who have CKD. Atorvastatin 20 mg is recommended as the preferred initial high-intensity statin because it is clinically and cost effective for the primary and secondary prevention of CVD.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of the availability of atorvastatin 20 mg within local service providers.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from local formularies.

b) Evidence of local systems to check whether adults with CKD are taking atorvastatin 20 mg and invite them to discuss starting treatment if not.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from local protocols and service specifications.

Process

Proportion of adults with CKD who receive atorvastatin 20 mg.

Numerator – the number in the denominator who receive atorvastatin 20 mg.

Denominator – the number of adults with CKD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records. [CVD Prevent's indicator CVDP010CHOL](#) reports the percentage of patients aged 18 and over with GP-recorded CKD (G3a to G5), who are currently having treatment with lipid-lowering therapy. This measures lipid-lowering therapies and is not specific to a statin.

Outcomes

a) Prevalence of cardiovascular disease among people with CKD.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records.

b) Incidence of cardiovascular events for people with CKD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records.

c) Cardiovascular mortality rates among people with CKD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records.

d) Proportion of people with CKD on a statin without a diagnosis of CVD with a greater than 40% reduction in non-high-density lipoprotein (HDL) cholesterol.

Numerator – the number in the denominator with a greater than 40% reduction in non-HDL cholesterol.

Denominator – the number of people with CKD on a statin without a diagnosis of CVD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from audit of health records.

e) Proportion of adults with CKD and CVD on a statin who have a low-density lipoprotein (LDL) cholesterol level of 2.0 mmol per litre or less, or non-HDL cholesterol level of 2.6 mmol per litre or less.

Numerator – the number in the denominator who have an LDL cholesterol level of 2.0 mmol per litre or less, or non-HDL cholesterol level of 2.6 mmol per litre or less.

Denominator – the number of adults with CKD and CVD on a statin.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

Service providers (such as general practices and secondary care services, including renal, cardiology, diabetes and rheumatology clinics) ensure that systems are in place for adults with CKD to be offered atorvastatin 20 mg. For example, this may be done through incorporating treatment algorithms into software applications to provide users with patient-specific recommendations on treatment.

Healthcare professionals (such as GPs, nephrologists, cardiologists, diabetologists, rheumatologists, nurses and pharmacists) check whether adults with CKD are taking a statin, and discuss the risks and benefits of starting statin therapy if not. They offer atorvastatin 20 mg and increase the dose if an adequate response to treatment is not achieved and eGFR is 30 ml/min/1.73 m² or more. If a person is not able to tolerate atorvastatin 20 mg or reports adverse effects, they discuss alternative options such as stopping the statin or changing the dose or type of statin.

Commissioners ensure that they commission services in which adults with CKD are offered atorvastatin 20 mg. Commissioners may do this by seeking evidence of practice through clinical audits.

Adults with CKD are at a higher risk of heart attacks and strokes. To help reduce the risk they are offered a type of medicine called a statin, which lowers the level of cholesterol (sometimes called lipids) in the blood. If their cholesterol level does not decrease enough, they may change to a higher dose. If the statin causes any side effects, their doctor might ask them to stop taking it for a while to check that they are caused by the statin. Their doctor might discuss reducing the dose or changing to a different statin.

Source guidance

- [Chronic kidney disease: assessment and management. NICE guideline NG203 \(2021\), recommendation 1.6.24](#)
- [Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 \(2023\), recommendations 1.6.1, 1.7.1, 1.8.1, 1.8.2 and 1.8.3](#)

Definitions of terms used in this quality statement

Adults with CKD

CKD is defined as abnormalities of kidney function or structure present for more than 3 months, with implications for health. This includes:

- people with markers of kidney damage, including albuminuria (albumin:creatinine ratio [ACR] more than 3 mg/mmol), urine sediment abnormalities, electrolyte and other abnormalities due to tubular disorders, abnormalities detected by histology, structural abnormalities detected by imaging or a history of kidney transplantation
- people with a glomerular filtration rate (GFR) of less than 60 ml/min/1.73 m² on at least 2 occasions separated by a period of at least 90 days (with or without markers of kidney damage).

[[NICE's guideline on chronic kidney disease](#), terms used in this guideline]

Adults with CKD and CVD

Adults with a diagnosis of CKD and angina, previous myocardial infarction, revascularisation, ischaemic stroke or TIA (excluding a history of haemorrhagic stroke) or symptomatic peripheral arterial disease. [[NICE indicator NM212](#)]

Update information

July 2017: This quality standard was updated and statements prioritised in 2011 were replaced. The topic was identified for update following the annual review of quality standards. The review identified changes in the priority areas for improvement.

Statements are marked as:

- **[new 2017]** if the statement covers a new area for quality improvement
- **[2011, updated 2017]** if the statement covers an area for quality improvement included in the 2011 quality standard and has been updated.

The [2011 quality standard for CKD](#) is available as a pdf.

Minor changes since publication

December 2023: Changes have been made to the source guidance and outcome measures sections for statement 3 to align them with the updated [NICE guideline on cardiovascular disease: risk assessment and reduction, including lipid modification](#). A definition of adults with CKD and CVD has been added to statement 3. Data sources have been reviewed throughout and updated for statement 1.

May 2023: Recommendation numbers have been amended in statement 3 to align them with the updated [NICE guideline on cardiovascular disease: risk assessment and reduction, including lipid modification](#). Hyperlinks, data sources and audience descriptors have been reviewed throughout and updated as needed.

August 2021: Recommendation numbers, references and links to source guidance have been updated throughout and definitions in statement 1 have been amended to align with the updated [NICE guideline on chronic kidney disease](#).

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision making, choice, and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standards advisory committees](#) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

impact work for the source guidance. Organisations are encouraged to use the [resource impact summary report for NICE's guideline on chronic kidney disease](#) and the [resource impact products for NICE's guideline on cardiovascular disease](#) to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Diabetes UK](#)
- [Kidney Care UK](#)
- [Royal College of Nursing \(RCN\)](#)
- [Royal College of General Practitioners \(RCGP\)](#)
- [UK Kidney Association](#)

- British Renal Society