# Secondary prevention following a myocardial infarction

# NICE quality standard

## Draft for consultation

March 2015

## Introduction

This quality standard covers secondary prevention following a myocardial infarction, including cardiac rehabilitation in adults (aged 18 years and over). For more information see the topic overview.

In addition to the areas covered by this draft quality standard, the Quality Standards Advisory Committee identified the prescribing of high-dose high-intensity statins for secondary prevention as an area for quality improvement. The draft quality standard on lipid modification has a statement about this. Please refer to the lipid modification draft quality standard for full details.

### *Why this quality standard is needed*

Myocardial infarction (MI) is one of the most severe presentations of coronary artery disease. It is usually caused by blockage of a coronary artery that results in tissue death and is commonly referred to as a heart attack.

People who have had an MI benefit from treatment to reduce the risk of another MI and progression of vascular disease. This is known as secondary prevention.

Secondary prevention for people who have had an MI includes the following:

- drug treatment such as anti-platelets, beta-blockers, angiotensin-converting enzyme inhibitors (ACE) and statins
- changes in lifestyle, for example, healthy eating, regular exercise and stopping smoking
- cardiac rehabilitation programmes.

MI is a preventable complication of coronary heart disease (CHD). The death rate from CHD has been falling since the early 1970s; for people under 75, the death rate fell by almost 25% between 1996 and 2004. The death rate from CHD varies with age, gender, socioeconomic status, ethnicity and UK geographic location. Death rates in men under 75 are 3 times higher than in women, and death rates in affluent areas in the UK are half of those in deprived areas. People of South Asian origin have almost a 50% higher death rate compared with the general population.

In England and Wales in 2013/14 more than 80,000 hospital admissions were because of MI according to the Myocardial Ischaemia National Audit Project (MINAP). Twice as many men had MIs than women. The data also showed that 30-day mortality decreased between 2003/04 and 2013/14 through improved treatment.

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

- life expectancy
- mortality
- incidence of cardiovascular disease (CVD) events
- health-related quality of life for people with long-term conditions
- readmissions
- functional ability after MI
- return to employment
- patient experience
- psychological wellbeing.

## *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 a particular area of health or care. 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 3 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2015-16.
- The Adult Social Care Outcomes Framework 2015-16
- Public Health Outcomes Framework 2013-16.

Tables 1–3 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***<br>1b Life expectancy at 75 i Males ii Females<br>***Improvement areas***<br>**Reducing premature mortality from the major causes of death**<br>1.1 Under 75 mortality rate from cardiovascular disease*<br>**Reducing premature death in people with mental illness**<br>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***<br>2 Health-related quality of life for people with long-term conditions**<br>***Improvement areas***<br>**Ensuring people feel supported to manage their condition**<br>2.1 Proportion of people feeling supported to manage their condition<br>**Improving functional ability in people with long-term conditions**<br>2.2 Employment of people with long-term conditions**<br>**Reducing time spent in hospital by people with long-term conditions**<br>2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) |
| 3 Helping people to recover from episodes of ill health or following injury | ***Overarching indicator***<br>3b Emergency readmissions within 30 days of discharge from hospital*<br>***Improvement areas***<br>**Helping older people to recover their independence after illness or injury**<br>3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service***<br>ii Proportion offered rehabilitation following discharge from acute or community hospital |
| 4 Ensuring that people have a positive experience of care | ***Overarching indicator***<br>4b Patient experience of hospital care |
| **Alignment across the health and social care system**<br>* Indicator shared with Public Health Outcomes Framework (PHOF)<br>** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)<br>*** Indicator shared with Adult Social Care Outcomes Framework (ASCOF) | |

**Table 2 The Adult Social Care Outcomes Framework 2015-16**

| Domain | Overarching and outcome measures |
|---|---|
| 1 Delaying and reducing the need for care and support | ***Outcome measures***<br>**Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help manage their care needs.**<br>2b Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services**. |
| | |

**Table 3 Public health outcomes framework for England, 2013–2016**

| Domain | Objectives and indicators |
|---|---|
| 2 Health improvement | ***Objective***<br>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities |
| 4 Healthcare public health and preventing premature mortality | ***Objective***<br>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities<br>***Indicators***<br>4.4 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)<br>4.9 Excess under 75 mortality in adults with serious mental illness**<br>4.11 Emergency readmissions within 30 days of discharge from hospital* |
| ***Aligning across the health and care system***<br>* Indicator complementary<br>** Indicator shared | |

## *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 secondary prevention following an MI.

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 are 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 sources 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 secondary prevention following an MI 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 people after an MI.

