NICE National Institute for Health and Care Excellence

Indicator development programme

Consultation report

Cardiovascular disease risk assessment

This paper presents consultation feedback received in response to the draft indicators on cardiovascular disease risk assessment. Consultation was held 29 February to 28 March 2024.

Contents

Consultation report - cardiovascular disease risk assessment

In March 2024, the following three indicators went out to consultation-:

- IND2023-164-: The percentage of people aged 45 to 84 years who have a recorded CVD risk assessment score in the preceding 5 years.
- IND2023-165-: The percentage of people aged 43 to 84 years with a modifiable risk factor or comorbidity who have a recorded CVD risk assessment score in the preceding 3 years.
- IND2023-166-: The percentage of people aged 43 to 84 years with a modifiable risk factor who have a recorded CVD risk assessment score in the preceding 3 years.

Indicator type

The indicators were proposed as suitable for use in the Quality Outcomes Framework.

Source guidance

NICE's guideline on cardiovascular disease: risk assessment and reduction, including lipid modification. NICE guideline NG238 (2023), recommendations 1.1.1 and 1.1.2.

Rationale

For primary prevention of cardiovascular disease, NICE guidance recommends using a systematic strategy in primary care to identify people who are likely at high risk of CVD. Once an increased risk has been found, many CVD risk factors are modifiable through lifestyle changes or medical interventions.

Three indicators were proposed to provide options with decreasing denominator size.

- IND2023-164 -: This indicator uses a population aged 45 to 84 years to provide a 5-year window in which the initial risk assessment can take

place. A frequency of 5 years for repeat CVD risk assessment was chosen to align with the NHS Health Check programme. CVD risk can be estimated based on existing factors already recorded in primary care electronic medical records.

- IND2023-165-: This indicator focuses on those who have modifiable risk factors or comorbidities as highlighted in the QRISK3 assessment tool because these patients are more likely to have higher CVD risk. Although the QRISK3 assessment tool is validated in people aged 25 to 84 years, this indicator uses a population aged 43 to 84 years to provide a 3-year window in which the initial risk assessment can take place. This means the target population starts at 40 years old, aligning with the starting age of the NHS health check programme. A frequency of 3 years was chosen because cardiovascular risk may change more rapidly in people with a modifiable risk factor or comorbidity. CVD risk can be estimated based on existing factors already recorded in primary care electronic medical records.

- IND2023-166: This indicator focuses on those who have modifiable risk factors as highlighted in the QRISK3 assessment tool because these patients are more likely to have higher CVD risk. This indicator may provide a more pragmatic approach to identifying people likely to be at high risk, with fewer patients per practice than the two previous indicators stated above. Although the QRISK3 assessment tool is validated in people aged 25 to 84 years, this indicator uses a population aged 43 to 84 years to provide a 3-year window in which the initial risk assessment can take place. This means the target population starts at 40 years old, aligning with the starting age of the NHS health check programme. A frequency of 3 years was chosen because cardiovascular risk may change more rapidly in people with a modifiable risk factor. CVD risk can be estimated based on existing factors already recorded in primary care electronic medical records.

Summary of consultation comments

The stakeholder comments are summarised below, please see all the stakeholders' responses in Appendix A.

Overarching comments

Stakeholders generally support integrating cardiovascular disease risk assessment into the QOF, emphasising the importance of addressing implementation challenges and unintended consequences. There was consensus on the importance of CVD risk assessment and targeting high-risk groups, coupled with the need for meticulous planning to ensure equitable access and effective interventions.

Some stakeholders agreed that the proposed indicators will lead to improvements in care and outcomes for patients, through identification of unmet need or unwarranted variation. Other stakeholders expressed concern that the indicators will not be viable considering the current state of the NHS health check scheme, however, they may present an opportunity to engage groups traditionally overlooked by traditional communication channels and share learnings across primary care networks and practices.

Stakeholders made direct links to provision of NHS Health Checks. Based on their observation of the NHS health checks programme, there was concern that the indicators would exacerbate existing health inequalities related to lack of universal coverage, variation in funding and implementation across regions and lower attendance amongst the populations most in need.

Adding value

Given the existing NHS health check programme, stakeholders acknowledged there is value in having an indicator focused on CVD risk assessment, with one stakeholder appreciating the concept and suggesting running this indicator alongside existing health checks to address potential health inequalities. They proposed proactive targeting of high-risk patients, potentially through a CVD care coordinator, and emphasised the need for a

nuanced approach to reach specific at-risk groups. They believe this approach could complement the existing NHS Health Check program and help identify gaps in data integration between health checks and GP records if performance is compared to Heath Check data.

One stakeholder highlighted concerns regarding the limitations of incorporating cardiovascular risk assessments within the NHS Health Check programme or as a separate indicator, noting that it fails to incentivise clinical activity effectively. Another stakeholder suggestions to lower the age for health checks and referred to recommendations from The Health Foundation report and government sources to support their views.

Barriers to implementation

Stakeholders identified several barriers to implementing the indicators, including the challenge of addressing large numbers of eligible patients, as primary care may find it too challenging to reach out to the general population cohort and may be unaffordable; geographical variation in service provision, workforce capacity limitations in primary care, varied commissioning and funding arrangements as evidenced by the NHS Health Check programme, and the preference for a population-level indicator and absence of accurate data in GP records to enable calculation of cardiovascular risk assessment scores.

They offered some suggestions to overcoming barriers including - setting up automatic call/recall systems, spreading workload to other health professionals like pharmacists, increased uptake of NHS health checks and blood pressure checks to ensure availability of metrics, increasing relevance and validity of the calculated risk scores, using an audit tool to extract the qualifying patients that require to be addressed and target the higher CVD risk individuals first, non-labour-intensive approaches such as automated systems and digitalising the way information is provided to patients, and developing innovative ways of reaching out to different patient groups by working with the ‘integrated neighbourhood team’ or social prescribers, for example from the third sector.

