NORTH EAST QUALITY OBSERVATORY SERVICE (NATIONAL COLLABORATING CENTRE FOR INDICATOR DEVELOPMENT)

FOR

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

INDICATOR DEVELOPMENT PROGRAMME

Feedback report on piloted indicators

Topic area: Cardiovascular disease prevention: Risk assessment

Pilot period: January – March 2024

IAC meeting date: 5th June 2024

Output: Findings from qualitative pilot to contribute towards recommendations for NICE indicator menu

1. Summary of pilot findings

The three draft indicators proposed for this topic relate to the primary prevention of CVD through the provision of formal risk assessment but differ in the population on which they focus. These indicators are intended for use at GP practice level and are suitable for QOF.

The majority of practices were in support of this topic, recognising the potential benefits of the indicators on the quality of care and improved outcomes for patients. Some concerns were raised about the impact the indicators could have on widening health inequalities.

It was recognised by practices that these indicators could overlap with the [NHS Health Check](#) programme and result in payment duplication, but also that limits were currently being imposed by some local Public Health teams on this activity. Concerns were raised about the lack of coherence in definition between the indicators and Health Checks in terms of the age range and the review time period, and also regarding the potential additional workload that the indicators could generate (see implementation assessment section below).

There were mixed views at interview on indicator preference based on the potential for greatest impact on patient outcomes versus workload and resource concerns. Two practices preferred indicator 1 only (based on the general population), a further three preferred indicator 2 (those with modifiable risk factors or comorbidities) and one practice favoured indicator 3 (modifiable risk factors only). Four further practices expressed a preference for both indicator 1 and 3.

Indicator 1: Cardiovascular disease prevention: Risk assessment (general population)

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

(This indicator excludes those with Type 1 diabetes, cardiovascular disease, familial hypercholesterolaemia, chronic kidney disease stages 3a to 5, on lipid lowering therapies or had a 20% risk of CVD ever recorded).

Acceptability assessment

Most survey respondents (73.6%, 39/53) felt that this indicator would improve the quality of care for patients with a further 20.8% (11/53) suggesting that it would have no impact. Under half of respondents (47.2%, 25/53) thought that this indicator represents an issue that is important for patients, their families and carers, with a further 34.0% of respondents (18/53) stating that this was not the case. There were positive views on whether the indicator was suitable for financial incentivisation with 71.7% of respondents in support of this (38/53). The views from practices in the interviews reflected the responses from the survey.

Indicator 2: Cardiovascular disease prevention: Risk assessment (modifiable risk factors or comorbidities)

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.

(Comorbidities: Type 2 diabetes, erectile dysfunction, serious mental illness, rheumatoid arthritis, atrial fibrillation and systemic lupus erythematosus. Modifiable risk factors: current smoker, obesity, hypertension and hypercholesterolaemia. The exclusions from indicator 1 also apply).

Acceptability assessment

Most survey respondents (69.8%, 37/53) felt that this indicator would improve the quality of care for patients with a further 22.6% (12/53) suggesting that it would have no impact. Over half of respondents (54.7%, 29/53) thought that this indicator represents an issue that is important for patients, their families and carers, with a further 24.5% (13/53) stating that this was not the case. There were positive views on whether the indicator was suitable for financial incentivisation with 71.7% of respondents in support of this (38/53). The views from practices in the interviews reflected the responses from the survey.

Indicator 3: Cardiovascular disease prevention: Risk assessment (modifiable risk factors)

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.

(Modifiable risk factors: current smoker, obesity, hypertension and hypercholesterolaemia. The exclusions from indicator 1 also apply).

Acceptability assessment

Most survey respondents (71.7%, 38/53) felt that this indicator would improve the quality of care for patients with a further 20.8% (11/53) suggesting that it would have no impact. Over half of respondents (56.6%, 30/53) thought that this indicator represents an issue that is important for patients, their families and carers, with a further 24.5% (13/53) stating that this was not the case. There were positive views on whether the indicator was suitable for financial incentivisation with 71.7% of respondents in support of this (38/53). The views from practices in the interviews reflected the responses from the survey.

Implementation assessment

Despite the strong support for the rationale of the indicators, some potential issues associated with their implementation were highlighted by practices, as outlined in the table below, with some mitigations available.

