



Medicines optimisation

Quality standard

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Contents

Quality statements	4
Quality statement 1: Shared decision-making	5
Quality statement.....	5
Rationale	5
Quality measures.....	5
What the quality statement means for different audiences.....	6
Source guidance.....	7
Definitions of terms used in this quality statement	7
Equality and diversity considerations	7
Quality statement 2: Patient involvement in reporting medicines-related patient safety incidents	8
Quality statement.....	8
Rationale	8
Quality measures.....	8
What the quality statement means for different audiences.....	9
Source guidance.....	10
Definitions of terms used in this quality statement	10
Equality and diversity considerations	11
Quality statement 3: Learning from medicines-related patient safety incidents.....	12
Quality statement.....	12
Rationale	12
Quality measures.....	12
What the quality statement means for different audiences.....	13
Source guidance.....	14
Definitions of terms used in this quality statement	14
Quality statement 4: Medicines reconciliation in acute settings.....	16
Quality statement.....	16

Rationale	16
Quality measures.....	16
What the quality statement means for different audiences.....	17
Source guidance.....	18
Definitions of terms used in this quality statement	18
Equality and diversity considerations	19
Quality statement 5: Medicines reconciliation in primary care	20
Quality statement.....	20
Rationale	20
Quality measures.....	20
What the quality statement means for different audiences.....	22
Source guidance.....	23
Definitions of terms used in this quality statement	23
Equality and diversity considerations	23
Quality statement 6: Structured medication review	24
Quality statement.....	24
Rationale	24
Quality measures.....	24
What the quality statement means for different audiences.....	26
Source guidance.....	27
Definitions of terms used in this quality statement	27
Equality and diversity considerations	27
About this quality standard	28
Diversity, equality and language.....	28

This standard is based on NG5.

This standard should be read in conjunction with QS97, QS85, QS15, QS125, QS6, QS132, QS135, QS25, QS9, QS153, QS156, QS41, QS164, QS168, QS170, QS171, QS81, QS93 and QS201.

Quality statements

Statement 1 People are given the opportunity to be involved in making decisions about their medicines.

Statement 2 People who are prescribed medicines are given an explanation on how to identify and report medicines-related patient safety incidents.

Statement 3 Local health and social care providers monitor medicines-related patient safety incidents to inform their learning in the use of medicines.

Statement 4 People who are inpatients in an acute setting have a reconciled list of their medicines within 24 hours of admission.

Statement 5 People discharged from a care setting have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued.

Statement 6 Local healthcare providers identify people taking medicines who would benefit from a structured medication review.

Quality statement 1: Shared decision-making

Quality statement

People are given the opportunity to be involved in making decisions about their medicines.

Rationale

Clinical outcomes and patient satisfaction are likely to be better when decisions about medicines are made jointly between the person taking the medicine and the prescriber (shared decision-making). A person's preferences and how they value treatment options and outcomes should be taken into account. People also need to have enough information to make informed choices. Patient decision aids can be used to support shared decision-making. Choices may include decisions not to take specific medicines.

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 prescribers give people information about the potential benefits and harms of using medicines.

Data source: Local data collection.

b) Evidence that prescribers take into account people's preferences and values about treatment options that includes the use of medicines.

Data source: Local data collection.

c) Evidence that prescribers offer people the opportunity to use available decision aids to make informed choices about the use of medicines that take account of the trade-off between potential benefits and harms.

Data source: Local data collection.

Outcome

a) Medicines adherence.

Data source: Local data collection.

b) Patient satisfaction with outcomes from the use of medicines.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as primary and secondary care and pharmacy services) ensure that people are given the opportunity to be involved in making decisions about their medicines in partnership with professionals who prescribe medicines.

Healthcare professionals (such as prescribers and community pharmacists) ensure that people are given the opportunity to be involved in making decisions about their medicines. For example, healthcare professionals can use patient decision aids to support shared decision-making and they should ensure that people who take medicines have information about the potential benefits and harms.

Commissioners ensure they commission services in which people are given the opportunity to be involved in making decisions about their medicines in partnership with professionals who prescribe medicines.

People who are considering whether or not to take a medicine are given the opportunity to be involved in making the decision with their healthcare professional. The decision should be in line with the person's preferences and what they consider is important, and should take into account information about the potential benefits and harms of the

medicine.