They proposed that the indicator might be better suited for implementation outside of the QOF, potentially through the CVDPREVENT audit.

Feasibility and unintended consequences

One stakeholder suggested that there may be concerns about increasing stigma in attempts to target groups traditionally overlooked.

Stakeholders 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. They also noted spikes in activity prior to Quality and Outcomes Framework (QoF) deadlines, suggesting the need for consistent activity spread throughout quarters to meet targets.

Specific to IND2023-165, one stakeholder criticised the limited effectiveness of the indicator in incentivising clinical activity, emphasising the need for incentives within the Quality and Outcomes Framework (QOF) to improve care quality, particularly in addressing smoking cessation. The comment also referenced the Inverse Care Law, advocating for prioritising access to healthcare in disadvantaged areas.

Specific to indicators IND2023-165 and IND2023-166, some stakeholders expressed doubts about the feasibility of performing health checks every three years due to prioritisation of acute care.

Moreover, they advocated for a more holistic, lifestyle-focused approach to addressing modifiable risk factors rather than solely relying on medications and statins.

Preferred indicator

There were mixed views on the three proposed indicators. Some stakeholders favoured IND2023-164 as they commended its comprehensive approach to prevention, incorporating more risk factors from the QRISK3 assessment tool and potential to minimise exacerbation of health inequalities.

However, other stakeholders saw IND2023-165 and IND2023-166 as more practical due to their systematic risk stratification approach, although they are reliant on accurate reporting in GP records, which could lead to missed individuals, especially in vulnerable populations.

Stakeholders also recognised the potential of IND2023-165 for high-risk patients but raised concerns about health inequalities if relying solely on recorded factors. They stressed the importance of optimizing resources while linking this approach with locally commissioned services to address health disparities. One stakeholder suggested periodic reviews and expanding beyond modifiable factors if NHS workforce strategies succeed.

Regarding IND2023-166, stakeholders acknowledged its focus on modifiable risk factors but criticized its narrow medical approach, fearing it may miss individuals at high risk of cardiovascular disease, particularly in underserved populations, worsening health disparities.

Conclusion

Stakeholders generally support the integration of cardiovascular disease risk assessment into the QOF, recognising its importance in targeting high-risk groups and improving care outcomes. However, concerns persist regarding implementation challenges and unintended consequences, particularly in exacerbating existing health inequalities.

Mixed views exist regarding the preferred indicator, with some favouring a more holistic approach to risk assessment to avoid exacerbating disparities in care provision. Concerns persist regarding the potential overlooking of underserved populations and the need for a nuanced, locally commissioned approach to prevent widening health inequalities.

Appendix A: Stakeholder comments

ID	Stakeholder organisation	Comment	Responses
IND2023-164	British Medical Association	There has been evidence that the approach of providing NHS health checks far from prioritising the most in need prioritises those that wish to have a health check. Many commissioners moved away from this blanket approach for that reason.	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. Allowing estimated CVD risk scores using data already on the health record was thought to be one method to help drive preventative healthcare in underserved populations. However, it was noted that it was precisely these populations who are more likely to have missing or inaccurate data. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.

ID	Stakeholder organisation	Comment	Responses
IND2023-164/5/6	British Medical Association	This indicator appears to have been predicated on the NHS health check scheme. This is not a universal scheme. The way the NHS health check has been commissioned means that there is not universal coverage. For example, some areas are already limiting to only patients with modifiable risk factors, some have actually limited to patients only within certain postcodes. Many areas also have a cap on the number of patients that can access the scheme and some have non-GP providers.(See PH England Health Check Delivery Survey 2020). This risks driving further health inequalities by rewarding areas that already have well-funded NHS health check schemes.	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. Allowing estimated CVD risk scores using data already on the health record was thought to be one method to help drive preventative healthcare in underserved populations. However, it was noted that it was precisely these populations who are more likely to have missing or inaccurate data. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.

ID	Stakeholder organisation	Comment	Responses
IND2023-164/5/6	British Medical Association	The health check is differentially funded from area to area with some areas already. This risks areas with low funding being further disadvantaged as the health check is not cost effective- from aforementioned document funding varies by more than 50%.	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. Allowing estimated CVD risk scores using data already on the health record was thought to be one method to help drive preventative healthcare in underserved populations. However, it was noted that it was precisely these populations who are more likely to have missing or inaccurate data. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.

ID	Stakeholder organisation	Comment	Responses
IND2023-164/5/6	NHS England	Overall comment on recording of CVD risk. It is possible to check the QRISK scores of everyone at a practice (within the eligible age range for the score) without actually recording the QRISK in the record. For example, you can run a report for everyone with QRISK > 10%, and it will bring up everybody with a such a QRISK if you calculated it right now according to the last recorded data (with default values used if data is missing) - and many of them will never have had a QRISK actually recorded in the notes. So if the intention of the indicator is so that practices systemically identify those that have QRISK above a threshold and are offered treatment, this does not necessarily require everyone to have a recorded risk assessment score. Further, you can check QRISK and record it, without having recent values for the risk factors included in scoring - e.g. BP, BMI, lipids etc - instead default values are used by the clinical system. Incentivising the checking of the risk score in itself, will not necessarily result in all the relevant clinical measures being checked and obtaining a 'reliable estimate' of risk. It may therefore be worth providing some imperative to obtain recent data on, for example, blood pressure, lipids, and BMI.	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. The committee agreed with the concerns raised and these have been noted in the validity assessment document which accompanies the indicator when published. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.
IND2023-166	Association of Respiratory Nurse	As it is not just tobacco with nicotine that causes damage but nicotine in any product. Nicotine causes vaso-constriction causing CVD. So does vaping and all types of nicotine use e.g. chewing tobacco need to be illustrated. Maybe the wording needs to say nicotine products (such as, cigarettes, vapes, smokeless tobacco).	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. The committee agreed the definition of current smoking should align with that used for existing smoking indicators in the QOF.