Issues to consider prior to implementation:

Issue	Indicator	Detail	Mitigating activity
Overlap with NHS Health Checks	All 3 indicators	There was strong recognition of the overlap with NHS Health Checks, with the CVD risk score calculated in the check	Greater clarity on how these indicators fit with the existing programme to ensure no duplication of payment
Limit / cap on Health Check activity by practices in a financial year	All 3 indicators	Limits imposed on Health Check numbers due to local authority funding	
CVD risk score available	All 3 indicators	Variation in the proportion of Health Checks done with a risk score calculated (should be 100%)	Improve data reporting process from Health Check services

Issue	Indicator	Detail	Mitigating activity
Upper limit of age range	All 3 indicators	Too high (implications for workload, clinical evidence)	Align with NHS Health Check age range
Indicator review period	Indicators 2 and 3	3 years proposed which conflicts with NHS Health Checks	Align with NHS Health Check time period
Coding accuracy for comorbidities and modifiable risk factors	Indicators 2 and 3	Current coding could be out of date (not current)	Coding standardisation and use of templates
CVD risk tool available	All 3 indicators	QRISK2 used but QRISK3 recommended (but manual process increases workload)	Clinical system suppliers to resolve
CVD risk score calculation	All 3 indicators	Possible for risk scores to be batch coded and use estimates	
Size of the role of primary care in primary prevention	All 3 indicators (mainly indicator 1)	Capacity to be a prevention service versus treating acute and long-term conditions	
Healthy patient engagement	Indicator 1	Difficult to engage healthy people in primary prevention	
Workload	All 3 indicators (mainly indicator 1)	Indicator denominator could be large (assess clinical impact against practicality)	
Workload	All 3 indicators	Concern about the volume of patients (impact on blood test service capacity and general practice appointment capacity)	Consider setting a lower achievement threshold initially?
Indicator definition	Indicators 2 and 3	Propose the inclusion of pre-diabetes, fatty liver disease and substance	Amend indicator definition?

Issue	Indicator	Detail	Mitigating activity
		misuse as modifiable risk factors	

2. Background

As part of the NICE indicator development process, all clinical and health improvement indicators proposed for inclusion in the NICE Indicator Menu are piloted, using an agreed methodology, in a representative sample of GP practices across England.

The aim of piloting is to test whether indicators work in practice, have any unintended consequences, and are fit for purpose.

The full background to the inclusion of this topic in the pilot, including a list of piloted indicators, is presented in Appendix A along with a description of the method and approach to piloting.

3. Practice recruitment

A summary of the general practice recruitment methodology is shown in Appendix B.

Number of practices recruited, ready to commence pilot (January 2024) **30**

Final number of practices in the pilot **22**

Number of practices participating in feedback **22**

Feedback was obtained via interviews and an online survey, and it was possible for individuals to participate in both the survey and the interviews. At least one survey was completed (or partially completed) by each of the 22 participating practices. The quantitative responses to the online survey are shown in Appendix E. The table below indicates the practice participation in the pilot specifically for the cardiovascular disease (CVD) prevention topic.

<u>Feedback participation for CVD prevention topic by role and method</u>

Staff role	Interviews - number of participants	Survey - number of respondents
GP	11	31
Pharmacist	1	1
Nurse	0	4
Practice manager	6	12
Other senior management	1	1
Practice administrative staff	0	4
Number of participants	**19**	**53**
Number of practices	**12**	**22**

As described in Appendix A, not all interviews covered all topics and 19 participants from 12 of the 22 practices were asked questions about the CVD topic in their interviews.

Not all respondents completed all of the CVD-related indicator survey questions (see Appendix A) and therefore the denominator for each question is included throughout this report.

Following the interviews, a small number of practices sent documents they had prepared in advance of the calls, which contained their thoughts on one or more topics, reflecting the preparation they had done. These views were incorporated as appropriate, building on the answers they had provided during the interviews. A GP at one additional practice (whose own interview did not cover the CVD topic) provided views via this route. This GP is not counted in the table above.

4. Assessment of clarity, feasibility, reliability and acceptability

The three draft indicators proposed for this topic relate to the primary prevention of CVD through the provision of formal risk assessment but differ in the population on which they focus.

4.1. Clarity

There were no specific problems with ambiguity for any of the three indicators, although greater clarity on how these indicators fit with the existing NHS Health Check programme requirements was suggested by practices in the interviews. Amendments to the indicator definitions and wording were proposed by practices in both the interviews and survey, including the age range of the population and the time period for achievement (see report section 5 for detail).

