NICE National Institute for Health and Care Excellence

NICE quality standard

Cardiovascular risk assessment and lipid modification

Quality standard
Published: 4 September 2015
Last updated: 23 July 2025

www.nice.org.uk/guidance/qs100

Contents

This standard is based on NG238, TA694, TA385 and PH15.

This standard should be read in conjunction with QS103, QS99, QS95, QS93, QS84, QS82, QS80, QS68, QS52, QS43, QS41, QS28, QS21, QS11, QS9, QS6, QS5, QS2, QS111 and QS143.

Quality statements

Statement 1 General practices use a systematic strategy to identify adults likely to be at high risk of cardiovascular disease. **[new 2025]**

Statement 2 Adults with a 10-year risk of cardiovascular disease of 10% or more receive tailored advice on diet and lifestyle changes within 3 months of their cardiovascular disease risk assessment score being recorded. **[2015, updated 2025]**

Statement 3 Adults with a 10-year risk of cardiovascular disease of 10% or more are prescribed a high-intensity statin or other lipid-lowering treatment if a high-intensity statin is contraindicated or not tolerated. **[2015, updated 2025]**

Statement 4 Adults starting or changing lipid-lowering treatment have a full lipid profile and their liver transaminases measured at 2 to 3 months. **[2015, updated 2025]**

Statement 5 Adults with cardiovascular disease have a low-density lipoprotein (LDL) cholesterol level of 2.0 mmol per litre or less, or a non-high-density lipoprotein (non-HDL) cholesterol level of 2.6 mmol per litre or less. **[new 2025]**

In 2025 this quality standard was updated and statements prioritised in 2015 were updated (2015, updated 2025) or replaced (new 2025). For more information, see update information.

The previous version of the quality standard for cardiovascular risk assessment and lipid modification is available as a pdf.

Quality statement 1: Identifying adults who are likely to be at high risk

Quality statement

General practices use a systematic strategy to identify adults likely to be at high risk of cardiovascular disease. **[new 2025]**

Rationale

Cardiovascular disease (CVD) is the most common cause of death in the UK, and is a major cause of illness, disability and poor quality of life. To improve primary prevention, adults at increased risk of CVD need to be identified using a systematic strategy so that their risk factors can be managed in the most effective way. This should not prevent people being identified opportunistically but may help to ensure that those with the highest risk of CVD are reviewed in an effective and efficient way. Factors routinely recorded in electronic patient records can be used to estimate CVD risk using a CVD risk assessment tool, and those at high risk should be invited for full formal risk assessment.

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 that general practices use a systematic strategy to identify adults who are likely to be at high risk of CVD.

Data source: Data can be collected from local implementation plans.

b) Evidence that general practices use the QRISK3 tool to estimate CVD risk, or QRISK2 if QRISK3 is not currently embedded in electronic clinical systems.

Data source: Data can be collected from local implementation plans.

Process

The systematic strategies used by different localities will focus on different groups of people depending on the individual GP practice and so example process measures have not been provided. Some localities may want to focus on known local health inequalities or NHS England's Core20PLUS5, for example, by disaggregating data by socioeconomic status, ethnic family background, sex or presence of a learning disability. Measures could also focus on adults with modifiable risk factors or coexisting conditions that increase CVD risk.

What the quality statement means for different audiences

Service providers (primary care providers) ensure that they use a systematic strategy to identify adults who are likely to be at high risk of CVD. The strategy could use general practice records or systematic searches in pre-identified areas or with specific populations.

Healthcare professionals (such as GPs, nurses and pharmacists) identify adults who are likely to be at high risk of CVD using risk factors already in patient records. They review estimates of CVD risk on an ongoing basis for adults aged over 40.

Commissioners ensure that they commission services that use systematic strategies to identify adults who are likely to be at high risk of CVD using CVD risk factors already recorded.

Adults who are likely to have a high risk of CVD are identified by their healthcare provider so that their risk factors can be managed in the most effective way.

Source guidance

- Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendations 1.1.1 to 1.1.4
- Cardiovascular disease: identifying and supporting people most at risk of dying early.

NICE guideline PH15 (2008), recommendation 1

Definitions of terms used in this quality statement

Factors routinely recorded in electronic patient records

Factors routinely recorded in general practice patient records that could be used as part of a systematic strategy to identify adults with an increased CVD risk, include, but are not limited to:

- age
- sex
- family history of CVD
- ethnicity
- smoking status
- presence of other conditions known to associate with higher CVD risk such as diabetes, chronic kidney disease, atrial fibrillation, rheumatoid arthritis, systemic lupus erythematosus, severe mental illness, migraine and erectile dysfunction
- use of antipsychotic, immunosuppressant or steroid medication
- blood pressure
- lipid levels
- BMI.

