

Hypertension in adults

Quality standard

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[nice.org.uk/guidance/qs28](https://www.nice.org.uk/guidance/qs28)

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This standard is based on CG127.

This standard should be read in conjunction with QS21, QS15, QS35, QS52, QS68, QS92, QS93, QS100, QS99, QS2 and QS6.

Introduction and overview

Introduction

Hypertension (high blood pressure) is one of the most important preventable causes of premature morbidity and mortality in the UK. It increases the risk of atrial fibrillation and is a major risk factor for stroke (ischaemic and haemorrhagic), myocardial infarction, heart failure, chronic kidney disease, cognitive decline and premature death. Raised blood pressure is one of the three main modifiable risk factors for cardiovascular disease, which account for 80% of all cases of premature coronary heart disease (CHD).

This quality standard covers the management of primary hypertension in adults, including diagnosis and investigations, treatment to reduce risk of cardiovascular disease, monitoring of treatment efficacy, and specialist referral. For more information see the [scope](#) for 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. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. The quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following frameworks:

- [NHS outcomes framework 2013–14](#).
- Improving outcomes and supporting transparency: Part 1: a [public health outcomes framework for England, 2013–2016](#).

The table below shows the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving:

NHS outcomes framework 2013–14

<p>Domain 1: Preventing people from dying prematurely</p>	<p>Overarching indicators</p> <p>1a Potential years of life lost (PYLL) from causes considered amenable to healthcare</p> <p>1b Life expectancy at 75 in males ii females</p> <p>Improvement areas</p> <p><i>Reducing premature mortality from the major causes of death</i></p> <p>1.1 Under 75 mortality rate for cardiovascular disease</p>
<p>Domain 2: Enhancing quality of life for people with long-term conditions</p>	<p>Overarching indicator</p> <p>2 Health-related quality of life for people with long-term conditions</p> <p>Improvement areas</p> <p><i>Ensuring people feels supported to manage their condition</i></p> <p>2.1 Proportion of people feeling supported to manage their condition</p> <p><i>Improving functional ability in people with long-term conditions</i></p> <p>2.2 Employment of people with long-term conditions</p> <p><i>Reducing times spent in hospital by people with long-term conditions</i></p> <p>2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)</p>
<p>Public health outcomes framework 2013–16</p>	
<p>Domain 1: Improving the wider determinants of health</p>	<p>Objective</p> <p>Improvements against wider factors that affect health and wellbeing and health inequalities</p> <p>Indicators</p> <p>1.8 Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness</p> <p>1.9 Sickness absence rate</p>

Domain 4: Healthcare public health and preventing premature mortality	<p>Objective</p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</p> <p>Indicators</p> <p>4.4 Mortality from all cardiovascular diseases (including heart disease and stroke)</p> <p>4.13 Health-related quality of life for older people (placeholder)</p>
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Overview

The quality standard for hypertension states that services should be commissioned from and coordinated across all relevant agencies encompassing the hypertension care pathway. A person-centred approach to provision of services is fundamental in delivering high-quality care to adults with hypertension.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should cross refer across the library of NICE quality standards when designing high-quality services.

Patients, service users and carers may use the quality standard to find out about the quality of care they should expect to receive; support asking questions about the care they receive; and to make a choice between providers of social care services.

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 adults with hypertension should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.

List of quality statements

Statement 1. People with suspected hypertension are offered ambulatory blood pressure monitoring (ABPM) to confirm a diagnosis of hypertension.

Statement 2. People with newly diagnosed hypertension receive investigations for target organ damage within 1 month of diagnosis.

Statement 3. This statement has been replaced by quality statements on primary and secondary prevention of cardiovascular disease in [cardiovascular disease risk assessment and lipid modification](#) (NICE quality standard 100).

Statement 4. People with treated hypertension have a clinic blood pressure target set to below 140/90 mmHg if aged under 80 years, or below 150/90 mmHg if aged 80 years and over.

Statement 5. People with hypertension are offered a review of risk factors for cardiovascular disease annually.

Statement 6. People with resistant hypertension who are receiving 4 antihypertensive drugs and whose blood pressure remains uncontrolled are referred for specialist assessment.

Other quality standards that should also be considered when choosing, commissioning or providing a high-quality hypertension service are listed in [related NICE quality standards](#).