Source guidance

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline NG5 (2015), recommendations 1.6.1, 1.6.2, 1.6.4 and 1.6.6

Definitions of terms used in this quality statement

Involved in making decisions

Patients should have the opportunity to make informed decisions about their medicines, in partnership with their healthcare professionals. Healthcare professionals should take account of a person's values and preferences by discussing what is important to them about treating or managing their condition(s) and their medicines. They should ask open questions to understand the person's ideas, concerns and expectations. This process can be helped by using patient decision aids. The person's values and preferences about treatment options may be different from those of the healthcare professional, and making assumptions about these should be avoided. [NICE's guideline on medicines optimisation, recommendation 1.6.2 and full guideline]

Equality and diversity considerations

People who are offered or prescribed medicines may have different values and preferences to those of their healthcare professional, and these values and preferences may affect their choices about medicines. Healthcare professionals should be sensitive and supportive to ensure that everyone can express their preferences about the use of medicines and take part in shared decision-making. Healthcare professionals should take into account that some people may need additional support in communicating their preferences or in understanding the information given to them. This might be, for example, because English is not their first language or they have communication or sensory difficulties.

Quality statement 2: Patient involvement in reporting medicines-related patient safety incidents

Quality statement

People who are prescribed medicines are given an explanation on how to identify and report medicines-related patient safety incidents.

Rationale

Reporting of, and learning from, medicines-related patient safety incidents can be more effective when the people who are prescribed medicines are encouraged and empowered to report incidents. People can be told about identifying and reporting medicines-related patient safety incidents when a prescription is written or dispensed, or when medication is reviewed. Patient involvement can increase the number of incidents reported through better identification, and can aid learning by health and social care practitioners and organisations responsible for medicines optimisation.

Quality measures

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

Structure

a) Evidence of arrangements to ensure that people who are prescribed medicines have an explanation of how to identify medicines-related patient safety incidents.

Data source: Local data collection.

b) Evidence of arrangements to ensure that people who are prescribed medicines have an

explanation of how to report medicines-related patient safety incidents.

Data source: Local data collection.

Process

Proportion of new prescriptions of medicines for which patients are given an explanation on how to identify and report medicines-related patient safety incidents.

Numerator – the number in the denominator for which patients are given an explanation on how to identify and report medicines-related patient safety incidents.

Denominator – the number of new prescriptions of medicines.

Data source: Local data collection.

Outcome

Harm attributable to errors in medication.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as primary and secondary care and pharmacy services) ensure that people who are prescribed medicines to have an explanation on how to identify and report medicines-related patient safety incidents.

Healthcare professionals (such as prescribers and community pharmacists) ensure that they explain to people who are prescribed medicines how to identify and report medicines-related patient safety incidents. Healthcare professionals can do this when a prescription is written or dispensed, or when medication is reviewed.

Commissioners ensure that they commission services that explain to people who are prescribed medicines how to identify and report medicines-related patient safety incidents.

People who are prescribed medicines are told what a medicines-related patient safety incident is, how to identify and report an incident, and who they can ask for help. They can be told this when a prescription is written or dispensed, or when medication is reviewed.

Source guidance

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline NG5 (2015), recommendations 1.1.2 and 1.1.6

Definitions of terms used in this quality statement

Medicines-related patient safety incidents

Medicines-related patient safety incidents are unintended or unexpected incidents that were specifically related to medicines use, which could have, or did, lead to patient harm. These include:

- potentially avoidable medicines-related hospital admissions and re-admissions
- prescribing errors
- dispensing errors
- administration errors
- monitoring errors
- potentially avoidable adverse events
- missed doses of medicines
- near misses (a prevented medicines-related patient safety incident which could have led to patient harm).

Medicines-related patient safety incidents do not include expected medicines side effects. [NICE's guideline on medicines optimisation, section 1.1 and expert opinion]

Equality and diversity considerations

Healthcare professionals should recognise that people's ability to understand the issue of medicines-related patient safety incidents may differ, and take this into account in discussions with the person. Some people may need additional support to understand the information being discussed or to express their concerns about a possible medicines-related patient safety incident, especially if English is not their first language or if they have communication or sensory difficulties. Healthcare professionals should also take into account that some people may not be able to report an incident online due to lack of access to information technology or because they have insufficient knowledge on how to use it.

Quality statement 3: Learning from medicines-related patient safety incidents

Quality statement

Local health and social care providers monitor medicines-related patient safety incidents to inform their learning in the use of medicines.

Rationale

Monitoring medicines-related patient safety incidents can help to identify trends and causes of incidents. Learning from incident reporting and reviewing clinical case notes, and sharing the outcome of learning among local health and social care providers can lead to effective action. This might include setting up computer alerts and delivering continuing professional development. Learning from past incidents can help to minimise the risk of future medicines-related patient safety incidents and produce better outcomes for people who take medicines.