[Adapted from NICE's clinical knowledge summary on risk factors for CVD and expert opinion]

Adults likely to be at high risk of CVD

Adults with an estimated 10-year risk of CVD of 10% or more. [NICE's guideline on cardiovascular disease: risk assessment and reduction, including lipid modification, section 1.1 and recommendation 1.1.4]

Equality and diversity considerations

CVD risk can be estimated based on factors routinely recorded in general practice. However, the accuracy of estimated risk scores will be adversely affected if relevant data is not accurately recorded in GP records, which is especially likely for vulnerable and underserved populations. To mitigate perpetuating or exacerbating existing health inequalities, 'batch coding' without clinical judgement should be avoided. Additionally, resultant data should be disaggregated by deprivation, ethnicity, age and gender to help reduce the risk of widening health inequalities.

Clinical judgement should inform interpretation of results from CVD risk tools because tools may underestimate the risk for certain groups of people, including, but not limited to:

- people treated for HIV
- people already taking medicines to treat CVD risk factors
- people who have recently stopped smoking
- people taking medicines that can cause dyslipidaemia, such as immunosuppressant drugs
- people with severe mental illness
- people with autoimmune disorders, and other systemic inflammatory disorders.

When using a QRISK3 risk score to inform treatment decisions in these populations, particularly if it is near the threshold for treatment, take into account other factors that may predispose the person to premature CVD that may not be included in calculated risk scores. [Adapted from NICE's guideline on cardiovascular disease: risk assessment and reduction, including lipid modification, recommendation 1.1.10]

Quality statement 2: Diet and lifestyle advice for primary prevention

Quality statement

Adults with a 10-year risk of cardiovascular disease of 10% or more receive tailored advice on diet and lifestyle changes within 3 months of their cardiovascular disease risk assessment score being recorded. **[2015, updated 2025]**

Rationale

Making improvements to diet, stopping smoking, increasing physical activity, managing weight and reducing alcohol consumption can reduce the risk of cardiovascular disease (CVD). Healthcare professionals should offer advice to adults with a 10-year CVD risk score of 10% or more after a full formal risk assessment, based on their individual needs, preferences and circumstances.

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.

Process

Proportion of adults with a 10-year risk of CVD of 10% or more who receive advice on diet and lifestyle changes within 3 months of their CVD risk assessment score being recorded.

Numerator – the number in the denominator who receive advice on diet and lifestyle changes within 3 months of their CVD risk assessment score being recorded.

Denominator – the number of adults with a 10-year risk of CVD of 10% or more.

Data source: Data can be collected from information recorded locally by healthcare

professionals and provider organisations, for example from electronic patient records.

What the quality statement means for different audiences

Service providers (such as primary care services) ensure that systems are in place for adults with a 10-year risk of CVD of 10% or more to be given advice on diet and lifestyle changes within 3 months of their cardiovascular risk assessment score being recorded.

Healthcare professionals (such as GPs, nurses, healthcare support workers, and pharmacists) give advice on diet and lifestyle changes for the primary prevention of CVD to adults with a 10-year risk of CVD of 10% or more within 3 months of their cardiovascular risk assessment score being recorded. They take the person's individual needs, preferences and circumstances into account when giving advice.

Commissioners ensure that they commission services that can deliver diet and lifestyle advice to adults with a 10-year risk of CVD of 10% or more within 3 months of their cardiovascular risk assessment score being recorded.

Adults with a 1 in 10 chance or more of developing CVD in the next 10 years (a 10-year risk of 10% or more) are given advice on diet and lifestyle changes, such as stopping smoking, losing weight, eating a healthy diet and exercising when they are found to be at risk. These changes may help to reduce their chances of having a heart attack or stroke in the future. The advice reflects their needs, preferences and circumstances.

Source guidance

Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendations 1.3.1 to 1.3.11, 1.6.2 and 1.6.3

The 3-month timeframe is based on expert opinion. The 3-month timeframe is not derived from NICE guideline on cardiovascular disease: risk assessment and reduction, including lipid modification. It is considered a practical timeframe to enable stakeholders to measure performance. The timeframe is used in NICE's indicator on cardiovascular disease prevention: primary prevention with lifestyle changes.

