Lipid modification

NICE quality standard

Draft for consultation

March 2015

Introduction

This quality standard covers lipid modification for the primary and secondary prevention of cardiovascular disease in adults (aged 18 years and over). For more information see the lipid modification overview.

Why this quality standard is needed

Cardiovascular disease (CVD) describes disease of the heart and blood vessels caused by the process of atherosclerosis. It is the leading cause of death in England and Wales, accounting for almost one-third of deaths. In 2010, 180,000 people died from CVD – around 80,000 of these deaths were caused by coronary heart disease and 49,000 were caused by strokes. Of the 180,000 deaths, 46,000 occurred in people aged 75 years or younger, and 70% of those were in men. It is estimated that 60% of the CVD mortality decline in the UK during the 1980s and 1990s was attributable to reductions in major risk factors, principally smoking, and that drug treatment, including secondary prevention, accounts for the remaining 40% of the decline in mortality. Since 2000, immediate fatal CVD deaths have halved. In spite of evidence that mortality from CVD is falling, morbidity appears to be rising. CVD has significant cost implications and was estimated to cost the NHS in England almost £6,940 million in 2003, rising to £7,880 million in 2010.

A range of interventions are offered to prevent CVD, both for people who have been identified as having a high risk of developing CVD (primary prevention) and for people with established CVD (secondary prevention). These include lifestyle interventions, such as smoking cessation and appropriate advice on diet, physical activity and drinking. If appropriate, treatment for high blood pressure and cholesterol

may be offered to target individual risk factors to reduce the risk of developing CVD or to prevent the worsening of CVD.

One of the main strategies for CVD risk management is the use of lipid-lowering therapies, especially statins. Statin therapy requires long-term treatment to be fully beneficial. Key challenges in the field of CVD prevention include improving adherence in people who have experienced CVD events, convincing people who feel well that they need to make substantial lifestyle changes and/or that they may need lifelong drug treatment. This requires high-quality information and communication on the benefits and risks associated with these therapies.

The quality standard is expected to contribute to improvements in the following outcomes:

- incidence of CVD
- mortality from CVD
- patient experience of GP services

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–2016

Tables 1–2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicator*** 1b Life expectancy at 75 i Males ii Females ***Improvement areas*** **Reducing premature mortality from the major causes of death** 1.1 Under 75 mortality rate from cardiovascular disease* **Reducing premature death in people with mental illness** 1.5 Excess under 75 mortality rate in adults with serious mental illness*
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition** **Improving functional ability in people with long-term conditions** 2.2 Employment of people with long-term conditions*/**
4 Ensuring that people have a positive experience of care	***Overarching indicator*** 4a Patient experience of primary care i GP services
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)	

Table 2 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors which affect health and wellbeing and health inequalities ***Indicators*** 1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services*
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities ***Indicators*** 4.4 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)* 4.9 Excess under 75 mortality in adults with serious mental illness*
Aligning across the health and social care system * Indicator shared with the NHS Outcomes Framework	

Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to lipid modification.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development source(s) for quality standards that impact on patient experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for lipid modification specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to adults receiving interventions for lipid modification.

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 refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing high-quality interventions for lipid modification are listed in Related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating adults receiving interventions for lipid modification should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source(s) on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting adults receiving interventions for lipid modification. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. Adults with a 10-year risk of CVD of 10% or more are assessed for secondary causes of dyslipidaemia before any offer of statin therapy.

Statement 2. Adults with a 10-year risk of CVD of 10% or more have the benefits of lifestyle changes for primary prevention discussed with them before any offer of statin therapy.

Statement 3. Adults with a 10-year risk of CVD of 10% or more for whom lifestyle changes have been ineffective or are inappropriate are offered atorvastatin 20 mg for primary prevention.

Statement 4. Adults with CVD are offered atorvastatin 80 mg for secondary prevention.

Statement 5. Adults who develop adverse effects on high-intensity statins are offered alternative doses of statins or an alternative statin.

Statement 6. Adults on high-intensity statins have a 3-month review after the start of treatment.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Question 3 For each quality statement what do you think could be done to support improvement and help overcome barriers?