IND2023-165	National Rheumatoid Arthritis Society	Cardiovascular disease (CVD) is a leading cause of mortality in rheumatoid arthritis (RA). Because of the increased CVD risk faced by RA patients (50% increased risk of CVD over the general population), there is a need to address modifiable risk factors on a regular basis. This is currently not universally happening or being addressed. Prior to the pandemic, progress was being made as demonstrated by the NEIAA audit (BSR) to increase the number of people with RA who were getting an annual holistic review to measure co-morbidities including CVD as recommended in the NICE Guideline for adults over 16 with RA, NG100 and in NICE Quality Standards QS33, Quality Statement 5 "Adults with rheumatoid arthritis have a comprehensive annual review that is coordinated by rheumatology services. [2013, updated 2020]" However, post pandemic, a combination of a number of factors has led to periodic holistic reviews for people with RA to measure comorbidities including CVD falling off the agenda. These factors include: Workforce shortages and issues, large backlogs of patients (we know some units have many patients who have not even been seen since pre-pandemic for routine follow-up), the introduction of Patient Initiated Follow-up (PIFU), whereby patients suitable for PIFU may not be seen for anything up to 3 years unless they initiate an appointment which is leading to a loss of focus/attention to disease prevention which could be picked up in annual review, primary care not doing routine assessment of people with RA for prevention of CVD, Osteoporosis, Diabetes, Mental Health etc. (which they are well placed but not incentivised through the Outcomes Framework to do!). One of the key problems and the reason that RA patients are not being well served in this area is that rheumatology teams see the preventative screening for things like heart disease as being something that should be done in primary care. They maintain that primary care are	Thank you for your comment. We acknowledge your concerns and support for the proposed indicator IND2023-165. At the post consultation advisory meeting, the committee did not progress the proposed indicator IND2023-165. They noted the higher likelihood of existing planned reviews in people with comorbidities.

ID	Stakeholder organisation	Comment	Responses
		better at this than Consultant Rheumatologists and would have to prescribe any medication which might be needed as a result of doing a QRISK3 for example such as statins. However, whilst primary care do this kind of preventative screen for people with diabetes, they are not incentivised through the OF to do it for people with inflammatory arthritis. As a result, people with RA are not regularly having their BP checked or having lipids tested annually as part of their routine blood monitoring. This has to change and IND2023-165 would be the way to do it.	

IND2023-164/165	Action on Smoking and Health	The limitation of carrying out the QRISK either in the NHS Health Check Programme or in a separate indicator is that it does not incentivise clinical activity. Clinical activity within QOF will be the most helpful in improving care quality rather than simply recording risk factors. For example, QOF currently incentivises the recording of a patients' smoking status and delivery of cessation advice; GPs prompting quit attempts peaked at 9% in 2011, but over the last decade has declined to 3% (Smoking Toolkit Study) and produced "no change in prescribing pharmacotherapy for cessation (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4684030/)." This demonstrates that QOF isn't going far enough and in order to improve patients' health and address healthcare inequalities through tackling its biggest exacerbator, smoking. Clinical activity therefore needs to be incentivised. We would also recommend extending the age range to people under 45 (rather than just over 70 as this indicator proposes) to help prevent development of disease, especially smoking related disease including cardiovascular disease, as smoking remains the main driver of preventable disease and the greatest contributor to health inequalities in cardiovascular disease. Addressing smoking earlier in the life course will help maintain the health of the working age populations, which is of increasing importance as the working age populations shrinks in relation to the elderly population as outlined in The Health Foundation report "Health in 2040: projected patterns of illness in England". Lowering the age of the eligible population for health checks to include those aged 30-39 was one of the recommendations in this paper: Preventing illness and improving health for all: a review of the NHS Health Check programme and recommendations - GOV.UK (www.gov.uk). The Inverse Care Law found "the availability of good medical care tends to vary inversely with the need for it in the	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. The committee agreed with the concerns raised and these have been noted in the validity assessment document which accompanies the indicator when published. There is scope to develop an indicator that will focus on clinical activity. Regarding the age range, the committee noted that the NICE guideline (NG238) recommends frequent CVD risk assessments for people aged 40 and over. The current indicator sets the age at 45 to allow assessments for those who have been 40 at any point in the past five years. Lowering the age to 40 or younger would imply that CVD risk assessments should start at age 35 or lower, which is not currently supported by the guidelines. We note the included references, the indicators can be amended if/when the guidelines change.

ID	Stakeholder organisation	Comment	Responses
		population served" (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(71)92410-X/fulltext) which would mean finding ways to access people in disadvantaged areas should be prioritised. An example could be having a requirement for proactive communication with all smokers once a year via text or email AND additional incentive points for key target groups as identified in the CORE20PLUS5 framework. In GP patients wanting to quit, a randomised trial showed that a call from the services to the patient increased engagement with stop smoking support 13-fold compared with asking the patient to initiate contact. Overall, this strategy, known as opt-out as opposed to opt-in, can increase quitting fourfold ([1] Skov-Ettrup LS, Dalum P, Bech M, Tolstrup JS. The effectiveness of telephone counselling and internet- and text-message based support for smoking cessation: results from a randomized controlled trial. Addiction. 2016 Jul;111(7):1257-66. doi: 10.1111/add.13302. Epub 2016 Apr 13. PMID: 26748541.) Smoking is far more common among people with lower incomes. The more disadvantaged someone is, the more likely they are to smoke and to suffer from smoking-related disease and premature death (https://ash.org.uk/uploads/ASH-Briefing_Health-Inequalities.pdf). Therefore, relative improvement targets, based on national smoking rates and disadvantages populations, would ensure that national health inequalities are addressed effectively.	