4.2. Feasibility and reliability

No issues were raised by practices regarding the feasibility of identifying the patient cohort for indicator 1 (risk assessment in the general population) as the only exclusions were patients with existing CVD or those already classified as being at high risk of CVD. There was a common view that it would be easy to identify patients with the comorbidities stated in indicator 2, with two practices also suggesting that patients with pre-diabetes and fatty liver disease should be included in the modifiable risk factors definition. Some practices raised concerns that the recording of some comorbidities and modifiable risk factors (indicators 2 and 3) for their patients may not be current, including erectile dysfunction, smoking status and body mass index, and one practice suggested there could be comorbidities that the patient has not disclosed to the practice.

One practice described that a proportion of their registered patients attended regular private medical appointments, and these services could share the key metrics from health checks to include in the patient record so a CVD risk score could be calculated, although this was not always the case.

Practices reported that they currently used the QRISK2 tool which was built into their clinical systems to calculate the CVD risk score, but acknowledged that QRISK3 was currently recommended. Two practices specifically highlighted in the interviews that

using QRISK3 was currently a manual process and more labour intensive, and one survey respondent raised concerns about the negative consequences if the QRISK tool was withdrawn from the clinical system.

"We generally run QRISK2 and if there's any debate or they're high risk, we do run a manual QRISK3 but that's obviously more labour intensive so that's just one thing that we would flag." [GP, interview]

There were mixed views from some practices regarding the proportion of patients with a CVD risk score recorded following a Health Check. Two practices confirmed that including the risk score would be routine practice and another stated that coding the CVD risk score in the patient record was variable due to the time delay in receiving blood test results before the risk score could be calculated.

Half of the practices interviewed highlighted that a CVD risk score could be generated (batch coded) by the clinical system using a combination of actual measures and clinical system-generated estimates for the patient, with the additional risk that some actual measures could be historic and not current. There was a general view that this batch-coding activity was poor quality care however one practice highlighted that this could take place if the practices was 'short on QOF points' and another recognised that this was 'gaming the system'. Conversely, one practice maintained the view that they only used actual measures to calculate the risk score following a face-to-face patient consultation.

"With EMIS and QRISKs, if you haven't got all the data, it will fill the gaps sometimes with an assumed weight, an assumed blood pressure. So [...] you're not going to say it's an accurate risk but you're getting a risk on the patient record. Now is that really helping patient care? That's what the QOF is meant to be targeting, improving these outcomes and improving patient care." [GP, interview]

"If we're talking about running batch codes against everybody to get a QRISK, that is a nightmare scenario in that we've done something similar for frailty and it threw up more problems than solutions." [Practice manager, interview]

"It's what goes into calculating a CVD risk accurately. So, you have to have measurements that can only be done face-to-face, so the patient, first of all, needs to come in, we need to weigh them, we need to do their blood pressure. For an accurate CVD risk, you're talking about blood tests as well, to measure their lipids and so on. So, it's not just a calculation as such, there is a lot that goes into getting that…" [GP, interview].

4.3. Acceptability

This section summarises practice views from the interviews and the survey on the acceptability of the topic; and the potential impact of the indicator on quality of care; the importance of the issue for patients and their families; the role of financial incentivisation; and separately for each indicator, any specific acceptability issues identified.

Topic feedback

The majority of practices interviewed (and the practice providing views via email narrative) were in support of this topic, recognising the potential benefits of the indicators on the quality of care and improved outcomes for patients and noting that this work was already largely fulfilled via the NHS Health Check programme and within annual reviews for patients with long term conditions. There was a general view that the indicators could have fewer benefits for the most elderly patients in the proposed age range (see report section 4.3.5 for detail).

Four practices highlighted the value of the subsequent discussion with the patient based on their CVD risk score in terms of disease prevention and health promotion, but one of these practices also raised concerns about workload and the future direction of primary care:

"This is really good medical practice, identifying this cohort of patients and getting to them early and the translation to improved outcomes for diseases later on is brilliant. But then [...] actually this is a huge amount of work and what is primary care now? Are we moving more to a preventative sort of lifestyle-type service or are we continuing to provide acute services to our population and their chronic diseases? So if this is coming in, what is going out?" [GP, interview]

An additional two practices acknowledged that these indicators were associated with primary prevention and case finding, with one practice stating how they already focused on this with non-diabetic glycaemia and cholesterol indicators, and another practice agreed but was not quite ready to accept the proposed age ranges for the indicators.