Quality statement 1: Excluding secondary causes of dyslipidaemia

Quality statement

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

Rationale

Several conditions can cause dyslipidaemia. It is important that these are excluded before starting statin therapy because statin therapy can have adverse effects in adults with certain conditions. Possible common secondary causes of dyslipidaemia include excess alcohol, uncontrolled diabetes, hypothyroidism, liver disease and nephrotic syndrome. Excluding secondary causes will help to ensure that adults receive the appropriate treatment for their condition.

Quality measures

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 of dyslipidaemia before any offer of statin therapy.

Data source: Local data collection.

Process

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

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

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

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

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

Healthcare professionals ensure that they assess adults with a 10-year risk of CVD of 10% or more for secondary causes of dyslipidaemia before offering statin therapy.

Commissioners (NHS England area teams and clinical commissioning groups [CCGs]). NHS England should 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 of dyslipidaemia before offering statin therapy. CCGs should include this requirement in any relevant Local Enhanced Service (for example, cardiovascular), according to local arrangements.

What the quality statement means for patients, service users and carers

Adults with a 10-year risk of CVD of 10% or more are assessed for secondary causes of dyslipidaemia before being offered statin therapy. This will determine whether there is another reason for dyslipidaemia that needs alternative treatment.

Source guidance

- Lipid modification (2014) NICE guideline CG181, recommendations 1.3.6 and 1.3.13.

Definitions of terms used in this quality statement

10-year risk of CVD of 10% or more

For adults aged 84 and under, the 10-year risk of CVD is estimated using the QRISK2 assessment tool. Adults aged 85 years and older should be considered to be at high risk based on age alone, particularly those who smoke or have raised blood pressure. Adults with pre-existing clinical conditions such as type 1 diabetes,

familial hypercholesterolaemia or chronic kidney disease are already considered at high risk. [Lipid modification (NICE guideline CG181) recommendations 1.1.8, 1.1.9, 1.1.11, 1.1.15, 1.1.16, 1.1.21]

Secondary causes of dyslipidaemia

Secondary causes of dyslipidaemia include excess alcohol, uncontrolled diabetes, hypothyroidism, liver disease and nephrotic syndrome. [Lipid modification (NICE guideline CG181) recommendation 1.3.6]

Assessment for secondary causes of dyslipidaemia

An assessment for secondary causes of dyslipidaemia should include:

- smoking status
- alcohol consumption
- blood pressure
- body mass index
- total cholesterol
- HbA_{1c}
- renal function and estimated glomerular filtration rate (eGFR)
- transaminase level
- thyroid-stimulating hormone

[Lipid modification (NICE guideline CG181) recommendation 1.3.13]

Quality statement 2: Lifestyle interventions for primary prevention of cardiovascular disease

Quality statement

Adults with a 10-year risk of cardiovascular disease (CVD) of 10% or more have the benefits of lifestyle changes for primary prevention discussed with them before any offer of statin therapy.

Rationale

Lifestyle changes such as stopping smoking, increasing physical activity, eating a healthy diet, good weight management and reducing alcohol consumption can reduce cholesterol levels and prevent CVD events. 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 therapy.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with a 10-year risk of CVD of 10% or more have the benefits of lifestyle changes for primary prevention discussed with them before any offer of statin therapy.

Data source: Local data collection.

Process

Proportion of adults with a 10-year risk of CVD of 10% or more who have the benefits of lifestyle changes for primary prevention discussed with them before any offer of statin therapy.

Numerator – the number in the denominator who have the benefits of lifestyle changes for primary prevention discussed with them before any offer of statin therapy.

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

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (primary care) ensure that processes are in place for adults with a 10-year risk of CVD of 10% or more to have the benefits of lifestyle changes for primary prevention discussed with them before any offer of statin therapy.

Healthcare professionals ensure that they discuss the benefits of lifestyle changes for primary prevention with adults with a 10-year risk of CVD of 10% or more before they offer statin therapy.

Commissioners (NHS England area teams and clinical commissioning groups) ensure that GPs are aware that adults with a 10-year risk of CVD of 10% or more should have the lifestyle changes for primary prevention discussed with them before offering statin therapy. Commissioners may wish to consider incorporating this discussion into NHS Health Checks and Local Enhanced Service specifications where appropriate. Collaboration with local authorities (as the commissioner of NHS Health checks) may be necessary to achieve this.