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 MI 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 health and social care professionals involved in assessing, caring for and treating people with MI 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 people with MI. If appropriate, health and social care 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 admitted to hospital following an MI have an assessment of left ventricular function.

Statement 2. Adults leaving hospital following an MI have details of drug titration and blood pressure and renal function monitoring shared with their GP.

Statement 3. Adults admitted to hospital following an MI are referred for cardiac rehabilitation while they are in hospital.

Statement 4. Cardiac rehabilitation services provide both daytime and evening programmes in both community and home based settings.

Statement 5. Adults who enrol on a cardiac rehabilitation programme following an MI have an orientation session within 10 days of their discharge from hospital.

## 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?

## *Questions about the individual quality statements*

**Question 4** For draft quality statement 1: Is assessment of left ventricular function happening routinely in practice?

**Question 5** For draft quality statement 3: Would the definition of a cardiac rehabilitation programme be universally understood?

**Question 5** For draft quality statement 5: Would the definition of an orientation session be universally understood?

# Quality statement 1: Assessment of left ventricular function

## *Quality statement*

Adults admitted to hospital following an MI have an assessment of left ventricular function.

## *Rationale*

After a myocardial infarction (MI), some people have heart failure because of damage to heart muscle and impaired contraction of the left ventricle. This is known as left ventricular systolic dysfunction (LVSD). The effectiveness of drug treatment with ACE inhibitors, angiotensin receptor blockers (ARBs), aldosterone antagonists and beta-blockers depends on left ventricular function. The outcome of assessing left ventricular function informs the type, titration and duration of treatment given to a person who has had an MI.

## *Quality measures*

### Structure

Evidence of local arrangements to ensure that adults admitted to hospital following an MI have an assessment of left ventricular function.

***Data source:*** Local data collection.

### Process

Proportion of hospital admissions of adults following an MI who have an assessment of left ventricular function before discharge.

Numerator – the number in the denominator who have an assessment of left ventricular function before discharge.

Denominator – the number of hospital admissions of adults following an MI.

***Data source:*** Local data collection.

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

**Service providers** (secondary and tertiary care services) ensure that adults admitted to hospital following an MI have an assessment of left ventricular function.

**Healthcare professionals** ensure that they assess the left ventricular function of adults admitted to hospital following an MI.

**Commissioners** (clinical commissioning groups) ensure that they commission services that have the capacity and expertise to assess left ventricular function in adults admitted to hospital following an MI.

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

**Adults** who are admitted to hospital after a heart attack have a type of ultrasound scan (called an echocardiogram) to see how well the blood is being pumped through their heart. This helps with decisions about the type and dose of drug treatment.

### *Source guidance*

- Myocardial infarction - secondary prevention (2013) NICE guideline CG172, recommendation 1.3.4 (key priority for implementation)

### *Question for consultation*

Is assessment of left ventricular function happening routinely in practice?

# Quality statement 2: Communication with primary care

## *Quality statement*

Adults leaving hospital following an MI have details of drug titration, blood pressure and renal function shared with their GP.

## *Rationale*

A clear summary of drug titration and details of blood pressure and renal function monitoring ensures that people are on the clinically appropriate drug dose after they leave hospital. Most patients have several complex investigations during their hospital stay. Clear communication of these results and subsequent plans for discharge are important for smooth transitions between hospital and primary care.

## *Quality measures*

### Structure

Evidence of local arrangements to ensure that adults leaving hospital following an MI have details of drug titration and blood pressure and renal function monitoring shared with their GP.

***Data source:*** Local data collection.

### Process

Proportion of hospital discharges of adults following an MI with the details of their drug titration and blood pressure and renal function monitoring shared with their GP.

Numerator – the number in the denominator with the details of drug titration and blood pressure and renal function monitoring shared with their GP.

Denominator – the number of hospital discharges of adults following an MI.

***Data source:*** Local data collection.

### Outcome

Readmission/rehospitalisation rates.

Data source: National data on emergency readmissions within 30 days of discharge from hospital is available from the Health and Social care Information Centre.

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

**Service providers** (secondary and tertiary care services) ensure that adults discharged from hospital following an MI have details of drug titration and blood pressure and renal function monitoring shared with their GP.

**Healthcare professionals** ensure that adults discharged from hospital following an MI have details of drug titration and blood pressure and renal function monitoring shared with their GP.