"So this one is about case finding, isn't it, because it's not about the people we already know about who are coming to the long term condition (reviews) it dovetails nicely with the NHS Health Check... But a very good thing overall, a five yearly QRISK from debatable age to debatable age seems like absolutely a good practice for case finding." [GP, interview]

One GP whose practice did offer NHS Health Checks also had a strong view that there was limited evidence in terms of the impact of the programme on population health improvement. They suggested that these indicators should go through the National Screening Committee before they are considered for use in primary care, and suggested alternative public health activities that could have far more impact on reducing cardiovascular mortality.

"My gut feeling is that the answers to reducing cardiovascular disease are not in us screening for it, but actually in changing public health policy to increase active travel, reduce processed food and weight, and improve healthy lifestyles, better housing, better smoking, all of which aren't things that […] we can influence in primary care." [GP, interview]

The three draft indicators proposed relate to the primary prevention of CVD through the provision of formal risk assessment but differ in the population on which they focus. Ten of the twelve practices interviewed were keen to express an indicator preference and these are summarised below.

- Two practices preferred indicator 1 only (recognising this indicator had the potential to have the most impact on patient outcomes and capture those patients who were not yet engaged, but also had the biggest workload).

- A further three practices preferred indicator 2 only (describing this as the most 'comprehensive option' and in the intermediate position between the other two indicators), with one practice stating:

"…indicator two is the one where we could make the most difference and also have the best engagement with patients as well." [GP, interview]

A large proportion of practices interviewed confirmed that they would already undertake annual checks on patients with the comorbidities listed in the definition for indicator 2.

"I think that could lead to a group of people being swept up into a more regular check that would be beneficial, or at least being swept up into being invited to a more regular check." [GP, interview]

- One practice preferred indicator 3 only, considering this option to be more 'clinically relevant' and *"feels we're focusing on the people who potentially are at risk."* [GP, interview]

- The remaining four practices who expressed a view all preferred both indicator 1 and indicator 3, recognising the benefits and concerns with each, and acknowledging the wider clinical impact but larger eligible population associated with indicator 1 and the practicalities associated with prioritising the (smaller) cohort of indicator 3.

One survey respondent suggested that either indicator 2 or indicator 3 was preferred, but not to have both.

While there was support in theory for one or more of the indicators in this topic, some issues were highlighted in the interviews and survey: the upper age limit proposed (all indicators), patient engagement (particularly for indicator 1) and the large cohort of patients (indicators 1 and 2). The indicator-level feedback section later in this report contains further detail.

There were also some concerns around the implementation of the indicators in general, including limits imposed on NHS Health Check activity by Public Health teams in local authorities (see report section 6.3 for detail).

Indicator-level feedback

4.3.1. Quality of care

The majority of respondents to the survey felt that the three CVD prevention indicators would improve the quality of care for patients, with only a small number of

respondents raising concerns that the indicators could worsen the quality of care (Table 1). Views were relatively consistent across the indicators.

Most respondents (73.6%, 39/53) felt that indicator 1 which focused on the general population would improve the quality of care, and slightly fewer respondents thought this was the case for indicators 2 and 3. Just over a fifth of respondents felt that there would be no change to quality of care if any of these three indicators were implemented.

Table 1: Views on the impact of quality of care of CVD-related indicators (survey)

What impact do you think the following indicators could have on the quality of care for patients?

	Improve	No change	Worsen	Total
Indicator 1: CVD prevention: Risk assessment (general population)	39 (73.6%)	11 (20.8%)	3 (5.7%)	53
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	37 (69.8%)	12 (22.6%)	4 (7.5%)	53
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	38 (71.7%)	11 (20.8%)	4 (7.5%)	53

Please note where percentages do not total 100%, this is as a result of rounding.

4.3.2. Value to patients

There were mixed views on whether the indicators represented an issue that was important for patients, families and carers (Table 2). A slightly higher proportion of respondents (56.6%, 30/53) thought that indicator 3 (patients with comorbidities) was important to patients, families and carers than indicator 2 (patients with modifiable risk factors and comorbidities) or indicator 1 (general population), respectively. Around one fifth of respondents remained unsure as to whether the three indicators represented an issue that was important to patients, families and carers.

Do you think the following indicators represent an issue that is important for patients, families, and carers?

	Yes	No	Unsure	Total
Indicator 1: CVD prevention: Risk assessment (general population)	25 (47.2%)	18 (34.0%)	10 (18.9%)	53
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	29 (54.7%)	13 (24.5%)	11 (20.8%)	53
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	30 (56.6%)	13 (24.5%)	10 (18.9%)	53

Please note where percentages do not total 100%, this is as a result of rounding.

