NICE National Institute for Health and Care Excellence

Indicator development programme

NICE indicator validity assessment

Indicator IND269

The percentage of people aged 45 to 84 years who have a recorded CVD risk assessment score in the preceding 5 years.

Indicator type

Network / system level indicator.

Importance

Considerations	Assessment
The NHS Long Term Plan 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. It mentions ambitions to improve approaches to identifying high risk conditions; this indicator can contribute to these efforts.	The indicator reflects a specific priority area identified by NHS England.
The CVDPREVENT third Annual Audit Report found that the prevalence of CVD in adults in England was 6.0%, affecting over 2.5million people in the audit sample. The audit showed that the prevalence of CVD increased with age, deprivation (after an age adjustment), and males were more likely than females, across all age groups to suffer from premature CVD mortality.	The indicator relates to an area where there is known variation in practice. The indicator addresses identification of those at high risk of CVD.
Early identification of risk of cardiovascular disease is important because this can lead to opportunities for early interventions.	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 (2023), recommendations 1.1.1, 1.1.2 and 1.1.3	The indicator is derived from a high-quality evidence base. The indicator aligns with the evidence base.

Specification

Considerations	Assessment
Numerator: The number of people in the denominator with a recorded CVD risk assessment score in the preceding 5 years. Denominator: The number of people aged 45 to 84 years. Definitions: CVD risk assessment should preferably be undertaken using QRISK3; however, proposed indicator construction would include clinical codes for QRISK, QRISK2 and QRISK3 risk scores. For this indicator, estimated risk scores would be acceptable using factors already recorded in primary care electronic medical records however 'batch coding' without clinical judgement should be avoided. Exclusions: People with any of the following: • type 1 diabetes • cardiovascular disease • familial hypercholesterolaemia • CKD stage 3a to 5 • current treatment with lipid lowering therapies • a risk score of 20% or more ever recorded Current lipid lowering therapies is defined as a prescription of statins or other lipid lowering therapies in the last 6 months of reporting period. Cardiovascular disease is defined as angina, previous myocardial infarction, revascularisation, ischaemic stroke or TIA or symptomatic peripheral arterial disease. Existing NHS QOF registers could be used: CHD001, STIA001 excluding people with a history of haemorrhagic stroke, and PAD001.	The indicator has defined components necessary to construct the indicator, including numerator, denominator and exclusions.
Analysis of CPRD data shows that 23.8% of people in England were aged 45 to 84 years with no type 1 diabetes, cardiovascular disease, familial hypercholesterolaemia, CKD stage 3a to 5, current treatment with lipid lowering therapies or a risk score of 20% or more ever recorded: 2376 per 10,000 patients. Clinical Practice Research Datalink. (2024). CPRD Aurum March 2024 (Version 2024.03.001) [Data set]. Clinical Practice Research Datalink. https://doi.org/10.48329/yxmq-vk87.	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.
A number of indicators in QOF and in CVD Prevent use or have used codes for a CVD risk assessment. See QOF business rules for details of codes for cluster CVDASS2.	The indicator is measuring what it is designed to measure. The indicator uses existing data fields.

Acceptability

Considerations	Assessment
Consultation and piloting cautioned about risk of duplication if NHS Health Checks are conducted outside of primary care and not recorded in GP records.	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
Findings from the consultation and piloting cautioned about the risk of duplication in CVD risk assessments if NHS Health Checks are conducted outside of primary care and not properly recorded in GP records, which could strain primary care capacity. Accuracy of estimated risk scores will be affected if relevant data is not accurately recorded in GP records, especially in vulnerable and underserved populations. To mitigate against perpetuating or exacerbating existing health inequalities 'batch coding' without clinical judgement should be avoided. Additionally, resultant data should be disaggregated by deprivation, ethnicity, age and gender to help reduce the risk of widening health inequalities.	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. They advised that batch coding to achieve success should be avoided.