What the quality statement means for patients, service users and carers

Adults with a 10-year risk of CVD of 10% or more have the benefits of lifestyle changes for primary prevention discussed with them before being offered statin therapy. This may help them to make lifestyle changes that can reduce cholesterol levels and help prevent future heart attacks and strokes.

Source guidance

- Lipid modification (2014) NICE guideline CG181, recommendations 1.3.14 and 1.3.15 and 1.1.27.

Definitions of terms used in this quality statement

10-year risk of CVD of 10% or more

For adults aged 84 and under, the 10-year risk of CVD is estimated using the QRISK2 assessment tool. Adults aged 85 years and older should be considered to

be at high risk based on age alone, particularly those who smoke or have raised blood pressure. Adults with pre-existing clinical conditions such as type 1 diabetes, familial hypercholesterolaemia or chronic kidney disease are already considered at high risk. [Lipid modification (NICE guideline CG181) recommendations 1.1.8, 1.1.9, 1.1.11, 1.1.15, 1.1.16, 1.1.21]

Lifestyle changes

Lifestyle changes include:

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

[Lipid modification (2014) NICE guideline CG181, recommendations 1.2.1–1.2.17]

Quality statement 3: Statins for primary prevention of cardiovascular disease

Quality statement

Adults with a 10-year risk of cardiovascular disease (CVD) of 10% or more for whom lifestyle changes have been ineffective or are inappropriate are offered atorvastatin 20 mg for primary prevention.

Rationale

High-intensity statins are the most clinically effective treatment option for the primary prevention of CVD, reducing cholesterol levels and the incidence of CVD events. Lifestyle changes should be made where possible before statin treatment is offered as this can reduce the person's cholesterol levels. But if lifestyle changes have not helped, or if they are inappropriate for the person, statin therapy with atorvastatin 20 mg can be offered.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with a 10-year risk of CVD of 10% or more for whom lifestyle changes have been ineffective or are inappropriate are offered atorvastatin 20 mg for primary prevention.

Data source: Local data collection.

Process

Proportion of adults with a 10-year risk of CVD of 10% or more for whom lifestyle changes have been ineffective or are inappropriate who receive atorvastatin 20 mg for primary prevention.

Numerator – the number in the denominator receiving atorvastatin 20 mg for primary prevention.

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: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (primary care) ensure that adults with a 10-year risk of CVD of 10% or more for whom lifestyle changes have been ineffective or are inappropriate are offered atorvastatin 20 mg for primary prevention.

Healthcare professionals ensure that they offer atorvastatin 20 mg for primary prevention to adults with a 10-year risk of CVD of 10% or more for whom lifestyle changes have been ineffective or are inappropriate.

Commissioners (NHS England area teams and clinical commissioning groups) ensure that adults with a 10-year risk of CVD of 10% or more for whom lifestyle changes have been ineffective or are inappropriate are offered atorvastatin 20 mg for primary prevention. Commissioners may do this by seeking evidence of practice, through clinical audits.

What the quality statement means for patients, service users and carers

Adults with a 10-year risk of CVD of 10% or more for whom lifestyle changes have been ineffective or are inappropriate are offered atorvastatin 20 mg for primary prevention. This will help reduce cholesterol levels and help prevent adults from having heart attacks and strokes.

Source guidance

- Lipid modification (2014) NICE guideline CG181, recommendations 1.3.16, 1.3.17 and 1.3.18.

Definitions of terms used in this quality statement

10-year risk of CVD of 10% or more

For adults aged 84 and under, the 10-year risk of CVD is estimated using the QRISK2 assessment tool. Adults aged 85 years and older should be considered to be at high risk based on age alone, particularly those who smoke or have raised

blood pressure. Adults with pre-existing clinical conditions such as type 1 diabetes, familial hypercholesterolaemia or chronic kidney disease are already considered at high risk. [Lipid modification (NICE guideline CG181) recommendations 1.1.8, 1.1.9, 1.1.11, 1.1.15, 1.1.16, 1.1.21]

Ineffective lifestyle changes

Lifestyle changes such as stopping smoking, increasing physical activity and changing diet that have not resulted in a reduction in cholesterol levels when a risk assessment is repeated. [Adapted from Lipid modification (NICE guideline CG181) recommendation 1.3.16]

Quality statement 4: Statins for secondary prevention of cardiovascular disease

Quality statement

Adults with cardiovascular disease (CVD) are offered atorvastatin 80 mg for secondary prevention.

