Indicator development programme

Equality Impact Assessment

Cardiovascular disease indicators

- **IND2023-164 cardiovascular disease prevention: Risk assessment (general population)**
- **IND2023-165 cardiovascular disease prevention: Risk assessment (modifiable risk factors or comorbidities)**
- **IND2023-166 cardiovascular disease prevention: Risk assessment (modifiable risk factors)**

Have any potential equality issues been identified during the development process?

No potential issues have been identified during the development process of these indicators.

Have any population groups, treatments or settings been excluded from coverage by the indicator? Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

The indicators exclude people diagnosed with the following:

1. Type 1 diabetes
2. CVD
3. Familial hypercholesterolemia
4. CKD 3a to 5
5. Current lipid lowering therapies
6. 20% risk ever recorded.

These exclusions are justified. NICE guideline NG238 does not recommend CVD risk assessment in people who are already at established high risk of CVD because of type 1 diabetes, CKD 3a to 5 or familial hypercholesterolemia. These

individuals are most likely on treatment or surveillance, therefore do not need to be reassessed.

CVD risk assessment is also not validated in people who are diagnosed with CVD.

People on current lipid lowering therapies are excluded as the purpose of risk assessment is to help consider risk modification and this is already underway.

People with a previous risk score of 20% are excluded to avoid repeat assessment in people for whom risk modification should already be undertaken.

Does the indicator make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

No, the indicator does not make it difficult in practice for a specific group to access services compared with other groups.

Is there potential for the indicator to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No, the indicator does not require for a person to attend in person, the risk assessment can be carried out based on information already recorded in primary care electronic records.

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Approved by NICE quality assurance lead: Craig Grime

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NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE Centre for Guidelines

Indicator development programme

Equality and health inequalities assessment (EHIA)

IND270 Cardiovascular disease prevention: risk assessment (modifiable risk factors)

The considerations and potential impact on equality and health inequalities have been considered throughout the indicator development, process according to the principles of the NICE equality policy and those outlined in Indicators process guide.

STAGE 2. Final indicator

2.1 How inclusive was the consultation process on the draft indicator in terms of response from groups (identified in box 1.2) who may experience inequalities related to the topic?
10 stakeholders responded to a consultation in March 2024 for this indicator. This included NHS England, Department of Health and Social Care and a number of professional groups. A number of national patient and carers organisations also responded (Action on Smoking and Health, Diabetes UK, HEART UK and National Rheumatoid Arthritis Society). Stakeholders commented on the following inequality issues specific to this topic: • Stakeholders noted that this indicator may lead to improvements in care and outcomes through identification of unmet need or unwarranted variation. • NHS health check does not have universal coverage and some areas limit on postcode or have a cap on access. Funding varies by more than 50%. The proposed indicator risks driving further health inequalities by rewarding areas that already have well-funded NHS health checks. Stakeholder suggested that ways to enhance access to people in disadvantaged areas should be prioritised. • The denominator relies on accurate recording of information in the GP record. This risks widening health inequalities for underserved populations whose clinical record is less likely to be up to date. • The age range for this indicator excludes people aged under 43. Stakeholders highlighted the need for early intervention to maintain health. • Some of the exclusions from this indicator are more likely to impact older people.

2.2 Have any **further** equality and health inequalities issues beyond those identified at topic engagement and during development been raised during the consultation on the draft indicator, and, if so, how has the committee considered and addressed them?

1) *Protected characteristics outlined in the Equality Act 2010*
   Age: Stakeholders noted that the indicator has an age range. They also noted that older people are more likely to be impacted by some of the exclusions. The committee noted the alignment with the NHS health check and that the indicator uses age 43 to allow a 3-year window for assessments. The committee highlighted that the NICE guidance (NG238) recommends CVD risk assessments for people aged 40 and over. The exclusion criteria are also based on recommendations in the NICE guideline (NG238).
   Disability: None.
   Gender reassignment: None.
   Pregnancy and maternity: None.
   Race: None.
   Religion or belief: None.
   Sex: None.
   Sexual orientation: None.
2) *Socioeconomic status and deprivation (for example, variation by area deprivation such as Index of Multiple Deprivation, National Statistics Socio-economic Classification, employment status, income):* Stakeholders suggested that the proposed indicator risks driving further health inequalities by rewarding areas that already have well-funded NHS health checks. Stakeholders suggested that ways to enhance access to people in disadvantaged areas should be prioritised. The committee discussed these comments but felt that the indicator would have a positive impact. The supporting information for the indicator notes that resultant data should be disaggregated by deprivation, ethnicity, age and gender to help reduce the risk of widening health inequalities.
3) *Geographical area variation (for example, geographical differences in epidemiology or service provision- urban/rural, coastal, north/south):* Stakeholders highlighted that the NHS health check does not have universal coverage and some areas limit on postcode or have a cap on access. Funding varies by more than 50%. The proposed indicator risks driving further health inequalities by rewarding areas that already have well-funded NHS health checks. The committee discussed these comments but felt that the indicator would have a positive impact. The supporting information for the indicator notes that resultant data should be disaggregated by deprivation, ethnicity, age and gender to help reduce the risk of widening health inequalities.
4) *Inclusion health and vulnerable groups (for example, vulnerable migrants, people experiencing homelessness, people in contact with the criminal justice system, sex workers, Gypsy, Roma and Traveller communities, young people leaving care and victims of trafficking):* None.

2.3 If the indicator has changed after consultation, how could these changes impact on equality and health inequalities issues?

The indicator has not changed following consultation.

2.4 Following the consultation on the draft indicator and response to question 3.2, have there been any further committee considerations of equality and health inequalities issues across the four dimensions that have been reflected in the final indicator?
The validity assessment notes the risk of missing vulnerable people when relying on accurate reporting in GP records.

2.5 Please provide a summary of the key equality and health inequalities issues that should be highlighted in the guidance executive report before sign-off of the final indicator.
There was concern that this indicator could perpetuate or exacerbate existing health inequalities. Risk factors are less likely to be accurately recorded in underserved populations and therefore any resultant CVD risk assessment score is more likely to be inaccurate. The supporting information for the indicator notes that resultant data should be disaggregated by deprivation, ethnicity, age and gender to help reduce the risk of widening health inequalities. .

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Approved by NICE quality assurance lead: Craig Grime

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