Quality measures

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

Structure

a) Evidence of local arrangements to ensure that health and social care providers monitor medicines-related patient safety incidents.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that health and social care providers report medicines-related patient safety incidents using national patient safety reporting systems.

Data source: Local data collection, the National Reporting and Learning System, the Yellow Card Scheme.

c) Evidence of local arrangements to ensure that health and social care providers learn from the monitoring and reporting of medicines-related patient safety incidents.

Data source: Local data collection.

d) Evidence that local health and social care providers have arrangements to share learning about medicines-related patient safety incidents. This can include feedback on trends or significant incidents to support continuing professional development.

Data source: Local data collection.

Process

Proportion of reported medicines-related patient safety incidents that are investigated.

Numerator – the number in the denominator that are investigated.

Denominator – the number of reported medicines-related patient safety incidents.

Data source: Local data collection.

Outcome

Harm attributable to errors in medication.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as primary and secondary care, community care and social care) ensure that they have effective systems to monitor and report medicines-related patient safety incidents, and that they share learning with other local health and social care organisations to ensure the safe use of medicines.

Health and social care practitioners (such as prescribers, community pharmacists, and residential care practitioners) report medicines-related patient safety incidents using national reporting systems, contribute to the local monitoring of medicines-related patient safety incidents, and contribute to shared learning with other local health and social care organisations.

Commissioners ensure that providers demonstrate monitoring of medicines-related patient safety incidents and learning from those incidents.

People who take medicines are cared for by local health and social care providers who monitor and report patient safety incidents related to medicines. The providers share the information with other local care providers to ensure the safe use of medicines.

Source guidance

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline NG5 (2015), recommendations 1.1.3, 1.1.5 and 1.1.11

Definitions of terms used in this quality statement

Medicines-related patient safety incidents

Medicines-related patient safety incidents are unintended or unexpected incidents that were specifically related to medicines use, which could have, or did, lead to patient harm. These include:

- potentially avoidable medicines-related hospital admissions and re-admissions
- prescribing errors
- dispensing errors
- administration errors
- monitoring errors
- potentially avoidable adverse events
- missed doses of medicines

- near misses (a prevented medicines-related patient safety incident which could have led to patient harm).

Medicines-related patient safety incidents do not include expected medicines side effects. [[NICE's guideline on medicines optimisation](#), recommendation 1.1 and expert opinion]

Monitoring medicines-related patient safety incidents

Monitoring involves organisations having robust and transparent processes in place to identify, report, prioritise, investigate and learn from medicines-related patient safety incidents, in line with national patient safety reporting systems. This process should then encourage organisational learning. [[NICE's guideline on medicines optimisation](#), recommendation 1.1.3]

Quality statement 4: Medicines reconciliation in acute settings

Quality statement

People who are inpatients in an acute setting have a reconciled list of their medicines within 24 hours of admission.

Rationale

Medicines-related patient safety incidents are more likely when medicines reconciliation happens more than 24 hours after a person is admitted to an acute setting. Undertaking medicines reconciliation within 24 hours of admission to an acute setting (or sooner if clinically necessary) enables early action to be taken when discrepancies between lists of medicines are identified.

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 people who are inpatients in an acute setting have a reconciled list of their medicines within 24 hours of admission.

Data source: Local data collection and [NHS England's Medicines optimisation dashboard](#).

Process

Proportion of people who are inpatients in an acute setting who have a reconciled list of their medicines within 24 hours of admission.

Numerator – the number in the denominator who have a reconciled list of their medicines within 24 hours of admission.

Denominator – the number of people who are inpatients in an acute setting.

Data source: Local data collection.

Outcome

a) Harm attributable to errors in medication following acute inpatient admission.

Data source: Local data collection.

b) Patient satisfaction with outcomes from the use of medicines.

Data source: Local data collection.

c) Number of patient complaints relating to medication issues.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as secondary care and mental health providers) ensure that systems are in place for people who are inpatients in an acute setting, to have a reconciled list of their medicines within 24 hours of admission.

Healthcare professionals (such as doctors, nurses, pharmacists and pharmacist technicians) ensure that they reconcile a list of medicines for people who are inpatients in an acute setting within 24 hours of admission (or sooner if clinically necessary).

Commissioners ensure that they commission acute services that reconcile a list of medicines for people who are inpatients in an acute setting within 24 hours of admission.

People who go into hospital as inpatients have an up-to-date list of their medicines in their hospital record within 24 hours. They may be involved in this process if they wish to be.

