NICE National Institute for Health and Care Excellence

NICE quality standard

Cardiovascular risk assessment and lipid modification

Quality standard
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Contents

This standard is based on NG238.

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

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Statement 9 (placeholder). Identifying people with an estimated increased risk.

The previous version of the quality standard for cardiovascular risk assessment and lipid

modification is available as a pdf.

Quality statement 1: Full formal risk assessment using QRISK3

Quality statement

Adults aged between 25 and 84 years with an estimated increased risk of cardiovascular disease (CVD) are offered a full formal risk assessment using the QRISK3 tool.

Rationale

A full formal risk assessment for adults who have been identified to have an estimated increased risk of CVD is the most accurate method of targeting prevention strategies to improve clinical outcomes. QRISK3 is the recommended formal risk assessment tool to assess CVD risk for the primary prevention of CVD in people aged between 25 and 84 years. QRISK3 is an online assessment tool for estimating the 10-year risk of having a cardiovascular event, in people who do not already have heart disease. A person's 10-year risk of CVD can be used to inform treatment decisions, such as lifestyle advice or drug treatment.

Clinical judgement should inform interpretation of results from CVD risk tools when used in certain groups of people because tools may underestimate the risk (see NICE's guideline on cardiovascular disease, recommendation 1.1.10).

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 arrangements to ensure that the QRISK3 tool is used to formally risk assess adults between 25 and 84 years when an estimated increased risk of CVD is identified.

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

Process

Proportion of adults between 25 and 84 years with an estimated increased risk of CVD who have a full formal risk assessment using the QRISK3 tool.

Numerator – the number in the denominator having a full formal risk assessment using the QRISK3 tool.

Denominator – the number of adults between 25 and 84 years with an estimated increased risk of CVD.

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 (primary care services) ensure that systems are in place to offer adults between 25 and 84 years with an estimated increased risk of CVD a full formal risk assessment using the QRISK3 tool.

Healthcare professionals (such as GPs and nurses) ensure that they offer a full formal risk assessment using the QRISK3 tool to adults between 25 and 84 years with an estimated increased risk of CVD.

Commissioners ensure that they commission services that offer a full formal risk assessment using the QRISK3 tool to adults between 25 and 84 years with an estimated increased risk of CVD.

Adults between 25 and 84 years who may be at risk of developing CVD are offered a risk assessment. The GP or nurse uses a computer program called QRISK3 to fully assess their risk of developing CVD over the next 10 years. This takes into account factors including the person's age, sex, smoking status, blood pressure and cholesterol levels, all of which can affect the risk of developing CVD. It will help identify adults who need lifestyle advice

and possibly treatment to reduce their risk.

Source guidance

Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendations 1.1.4 and 1.1.7

Definitions of terms used in this quality statement

Estimated increased risk of CVD

To estimate risk of CVD, use CVD risk factors that are already recorded in primary care electronic medical records using a systematic strategy. [NICE's guideline on cardiovascular disease, recommendations 1.1.1 and 1.1.2]

Adults aged 85 years and over, and those with pre-existing CVD or other clinical conditions that increase CVD risk (such as type 1 diabetes, familial hypercholesterolaemia or chronic kidney disease) are already considered at high risk and so should be excluded from estimations of increased risk and formal risk assessment. [NICE's guideline on cardiovascular disease, recommendations 1.1.9 and 1.1.11]

Full formal risk assessment

This assessment should use the QRISK3 tool to calculate the estimated 10-year CVD risk for the primary prevention of CVD in people aged between 25 and 84 years. Clinical judgement should inform interpretation of results from CVD risk tools when used in certain groups of people because tools may underestimate the risk (see NICE's guideline on cardiovascular disease, recommendation 1.1.10). [NICE's guideline on cardiovascular disease, recommendations 1.1.7 and 1.1.10].

Equality and diversity considerations

The statement includes adults aged between 25 and 84 years because this is the population in which the QRISK3 tool is valid. Adults aged 85 years and older should be considered to be at high risk based on age alone, particularly those who smoke or have high blood pressure. People aged under 25 are not at high risk for CVD unless they have a

specific condition that increases risk.

Clinical judgement should inform interpretation of results from CVD risk tools when used in certain groups of people because tools may underestimate the risk (see NICE's guideline on cardiovascular disease, recommendation 1.1.10). 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.

