Indicator development programme

NICE indicator validity assessment

# Indicator IND275

# The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a lipid-lowering therapy (excluding patients with type 2 diabetes and a cardiovascular disease risk score of less than 10% recorded in the preceding 3 years).

# Indicator type

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

# Importance

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| **Considerations**  | **Assessment** |
| People with diabetes have an increased risk of cardiovascular disease. 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. |
| [NHS England’s Quality and Outcomes Framework 2023-4](https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data) indicator DM022 reported an achievement rate of 90.41% for people with diabetes on the register, aged 40 or over with no history of CVD and without moderate or severe frailty, who were treated with a statin in England. | The indicator relates to an area where there is known 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. | The indicator will lead to a meaningful improvement in patient outcomes. |

# Evidence base

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| **Considerations**  | **Assessment** |
| * [Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238](https://www.nice.org.uk/guidance/NG238) (2023), recommendations 1.6.7, 1.6.10 and 1.6.12
* [Bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia. NICE technology appraisal guidance 694](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 guidance 385](https://www.nice.org.uk/guidance/ta385) (2016)
 | The indicator is derived from a high-quality evidence base.  |

# Specification

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| **Considerations**  | **Assessment** |
| Numerator: The number of patients in the denominator who are currently treated with a lipid-lowering therapy.Denominator: The number of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty. Exclusions: * People with diagnosed cardiovascular disease (see IND276).
* Patients with type 2 diabetes and a cardiovascular disease risk score of less than 10% recorded in the preceding 3 years (as lipid-lowering therapy may not be needed).

Definitions: * Cardiovascular disease is defined as angina, previous myocardial infarction, revascularisation, stroke or TIA or symptomatic peripheral arterial disease.
* 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.

Personalised care adjustments or exception reporting should be considered to account for situations where the patient declines, does not attend or if treatment with a 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. QOF data for 2023 to 2024 shows that an average practice with 10,000 patients would have around 320 eligible patients. | The indicator does outline minimum numbers of patients needed to be confident in the assessment of variation. |

# Feasibility

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| **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

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| **Considerations**  | **Assessment** |
| Patients refusing lipid modifying therapy could affect the ability of clinicians to perform against the indicator.Personalised care adjustments can 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

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| **Considerations**  | **Assessment** |
| There was concern during development that there is limited evidence on the benefits or risks of statins for older people with moderate or severe frailty. It was therefore agreed to exclude people with moderate or severe frailty from the denominator. | The indicator has an acceptable risk of unintended consequences. |