ID	Stakeholder organisation	Comment	Responses
IND2023-164/5/6	HEART UK	Yes this can only lead to improvement in patient outcomes. However, risk should be explained clearly to all patients.	Thank you for your comments and support for the proposed indictors. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 and 166.
IND2023-164/5/6	NHS England	Absolutely. Indicators may lead to improvements in care and outcomes through identification of unmet need or unwarranted variation.	Thank you for your comments and support for the proposed indictors. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 and 166.
IND2023-164/5/6	British Medical Association	These are not viable given the current state of the NHS health check scheme.	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. The committee noted that the proposed indicators are different from the NHS health check as they only focus on the recording of cardiovascular (CVD) risk score for people aged 45 to 84 years. As stated in NICE guideline (NG238) the CVD risk score can be estimated using CVD risk factors already available on the primary care medical records.

ID	Stakeholder organisation	Comment	Responses
IND2023-164	Primary Care Cardiovascular Society	If this indicator pulls data from the GP record to 'calculate' the Qrisk score this is only useful if the Qrisk calculation identifies the highest CVD population. So, if the data in the clinical record is not present and therefore the calculated Qrisk relies on inadequate completion of the Qrisk fields this does not add particular value unless you also focus on significant increase in uptake of NHS health checks, BP checks etc to ensure that the Qrisk/CVD risk score calculated is relevant.	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. The committee agreed with the concerns raised and these have been noted in the validity assessment document which accompanies the indicator when published. There is scope to develop an indicator that will focus on clinical activity. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.

ID	Stakeholder organisation	Comment	Responses
IND2023 - 164	Royal College of General Practitioners	The NHS Health check programme has been delivered through local authority funding and there is variation in Commissioning arrangements over the years which leads to a baseline historic inequality at a General Practice level. For some practices where this work has been unfunded in previous years, it may represent a barrier for implementation.	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. Allowing estimated CVD risk scores using data already on the health record was thought to be one method to help drive preventative healthcare in underserved populations. However, it was noted that it was precisely these populations who are more likely to have missing or inaccurate data. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.

ID	Stakeholder organisation	Comment	Responses
IND2023 - 164	Royal College of General Practitioners	Performing a Health check every 3 years, on such a large population is unachievable given the prioritisation given to acute, on the day care.	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. Allowing estimated CVD risk scores using data already on the health record was thought to be one method to help reduce data and resource burden. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.
IND2023 - 164	Royal College of General Practitioners	Modifiable risks factors should also include a greater emphasis on a lifestyle approach. This seems to be very medicines and statins orientated and does not adopt a holistic personalised care approach which is more time consuming.	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. The committee agreed with the concerns raised and these have been noted in the validity assessment document which accompanies the indicator when published

ID	Stakeholder organisation	Comment	Responses
IND2023-164/5	British Medical Association	The large numbers are a potential barrier to improvement, and again given significant geographical variation in services and delivery this could widen health inequalities by rewarding areas with already high coverage and penalising those with low coverage and high numbers of patients.	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. Allowing estimated CVD risk scores using data already on the health record was thought to be one method to help reduce data and resource burden. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.
IND2023-164/5/6	Action on Smoking and Health	GPs conducting health checks in the run up to QoF deadlines, resulting in a peak in referrals and providers struggle to meet demand (anecdotal evidence from practice managers and health care assistants; we are following up with data colleagues to extract data on this area and can send this information on when it becomes available). We suggest that there needs to be a standard on consistent activity spread throughout the quarters to meet targets. Setting up automatic referral systems (to allow action to be taken on risk factors identified) and keeping referral systems updated. In some areas they have a referral hub to address this barrier.	Thank you for your comment. Timepoints for extraction of data for the QOF are not within NICE 's remit.
IND2023-164/5/6	HEART UK	Capacity could be but there is a need to spread workload to other disciplines, including pharmacy	Thank you for your comment.

ID	Stakeholder organisation	Comment	Responses
IND2023-164/5/6	NHS England	Time and staff, but am sure this could be included as part of an ARR role eg. Pharmacist or care coordinator Due to the large number of patients involved, barriers to implementation may include limitations in primary care capacity to deliver. Commissioning arrangements for the NHS Health Check may also present a barrier as delivery models will vary across the country with GPs not commissioned to deliver in all areas – this may mean that in some the ability to deliver the target may not be entirely within the GPs control.	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. Allowing estimated CVD risk scores using data already on the health record was thought to be one method to help reduce data and resource burden.
IND2023-164/5/6	Department of Health and Social Care	DHSC prefers #164 to either #165 or #166. DHSC thinks there is some added value in a population-level indicator to complement the NHS Health Check. Although #165 or #166 are more pragmatic based on data burden for the NHS, there is very limited value in these more targeted indicators as patients with established conditions would generally be expected to be receiving appropriate treatment for those conditions and relevant associated monitoring and advice, rather than necessarily a general assessment of their CVD risk. DHSC would welcome a conversation with NICE to address some of the specific comments raised in sections below, in particular on the proposed exclusions and inclusions. QRISK3 is validated for use in 25-84, not 40-84 as stated in the consultation paper	Thank you for your comments and support for the proposed indictors. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 and 166. They noted the higher likelihood of existing planned reviews in people with comorbidities. Regarding the QRISK3 validation, thank you for noting the error, we have now amended those papers.