Quality statement 2: Excluding secondary causes

Quality statement

Adults with a 10-year risk of cardiovascular disease (CVD) of 10% or more are assessed for secondary causes before any offer of statin treatment.

Rationale

Several conditions can increase a person's risk of CVD, which may also cause dyslipidaemia (abnormal lipid levels). It is important that these are identified before starting statin treatment, which can cause side effects in adults with certain conditions. Common secondary causes of increased risk of CVD or dyslipidaemia include uncontrolled diabetes, hypothyroidism, liver disease and nephrotic syndrome.

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 arrangements to ensure that adults with a 10-year risk of CVD of 10% or more are assessed for secondary causes before any offer of statin treatment.

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

Process

Proportion of adults with a 10-year risk of CVD of 10% or more who are assessed for secondary causes before any offer of statin treatment.

Numerator – the number in the denominator who are assessed for secondary causes before any offer of statin treatment.

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 patient records.

What the quality statement means for different audiences

Service providers (primary care services) should ensure that adults with a 10-year risk of CVD of 10% or more are assessed for secondary causes before offering statin treatment. This assessment should be recorded and made available for any monitoring requests.

Healthcare professionals (such as GPs and nurses) assess adults with a 10-year risk of CVD of 10% or more for secondary causes before offering statin treatment.

Commissioners ensure that GPs in their locality are aware of the need for adults with a 10-year risk of CVD of 10% or more to be assessed for secondary causes before offering statin treatment.

Adults with a 1 in 10 or more chance of developing CVD in the next 10 years (a 10-year risk of 10% or more) are checked to see if there are any underlying causes before being offered treatment with a medicine called a statin. This will indicate whether there is another reason for their increased risk that might need a different treatment.

Source guidance

Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendations 1.4.3 and 1.5.5

Definitions of terms used in this quality statement

Assessment for secondary causes

Secondary causes of increased CVD risk and dyslipidaemia include excess alcohol use, uncontrolled diabetes, hypothyroidism, liver disease and nephrotic syndrome. An assessment for secondary causes of CVD risk or dyslipidaemia should include:

- smoking status
- alcohol consumption
- blood pressure
- body mass index or other measure of obesity
- full lipid profile
- diabetes status
- renal function
- transaminase level
- thyroid-stimulating hormone in people with symptoms of underactive or overactive thyroid.

[NICE's guideline on cardiovascular disease, recommendations 1.4.3 and 1.5.5]

Equality and diversity considerations

The statement includes adults with a 10-year risk of CVD of 10% or more, as determined by their QRISK3 score if they are between 25 and 84 years. Adults aged 85 years and older should be considered to be at high risk based on age alone, particularly those who smoke or have high blood pressure. People aged under 25 are not at high risk for CVD unless they have a specific condition that increases risk.

Clinical judgement should inform interpretation of results from CVD risk tools when used in certain groups of people because tools may underestimate the risk (see NICE's guideline on cardiovascular disease, recommendation 1.1.10). When using a QRISK3 risk score to

inform drug 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.

Quality statement 3: Lifestyle advice for primary prevention

Quality statement

Adults with a 10-year risk of cardiovascular disease (CVD) of 10% or more receive advice on lifestyle changes before any offer of statin treatment.

Rationale

Lifestyle changes such as stopping smoking, increasing physical activity, eating a healthy diet, managing weight and reducing alcohol consumption can reduce the risk of CVD. Lifestyle changes should be made, if possible, before statin treatment is offered, because these can reduce a person's risk of CVD without the need for drug treatment. It is important that the benefits of lifestyle changes for primary prevention are discussed with adults at risk of CVD, to encourage uptake of lifestyle interventions before any offer of statin treatment.

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 arrangements to ensure that adults with a 10-year risk of CVD of 10% or more receive advice on lifestyle changes before any offer of statin treatment.

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

Process

Proportion of adults with a 10-year risk of CVD of 10% or more who receive advice on lifestyle changes before any offer of statin treatment.

Numerator – the number in the denominator who receive advice on lifestyle changes before any offer of statin treatment.

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 patient records.

What the quality statement means for different audiences

Service providers (primary care services) ensure that processes are in place for adults with a 10-year risk of CVD of 10% or more to be given advice on lifestyle changes before any offer of statin treatment.