**Commissioners** (clinical commissioning groups) ensure that the services they commission provide details of drug titration and blood pressure and renal function monitoring to GPs for adults discharged from hospital following an MI.

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

**Adults** who have had a heart attack have a plan of how their care should be provided sent to their GP. This includes details of the dose and type of drug treatment they should receive and how their blood pressure and kidney function should be monitored. This helps to ensure that people receive the right amount of treatment at the right time.

### *Source guidance*

- Myocardial infarction - secondary prevention (2013) NICE guideline CG172, recommendation 1.3.2

# Quality statement 3: Access to cardiac rehabilitation

## *Quality statement*

Adults admitted to hospital following an MI are referred for cardiac rehabilitation while they are in hospital.

## *Rationale*

Cardiac rehabilitation aims to address the underlying causes of cardiovascular disease and improve a person's physical and mental health. Participating in cardiac rehabilitation helps people to play a full part in their community, improves health behaviour and reverses progression of cardiac disease. Cardiac rehabilitation also reduces all-cause mortality and 'cardiac mortality' when compared with usual care. People who are pre-booked onto programmes before discharge show a higher rate of uptake and adherence compared with those who are referred using standard methods.

## *Quality measures*

### Structure

Evidence of local arrangements to ensure that adults admitted to hospital following an MI are referred for cardiac rehabilitation while they are in hospital.

***Data source:*** Local data collection.

### Process

Proportion of hospital admissions of adults following an MI referred for cardiac rehabilitation while they are in hospital.

Numerator – the number in the denominator referred for cardiac rehabilitation while they are in hospital.

Denominator – the number of hospital admissions of adults following an MI.

***Data source:*** Local data collection.

**Outcome**

a) Uptake rates of cardiac rehabilitation programmes.

***Data source:*** Local data collection. National data on the uptake of cardiac rehabilitation is available from National Audit of Cardiac Rehabilitation (NACR).

b) Incidence of cardiovascular events.

***Data source:*** Local data collection.

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

**Service providers** (secondary and tertiary care services) ensure that adults admitted to hospital following an MI are referred for cardiac rehabilitation while they are in hospital.

**Healthcare professionals** ensure that adults admitted to hospital following an MI are referred for cardiac rehabilitation while they are in hospital.

**Commissioners** (clinical commissioning groups) ensure that they commission services that have the capacity and expertise to refer adults admitted to hospital following an MI for cardiac rehabilitation while they are in hospital.

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

**Adults** who are admitted to hospital after a heart attack are referred for cardiac rehabilitation while they are in hospital. The programme includes exercise¸ information about health, lifestyle changes and how to cope with stress. It helps to slow down or stop heart disease.

## *Source guidance*

- Myocardial infarction - secondary prevention (2013) NICE guideline CG172, recommendation 1.1.1

## *Definitions of terms used in this quality statement*

**Cardiac rehabilitation**

Cardiac rehabilitation is a coordinated and structured programme of care designed to remove or reduce the underlying causes of cardiovascular disease, as well as to provide the best possible physical and mental health, so that people may make changes to their lifestyle to slow or reverse the progression of cardiovascular disease. [MI – secondary prevention (NICE guideline CG172) recommendation 1.1.1]

Programmes include a range of lifestyle interventions, such as risk factor management, psychosocial health, cardioprotective therapies, health behaviour changes and long-term management, including both physical exercise and dietary advice. [expert opinion]

## *Question for consultation*

Would the definition of a cardiac rehabilitation programme be universally understood?

# Quality statement 4: Provision of cardiac rehabilitation services

## *Quality statement*

Cardiac rehabilitation services provide both daytime and evening programmes in both community and home based settings.

## *Rationale*

Offering cardiac rehabilitation programmes at different times of day, including outside working hours, is likely to increase both uptake of and adherence to programmes. It is important that programmes are provided at both the daytime and the evening, so that they are accessible to people in employment and those with other commitments. Programmes should also be made available in a variety of settings, including at home, so that people can attend sessions in their preferred venue.

## *Quality measures*

### Structure

Evidence of local arrangements to ensure that cardiac rehabilitation services provide programmes in the daytime and the evening and in both community and home based settings.

***Data source:*** Local data collection.

### Outcome

Uptake rates of cardiac rehabilitation programmes.

***Data source:*** Local data collection. National data on the uptake of cardiac rehabilitation is available from the National Audit of Cardiac Rehabilitation (NACR).