IND2023-164/5/6	Action on Smoking and Health	The limitation of carrying out the QRISK either in the NHS Health Check Programme or in a separate indicator is that it does not incentivise clinical activity. Clinical activity within QOF will be the most helpful in improving care quality. For example, QOF currently incentivises the recording of a patients' smoking status and delivery of cessation advice; GPs prompting quit attempts peaked at 9% in 2011, but over the last decade has declined to 3% and produced "no change in prescribing pharmacotherapy for cessation ." This demonstrates that QOF isn't going far enough and in order to address healthcare inequalities through tackling its biggest exacerbator, smoking, clinical activity needs to be incentivised. Simply recording risk factors, including smoking status, does not improve patients' health or encourage behavioural change. Opt out smoking cessation support should be offered to all identified smokers. The Inverse Care Law found "the availability of good medical care tends to vary inversely with the need for it in the population served" which would mean finding ways to access people in disadvantaged areas should be prioritised. An example could be having a requirement for proactive communication with all smokers once a year via text or email AND additional incentive points for key target groups as identified in the CORE20PLUS5 framework. In GP patients wanting to quit, a randomised trial showed that a call from the services to the patient increased engagement with stop smoking support 13-fold compared with asking the patient to initiate contact. Overall, this strategy, known as opt-out as opposed to opt-in, can increase quitting fourfold . Smoking is far more common among people with lower incomes. The more disadvantaged someone is, the more likely they are to smoke and to suffer from smoking-related	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators.

ID	Stakeholder organisation	Comment	Responses
		disease and premature death . Therefore, relative improvement targets, based on national smoking rates and disadvantages populations, would ensure that national health inequalities are addressed effectively.	
IND2023-164/5/6	HEART UK	No only positive outcomes for patients	Thank you for your comments and support for the proposed indictors. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 and 166.
IND2023-164/5/6	NHS England	On the surface, it could increase stigma but the opportunity is working out how to engage some of the groups we have not reached out to ineffectively with our traditional communication channels, then to share the learning / improvement with other PCNs and practices. Risk of incentivising duplication if NHS Health Checks are carried out outside primary care and not appropriately recorded in GP record. Subsequent impact on primary care capacity. The indicator may be more suitable for implementation outside QOF, potentially through the CVDPREVENT audit.	Thank you for your comment. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 as a network / system level indicator. IND2023-166 was progressed as suitable for use in QOF.

ID	Stakeholder organisation	Comment	Responses
IND2023-165	Primary Care Cardiovascular Society	This would be a more pragmatic approach however it makes the assumption that all people with a modifiable risk factor have been identified and therefore may miss a more significant proportion of people who are at high/increased CVD risk and/or difficult to reach populations. This may increase inequalities in care	Thank you for your comment. The points raised were discussed at the post consultation advisory meeting. At the post consultation advisory meeting, the committee did not progress the proposed indicator IND2023-165. They noted the higher likelihood of existing planned reviews in people with comorbidities.
IND2023-165	British Medical Association	This approach may be more helpful given the limited resource available but would have to tie in with locally commissioned services. However, given the variability this could worsen health inequalities by not targeting hard to reach groups. This could only be done by targeting patients already known to have one of the denominator conditions.	Thank you for your comment. At the post consultation advisory meeting, the committee did not progress the proposed indicator IND2023-165. They noted the higher likelihood of existing planned reviews in people with comorbidities.

ID	Stakeholder organisation	Comment	Responses
IND2023-165	Diabetes UK	We welcome the inclusion of type 2 diabetes as a comorbidity within this indicator. We would agree with the need to have an indicator that focuses on people at increased risk of CVD to ensure that constraints to NHS workforce capacity do not prevent these groups from receiving these checks. This would be particularly necessary given the likely large numbers of eligible patients indicated by current NICE testing of this indicator. We would suggest that regular reviews are given to this indicator to reflect the workforce capacity of the NHS. If current/future strategies to increase the workforce are successful the indicator should be expanded to reach more than just those with modifiable risk factors or comorbidities, as in IND2023-164.	Thank you for your comment. At the post consultation advisory meeting, the committee did not progress the proposed indicator IND2023-165. They noted the higher likelihood of existing planned reviews in people with comorbidities.
IND2023-166	Primary Care Cardiovascular Society	Compared to proposed IND2023-165 this indicator would be a further reduction in patient population (and ambition). This cohort, if already diagnosed/recorded with one of these 4 markers (current smoker, obesity, hypertension, or hypercholesterolemia) are much more likely to have already had a risk assessment. As above may miss a more significant proportion of people who are at high/increased CVD risk and/or difficult to reach populations. This may increase inequalities in care.	Thank you for your comment. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.

ID	Stakeholder organisation	Comment	Responses
IND2023-166	British Medical Association	Very narrow denominator with 2 of the denominators already having required testing (lipids and BP). Again, this risks widening health inequalities by not targeting people who don't have known Obesity, smoking, hypertension or hyperlipidaemia.	Thank you for your comment. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.

IND2023-164	Department of Health and Social Care	The lower age limit (45) is reasonable. While QRISK3 is validated in younger age groups, NICE guidance only recommends that estimated CVD risk (the pre-cursor to formal risk assessment) is reviewed on an ongoing basis from the age of 40, and the NHS Health Check programme – the principle vehicle for full formal CVD risk assessment – is only offered from the age of 40, every 5 years. The upper age limit (84) is reasonable. However, it does not match the upper age limit of the NHS Health Check, which might result in the indicator being seen as an 'unfair' measure of performance, given it is not directly supported by a funded programme. The NHS Health Check is only offered up to the age of 74, so it is possible that those aged 75-84 are less likely to receive a full formal CVD risk assessment. However, given age is the biggest risk factor for CVD, those in this older age category are more likely to be excluded (based on the list of proposed exclusions). The basis on which the proposed exclusions have been identified is unclear. They don't appear to match in full either the exclusions for the NHS Health Check programme or for QRISK3.	Thank you for your comments. The points you raised were discussed at the post-consultation Indicator Advisory Committee meeting. The proposed indicators differ from the NHS Health Check programme because they focus solely on recording the cardiovascular (CVD) risk score for people aged 45 to 84 years. According to the NICE guideline NG238, the CVD risk score can be estimated using existing CVD risk factors in primary care medical records. This allows clinicians to prioritise patients estimated to have a high risk for a full formal CVD risk assessment. The indicator excludes people with type 1 diabetes, cardiovascular disease, familial hypercholesterolaemia, chronic kidney disease stage 3 to 5 (in line with NICE guidance) as they are at high risk and should proceed directly to lifestyle modification and lipid lowering therapies. People on current lipid lowering therapies or with a previous CVD risk score of 20% or more are excluded as repeat assessment is unnecessary. People with type 2 diabetes, hypertension, atrial fibrillation, or heart failure are not excluded because NICE