Healthcare professionals (such as GPs, nurses and pharmacists) give advice on lifestyle changes to adults with a 10-year risk of CVD of 10% or more before they offer statin treatment.

Commissioners ensure that GPs are aware that adults with a 10-year risk of CVD of 10% or more should be given lifestyle advice before offering statin treatment. Commissioners may wish to consider incorporating this discussion into NHS Health Checks and local enhanced service specifications.

Adults with a 1 in 10 or more chance of developing CVD in the next 10 years (a 10-year risk of 10% or more) are given advice on lifestyle changes, such as stopping smoking, losing weight, eating a healthy diet and exercising, before being offered statin treatment. These changes may help to reduce their chances of having a heart attack or stroke in the future.

Source guidance

Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendations 1.1.17, 1.6.2 and 1.6.3

Definitions of terms used in this quality statement

Lifestyle changes

Lifestyle changes include:

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

[NICE's guideline on cardiovascular disease, recommendations 1.3.1 to 1.3.12]

Equality and diversity considerations

The statement includes adults with a 10-year risk of CVD of 10% or more, as determined by their QRISK3 score if they are between 25 and 84 years. Adults aged 85 years and older should be considered to be at high risk based on age alone, particularly those who smoke or have high blood pressure. People aged under 25 are not at high risk for CVD unless they have a specific condition that increases risk.

Clinical judgement should inform interpretation of results from CVD risk tools when used in certain groups of people because tools may underestimate the risk (see NICE's guideline on cardiovascular disease, recommendation 1.1.10). When using a QRISK3 risk score to inform drug treatment decisions, 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.

The lifestyle advice given should be sensitive to people's culture and faith, and tailored to their needs. An interpreter should be consulted if needed for people whose first language is not English. 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.

Quality statement 4: Discussing risks and benefits of statins for primary prevention

Quality statement

Adults with a 10-year risk of cardiovascular disease (CVD) of 10% or more for whom lifestyle changes are ineffective or inappropriate, discuss the risks and benefits of starting statin treatment with their healthcare professional.

Rationale

People who are better informed and involved in decisions about their care are more likely to adhere to their chosen treatment plan, which improves patient experience and clinical outcomes.

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 arrangements to ensure that adults with a 10-year risk of CVD of 10% or more, for whom lifestyle changes are ineffective or inappropriate, discuss with their healthcare professional the risks and benefits of starting statin treatment.

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

Process

Proportion of adults with a 10-year risk of CVD of 10% or more, for whom lifestyle changes are ineffective or inappropriate, with a recorded discussion on the risks and benefits of

starting statin treatment.

Numerator – the number in the denominator who have a record of a discussion on the risks and benefits of starting statin treatment.

Denominator – the number of adults with a 10-year risk of CVD of 10% or more for whom lifestyle changes have been ineffective or are inappropriate.

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

Outcome

Proportion of adults with a 10-year risk of CVD of 10% or more on high-intensity statin.

Numerator – the number in the denominator who have a record of high-intensity statin.

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

Data source:CVD Prevent's indicator CVD006CHOL reports the percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 10% or more, on lipid lowering therapy.

What the quality statement means for different audiences

Service providers (primary care services) ensure that adults with a 10-year risk of CVD of 10% or more, for whom lifestyle changes are ineffective or inappropriate, have a documented discussion with their healthcare professional about the risks and benefits of starting statin treatment.

Healthcare professionals (such as GPs, nurse prescribers and pharmacists) discuss the risks and benefits of starting statin treatment with adults who have a 10-year risk of CVD of 10% or more for whom lifestyle changes have been ineffective or are inappropriate, and record details of the discussion and the person's decision.

Commissioners ensure that adults with a 10-year risk of CVD of 10% or more for whom

lifestyle changes are ineffective or inappropriate have a documented discussion with their healthcare professional about the risks and benefits of starting statin treatment. Commissioners may do this by seeking evidence of practice, through clinical audits.

Adults with a 1 in 10 or more chance of developing CVD in the next 10 years (a 10-year risk of 10% or more) for whom lifestyle changes have not helped or are unsuitable, discuss with their doctor the risks and benefits of starting statin treatment. This should include information about how statin therapy may help to reduce their chances of having a heart attack or stroke in the future.