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

**Service providers** (secondary and tertiary care services) ensure that cardiac rehabilitation programmes are provided in the daytime and the evening and in both community and home based settings.

**Healthcare professionals** offer adults admitted to hospital following an MI both daytime and evening cardiac rehabilitation programmes in both community and home based settings.

**Commissioners** (clinical commissioning groups) ensure that they commission cardiac rehabilitation services that have the capacity and expertise to provide programmes in the daytime and evening and in both community and home based settings.

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

**Adults** who leave hospital after a heart attack are given a choice of daytime or evening cardiac rehabilitation programmes in a choice of community and home based settings. This means they are more likely to be able to get to and take part in a programme. They will be able to choose the best place and time to suit them.

## *Source guidance*

- Myocardial infarction - secondary prevention (2013) NICE guideline CG172, recommendation 1.1.1

## *Definitions of terms used in this quality statement*

### Cardiac rehabilitation programme

Cardiac rehabilitation is a coordinated and structured programme of care designed to remove or reduce the underlying causes of cardiovascular disease, as well as to provide the best possible physical and mental health, so that people may make changes to their lifestyle to slow or reverse the progression of cardiovascular disease. [MI – secondary prevention (NICE guideline CG172) recommendation 1.1.1]

Programmes include a range of lifestyle interventions, such as risk factor management, psychosocial health, cardioprotective therapies, health behaviour changes and long-term management, including both physical exercise and dietary advice. [expert opinion]

# Quality statement 5: Uptake of cardiac rehabilitation

## *Quality statement*

Adults who enrol on a cardiac rehabilitation programme following an MI have an orientation session within 10 days of their discharge from hospital.

## *Rationale*

Starting cardiac rehabilitation as soon as possible after a heart attack significantly improves ongoing attendance at cardiac rehabilitation programmes and is cost saving through a reduced number of unplanned re-admissions for cardiac problems.

## *Quality measures*

### Structure

Evidence of local arrangements to ensure that adults who enrol on a cardiac rehabilitation programme following an MI have an orientation session within 10 days of their discharge from hospital.

***Data source:*** Local data collection.

### Process

a) Proportion of hospital admissions of adults following an MI enrolled on a cardiac rehabilitation programme who attend an orientation session within 10 days of discharge.

Numerator – the number in the denominator who attend an orientation session within 10 days of discharge.

Denominator – the number of hospital admissions of adults following an MI enrolled on a cardiac rehabilitation programme.

b) Proportion of hospital admissions of adults following an MI who attend a cardiac rehabilitation orientation session within 10 days of discharge who complete the programme.

Numerator – the number in the denominator who complete a cardiac rehabilitation programme.

Denominator – the number of hospital admissions of adults following an MI who attend a cardiac rehabilitation orientation session within 10 days of discharge.

***Data source:*** Local data collection. National data on adherence to cardiac rehabilitation is available from National Audit of Cardiac Rehabilitation (NACR).

**Outcome**

Uptake rates of cardiac rehabilitation programmes.

***Data source:*** Local data collection. National data on the uptake of cardiac rehabilitation is available from the National Audit of Cardiac Rehabilitation (NACR).

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

**Service providers** (secondary and tertiary care services) ensure that adults admitted to hospital following an MI enrolled on a cardiac rehabilitation programme have an orientation session within 10 days of discharge.

**Healthcare professionals** ensure that adults admitted to hospital following an MI enrolled on a cardiac rehabilitation programme have an orientation session within 10 days of discharge.

**Commissioners** (clinical commissioning groups) ensure that they commission services that have the capacity to give adults admitted to hospital following an MI who are enrolled on a cardiac rehabilitation programme an orientation session within 10 days of their discharge.

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

**People** who have enrolled on a cardiac rehabilitation programme after a heart attack have their orientation session within 10 days of leaving hospital. Starting cardiac rehabilitation as soon as possible encourages people to attend cardiac rehabilitation programmes and makes it more likely that they will carry on taking part.

## *Source guidance*

- Myocardial infarction - secondary prevention (2013) NICE guideline CG172, recommendation 1.1.13.

## *Definitions of terms used in this quality statement*

### Orientation session

An orientation session is the first session of a cardiac rehabilitation programme and includes advice on lifestyle and risk factors and an assessment of the person's cardiac function.

## *Question for consultation*

Would the definition of an orientation session be universally understood?

# 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 secondary prevention following a myocardial infarction. 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 and social care professionals for people with MI is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with MI 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.