Definitions of terms used in this quality statement

Diet and lifestyle changes

Diet and lifestyle changes include:

- stopping smoking
- healthy eating
- reaching and maintaining a healthy weight
- increasing physical activity
- reducing alcohol consumption.

[NICE's guideline on cardiovascular disease: risk assessment and reduction, including lipid modification, recommendations 1.3.1 to 1.3.11]

Equality and diversity considerations

Clinical judgement should inform interpretation of results from CVD risk tools because tools may underestimate the risk in certain groups of people, including, but not limited to:

- people treated for HIV
- people already taking medicines to treat CVD risk factors
- people who have recently stopped smoking
- people taking medicines that can cause dyslipidaemia, such as immunosuppressant drugs
- people with severe mental illness
- people with autoimmune disorders, and other systemic inflammatory disorders.

When using a QRISK3 risk score to inform treatment decisions in these populations, particularly if it is near the threshold for treatment, take into account other factors that may predispose the person to premature CVD that may not be included in calculated risk scores. [Adapted from NICE's guideline on cardiovascular disease: risk assessment and

reduction, including lipid modification, recommendation 1.1.10]

A person's sex will affect their CVD risk assessment score, and this should be considered when estimating risk for trans people. [Adapted from NICE's guideline on cardiovascular disease: risk assessment and reduction, including lipid modification, rationale and impact section on full formal risk assessment].

Quality statement 3: Lipid-lowering treatment for primary prevention

Quality statement

Adults with a 10-year risk of cardiovascular disease of 10% or more are prescribed a high-intensity statin or other lipid-lowering treatment if a high-intensity statin is contraindicated or not tolerated. **[2015, updated 2025]**

Rationale

High-intensity statins are the most clinically effective treatment option for the primary prevention of cardiovascular disease (CVD). After a full formal risk assessment that estimates an adult without CVD has a 10-year risk of CVD of 10% or more and following a discussion with a healthcare professional about the risks and benefits of starting statin treatment, an adult may choose statin treatment to reduce their risk of CVD. Atorvastatin 20 mg is recommended as the preferred high-intensity statin, but other lipid-lowering treatment could be used if atorvastatin 20 mg is contraindicated or not tolerated.

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.

Process

Proportion of adults with a 10-year risk of CVD of 10% or more who are prescribed a lipid-lowering treatment.

Numerator – the number in the denominator who are prescribed a lipid-lowering treatment.

Denominator – the number of adults with a 10-year risk of CVD of 10% or more.

Data source:CVDPREVENT indicator CVDP006CHOL reports the proportion of patients with no GP recorded CVD and a GP-recorded QRISK score of 10% or more, who are currently treated with lipid-lowering therapy. The indicator also reports data for inequality markers including sex, age, ethnicity, deprivation level and presence of a learning disability.

What the quality statement means for different audiences

Service providers (primary care services) ensure that systems are in place for adults with a 10-year risk of CVD of 10% or more to be offered a high-intensity statin or other lipid-lowering treatment, if required, to achieve their individual lipid target of a greater than 40% reduction in non-high density (HDL) cholesterol.

Healthcare professionals (such as GPs, nurses and pharmacists) offer a high-intensity statin to adults with a 10-year risk of CVD of 10% or more, or other lipid-lowering treatment if required, to achieve their individual lipid target of a greater than 40% reduction in non-high density (HDL) cholesterol. They are aware of strategies to address adverse effects of high-intensity statins when reported by an adult on a high-intensity statin. They could use the NHS England statin intolerance pathway to address statin intolerance.

Commissioners ensure that lipid-lowering treatment is available for adults with a 10-year risk of CVD of 10% or more.

Adults with a 1 in 10 chance or more of developing CVD in the next 10 years (a 10-year risk of 10% or more) are offered medicine to lower their cholesterol. They can use the NICE patient decision aid on should I take a statin? to talk about options with their doctor, nurse or pharmacist.

Source guidance

- Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendations 1.6.1, 1.6.2, 1.6.7, 1.6.13, 1.9.1, 1.9.3, 1.10.1 and 1.10.2
- Bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia. NICE technology appraisal guidance 694 (2021)

- Ezetimibe for treating primary heterozygous-familial and non-familial hypercholesterolaemia. NICE technology appraisal guidance 385 (2016).

Definitions of terms used in this quality statement

High-intensity statin or other lipid-lowering treatment

See NHS England's summary of national guidance for lipid management.