Source guidance

Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendations 1.5.1 and 1.5.2

Definitions of terms used in this quality statement

Ineffective lifestyle changes

Lifestyle changes such as stopping smoking, increasing physical activity and changing diet that have not resulted in a reduction in CVD risk when QRISK3 is repeated are considered to have been ineffective. Use clinical judgement to determine how long to wait before lifestyle changes are considered ineffective, because this depends on the type of lifestyle changes and the person's wishes and needs. [Adapted from NICE's guideline on cardiovascular disease, recommendation 1.6.4, and expert opinion]

Discussion about the risks and benefits of statin therapy

The discussion should include information about a person's risk of CVD and about the benefits and harms of statin treatment over a 10-year period. The discussion and the person's decision should be documented. This information should be in a form that:

- presents individualised risk and benefit scenarios
- presents the absolute risk of events numerically
- uses appropriate diagrams and text.

[Adapted from NICE's guideline on cardiovascular disease, recommendations 1.1.14 and 1.1.15, and NICE's guideline on shared decision making, recommendations 1.4.1, 1.4.2 and 1.4.7]

The NICE patient decision aid for NICE's guideline on cardiovascular disease: Should I take a statin? (2023) can be used to help make decisions about treatment with statins.

Equality and diversity considerations

The statement includes adults with a 10-year risk of CVD exceeding 10%, as determined by their QRISK3 score if they are aged between 25 and 84 years. Adults aged 85 years and older should be considered to be at high risk based on age alone, particularly those who smoke or have high blood pressure. People aged under 25 are not at high risk for CVD unless they have a specific condition that increases risk.

Clinical judgement should inform interpretation of results from CVD risk tools when used in certain groups of people because tools may underestimate the risk (see NICE's guideline on cardiovascular disease, recommendation 1.1.10). When using a QRISK3 risk score to inform drug treatment decisions, particularly if it is near to 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.

The discussion about the risks and benefits of starting statin treatment should be sensitive to people's culture and faith, and tailored to their needs. An interpreter should be consulted if it is not appropriate to use an English-language-based patient decision aid, for example, for people whose first language is not English. 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.

Quality statement 5: Statins for primary prevention

Quality statement

Adults choosing statin treatment for the primary prevention of cardiovascular disease (CVD) are offered atorvastatin 20 mg.

Rationale

High-intensity statins are the most clinically effective treatment option for the primary prevention of CVD – that is, reducing the risk of first CVD events. After a discussion of the risks and benefits of starting statin treatment with a healthcare professional, a person may choose statin treatment as an appropriate treatment to reduce their risk of CVD. When a person decides to have statin treatment, a statin of high intensity and low cost should be offered. Atorvastatin 20 mg is recommended as the preferred initial high-intensity statin to use because it is clinically and cost effective for the primary 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

Evidence of local arrangements to ensure that adults who choose statin treatment for primary prevention are offered atorvastatin 20 mg.

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

Process

Proportion of adults choosing statin treatment for primary prevention of CVD who are prescribed atorvastatin 20 mg.

Numerator – the number in the denominator prescribed atorvastatin 20 mg.

Denominator – the number of adults choosing statin treatment for primary prevention of CVD.

Data source: Data on prescription of atorvastatin 20 mg can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. Publicly available national data on use of lipid lowering therapies in general practice patients is available from CVD Prevent's indicator CVD006CHOL. This reports the percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 10% or more, on lipid lowering therapy.

Outcome

Proportion of adults choosing statin treatment for primary prevention of CVD who have a greater than 40% reduction in non-high-density lipoprotein (HDL) cholesterol at 3 months of treatment.

Numerator – the number in the denominator who have a greater than 40% reduction in non-HDL cholesterol at 3 months of treatment.

Denominator – the number of adults choosing statin treatment for primary prevention of CVD.

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 (primary care services) ensure that adults choosing statin treatment for primary prevention of CVD are offered atorvastatin 20 mg.

Healthcare professionals (GPs, nurse prescribers and pharmacists) offer atorvastatin 20 mg to adults choosing statin treatment for primary prevention of CVD.

Commissioners ensure that adults who choose statin treatment for primary prevention of CVD are offered atorvastatin 20 mg. Commissioners may do this by seeking evidence of practice through clinical audits.

Adults at risk of CVD who choose to have a statin to reduce their chances of CVD are offered one called atorvastatin. This may help to reduce their chances of having a heart attack or stroke in the future.