- MI – secondary prevention (2013) NICE guideline CG172

### *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)
- British Heart Foundation (2013) The national audit of cardiac rehabilitation 2013
- Department of Health (2013) Cardiovascular disease outcomes strategy: improving outcomes for people with or at risk of cardiovascular disease
- Department of Health (2013) Designing and planning cardiac facilities (Health Building Note 01-01)
- National Institute for Cardiovascular Outcomes Research (2013) Myocardial ischaemia national audit project: annual public report April 2012–March 2013
- Department of Health (2011) A review of emerging cardiac technologies: their potential impact on cardiac services over the next 10 years
- Chartered Society of Physiotherapy (2011) Physiotherapy works: cardiac rehab

### *Definitions and data sources for the quality measures*

- National Audit of Cardiac Rehabilitation (2013) NACR

## 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
- Anxiety disorders (2014) NICE quality standard 53

- 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
- Depression in adults (2011) NICE quality standard 8
- 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
- Atrial fibrillation. Publication expected July 2015
- Cardiovascular risk assessment. Publication expected September 2015
- Lipid modification. 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.
- Personality disorders (borderline and antisocial)
- 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, East Midlands

**Mr Barry Attwood**
Lay member

**Professor Gillian Baird**
Consultant Developmental Paediatrician, Guy's and St Thomas' NHS Foundation Trust

**Mrs Belinda Black**
Chief Executive Officer, Sheffcare, Sheffield

**Dr Ashok Bohra**
Consultant Surgeon, Dudley Group of Hospitals NHS Foundation Trust

**Dr Guy Bradley-Smith**
Freelance GP and Clinical Commissioning Lead for Learning Disability, North, East and West (NEW) Devon Clinical Commissioning Group

**Mrs Julie Clatworthy**
Governing Body Nurse, Gloucester Clinical Commissioning Group

**Mr Derek Cruickshank**
Consultant Gynaecological Oncologist/Chief of Service, South Tees NHS Foundation Trust

**Miss Parul Desai**
Consultant in Public Health and Ophthalmology, Moorfields Eye Hospital NHS Foundation Trust. London

**Mrs Jean Gaffin**

Lay member

**Dr Anjan Ghosh**

Consultant in Public Health, Public Health Merton, London

**Mr Jim Greer**

Principal Lecturer, Teesside University

**Dr Ulrike Harrower**

Consultant in Public Health Medicine, NHS Somerset

**Professor Richard Langford**

Consultant in Anaesthesia and Pain Medicine, Barts Health NHS Trust, London

**Mr Gavin Lavery**

Clinical Director, Public Health Agency

**Dr Tessa Lewis**

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

**Miss Ruth Liley**

Assistant Director of Quality Assurance, Marie Curie Cancer Care

**Dr Michael Rudolf (Chair)**

Consultant Physician, Ealing Hospital NHS Trust

**Mr David Minto**

Adult Social Care Operations Manager, Northumbria Healthcare Foundation Trust

**Dr Lindsay Smith**

GP, West Coker, Somerset

The following specialist members joined the committee to develop this quality standard:

**Dr Rajai Ahmad**

Consultant Cardiologist, Sandwell and West Birmingham Hospitals NHS Trust

**Ms Louise Batey**

CHD Nurse Clinical Lead/ Cardiac Rehabilitation Coordinator, University Hospital South Manchester

**Dr Ivan Benett**

General Practitioner and Clinical Director, NHS Central Manchester Clinical Commissioning Group

**Mr Sanjay Ramdany**

Community Matron with Special Interest in CVD, Isle of Wight NHS Trust

**Dr Alan Rees**

Consultant Physician in Diabetes, Endocrinology and Clinical Lipidology, University Hospital of Wales Cardiff

**Mr John Walsh**

Lay member

**Professor Anthony Wierzbicki**

Consultant in Metabolic Medicine/Chemical Pathology, Guy's & St Thomas' NHS Foundation Trust

**Dr Robert Wright**

Consultant Cardiologist, James Cook University Hospital, Middlesborough

## *NICE project team*

**Nick Baillie**

Associate Director

**TBC**

Consultant Clinical Adviser

**Rachel Neary-Jones**

Programme Manager

**Craig Grime**

Technical Adviser

**Justine Karpusheff**
Lead Technical Analyst

**Natalie Boileau / Esther Clifford**
Project Manager

**Nicola Cunliffe**
Coordinator

## 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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