Rationale

High-intensity statins are the most clinically effective option for the secondary prevention of CVD, reducing cholesterol levels and the incidence of CVD events. Evidence shows that atorvastatin 80 mg is the most cost effective high-intensity statin available for the secondary prevention of CVD.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with CVD are offered atorvastatin 80 mg for secondary prevention.

Data source: Local data collection.

Process

Proportion of adults with CVD who receive atorvastatin 80 mg for secondary prevention.

Numerator – the number in the denominator receiving atorvastatin 80 mg for secondary prevention.

Denominator – the number of adults with newly diagnosed CVD.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (primary care and secondary care) ensure that adults with CVD are offered atorvastatin 80 mg for secondary prevention.

Healthcare professionals ensure that they offer atorvastatin 80 mg to adults with CVD for secondary prevention.

Commissioners (NHS England area teams and clinical commissioning groups) ensure that adults with CVD are offered atorvastatin 80 mg for secondary prevention. Commissioners may do this by seeking evidence of practice through clinical audits.

What the quality statement means for patients, service users and carers

Adults with cardiovascular disease (CVD) are offered atorvastatin 80 mg for secondary prevention. This will help reduce cholesterol levels and prevent adults from having another heart attack or stroke.

Source guidance

- Lipid modification (2014) NICE guideline CG181, recommendation 1.3.20.

Quality statement 5: Adverse effects with statins

Quality statement

Adults who develop adverse effects on high-intensity statins are offered alternative doses of statins or an alternative statin.

Rationale

The use of high-intensity statins can cause side effects, but it is important that statin treatment doesn't just stop because of them. Any statin at any dose reduces cardiovascular disease (CVD) risk. Alternative strategies should be tried, such as reducing the dose of the statin or changing to a lower-intensity statin.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with adverse effects on high-intensity statins are offered alternative doses of statins or an alternative statin.

Data source: Local data collection.

Process

Proportion of adults with adverse effects on high-intensity statins who are given alternative doses of statins or an alternative statin.

Numerator – the number in the denominator who are given alternative doses of statins or an alternative statin.

Denominator – the number of adults prescribed high-intensity statins who report adverse effects.

Data source: Local data collection.

Outcome

Adherence to statin treatment.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (primary care and secondary care) should ensure that adults on high-intensity statins with adverse effects are offered alternative doses of statins or an alternative statin. Service providers can consult recommendation 1.3.42 in NICE's guideline on lipid modification for further information.

Healthcare professionals ensure that they offer alternative doses of statins or an alternative statin to adults on high-intensity statins who have adverse effects.

Commissioners (NHS England area teams and clinical commissioning groups) should ensure that providers are aware that adults on high-intensity statins with adverse effects should be offered alternative doses of statins or an alternative statin.

What the quality statement means for patients, service users and carers

Adults with adverse effects on high-intensity statins are offered alternative doses of statins or an alternative statin.

Source guidance

- Lipid modification (2014) NICE guideline CG181, recommendation 1.3.42.

Definitions of terms used in this quality statement

High-intensity statin

The intensity of a statin is defined based on the percentage reduction in low-density lipoprotein cholesterol (LDL) they produce. A high-intensity statin will produce a reduction above 40%. [Lipid modification (NICE guideline CG181)]

Quality statement 6: 3-month statin review

Quality statement

Adults on high-intensity statins have a 3-month review after the start of treatment.

Rationale

A 3-month review that includes a repeat lipid profile is important for adults started on high-intensity statins to see if they have achieved the expected 40% reduction in non-high-density lipoprotein (non-HDL) cholesterol. If this reduction is not achieved, there are several options. These include discussing adherence and timing of dose, optimising adherence to lifestyle changes and consideration of a higher dose.

Quality measures

Structure

Evidence of local arrangements to ensure that adults on high-intensity statins have a 3-month review after the start of treatment.