Source guidance

Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendations 1.6.1, 1.6.7 and 1.6.9

Quality statement 6: Statins for secondary prevention

Quality statement

Adults with newly diagnosed cardiovascular disease (CVD) are offered atorvastatin 80 mg.

Rationale

High-intensity statins are the most clinically effective option for the secondary prevention of CVD – that is, reducing the risk of future CVD events in people who have already had a CVD event, such as a heart attack or stroke. Evidence shows that atorvastatin 80 mg is the most cost-effective high-intensity statin for the secondary prevention of CVD, which can improve clinical outcomes.

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 arrangements to ensure that adults with newly diagnosed CVD are offered atorvastatin 80 mg.

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

Process

Proportion of adults with newly diagnosed CVD who are prescribed atorvastatin 80 mg.

Numerator – the number in the denominator prescribed atorvastatin 80 mg.

Denominator – the number of adults with newly diagnosed CVD.

Data source: Data on prescription of atorvastatin 80 mg for adults with newly diagnosed CVD can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. Publicly available national data on use of lipid lowering therapies in general practice patients with CVD is available from CVD Prevent's indicator CVD009CHOL. This reports the percentage of patients aged 18 and over with GP recorded CVD who are currently treated with lipid lowering therapy.

Outcome

Proportion of adults with CVD choosing statin treatment who have a low-density lipoprotein (LDL) cholesterol level of 2.0 mmol per litre or less, or non-high-density lipoprotein (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 CVD choosing statin treatment.

Data source: Data on achievement of NICE recommended lipid targets can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. Publicly available national data on lipid targets for adults with CVD is available from CVD Prevent's indicator CVD007CHOL and Quality Outcomes Framework (QOF) indicator CHOL002. CVD Prevent's indicator CVD007CHOL reports the percentage of patients aged 18 and over with GP recorded CVD in whom the most recent blood cholesterol level (measured in the preceding 12 months) is non-HDL cholesterol less than 2.5 mmol/L or LDL-cholesterol less than 1.8 mmol/L. QOF indicator CHOL002 measures the percentage of patients with CVD who have a recording of non-HDL cholesterol in the preceding 12 months that is lower than 2.5 mmol/L, or where non-HDL cholesterol is not recorded, a recording of LDL cholesterol in the preceding 12 months that is lower than 1.8 mmol/L.

What the quality statement means for different audiences

Service providers (such as primary care services and secondary care services) ensure

that adults with newly diagnosed CVD are offered atorvastatin 80 mg.

Healthcare professionals (such as GPs, doctors in secondary care, nurse prescribers and pharmacists) offer atorvastatin 80 mg to adults with newly diagnosed CVD.

Commissioners ensure that adults with newly diagnosed CVD are offered atorvastatin 80 mg. Commissioners may do this by seeking evidence of practice through clinical audits.

Adultswho have been newly diagnosed with CVD are offered a statin called atorvastatin to help reduce their chances of further problems, such as a heart attack or stroke.

Source guidance

Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendations 1.7.1 and 1.7.2

Definitions of terms used in this quality statement

Cardiovascular disease

Angina, previous myocardial infarction, revascularisation, ischaemic stroke or TIA (excluding a history of haemorrhagic stroke) or symptomatic peripheral arterial disease. [NICE indicator NM212]

Atorvastatin 80 mg

In May 2023, this was an off-label use of atorvastatin. See NICE's information on prescribing medicines.

Quality statement 7: Side effects of high-intensity statins

Quality statement

Adults on a high-intensity statin who have side effects are offered a lower dose or an alternative statin.

Rationale

The use of high-intensity statins can cause side effects, but to improve clinical outcomes it is important that alternative strategies are tried rather than stopping treatment. Any statin at any dose reduces the risk of cardiovascular disease (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

Evidence of local arrangements to ensure that adults on a high-intensity statin are monitored for side effects and offered a lower dose or an alternative statin if necessary.

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

Process

Proportion of adults reporting side effects from a high-intensity statin who are given a lower dose or alternative statin.

Numerator – the number in the denominator at which a lower dose or alternative statin is

prescribed.

Denominator – the number of presentations of adults reporting side effects from a high-intensity 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 primary care services and secondary care services) should ensure that adults on a high-intensity statin who have side effects are offered a lower dose or an alternative statin.