ID	Stakeholder organisation	Comment	Responses
			guidance does not rule out regular CVD risk assessment. The committee noted that there is variation in the delivery of NHS Health Checks, and the programme is not universal. Consequently, a proportion of individuals aged 40 and over are not receiving CVD risk assessments as recommended. The proposed indicators aim to aid in identifying high-risk individuals using already available medical record information. Regarding the upper age limit, the QRISK tool is validated for use up to 84 years.

ID	Stakeholder organisation	Comment	Responses
IND2023-164/165	Department of Health and Social Care	The lower age limit (43) is reasonable *given the proposed increased frequency with which checks should take place.* However, the exact basis for the increased frequency is unclear (see below). The upper age limit (84) is reasonable, but subject to the same issues set out under #164. The exact basis for the increased frequency is unclear. It does not align with the NHS Health Check programme requirements, and there doesn't appear to be related NICE guidance to support this increased frequency. It might therefore be seen as an 'unfair' measure of performance. For #165, the basis on which the list of modifiable risk factors and comorbidities to be included in the denominator has been identified is unclear. For #166, the basis on which the list of modifiable risk factors to be included in the denominator has been identified is unclear.	Thank you for your comment. The frequency was increased to 3 years based on the clinical expert opinion. The indicator advisory committee felt that the group with CVD risk factors and the comorbidities would require more regular checks compared to the general population. The list of modifiable risk factors and the comorbidities are based on the predictor variables usen the QRISK3 algorithm. We will amend our guidance documents to ensure this is clear.

ID	Stakeholder organisation	Comment	Responses
IND2023-164/5/6	Action on Smoking and Health	Potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group. The Inverse Care Law found "the availability of good medical care tends to vary inversely with the need for it in the population served" which would mean finding ways to access people in disadvantaged areas should be prioritised. An example could be having a requirement for proactive communication with all smokers once a year via text or email AND additional incentive points for key target groups as identified in the CORE20PLUS5 framework. In GP patients wanting to quit, a randomised trial showed that a call from the services to the patient increased engagement with stop smoking support 13-fold compared with asking the patient to initiate contact. Overall, this strategy, known as opt-out as opposed to opt-in, can increase quitting fourfold . Smoking is far more common among people with lower incomes. The more disadvantaged someone is, the more likely they are to smoke and to suffer from smoking-related disease and premature death . Therefore, relative improvement targets, based on national smoking rates and disadvantages populations, would ensure that national health inequalities are addressed effectively.	Thank you for your comments. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.
IND2023-164/5/6	HEART UK	Spreading the workload should help with this and also will help with reaching those who would not normally access healthcare	Thank you for your comment and support for the proposed indicators.

ID	Stakeholder organisation	Comment	Responses
IND2023-164/5/6	NHS England	It will allow us to be more nuanced with our messaging around how we reach out to different groups to engage them and hopefully get better traction with a more targeted approach – if we can help achieve the outcome of stopping / reducing people having CVD then that can only be a good thing for them, their families and society. Age range covered by the indicator is not aligned to eligibility for the NHS Health Check. Implementation of the indicator within QOF may lead to increased CVD risk checks being carried out in people over 75 years who currently do not have a commissioned service available. Lack of alignment with the lower age limit for the NHS health check may cause confusion, suggest a lower age of 40 years.	Thank you for your comment and support of the proposed indicators. The indicators use an upper age limit of 84 in line with the population for which QRISK is validated and recommended by NICE guidance. The committee noted that there will be some people not eligible for the NHS Healthcheck who should still be receiving repeat CVD risk scoring. The indicators use 43 or 45 years as the lower age limit to allow time for initial CVD risk scores to be recorded in line with the specified frequency.

Question: Given the existing NHS Health Check Programme, is there added value in IND2023-164 focused on CVD risk assessment?

ID	Stakeholder organisation	Comment	Responses
IND2023-165	National Rheumatoid Arthritis Society	Yes, absolutely	Thank you for your response and support for the proposed indicators.

IND2023-164/5/6	Action on Smoking and Health	The NHS Health check programme also assesses smoking status as part of the QRISK assessment tool. The limitation of carrying out the QRISK either in the NHS Health Check Programme or in a separate indicator is that it does not incentivise clinical activity. Clinical activity within QOF will be the most helpful in improving care quality rather than simply recording risk factors. For example, QOF currently incentivises the recording of a patients' smoking status and delivery of cessation advice; GPs prompting quit attempts peaked at 9% in 2011, but over the last decade has declined to 3% (Smoking Toolkit Study) and produced "no change in prescribing pharmacotherapy for cessation (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4684030/)." This demonstrates that QOF isn't going far enough and in order to improve patients' health and address healthcare inequalities through tackling its biggest exacerbator, smoking. Clinical activity therefore needs to be incentivised. We would also recommend extending the age range to people under 45 (rather than just over 70 as this indicator proposes) to help prevent development of disease, especially smoking related disease including cardiovascular disease, as smoking remains the main driver of preventable disease and the greatest contributor to health inequalities in cardiovascular disease. Addressing smoking earlier in the life course will help maintain the health of the working age populations, which is of increasing importance as the working age populations shrinks in relation to the elderly population as outlined in The Health Foundation report "Health in 2040: projected patterns of illness in England". Lowering the age of the eligible population for health checks to include those aged 30-39 was one of the recommendations in this paper: Preventing illness and improving health for all: a review of the NHS Health Check programme and recommendations - GOV.UK (www.gov.uk).	Thank you for your comment. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need. Regarding the age range, the committee noted that the NICE guideline (NG238) recommends frequent CVD risk assessments for people aged 40 and over. The current indicator sets the age at 45 to allow assessments for those who have been 40 at any point in the past five years. Lowering the age to 40 or younger would imply that CVD risk assessments should start at age 35 or lower, which is not currently supported by the guidelines. We note the included references, the indicators can be amended if/when the guidelines change.