Quality statement 1: Diagnosis – ambulatory blood pressure monitoring

Quality statement

People with suspected hypertension are offered ambulatory blood pressure monitoring (ABPM) to confirm a diagnosis of hypertension.

Rationale

ABPM is the most accurate method for confirming a diagnosis of hypertension, and its use should reduce unnecessary treatment in people who do not have true hypertension. ABPM has also been shown to be superior to other methods of multiple blood pressure measurement for predicting blood pressure-related clinical events.

Quality measure

Structure: Evidence of local arrangements to ensure people with suspected hypertension are offered ABPM to confirm a diagnosis of hypertension.

Process: Proportion of people with suspected hypertension who receive ABPM to confirm a diagnosis of hypertension.

Numerator – the number of people in the denominator who receive ABPM to confirm a diagnosis of hypertension.

Denominator – the number of people with suspected hypertension.

What the quality statement means for each audience

Service providers ensure systems are in place to offer ABPM to confirm a diagnosis of hypertension.

Healthcare professionals offer ABPM to confirm a diagnosis of hypertension.

Commissioners ensure they commission services that offer ABPM to confirm a diagnosis of hypertension.

People with suspected hypertension (high blood pressure) are offered ambulatory blood pressure monitoring (which involves wearing a blood pressure monitor during their normal waking hours) to

confirm whether or not they have hypertension.

Source guidance

[NICE clinical guideline 127](#) recommendation [1.2.3](#) (key priority for implementation).

Data source

Structure: Local data collection.

Process: Local data collection. Contained within [NICE clinical guideline 127 clinical audit tool: diagnosing hypertension](#), criterion 1.

Definitions

Ambulatory blood pressure monitoring (ABPM)

[Clinical guideline 127 Hypertension: full guideline](#): Ambulatory blood pressure monitoring (ABPM) involves a cuff and bladder connected to electronic sensors which detect changes in cuff pressure and allow blood pressure to be measured oscillometrically. Systolic and diastolic pressure readings are deduced from the shape of oscillometric pressure changes using an algorithm built into the measuring device. A patient's blood pressure can be automatically measured at repeated intervals throughout the day and night, while they continue routine activities. Systolic and diastolic pressure can be plotted over time, with most devices providing average day, night and 24-hour pressures. NICE recommends recording a daytime average to confirm diagnosis.

Suspected hypertension

[NICE clinical guideline 127](#) recommendation [1.2.3](#) describes suspected hypertension as clinic blood pressure of 140/90 mmHg or higher without a confirmed diagnosis of hypertension.

Equality and diversity considerations

ABPM may not be suitable for everyone, for example people with particular learning or physical disabilities. Some people may be unable to tolerate ABPM and some people may decline it.

Home blood pressure monitoring should be offered as an alternative to ABPM in such cases, in line with [NICE clinical guideline 127](#) recommendation [1.2.4](#). If a person is unable to tolerate ABPM, home blood pressure monitoring (HBPM) is a suitable alternative to confirm the diagnosis of

hypertension.

Quality statement 2: Investigations for target organ damage

Quality statement

People with newly diagnosed hypertension receive investigations for target organ damage within 1 month of diagnosis.

Rationale

Assessment of target organ damage can alert the clinician to possible secondary causes of hypertension, some of which are potentially life threatening and some that may be amenable to potentially curative interventions. It can also support the clinician to decide the appropriate blood pressure threshold at which to consider drug therapy for the treatment of hypertension.

Quality measure

Structure: Evidence of local arrangements for people with newly diagnosed hypertension to receive all investigations for target organ damage within 1 month of diagnosis.

Process: Proportion of people with newly diagnosed hypertension who receive all investigations for target organ damage within 1 month of diagnosis.

Numerator – the number of people in the denominator who receive all investigations for target organ damage within 1 month of diagnosis.

Denominator – the number of people with newly diagnosed hypertension.

What the quality statement means for each audience

Service providers ensure systems are in place for people with newly diagnosed hypertension to receive all investigations for target organ damage within 1 month of diagnosis.

Healthcare professionals carry out all investigations for target organ damage for people with newly diagnosed hypertension within 1 month of diagnosis.

Commissioners ensure they commission services that carry out all investigations for target organ damage for people with newly diagnosed hypertension within 1 month of diagnosis.

People with newly diagnosed hypertension (high blood pressure) receive tests within 1 month of being diagnosed to check for any damage to organs such as their eyes, heart or kidneys.