One survey respondent suggested in relation to indicator 1 that it was difficult to get healthy people to attend the practice for CVD monitoring, a view that was corroborated by a GP in the interviews.

4.3.3. Financial incentivisation

Most respondents to the survey (71.7%, 38/53) thought that each of the three CVD prevention indicators should be financially incentivised (Table 3). There were similar views for all three indicators in terms of the number of respondents who disagreed with financial incentivisation and those that were unsure.

Table 3: Views on financial incentivisation of the CVD-related indicators (survey)

Do you think the following indicators should be financially incentivised?

	Yes	No	Unsure	Total
Indicator 1: CVD prevention: Risk assessment (general population)	38 (71.7%)	9 (17.0%)	6 (11.3%)	53
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	38 (71.7%)	6 (11.3%)	9 (17.0%)	53
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	38 (71.7%)	8 (15.1%)	7 (13.2%)	53

In the interviews one practice suggested that if the indicators were successful and included in an incentivised framework, that the points allocated to achievement could be based on population size to reflect the workload requirements. A practice manager highlighted that NHS Health Checks were already incentivised and more clarity was required to ensure there would be no duplication of payment, with a GP

from another practice suggesting that the financial incentivisation could be associated with the time required to discuss the CVD risk score with the patient and 'for the afterwork'. A GP from a third practice stated that any incentivisation would need to be additional funding as it would not be possible to undertake the requirements of the indicator on the current funding that was available.

4.3.4. Quality improvement

There were mixed views on whether the CVD indicators were suitable as an aid for quality improvement without financial incentive, with around 30% of respondents in support of this for each of the three indicators (Table 4). Approximately half of respondents did not think these indicators were suitable for quality improvement, with the remaining respondents being unsure.

Table 4: Views on suitability of the CVD-related indicators for quality improvement (survey)

Do you think the following indicators could be suitable for quality improvement, without financial incentive?

	Yes	No	Unsure	Total
Indicator 1: CVD prevention: Risk assessment (general population)	16 (30.2%)	28 (52.8%)	9 (17.0%)	53
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	16 (30.2%)	26 (49.1%)	11 (20.8%)	53
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	17 (32.1%)	25 (47.2%)	11 20.8%)	53

Please note where percentages do not total 100%, this is as a result of rounding.

4.3.5. Specific issues identified in interviews and survey

Upper limit of age range

Indicators 1, 2 and 3 – general theme

A general issue was raised in the interviews which related to all three CVD indicators. Seven practices expressed concerns about the proposed upper age limit of 84 years (to note that this is consistent with the age limit used in the QRISK3 tool). A similar view of the upper age limit being too high was obtained from nine survey respondents who provided comments on this issue (see report section 5 for detail).

Two practices thought that as lifestyle changes and the treatment of risk factors could take several years to have any impact, the indicator should instead focus on the younger population who may have much greater modifiable risk factors to address. A further two practices raised concerns that a large proportion of patients aged 80 years and over would have a high CVD risk score (as age is a risk factor) but also questioned whether starting statin treatment in those aged over 80 years was appropriate, a view corroborated by a survey respondent.

"I guess for us, just the concern about using that sort of population risk up to such an advanced age is almost everybody in their 80s has a QRISK over 20%." [GP, interview]

"If you reach the lucky age of 83 [...] I'm much less engaged in, "Gosh, we better get you in and talk to you about your cardiovascular risk." If you've managed to get to 83 with whatever diet and habits that you've got and you haven't had a heart attack or stroke and you're not hypertensive, you are lucky and you're probably doing as good a job as you're going to." [GP, interview]

"On the one hand you have the medicines optimisation team in the ICB asking for elderly patients to have medicines stopped e.g. statins, yet you might have this indicator suggesting your 84 year old has a high CVD score and thus the intervention is to encourage that 84 year old to be on a statin…" [GP, survey]

Cohort identification

Indicator 1: Cardiovascular disease prevention: Risk assessment (general population)

Whilst there was agreement that indicator 1 could have the greatest impact on patient outcomes, most of the practices interviewed expressed concerns that this population denominator could be very large (even if the age range was reduced, as mentioned in the previous section and detailed in section 5). These concerns are explored in more detail in the 'Workload, utilisation and costs' section of this report.