Healthcare professionals (GPs, doctors in secondary care, nurse prescribers and pharmacists) offer a lower dose or an alternative statin to adults who have side effects from a high-intensity statin.

Commissioners should ensure that providers are aware that adults on a high-intensity statin who have side effects should be offered a lower dose or an alternative statin.

Adults taking a statin who have side effects are offered a lower dose or a different statin.

Source guidance

Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendations 1.9.2 and 1.9.4

Definitions of terms used in this quality statement

Alternative statin

A different statin in the same intensity group (rosuvastatin if already receiving atorvastatin) or changing the statin to a lower intensity group. [NICE's guideline on cardiovascular disease, recommendation 1.9.2]

High-intensity statin

The intensity of a statin is defined based on the percentage reduction in low-density lipoprotein (LDL) cholesterol it can produce. High-intensity statins include:

- atorvastatin 20 mg to 80 mg
- rosuvastatin 10 mg to 40 mg.

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

Quality statement 8: 3-month statin review

Quality statement

Adults on lipid-lowering treatment have a repeat measurement of full lipid profile and liver transaminases at 2 to 3 months of treatment.

Rationale

Repeating lipid profiles and measuring liver transaminases is important for patient safety and to ensure the effectiveness of lipid-lowering treatment. A repeat lipid profile can be used to determine whether the expected cholesterol levels have been met. Repeat 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. The quality measures use a timeframe of 3 months for measurement purposes.

Structure

Evidence of local arrangements to ensure that adults on lipid-lowering treatment have a repeat measurement of full lipid profile and liver transaminases at 3 months of treatment.

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

Process

Proportion of adults on lipid-lowering treatment who have had a repeat measurement of

lipids and liver transaminases at 3 months of treatment.

Numerator – the number in the denominator who have had a repeat measurement of lipids and liver transaminases at 3 months of treatment.

Denominator – the number of adults prescribed lipid-lowering treatment for at least 3 months.

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 (primary care services) ensure that adults on lipid-lowering treatment have a repeat measurement of lipids and liver transaminases at 2 to 3 months of treatment. Evidence should be made available on request to commissioners.

Healthcare professionals (such as GPs and nurses) take a repeat measurement of lipids and liver transaminases at 2 to 3 months of treatment for adults on lipid-lowering treatment.

Commissioners should monitor whether adults on lipid-lowering treatment have a repeat measurement of lipids and liver transaminases at 2 to 3 months of treatment. Commissioners may wish to stipulate this in any local enhanced service specifications.

Adults taking medicine to reduce their chance of a heart attack or stroke in the future have a review 3 months after their treatment starts to see if the medicine is reducing their cholesterol levels and to check it is not affecting their liver.

Source guidance

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

Quality statement 9 (placeholder): Identifying people with an estimated increased risk

What is a placeholder statement?

A placeholder statement is an area of care that has been prioritised by the quality standards advisory committee but for which no source guidance is currently available. A placeholder statement indicates the need for evidence-based guidance to be developed in this area.

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, people at increased risk of CVD need to be identified and their risk factors managed in the most effective way. It is estimated that half of men over 50 and one-fifth of women over 65 have a CVD risk of 20% or more. Current guidance recommends using a systematic strategy in primary care using electronic records to identify people with an estimated increased risk of CVD. However, clarification of the strategies to prioritise people for assessment was not included in guideline recommendations. Further guidance is needed on methods to use across the healthcare pathway to identify people with an estimated increased risk of CVD, how frequently this identification should be done and which healthcare professionals should carry it out.

Update information

May 2023: Changes have been made to align this quality standard with the updated NICE guideline on cardiovascular disease: risk assessment and reduction, including lipid modification. Statements 1 and 7 have been updated to reflect changes to the guidance on identifying and assessing cardiovascular disease risk, and lipid modification therapy for the primary and secondary prevention of cardiovascular disease. Links, definitions, equality and diversity considerations and source guidance sections have also been updated throughout.

Minor changes since publication

December 2023: Changes have been made to the source guidance sections of this quality standard to align with the updated NICE guideline on cardiovascular disease: risk assessment and reduction, including lipid modification. Quality measures have been updated to include reference to sources of nationally collected data where available and additional process and outcome measures added to statements 4, 5 and 6. Quality statement 8 has been amended to align with underpinning recommendations that have been updated.

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 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)