Source guidance

[NICE clinical guideline 127](#) recommendations [1.2.6](#) and [1.3.3](#)

Data source

Structure: Local data collection.

Process: Local data collection. Contained within [NICE clinical guideline 127 clinical audit tool: diagnosing hypertension](#), criterion 3.

Definitions

Investigations for target organ damage

[NICE clinical guideline 127](#) recommendation [1.3.3](#) recommends that for all people with hypertension, healthcare professionals should offer to:

- test for the presence of protein in the urine by sending a urine sample for estimation of the albumin:creatinine ratio and test for haematuria using a reagent strip
- take a blood sample to measure plasma glucose, electrolytes, creatinine, estimated glomerular filtration rate, serum total cholesterol and HDL cholesterol
- examine the fundi for the presence of hypertensive retinopathy
- arrange for a 12-lead electrocardiograph to be performed.

Target organ damage

[NICE clinical guideline 127](#) recommendation [1.2.6](#) lists left ventricular hypertrophy, chronic kidney disease and hypertensive retinopathy as examples of target organ damage.

Quality statement 3: Statin therapy

Quality statement 3 has been replaced by quality statements on primary and secondary prevention of cardiovascular disease in [cardiovascular risk assessment and lipid modification](#) (NICE quality standard 100).

Quality statement 4: Blood pressure targets

Quality statement

People with treated hypertension have a clinic blood pressure target set to below 140/90 mmHg if aged under 80 years, or below 150/90 mmHg if aged 80 years and over.

Rationale

Hypertension is associated with a higher risk of cardiovascular events. Setting blood pressure to recommended levels aims to promote primary and secondary prevention of cardiovascular disease, and to lower the risk of cardiovascular events.

Quality measure

Structure:

- a) Evidence of local arrangements to ensure people aged under 80 years with treated hypertension have a clinic blood pressure target set to below 140/90 mmHg.
- b) Evidence of local arrangements to ensure people aged 80 years and over with treated hypertension have a clinic blood pressure target set to below 150/90 mmHg.

Outcome: People with treated hypertension whose target blood pressure is achieved.

What the quality statement means for each audience

Service providers ensure systems are in place for people aged under 80 years with treated hypertension to have a clinic blood pressure target set to below 140/90 mmHg, and for people aged 80 years and over with treated hypertension to have a clinic blood pressure target set to below 150/90 mmHg.

Healthcare professionals ensure that people aged under 80 years with treated hypertension have a clinic blood pressure target set to below 140/90 mmHg, and people aged 80 years and over with treated hypertension have a clinic blood pressure target set to below 150/90 mmHg.

Commissioners ensure they commission services that have arrangements for people aged under 80 years with treated hypertension to have a clinic blood pressure target set to below 140/

90 mmHg, and for people aged 80 years and over with treated hypertension to have a clinic blood pressure target set to below 150/90 mmHg.

People who are receiving treatment for hypertension (high blood pressure) have a target clinic blood pressure (blood pressure measured in their GP practice or clinic) below 140/90 mmHg if they are aged under 80 years, or a clinic blood pressure below 150/90 mmHg if they are aged 80 years or over.

Source guidance

[NICE clinical guideline 127](#) recommendations [1.5.5](#) and [1.5.6](#)

Data source

Structure: a) and b) Local data collection.

Outcome:

[Quality and Outcomes Framework \(QOF\) indicator HYP002](#): The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 150/90 mmHg or less.

[Quality and Outcomes Framework \(QOF\) indicator HYP003](#): The percentage of patients aged 79 and under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less.

Definitions

Clinic blood pressure

Clinic blood pressure refers to blood pressure measured in the clinic.

For a clinic blood pressure of 140/90 mmHg, the corresponding ambulatory blood pressure monitoring (ABPM) daytime average or home blood pressure monitoring (HBPM) average blood pressure is 135/85 mmHg.

For a clinic blood pressure of 160/100 mmHg or higher, the corresponding ABPM daytime average or HBPM average blood pressure is 150/95 mmHg or higher.

Treated hypertension

Treated hypertension includes treatment with antihypertensive drugs.

Equality and diversity considerations

Targets are based on evidence of safe practice. A person aged 80 years or over with treated hypertension would not have a target clinic blood pressure of 150/90 mmHg if their blood pressure was already treated to below this threshold.