ID	Stakeholder organisation	Comment	Responses
IND2023-164/5/6	NHS England	Really like this thinking. Health checks are a great idea but may fuel health inequalities as they rely on people responding to an invite and coming in to be seen. This indicator could run in parallel and could be searched automatically so practices are aware of their highest risk patients and can then proactively target them in different evidence based ways to improve traction of preventative approaches. This would lend itself to a 'CVD care coordinator'. There might be 'at risk groups' already identified like severe mental illness or certain ethnic groups or perhaps areas of deprivation which will require a more nuanced approach to reaching them – this can't be offered with health checks alone. Potential added value even with existing NHS Health Check programme. This indicator may help to identify potential health inequalities. Implementation may also highlight where Health Check data is not feeding through to GP care records if performance is compared to Heath Check data.	Thank you for your response and support for the proposed indicators. Allowing estimated CVD risk scores using data already on the health record was thought to be one method to help reduce data and resource burden. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.

Question: NICE is currently testing IND2023-164 using a primary care research database given the likely large number of eligible patients per practice. Would you expect the potential large numbers of eligible patients per practice to be a substantial barrier to implementation? What achievement level could represent an acceptable target for improvement?

ID	Stakeholder organisation	Comment	Responses
IND2023-164	HEART UK	Start with using an audit tool to extract the qualifying patients that require to be addressed, but target the higher CVD risk individuals first.	Thank you for your response.
IND2023-164	NHS England	It could be automated to reduce staff input, also then come up with innovative ways of reaching out to different patient groups, work with the 'integrated neighbourhood team' or social prescriber, perhaps third sector – there will be a way of mitigating the workload. In terms of achievement, running the tool should be 100% update as it is automated, in terms of reaching and improving care / outcomes then you could incentivise learning from other areas in a QI way so teams look out and don't re-invent the wheel in terms of engaging with different patient cohorts / communities. The indicator will identify a very large number of patients, meaning the implementation in QOF may be unaffordable. Without the baseline information it would be difficult to set a target. Suggest the indicator may be more suitable for consideration within the CVDPREVENT audit.	Thank you for your response. Allowing estimated CVD risk scores using data already on the health record was thought to be one method to help reduce data and resource burden. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.

ID	Stakeholder organisation	Comment	Responses
IND2023-164	Primary Care Cardiovascular Society	The number of eligible patients may be a barrier to this indicator being implemented in any meaningful way as primary care may find it too challenging to reach out to the general population cohort. If there was a digital (non- labour intensive) solution for people to provide the relevant information to primary care this may mitigate.	Thank you for your comment. Allowing estimated CVD risk scores using data already on the health record was thought to be one method to help reduce data and resource burden. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.
IND2023-164/5/6	Action on Smoking and Health	No comment	Thank you for your response.

Question: Would indicators IND2023-165 and IND2023-166 be more pragmatic approaches to increasing CVD risk assessment in at risk populations?

ID	Stakeholder organisation	Comment	Responses
IND2023-164	NHS England	Yes, more systematic way of risk stratifying the population and then targeting. IND2023-164 appears to have the smallest risk of introducing further inequalities. IND2023-165 and 166 rely on modifiable risk factors and comorbidities being accurately reported in GP care records. It is likely that people will be missed as these factors are not recorded and possible that those populations who do not have these factors recorded are also likely to be at increased risk of health inequality.	Thank you for your response. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 as suitable for at network or system level and IND2023-166 as suitable for use in QOF. IND2023-165 will not be progressed. They noted the higher likelihood of existing planned reviews in people with comorbidities.
IND2023-164/5/6	Action on Smoking and Health	No comment	Thank you for your response.
IND2023-164/5/6	HEART UK	IND2023-164 is the best indicator as it approaches prevention properly by using more risk factors that do appear in QRISK3.	Thank you for your response. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 as suitable for at network or system level and IND2023-166 as suitable for use in QOF. IND2023-165 will not be progressed.

Question: Is only including people with a modifiable risk factor an acceptable pragmatic option for focusing on people at increased risk?

ID	Stakeholder organisation	Comment	Responses
IND2023-165	NHS England	Yes, in terms of risk strat, these people are very high risk with potentially the most to gain from adopting healthier lifestyles or taking various mitigations – a lot of added value. IND2023-164 appears to have the smallest risk of introducing further inequalities. IND2023-165 and 166 rely on modifiable risk factors and comorbidities being accurately reported in GP care records. It is likely that people will be missed as these factors are not recorded and possible that those populations who do not have these factors recorded are also likely to be at increased risk of health inequality.	Thank you for your response. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 as suitable for at network or system level and IND2023-166 as suitable for use in QOF. IND2023-165 will not be progressed. Allowing estimated CVD risk scores using data already on the health record was thought to be one method to help drive preventative healthcare in underserved populations. However, it was noted that it was precisely these populations who are more likely to have missing or inaccurate data. The committee noted that the indicators should be seen as part the wider package of existing indicators focused on primary and secondary of cardiovascular disease. NICE will continue to explore new indicators focused on ensuring risk is accurately recorded and prioritising those most at need.

