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NICE CG181: July 2014. Summary for CCGs.

Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease

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Lipid Modification:

NICE Guideline CG181 Published date: July 2014

Purpose

This paper is designed to give an executive summary of the key points in relation to medicines optimisation arising from NICE CG 181[1].

It highlights some issues CCGs may wish to consider in terms of implementation of the guidance.

Summary

The guideline states that CVD 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[2] – around 80,000 of these deaths were caused by coronary heart disease and 49,000 were caused by strokes.
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.

The two main changes in relation to cost impact arising from this guidance are:

- The lowering of the threshold for primary prevention of CVD from a 10 yr CVD risk of 20% to 10%
- The use of atorvastatin as the first line statin in both primary and secondary prevention.

It is anticipated that implementation of this guideline will occur over a period of 5 years. Expert opinion suggests the best estimate is equally over a 5-year period.

The annual change in resource arising from implementation of the recommendations considered in the costing analysis[3] is summarised below. It is worth noting that these costs are based on national assumptions relating to current prescribing patterns. The North East has traditionally been a high user of low cost generic statins and therefore these assumptions may be conservative in local CCG areas.

Costs per 100,000 population per annum:

Recommendation	**Recommendation number**	**Cost Impact**
Impact on new population Offer atorvastatin 20mg for the primary prevention of CVD to people who have a 10% or greater 10-year risk of developing CVD. Estimate the level of risk using the QRISK2 assessment tool.	1.3.18	**£75,000**
Impact on current population Offer atorvastatin 20mg for the primary prevention of CVD to people who have a 10% or greater 10-year risk of developing CVD .Estimate the level of risk using the QRISK2 assessment tool. Start statin treatment in people with CVD with atorvastatin 80mg. Use a lower dose of atorvastatin if any of the following apply: • potential drug interactions • risk of adverse events • patient preference	1.3.18 And 1.3.20	**£14,000**
Total cost		**£89,000**

It estimated that there will be savings from CVD events avoided of £43,000 per 100,000 population.

The costs and savings outlined relate to direct costs to the NHS. The following benefits are also anticipated:

- a reduction in the number of deaths due to CVD events
- improved quality of life for people with CVD
- reduced side effects for people taking statins
- may reduce accident and emergency attendances
- Implementation of the guideline is likely to have wider societal benefits in terms of people being able to work for longer and a reduction in time off work due to ill health.

Commissioning Considerations

- Implementing the clinical guideline is expected to result in a reduction in the number of deaths due to CVD events but commissioners will need to decide how to manage the increased cost pressure in prescribing and how best to utilise the savings from avoidance of events.
- Recommendation 1.1.1 suggests using a systematic strategy to identify people who are likely to be at high risk of CVD. This recommendation has not been costed in the NICE Costing Report as NICE envisage that this will be done as part of the national NHS Health Check programme. NHS Health Check activity is varied and CCGs may wish to explore with their Health and Wellbeing boards what local activity is currently taking place.
- Recommendation 1.3.4 advises the use of non-high-density lipoprotein (non-HDL) cholesterol rather than low-density lipoprotein (LDL) cholesterol. This is a significant change in clinical practice, although it is not anticipated to have a significant resource impact, because the cost of the test is the same. The key change is in the education of laboratory and clinical staff in the reporting and interpretation of the results. There may need to be local discussions with providers of laboratory facilities to ensure this change is implemented.
- There are new restrictions on the role of fibrates, nicotinic acid, bile acid sequestrants, omega 3 fatty acids and combinations of drugs together with recommendations for first line statin choices which will have implications for local formularies and patient review.
- Where local guidance has been produced, e.g. FATS, this will need reviewed.
- Rosuvastatin and ezetimibe use may need to be reviewed as part of the practice audit workplan to ensure use is in line with the new recommendations. The sensitivity analysis used in the costing methodology assumed a reduction in the future prescribing of rosuvastatin by 50% (and replacement with atorvastatin) which could lead to additional savings of £32,000 per 100,000 population, depending on baseline prescribing levels.
- Consider baseline assessment and clinical audit to monitor and prioritise implementation of the guidance.
- Consider provision of services to allow for implementation of recommendation 1.3.43:
    - Seek specialist advice for options for treating people at high risk of CVD such as those with CKD, type 1diabetes, type 2 diabetes or genetic dyslipidaemias and those intolerant to 3 different statins.

Practice Considerations

- Recommendation 1.1.4 prioritises people for a full formal risk assessment if their estimated 10-year risk of CVD is 10% or more .This recommendation has not been costed by NICE as they envisage that this can be achieved within existing healthcare resources, by either a GP or a practice nurse. It is expected however that there will be 8135 additional eligible people per 100,000 and therefore an impact on practice time.
- Use of the QRISK2 risk assessment tool to assess CVD risk for the primary prevention of CVD in people up to and including age 84 years is unlikely to have a significant resource impact, because expert opinion suggests the tool is already widely used. However practices not already utilising this risk assessment tool will need to consider how to implement this recommendation
- Recommendation 1.3.30 recommends discussion with people who are stable on a low-or middle-intensity statin the likely benefits and potential risks of changing to a high-intensity statin when they have a medication review and agree with the person whether a change is needed. Medication reviews are recommended annually for all patients on statins.
- At the time of publication (July 2014), atorvastatin did not have a UK marketing authorisation for the use of Atorvastatin 80mg in people with existing CVD. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented.
- Recommendation 1.1.26 recommends people are offered information about the risks and benefits of treatment but do not give specific validated tools that can be used. Several tools are available to support these discussions including, but not limited to, an existing National Prescribing Centre patient decision aid[5,] resources available from the Mayo clinic[4] and resources available on the NHS Shared Decision Making website[6]
- Review annual medication review templates for people taking statins to ensure they incorporate the requirement to discuss medicines adherence and lifestyle modification and address CVD risk factors as well as considering an annual non-fasting blood test for non-HDL cholesterol.
- Review recall processes in practice to ensure recommendation 1.3.28, which states ”Measure total cholesterol, HDL cholesterol and non-HDL cholesterol in all people who have been started on high-intensity statin treatment at 3 months of treatment and aim for a greater than 40% reduction in non-HDL cholesterol” is incorporated into the process .

References with hyperlinks:

1. CG181 Lipid modification (update): full guideline [CG180] Published date: July Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease | Guidance and guidelines | NICE
2. UK National Statistics. Home: UK National Statistics Publication Hub
3. NICE Costing report. http://www.nice.org.uk/guidance/cg181/resources/cg181-lipid-modification-update-costing-report2
4. Mayo clinic Patient Decision Aids - Cardiovascular Prevention DAs (Statin & Aspirin) | Shared Decisions
5. National Prescribing centre PDA - Cardiovascular disease - Lipids | Patient decision aids
6. Shared Decision Making (SDM) - NHS