Quality statement 5: Review of cardiovascular disease risk factors

Quality statement

People with hypertension are offered a review of risk factors for cardiovascular disease annually.

Rationale

People's blood pressure and cardiovascular disease risk will increase over time. A review of risk factors for cardiovascular disease delivered as part of an annual review of care should support identification of increased risk and provide an opportunity to address modifiable risk factors.

Quality measure

Structure: Evidence of local arrangements to ensure people with hypertension are offered a review of risk factors for cardiovascular disease annually.

Process: Proportion of people who have had hypertension for 12 months or longer who have had a review of risk factors for cardiovascular disease within the past 12 months.

Numerator – the number of people in the denominator who have had a review of risk factors for cardiovascular disease within the past 12 months.

Denominator – the number of people who have had hypertension for 12 months or longer who do not have established cardiovascular disease.

What the quality statement means for each audience

Service providers ensure systems are in place to offer people with hypertension a review of risk factors for cardiovascular disease annually.

Healthcare professionals offer people with hypertension a review of risk factors for cardiovascular disease annually.

Commissioners ensure they commission services that offer people with hypertension a review of risk factors for cardiovascular disease annually.

People with hypertension (high blood pressure) are offered a review of risk factors for cardiovascular

disease annually.

Source guidance

NICE clinical guideline 127 recommendation 1.7.3.

Data source

Structure: Local data collection.

Process:

Quality and Outcomes Framework (QOF) indicator CVD-PP02: The percentage of patients diagnosed with hypertension (diagnosed on or after 1 April 2009) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet.

Quality and Outcomes Framework (QOF) indicator SMOK005: The percentage of patients with any or any combination of the following conditions: CHD PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months.

Definitions

Annual review of care

NICE clinical guideline 127 recommendation 1.7.3 recommends that an annual review of care should be provided to monitor blood pressure, provide people with support and discuss their lifestyle, symptoms and medication.

Review of risk factors for cardiovascular disease

Review of risk factors for cardiovascular disease could include:

- smoking status
- alcohol consumption
- blood pressure

- body mass index or other measure of obesity
- total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides
- blood glucose
- renal function
- liver function (transaminases) if receiving statins
- heart rate and rhythm (pulse measurement).

(adapted from [NICE clinical guideline 67](#) recommendation [1.4.2](#))

Blood pressure should be measured more frequently than annually for patients who need more frequent monitoring.

Quality statement 6: Referral to a specialist for people with resistant hypertension

Quality statement

People with resistant hypertension who are receiving 4 antihypertensive drugs and whose blood pressure remains uncontrolled are referred for specialist assessment.

Rationale

People with resistant hypertension will usually be at high risk of cardiovascular disease. Specialist assessment and evaluation supports management of their condition.

Quality measure

Structure: Evidence of local arrangements for people with resistant hypertension who are receiving 4 antihypertensive drugs and whose blood pressure remains uncontrolled to be referred for specialist assessment.

Process: Proportion of people with resistant hypertension who are receiving 4 antihypertensive drugs and whose blood pressure remains uncontrolled who are referred for specialist assessment.

Numerator – the number of people in the denominator who are referred for specialist assessment.

Denominator – the number of people with resistant hypertension who are receiving 4 antihypertensive drugs and whose blood pressure remains uncontrolled.

What the quality statement means for each audience

Service providers ensure local arrangements are in place for people with resistant hypertension who are receiving 4 antihypertensive drugs and whose blood pressure remains uncontrolled to be referred for specialist assessment.

Healthcare professionals refer people with resistant hypertension who are receiving 4 antihypertensive drugs and whose blood pressure remains uncontrolled for specialist assessment.

Commissioners ensure they commission services that refer people with resistant hypertension

who are receiving 4 antihypertensive drugs and whose blood pressure remains uncontrolled for specialist assessment.

People with resistant hypertension (high blood pressure that is difficult to control) who are receiving 4 antihypertensive drugs are referred for a specialist assessment.

Source guidance

NICE clinical guideline 127 recommendations [1.6.18](#) and [1.6.22](#).

Data source

Structure: Local data collection.

Process: Local data collection.

Definitions

Referral for specialist assessment

Referral should be to a healthcare professional, usually in secondary care, with specialist expertise in high blood pressure.