Question: NICE is currently testing IND2023-165 using a primary care research database given the likely large number of eligible patients per practice. Would you expect the potential large numbers of eligible patients per practice to be a substantial barrier to implementation? What achievement level could represent an acceptable target for improvement?

ID	Stakeholder organisation	Comment	Responses
IND2023-165	NHS England	Hard to put a number on it, but in terms of delivering improved outcomes this is the group we should be working to target and learn / share between practices / PCNs / ICBs about how different 'places' have improved their uptake etc. This provides the perfect opportunity to help professional become more 'curious' about success in other areas. The indicator will identify a very large number of patients, meaning the implementation in QOF may be unaffordable. Without the baseline information it would be difficult to set a target. Suggest the indicator may be more suitable for consideration within the CVDPREVENT audit.	Thank you for your response. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 as suitable for at network or system level and IND2023-166 as suitable for use in QOF. IND2023-165 will not be progressed.

ID	Stakeholder organisation	Comment	Responses
IND2023-165	National Rheumatoid Arthritis Society	There are 450,000 people with RA in the UK so we understand that this is a large number of people, however, given that most of us with RA will likely ultimately die of heart disease as a consequence of having RA, not doing anything about periodic measurement of CVD risk is going to cost the NHS more in the longer term. We have the same risk of CVD as people with type II diabetes and they are well screened in primary care. Why would we not be able to access the same level of preventative care? It makes no sense not to. We are supposed to have a 15 min. meeting annually with the GP, however, it is stated that “As a minimum, it is advised that this review covers disease activity and damage, the effect of the disease on the patient's life and whether they would benefit from any referrals to the MDT”. Nothing is measured and to be honest, such reviews are often a waste of the GP and the individual’s time as their disease is routinely managed by their rheumatology team. What is, however, of huge value is for CVD, (QRISK3), Osteoporosis (FRAX) and mental health to be measured using validated measures, along with any other co-morbidities or symptoms flagged by the patient, and action taken based on the findings. This will save the NHS money.	Thank you for your response. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 as suitable for at network or system level and IND2023-166 as suitable for use in QOF. IND2023-165 will not be progressed. They noted the higher likelihood of existing planned reviews in people with comorbidities. Existing indicator IND108 on the NICE menu focuses on CVD risk assessment in people with rheumatoid arthritis.

Question: Given the existing NHS Health Check Programme, is there added value in IND2023-166 focusing on CVD risk assessment specifically in people with a modifiable risk factor?

ID	Stakeholder organisation	Comment	Responses
IND2023-166	NHS England	Absolutely, given the morbidity and mortality associated with CVD and how the conditions are inextricably linked to unfair and unjust health inequalities, we need to find ways of reducing this risk for patients and our systems and this will take more then an invite to a health check. We need to find ways of targeting cohorts, share learning etc. Potential added value even with existing NHS Health Check programme. This indicator may help to identify potential health inequalities. Implementation may also highlight where Health Check data is not feeding through to GP care records if performance is compared to Heath Check data.	Thank you for your response and support for the proposed indicators.

Question: Is only including people with a modifiable risk factor an acceptable pragmatic option for focusing on people at increased risk?

ID	Stakeholder organisation	Comment	Responses
IND2023-166	NHS England	Perhaps a pragmatic solution to focus on modifiable risk factors but think we are making this too medical (in my opinion). These people may well be at higher risk of having other conditions, perhaps smoking related lung disease, CKD, may be missing out on cancer screening, also not attending for covid / flu vaccines etc etc. They may have mental health challenges, may have deprivation related issues like poor housing, food poverty or fuel poverty etc.	Thank you for your response. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 as suitable for at network or system level and IND2023-166 as suitable for use in

		Think the high risk group (modifiable and unmodifiable) should have a 'care bundle' of interventions offered and coordinated by a care coordinator. CVD kills more people then any other condition, so it is worth taking this head on. IND2023-164 appears to have the smallest risk of introducing further inequalities. IND2023-165 and 166 rely on modifiable risk factors and comorbidities being accurately reported in GP care records. It is likely that people will be missed as these factors are not recorded and possible that those populations who do not have these factors recorded are also likely to be at increased risk of health inequality.	QOF. IND2023-165 will not be progressed. The concerns raised have been noted in the validity assessment document which accompanies the indicators when published.
IND2023-166	Heart UK	IND2023-164 is the best indicator as it approaches prevention properly by using more risk factors that do appear in QRISK3.	Thank you for your response. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 as suitable for at network or system level and IND2023-166 as suitable for use in QOF. IND2023-165 will not be progressed.

Question: NICE is currently testing IND2023-166 using a primary care research database given the likely large number of eligible patients per practice. Would you expect the potential large numbers of eligible patients per practice to be a substantial barrier to implementation? What achievement level could represent an acceptable target for improvement?

ID	Stakeholder organisation	Comment	Responses
IND2023-166	NHS England	Potentially, but think using a QI approach, this should be tested in a smaller group of 'keen' practices in a PDSA manner to see the impact and what could be achieved. It feels too theoretical at present. The other element to consider is, is this new work and therefore could be an issue given limited capacity. Saying that, often these patients are known to other health professionals and so it doesn't have to be 'new work' and there will be creative ways of doing this important work. For example, a pharmacist, care coordinator and social prescriber could do a lot of this. The indicator will identify a very large number of patients, meaning the implementation in QOF may be unaffordable. Without the baseline information it would be difficult to set a target. Suggest the indicator may be more suitable for consideration within the CVDPREVENT audit	Thank you for your response. At the post consultation advisory committee meeting, the committee decided to progress IND2023-164 as suitable for at network or system level and IND2023-166 as suitable for use in QOF. IND2023-165 will not be progressed. The concerns raised have been noted in the validity assessment document which accompanies the indicators when published.