Data source: Local data collection.

Process

Proportion of adults on high-intensity statins who had a 3-month review after the start of treatment.

Numerator – the number in the denominator who had a 3-month review after the start of treatment.

Denominator – the number of adults prescribed high-intensity statins for at least 3 months.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (primary care) ensure that adults on high-intensity statins have a 3-month review after the start of treatment. Evidence should be made available on request to commissioners.

Healthcare professionals ensure that they give a 3-month review from the start of treatment to adults on high-intensity statins.

Commissioners (NHS England area teams and clinical commissioning groups [CCGs]) should monitor that adults on high-intensity statins have a 3-month review after the start of treatment. CCGs may wish to stipulate this in any Local Enhanced Service specifications.

What the quality statement means for patients, service users and carers

Adults on high-intensity statins have a 3-month review after the start of treatment to see if the treatment is reducing cholesterol levels. If it is not, then other options can be taken.

Source guidance

- Lipid modification (2014) NICE guideline CG181, recommendation 1.3.28.

Definitions of terms used in this quality statement

High-intensity statin

The intensity of a statin is defined based on the percentage reduction in low-density lipoprotein (LDL) cholesterol they produce. A high-intensity statin will produce a reduction above 40%. [Lipid modification (NICE guideline CG181)]

3-month review

A follow-up appointment that takes place 3 months after the start of treatment, which includes a repeat lipid profile to measure total cholesterol, HDL cholesterol and non-HDL cholesterol. [Lipid modification (NICE guideline CG181), recommendation 1.3.28]

Status of this quality standard

This is the draft quality standard released for consultation from 9 March to 8 April 2015. It is not NICE's final quality standard on lipid modification. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 8 April 2015. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from September 2015.

Using the quality standard

Quality measures

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

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

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, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

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 alongside the documents listed in Development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between health, public health and social care practitioners and adults receiving lipid modification 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. Adults receiving lipid modification 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 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.

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Lipid modification (2014) NICE guideline CG181.

Policy context

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

- NHS England (2014) Strategic and operational planning 2014 to 2019: Reduce premature mortality 3. Cardiovascular disease (CVD)
- Department of Health (2013) Cardiovascular Disease Outcomes Strategy: improving outcomes for people with or at risk of cardiovascular disease

Related NICE quality standards

Published

- Psychosis and schizophrenia in adults (2015) NICE quality standard 80
- Acute coronary syndromes (including myocardial infarction) (2014) NICE quality standard 68
- Peripheral arterial disease (2014) NICE quality standard 52
- Smoking cessation: supporting people to stop smoking (2013) NICE quality standard 43
- Familial hypercholesterolaemia (2013) NICE quality standard 41
- Hypertension (2013) NICE quality standard 28
- Stable angina (2012) NICE quality standard 21
- Alcohol dependence and harmful alcohol use (2011) NICE quality standard 11
- Chronic heart failure (2011) NICE quality standard 9
- Diabetes in adults (2011) NICE quality standard 6
- Chronic kidney disease (2011) NICE quality standard 5
- Stroke (2010) NICE quality standard 2

In development

- Physical activity: encouraging activity in all people in contact with the NHS (staff, patients and carers). Publication expected March 2015
- Smoking: reducing tobacco use in the community. Publication expected March 2015
- Bipolar disorder in adults. Publication expected June 2015
- Atrial fibrillation. Publication expected July 2015
- Cardiovascular risk assessment. Publication expected September 2015
- Secondary prevention following myocardial infarction. Publication expected September 2015
- Acute heart failure. Publication expected December 2015

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Obesity (adults)
- Obesity – prevention and management in adults
- Physical activity: encouraging activity within the general population

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 2. Membership of this committee is as follows:

Mr Ben Anderson

Consultant in Public Health, Public Health England

Mr Barry Attwood

Lay member

Professor Gillian Baird

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GP and Chair of the All Wales Prescribing Advisory Group, Carreg Wen Surgery

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Ms Teresa Middleton
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Mr David Minto
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The following specialist members joined the committee to develop this quality standard:

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Consultant Cardiologist, Sandwell and West Birmingham Hospitals NHS Trust

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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.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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