Resistant hypertension

NICE clinical guideline 127 recommendation [1.6.18](#) recommends that clinic blood pressure that remains higher than 140/90 mmHg despite step 3 treatment with the optimal or best tolerated doses of an angiotensin-converting enzyme (ACE) inhibitor or an angiotensin II receptor blocker (ARB) plus a calcium-channel blocker (CCB) plus a diuretic should be regarded as resistant hypertension. People aged 80 years and over are considered to have resistant hypertension if their clinic blood pressure remains higher than 150/90 mmHg despite optimal or best tolerated doses of step 3 treatment.

Recommendation [1.6.22](#) recommends that expert advice should be sought if blood pressure remains uncontrolled with step 4 treatment of optimal or maximum tolerated doses of 4 drugs if expert advice has not yet been obtained.

Using the quality standard

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered by commissioners, providers, health and social care professionals, patients, service users and carers alongside the documents listed in [development sources](#).

NICE has produced a [support document to help commissioners and others](#) consider the commissioning implications and potential resource impact of this quality standard. Full [guides for commissioners](#) on hypertension that support the local implementation of NICE guidance are available. [Information for the public](#) using the quality standard is also available.

The quality measures accompanying the quality statements aim to improve structures, processes and outcomes of care in areas identified as requiring quality improvement. They are not a new set of targets or mandatory indicators for performance management.

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

We have illustrated where national indicators currently exist and measure the quality statement. National indicators include those developed by the Health and Social Care Information Centre through their [Indicators for Quality Improvement Programme](#). If national quality indicators do not exist, the quality measures should form the basis of audit criteria developed and used locally to improve the quality of care.

For further information, including guidance on using quality measures, please see [What makes up a NICE quality standard](#).

Diversity, equality and language

During the development of this quality standard, equality issues have been considered. [Equality assessments](#) are available.

Good communication between health and social care services and people with hypertension is essential. Treatment, care and support, and the information given about it, should be culturally

appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with hypertension should have access to an interpreter or advocate if needed.

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

Development sources

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited sources that were used by the Topic Expert Group to develop the quality standard statements and measures.

- [Hypertension: clinical management of primary hypertension in adults](#). NICE clinical guideline 127 (2011).
- [Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease](#). NICE clinical guideline 67 (2008).

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Royal College of Physicians (2007) [Pharmacological management of hypertension](#).
- UK National Screening Committee (2006) [The UK NSC policy on hypertension screening in adults](#).

Definitions and data sources for the quality measures

References included in the definitions and data sources sections:

- [Hypertension: clinical audit tool \(diagnosing hypertension\)](#). NICE clinical guideline 127 (2011).
- [Hypertension: clinical audit tool \(drug treatment\)](#). NICE clinical guideline 127 (2011).
- [Lipid modification: audit support](#). NICE clinical guideline 67 (2008).
- NHS Employers (2013) [Quality and Outcomes Framework \(QOF\) for 2013/14](#)

Related NICE quality standards

Published

- [Patient experience in adult NHS services](#). NICE quality standard 15 (2012).

In development

- [Hypertension in pregnancy](#). Publication expected July 2013.

Future quality standards

- [Lipid modification](#).
- [Medicines optimisation](#) (covering medicines adherence and safe prescribing).
- [Risk assessment of modifiable cardiovascular risk factors](#).
- [Secondary care management of malignant hypertension](#).

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Changes after publication

September 2015: This quality standard has been updated to ensure alignment with the NICE quality standard for [cardiovascular disease and lipid modification](#) (NICE quality standard 100) published in September 2015.

Statement 3 on statin therapy has been removed and replaced by statements in the quality standard for cardiovascular disease and lipid modification that cover primary and secondary prevention of cardiovascular disease.

May 2015: Minor maintenance.

April 2015: Minor maintenance.

December 2014: Minor maintenance.

July 2013: Quality and Outcomes Framework indicators updated.

June 2013: List of Topic Expert Group and NICE project team members added.

April 2013: Minor maintenance.

About this quality standard

NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

The methods and processes for developing NICE quality standards are described in the [healthcare quality standards process guide](#).

This quality standard has been incorporated into the [NICE pathway for hypertension](#).

We have produced a [summary for patients and carers](#).

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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.

- [Arrhythmia Alliance](#)
- [Blood Pressure UK](#)
- [British Hypertension Society](#)
- [Royal College of Obstetricians and Gynaecologists](#)