Cardiovascular disease prevention: primary prevention with lifestyle changes

NICE indicator
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www.nice.org.uk/indicators/ind228

Indicator

The percentage of patients with a cardiovascular disease risk assessment score of 10% or more identified in the preceding 12 months who are offered advice and support for smoking cessation, safe alcohol consumption, healthy diet and exercise within 3 months of the score being recorded.

Indicator type

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

This document does not represent formal NICE guidance. For a full list of NICE indicators, see our menu of indicators.

To find out how to use indicators and how we develop them, see our NICE indicator process guide.

Rationale

Cardiovascular risk assessment aims to identify people who do not already have cardiovascular disease but who may be at high risk of developing it. Those people can then be offered focused interventions, including help to stop smoking, and advice on diet (including alcohol intake) and physical activity to support primary prevention of cardiovascular disease through managing lifestyle risk factors. A timeframe of 3 months has been chosen for measurement purposes only.

Source guidance

Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2014, updated 2023), recommendations 1.3.1 to 1.3.11

Specification

Numerator: The number in the denominator who are offered advice and support for smoking cessation, safe alcohol consumption, healthy diet and exercise within 3 months of the score being recorded.

Denominator: The number of patients with a cardiovascular disease risk assessment score of 10% or more identified in the preceding 12 months.

Calculation: Numerator divided by the denominator, multiplied by 100.

Exclusions: People with diagnosed cardiovascular disease. Cardiovascular disease is defined as angina, previous myocardial infarction, revascularisation, stroke or transient ischaemic attack (TIA) or symptomatic peripheral arterial disease.

Personalised care adjustments or exception reporting should be considered to account for situations where the patient declines, does not attend or if the indicator is not appropriate.

Expected population size: The indicator would be appropriate to assess performance at individual general practice level.

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 before application of personalised care adjustments. Piloting data showed approximately 254 eligible patients for an average practice with 10,000 patients (using Office for National Statistics [ONS] population statistics).

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