This ensures that any mistakes with their medicines are quickly noticed and sorted out.

Source guidance

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline NG5 (2015), recommendations 1.3.1 and 1.3.5

Definitions of terms used in this quality statement

Acute care settings

Acute care settings include secondary care, tertiary care and mental health services.
[Expert opinion]

Reconciled list

Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing it with the current list in use. The information can be obtained from a variety of sources such as: medication brought to hospital by the patient, GP surgery patient records, repeat prescription slips, hospital case notes, community pharmacy patient medication records and care home medicines administration record. The list should include name, dosage, frequency and route of administration. Any discrepancies should be identified and any changes documented. The result is a complete list of medicines, accurately communicated to all health and social care professionals involved in the person's care, in which any issues with the medicines, such as wrong dosage or omission, have been addressed. [NICE's guideline on medicines optimisation and expert opinion]

Within 24 hours of admission

Medicines reconciliation for people who are inpatients in an acute setting should occur within 24 hours of admission, regardless of the time of admission or the day of the week.
[Expert opinion]

Equality and diversity considerations

Healthcare professionals should recognise that people's ability to understand the issue of medicines reconciliation may differ, and take this into account in discussions with the person. Some people may need additional support to understand the issue, for example, if English is not their first language or if they have communication or sensory difficulties.

Quality statement 5: Medicines reconciliation in primary care

Quality statement

People discharged from a care setting have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued.

Rationale

Medicines-related patient safety incidents are more likely when medicines reconciliation happens more than a week after discharge from a care setting such as a hospital or care home. Undertaking medicines reconciliation in primary care within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued, allows early action to be taken when discrepancies between lists of medicines are identified. For example, it can prevent people from being prescribed medicines that were stopped while they were in hospital.

Quality measures

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

Structure

a) Evidence of local arrangements to ensure that people discharged from a care setting have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that people discharged from a care setting

are not issued a prescription or new supply of medicines until they have a reconciled list of their medicines in their GP record.

Data source: Local data collection.

Process

a) The proportion of people on medicines discharged from a care setting who have a reconciled list of their medicines within 1 week of the GP practice receiving the information.

Numerator – the number in the denominator who have a reconciled list of their medicines within 1 week of the GP practice receiving the information.

Denominator – the number of people on medicines who are discharged from a care setting.

Data source: Local data collection.

b) Proportion of new prescriptions within 1 month of discharge from a care setting where there was a reconciled list of medicines in the patient's GP record.

Numerator – Number in the denominator where there was a reconciled list of medicines in the patient's GP record.

Denominator – Number of new prescriptions within 1 month of discharge from a care setting.

Data source: Local data collection.

Outcome

a) Harm attributable to errors in medication following discharge from a care setting.

Data source: Local data collection.

b) Patient satisfaction with outcomes from the use of medicines.

Data source: Local data collection.

c) Number of patient complaints relating to medication issues following discharge from a care setting.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as GP practices, secondary care and mental health providers) ensure that systems are in place for people discharged from a care setting to have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued. Care providers should ensure comprehensive and accurate information on medicines is supplied to general practices in a timely manner on discharge. GP practices should have systems in place to act on the information received within 1 week.

Health and social care practitioners (such as GPs, secondary care consultants and residential care practitioners) ensure that people discharged from a care setting have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued. Health and social care practitioners should send comprehensive and accurate information on medicines to general practices in a timely manner on discharge. GPs should undertake medicines reconciliation within 1 week, and should not issue new prescriptions or supplies of medicines before medicines reconciliation is complete. General practices may also liaise with community pharmacies about any medicines discharge information the pharmacies receive.

Commissioners commission services that ensure that people discharged from a care setting have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued.

People who take medicines who are discharged from a care setting such as a hospital or residential care have an up-to-date list of any medicines they are taking in their GP record within 1 week of the GP practice receiving the information. The person may be involved in making the list if they wish to be. The GP practice should not give new prescriptions or a new supply of medicines until the person's list of medicines has been made and checked.