Equality and diversity considerations

Clinical judgement should inform interpretation of results from CVD risk tools because tools may underestimate the risk in certain groups of people , including, but not limited to:

- people treated for HIV
- people already taking medicines to treat CVD risk factors
- people who have recently stopped smoking
- people taking medicines that can cause dyslipidaemia, such as immunosuppressant drugs
- people with severe mental illness
- people with autoimmune disorders, and other systemic inflammatory disorders.

When using a QRISK3 risk score to inform treatment decisions in these populations, particularly if it is near the threshold for treatment, take into account other factors that may predispose the person to premature CVD that may not be included in calculated risk scores. [Adapted from NICE's guideline on cardiovascular disease: risk assessment and reduction, including lipid modification, recommendation 1.1.10]

A person's sex will affect their CVD risk assessment score, and this should be considered when estimating risk for trans people. [Adapted from NICE's guideline on cardiovascular disease: risk assessment and reduction, including lipid modification, rationale and impact section on full formal risk assessment].

For adults aged 85 and older, treatment with atorvastatin 20 mg should be considered

with awareness of factors that may make treatment inappropriate, such as the person's preference, presence of comorbidities, whether they are on multiple medications, whether they are frail, their cognitive status, and their life expectancy. [NICE's guideline on cardiovascular disease: risk assessment and reduction, including lipid modification, recommendations 1.5.2 and 1.6.9 and expert opinion]

Quality statement 4: Assessing response to lipid-lowering treatment

Quality statement

Adults starting or changing lipid-lowering treatment have a full lipid profile and their liver transaminases measured at 2 to 3 months. **[2015, updated 2025]**

Rationale

Repeating lipid profiles and measuring liver transaminases after starting or changing lipid-lowering treatment (and after a baseline blood sample has been taken), is important for patient safety and to ensure the effectiveness of the treatment. A repeat lipid profile can be used to determine whether the expected lipid levels have been met and can indicate the need for escalation of treatment. Measurement of liver transaminase is important to detect any increased levels of these enzymes, which may indicate problems with liver function.

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.

Process

Proportion of adults starting or changing lipid-lowering treatment who had a full lipid profile and their liver transaminases measured at 2 to 3 months.

Numerator – the number in the denominator who had a full lipid profile and their liver transaminases measured at 2 to 3 months.

Denominator – the number of adults starting or changing lipid-lowering treatment.

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

What the quality statement means for different audiences

Service providers (such as primary care services or secondary care services) ensure that adults on lipid-lowering treatment have a full lipid profile and their liver transaminases measured 2 to 3 months after starting or changing treatment.

Healthcare professionals (such as GPs, doctors, nurses and pharmacists) measure a full lipid profile and liver transaminases 2 to 3 months after adults start or change lipid-lowering treatment.

Commissioners ensure that adults on lipid-lowering treatment have a full lipid profile and liver transaminases measured 2 to 3 months after starting or changing treatment.

Adults taking medicine to reduce their chance of a heart attack or stroke have a blood test 2 to 3 months after starting or changing medicine to check that it is reducing their cholesterol levels and not affecting their liver.

Source guidance

Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendation 1.11.1

Definitions of terms used in this quality statement

Full lipid profile

This involves taking a blood sample to measure total cholesterol, HDL cholesterol and triglyceride levels and then calculating non-HDL cholesterol and LDL cholesterol (a fasting sample is not mandated). LDL cholesterol results may not be reported in participants with triglyceride levels more than 4.5 mmol per litre or 9 mmol per litre depending on the formula used by local laboratories. [NICE's guideline on cardiovascular disease: risk assessment and reduction, including lipid modification, terms used in this guideline]

Quality statement 5: Secondary prevention of cardiovascular disease

Quality statement

Adults with cardiovascular disease have a low-density lipoprotein (LDL) cholesterol level of 2.0 mmol per litre or less, or a non-high-density lipoprotein (non-HDL) cholesterol level of 2.6 mmol per litre or less. **[new 2025]**

Rationale

Management of LDL cholesterol or non-HDL cholesterol is important to reduce the risk of future cardiovascular events in adults with existing cardiovascular disease. High-intensity statins are the most clinically effective treatment option for the secondary prevention of cardiovascular disease (CVD) by reduction of lipid levels. Atorvastatin 80 mg is recommended as the preferred high-intensity statin, but other lipid-lowering treatments could be used if atorvastatin 80 mg is contraindicated, not tolerated or the target cholesterol level is not achieved. A non-HDL cholesterol target can be used if an LDL cholesterol level has not been requested or calculated.

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.

