Indicator development programme

NICE indicator validity assessment

# Indicator IND229

The percentage of patients with a cardiovascular disease risk assessment score of 10% or more who are currently treated with a lipid lowering therapy.

# Indicator type

General practice indicator suitable for use in the Quality and Outcomes Framework.

# Importance

|  |  |
| --- | --- |
| **Considerations**  | **Assessment** |
| The [NHS Long Term Plan](https://www.longtermplan.nhs.uk/) identifies cardiovascular disease as a clinical priority, and the single biggest condition where lives can be saved by the NHS over the next 10 years.  | The indicator reflects a specific priority area identified by NHS England. |
| The [CVDPREVENT Second Annual Audit Report](https://www.nhsbenchmarking.nhs.uk/cvdprevent-outputs) found that the percentage of patients with a QRISK score of 10% or more on lipid lowering therapy was 44.5%. This also varied by gender (44.2% for females, 42.4% for males), ethnicity (Asian ethnic most likely at 56.1%) and socio-economic status (49.3% in the most deprived quintile, and 39.2% in the least deprived quintile). There was variation across CCGs, ranging from 35.5% to 52.6% of patients. Data to June 2024 showed achievement for England of 53.58%. | The indicator relates to an area where there is variation in practice.The indicator addresses under-treatment. |
| Lipid lowering therapies can help lower LDL cholesterol as part of primary prevention of CVD if lifestyle interventions are ineffective or inappropriate. Atorvastatin 20 mg is recommended as first line therapy for the primary prevention of CVD to people who have a 10% or more 10‑year risk of developing CVD. | The indicator will lead to a meaningful improvement in patient outcomes. |

# Evidence base

|  |  |
| --- | --- |
| **Considerations**  | **Assessment** |
| * [Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238](https://www.nice.org.uk/guidance/NG238) (2023), recommendation 1.6.7
* [Bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia. NICE technology appraisal TA694](https://www.nice.org.uk/guidance/ta694) (2021)
* [Evolocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia. NICE technology appraisal guidance 394](https://www.nice.org.uk/guidance/ta394) (2016)
* [Alirocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia. NICE technology appraisal guidance 393](https://www.nice.org.uk/guidance/ta393) (2016)
* [Ezetimibe for treating primary heterozygous-familial and non-familial hypercholesterolaemia. NICE technology appraisal TA385](https://www.nice.org.uk/guidance/ta385) (2016)
 | The indicator is derived from a high-quality evidence base. The indicator aligns with the evidence base. |

# Specification

|  |  |
| --- | --- |
| **Considerations**  | **Assessment** |
| Numerator: The number in the denominator who are currently treated with a lipid lowering therapy.Denominator: The number of patients with a last recorded cardiovascular disease risk score of 10% or more.Calculation: Numerator divided by the denominator, multiplied by 100.Definitions: Current treatment with a lipid lowering therapy is defined as prescription of a statin or non-statin lipid lowering therapy in the last 6 months of the reporting period. Exclusions: * People with diagnosed cardiovascular disease (see indicator IND230). Cardiovascular disease is defined as angina, previous myocardial infarction, revascularisation, stroke or TIA or symptomatic peripheral arterial disease.
* Patients aged 24 and under (QRISK3 is not validated in people under 25 years).
* Patients aged 85 and older (QRISK3 is not validated in people over 84 years).

Personalised care adjustments or exception reporting should be considered to account for situations where the patient declines, does not attend or if lipid lowering therapy is not appropriate. | The indicator has defined components necessary to construct the indicator, including numerator, denominator and exclusions. |
| To be classified as suitable for use in QOF, there should be an average minimum population of more than 20 patients per practice eligible for inclusion in the denominator prior to application of personalised care adjustments. CVD Prevent data up to June 2024 compared with ONS population statistics shows that an average practice with 10,000 patients would have around 1006 eligible patients. | The indicator does outline minimum numbers of patients needed to be confident in the assessment of variation. |

# Feasibility

|  |  |
| --- | --- |
| **Considerations**  | **Assessment** |
| Data can be collected from GP systems using SNOMED coding.  | The indicator is repeatable. |
| Existing data fields and code clusters are used in diabetes and cholesterol indicators in the 2024/25 QOF. | The indicator is measuring what it is designed to measure. The indicator uses existing data fields. |

# Acceptability

|  |  |
| --- | --- |
| **Considerations**  | **Assessment** |
| Patients refusing lipid modifying therapy could affect the ability of clinicians to perform against the indicator.Personalised care adjustments are able to be used if lipid modifying therapy is contra-indicated or declined | The indicator assesses performance that is attributable to or within the control of the audience |
| Data can be extracted and used to compare practice within the GP practice or with other GP practices. | The results of the indicator can be used to improve practice. |

# Risk

|  |  |
| --- | --- |
| **Considerations**  | **Assessment** |
| In consultation some stakeholders felt that a CVD risk assessment score of 10% or more captured a high number of patients and might have a significant impact on primary care workload. Some stakeholders felt that the indicator should focus on statins only.The committee agreed that a 10% or more threshold was appropriate as it aligned with NICE guidance and that early intervention was key for positive health outcome. Workload implications were considered, and it was agreed that the long-term workload increase would be far greater without early intervention, and could be split between different primary care roles to reduce impact. The committee considered limiting the indicator to statins only, and agreed that while statins would be first line treatment, there needs to be consideration for other treatment options, and chose to retain the wording of lipid modifying therapy. | The indicator has an acceptable risk of unintended consequences. |

# NICE indicator advisory committee recommendation

The NICE indicator advisory committee approved this indicator for publication on the menu.