Source guidance

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline NG5 (2015), recommendations 1.3.3 and 1.3.5

Definitions of terms used in this quality statement

Care settings

Care settings from which people are discharged include hospitals, mental health settings and social care residential settings. These care settings should provide lists of medicines to general practices for medicines reconciliation in primary care. [Expert opinion]

Reconciled list

Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing it with the current list in use. The information can be obtained from a variety of sources such as: medication brought to hospital by the patient, GP surgery patient records, repeat prescription slips, hospital case notes, community pharmacy patient medication records and care home medicines administration record. The list should include name, dosage, frequency and route of administration. Any discrepancies should be identified and any changes documented. The result is a complete list of medicines, accurately communicated to all health and social care professionals involved in the person's care, in which any issues with the medicines, such as wrong dosage or omission, have been addressed. [NICE's guideline on medicines optimisation and expert opinion]

Equality and diversity considerations

Primary healthcare professionals should recognise that people's ability to understand the issue of medicines reconciliation may differ, and take this into account if the person wishes to be involved in the medicines reconciliation process. Health and social care practitioners should consider that people may need additional support to understand the issue, for example, if English is not their first language or if they have communication or sensory difficulties.

Quality statement 6: Structured medication review

Quality statement

Local healthcare providers identify people taking medicines who would benefit from a structured medication review.

Rationale

A structured medication review, with the clear purpose of optimising the use of medicines for some people (such as those who have long-term conditions or who take multiple medicines), can identify medicines that could be stopped or need a dosage change, or new medicines that are needed. Structured medication review can lead to a reduction in adverse events. To offer a structured medication review to people who would benefit, local healthcare providers must first have systems in place to identify those people.

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 local healthcare providers have arrangements to identify people taking medicines who would benefit from a structured medication review.

Data source: Local data collection.

b) Evidence that local healthcare providers have arrangements to offer structured medication reviews to people who are likely to benefit.

Data source: Local data collection.

Process

a) Proportion of people taking medicines for long-term conditions who are identified as potentially benefiting from a structured medication review.

Numerator – the number in the denominator who are identified as potentially benefiting from a structured medication review.

Denominator – the number of people taking medicines for long-term conditions.

b) Proportion of people taking multiple medicines who are identified as potentially benefiting from a structured medication review.

Numerator – the number in the denominator who are identified as potentially benefiting from a structured medication review.

Denominator – the number of people taking multiple medicines.

Data source: Local data collection.

c) The proportion of people identified as potentially benefiting from a structured medication review who have a structured medication review.

Numerator – the number in the denominator who have a structured medication review.

Denominator – the number of people identified as potentially benefiting from a structured medication review.

Data source: Local data collection.

Outcome

a) People with long-term conditions gain optimum outcomes from use of medicines.

Data source: Local data collection.

b) People using multiple medicines gain optimum outcomes from use of medicines.

Data source: Local data collection.

c) Patient satisfaction with outcomes from the use of medicines.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as GP practices, acute and mental health services) ensure that systems are in place to identify people taking medicines who would benefit from a structured medication review. Such patients may include people taking medicines for long-term conditions and people taking multiple medicines.

Healthcare professionals (such as GPs and pharmacists) ensure that they identify people taking medicines who would benefit from a structured medication review. Such patients may include people taking medicines for long-term conditions and people taking multiple medicines. Healthcare professionals should carry out the review with patients who agree to attend when the need and purpose of the structured medication review is clear. The healthcare professional should take into account the person's views, whether the person has had or has any risk factors for developing adverse drug reactions and any monitoring that is needed.

Commissioners ensure that they commission services that identify people taking medicines who would benefit from a structured medication review. Where the need and purpose is clear, structured medication reviews should be carried out with patients who agree to attend.

People who may benefit from a structured medication review of their medicines are invited to talk about this with their healthcare professional. They might be asked because they are taking several medicines or are taking medicines for long-term conditions. The review can help to identify any medicines that are no longer needed or any that need the dosage changed. The healthcare professional should listen to the person's views and take these into account. They should also think about whether the person has had or has any risk factors for developing adverse drug reactions and whether any monitoring is needed.

Source guidance

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline NG5 (2015), recommendations 1.4.1, 1.4.2 and 1.4.3

Definitions of terms used in this quality statement

Structured medication review

A structured medication review is a critical examination of a person's medicines with the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste. [[NICE's guideline on medicines optimisation](#)]

Equality and diversity considerations

Healthcare professionals should recognise that people's ability to understand the importance of medication reviews may differ, and ensure that people are supported to understand the purpose and benefits of a structured medication review. Healthcare professionals should take into account that people may need additional support to understand the issue, for example, if English is not their first language or if they have communication or sensory difficulties.

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.

Diversity, equality and language

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

quality statements are highlighted in each statement.

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

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Endorsing organisation

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

Supporting organisations

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

- [Royal Pharmaceutical Society](#)
- [Guild of Healthcare Pharmacists](#)
- [British Thoracic Society \(BTS\)](#)