Outcome

Proportion of adults with CVD in whom the last recorded LDL or non-HDL cholesterol level (measured in the preceding 12 months) is 2.0 mmol per litre or less for LDL cholesterol, or 2.6 mmol per litre or less for non-HDL cholesterol.

Numerator – the number in the denominator in whom the last recorded LDL or non-HDL cholesterol level (measured in the preceding 12 months) is 2.0 mmol per litre or less for

LDL cholesterol, or 2.6 mmol per litre or less for non-HDL cholesterol.

Denominator – the number of adults with CVD.

Data source:CVDPREVENT indicator CVDP012CHOL reports the proportion of patients with GP-recorded CVD (narrow definition which includes coronary heart disease [CHD], non-haemorrhagic stroke and stroke cause not specified, transient ischaemic attack [TIA] and peripheral arterial disease), whose most recent blood cholesterol level is LDL cholesterol less than or equal to 2.0 mmol per litre or, non-HDL cholesterol less than or equal to 2.6 mmol per litre in the preceding 12 months. The indicator also reports data for inequality markers including sex, age, ethnicity, deprivation level and presence of a learning disability.

QOF indicator CHOL004 reports the percentage of patients on the QOF CHD, PAD or stroke/TIA register with the most recent cholesterol measurement in the preceding 12 months, showing as 2.0 mmol per litre or less if it was an LDL (low-density lipoprotein) cholesterol reading or 2.6 mmol per litre or less if it was a non-HDL (high-density lipoprotein) cholesterol reading.

What the quality statement means for different audiences

Service providers (for example primary care services and secondary care services) ensure that systems are in place for adults with CVD to achieve their lipid target, for example ensuring that LDL cholesterol or non-HDL cholesterol can be measured, and that lipid-lowering treatment can be offered.

Healthcare professionals (such as GPs, nurses, doctors, and specialist nurses) are aware of treatment targets for secondary prevention of CVD and offer adults with CVD treatment with atorvastatin 80 mg, or other lipid-lowering treatment if required, to achieve the target. They could use NHS England's summary of national guidance for lipid management. They discuss lifestyle change with the patient at the same time. Treatment and any changes to treatment should be made after an informed discussion between the healthcare professional and the adult with CVD. They are aware of strategies to address adverse effects of high-intensity statins if reported by the adult on a high-intensity statin and could use NHS England's statin intolerance pathway to address statin intolerance. They repeat measurement of LDL cholesterol or non-HDL cholesterol in adults with CVD after 2 to

3 months of treatment and consider escalation of treatment with alternative lipid-lowering treatment if the target is not achieved.

Commissioners ensure that they commission services in which adults with CVD have treatment to achieve their target lipid level.

Adults with CVD are aware of their target cholesterol level and receive treatment, and advice on lifestyle changes, that lower their bad cholesterol (non-high-density lipoprotein [non-HDL], which is mainly composed of low-density lipoprotein [LDL] cholesterol) to a level that reduces their chances of having a heart attack or stroke in the future after discussion with their healthcare professional.

Source guidance

Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendation 1.7.1

Definitions of terms used in this quality statement

Adults with cardiovascular disease

Including coronary heart disease, ischaemic stroke or TIA (excluding a history of haemorrhagic stroke) or peripheral arterial disease. [Adapted from Quality and Outcomes Framework indicator CHOL004, NICE's indicator on cardiovascular disease prevention: secondary prevention with lipid lowering therapies and expert opinion]

Update information

July 2025: This quality standard was updated and statements prioritised in 2015 were replaced. The topic was identified for update following the annual review of quality standards. The review identified updated guidance on cardiovascular disease: risk assessment and reduction, including lipid modification.

Statements are marked as:

- **[new 2025]** if the statement covers a new area for quality improvement
- **[2015, updated 2025]** if the statement covers an area for quality improvement included in the 2015 quality standard and has been updated.

The previous version of the quality standard for cardiovascular risk assessment and lipid modification is available as a pdf.

Minor changes since publication

September 2025: We update the source guidance for statement 3 to align with updated recommendations in NICE's guideline on cardiovascular disease that refer to relevant technology appraisals.

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 high-quality external 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 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 report for NICE's guideline on cardiovascular disease: risk assessment and reduction, including lipid modification 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.

For all quality statements where information is given, it is important that people are provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter if needed. People should also have access to an advocate, if needed, as set out in NICE's guideline on advocacy services for adults with health and social care needs.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

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.

ISBN: 978-1-4731-7122-0

Endorsing organisation

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

Supporting organisation

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.

- British and Irish Association of Stroke Physicians