Indicator 2: Cardiovascular disease prevention: Risk assessment (modifiable risk factors or comorbidities)

In general the practices seemed confident in identifying the patients defined within this indicator. One GP raised concerns in the interviews that the patient cohort definition initially looked confusing, but the practice manager from the same practice

provided assurance that this could be resolved through the consistent use of templates by all practice staff. One survey respondent also made a comment that the cohorts looked complicated and gave the suggestion to *"Keep the message on Health Checks simple without subdividing groups."* [GP, survey]

One interviewed GP endorsed this indicator in terms of practice education to highlight these conditions as risk factors for CVD, with another GP acknowledging that they wouldn't have otherwise considered systemic lupus erythematosus (SLE). One practice suggested that the population denominator for this indicator could still be very large, with most patients in their population meeting at least one of the inclusion criteria.

In the interviews practices discussed whether condition severity should be considered, with three of the four practices expressing a view that this would overcomplicate the indicator definition, and one practice suggesting it could work for some conditions (such as smoking and obesity) better than others (such as patients with SMI).

"I think if you start putting a threshold on things like a cholesterol level or numbers of how many cigarettes you smoke, it starts to become very personal to the patient: why are you targeting me? […] That makes the conversation more difficult with patients as well" [GP, interview]

"I think there is a huge difference in someone's CVD risk if they smoke two cigarettes on a Saturday night with a pint of beer verses smoking twenty cigarettes a day or more." [GP, interview]

As mentioned earlier in the report (section 4.2) and also applicable to indicator 3, there were concerns by some practices that the recording of some comorbidity and modifiable risk factor codes may not be kept up to date by practices, however it was acknowledged that this could be resolved via additional communication with patients and changing practice-level administrative processes.

5. Suggested amendments to indicator definitions and/or wording

Indicators 1, 2 and 3 – general themes

Some issues with the definition and wording of the three indicators were highlighted by practices in both the survey and interviews. Most survey respondents did not think the wording needed to be changed for the three indicators, with a small number being 'unsure' (Table 5). Views were relatively consistent across the indicators.

Table 5: Views on wording changes for the CVD-related indicators (survey)

Should the wording be changed on any of the indicators?

	Yes	No	Unsure	Total
Indicator 1: CVD prevention: Risk assessment (general population)	12 (23.1%)	33 (63.5%)	7 (13.5%)	52
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	12 (23.1%)	32 (61.5%)	8 (15.4%)	52
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	13 (25.0%)	31 (59.6%)	8 (15.4%)	52

Please note where percentages do not total 100%, this is as a result of rounding.

Age range

Of the survey respondents who thought that the wording should be changed, nine respondents provided comments relating to the age range of the indicators, stating that the upper age limit was too high (as mentioned in section 4.3.5 of this report). Four of these respondents proposed that the upper age limit should be 75 or under and a further two respondents thought that 80 years should be the upper limit. The general view from the interviewed practices was that the upper age limit should be reduced to 74 years as per the NHS Health Check.

With regard to the lower age limit being raised from the NHS Health Check minimum of 40 years (to 45 years for indicator 1 and to 43 years for indicators 2 and 3) to allow time for the CVD risk assessment to take place, one interviewed GP acknowledged this as helpful, and a survey respondent (GP) questioned this rationale.

Review timing

There were two additional comments regarding wording changes for the indicators; one survey respondent highlighted that the indicator review time intervals conflicted with the requirements of the NHS Health Check, a view that was also expressed by seven practices in the interviews. It was proposed by these practices that the five-year review period should be applied to all three indicators (despite practices separately confirming that patients with comorbidities were mainly seen in an annual review). The other comment was a request that the CVD risk assessment tool should be defined in the indicator. One interviewed practice was of the view that patients received a Health Check once they reached 40 years old, but that this was not then repeated every five years for those still eligible.

Definitions

As mentioned earlier in the report (section 4.2) there were suggestions by at least two practices in the interviews that pre-diabetes and fatty liver disease should be included as modifiable risk factors (and included in indicators 2 and 3), and one further practice suggested the inclusion of substance misuse. One survey respondent and one GP interviewee questioned the inclusion of erectile dysfunction in the list of comorbidities however one interviewee was confident that this condition should remain in the list. There were no suggestions of patient groups that should be excluded from this indicator in either the survey or the interviews.

To note that the additional (13th) respondent who stated that the wording should be changed on indicator 3 made a comment that they were not clear how much this indicator differed from indicator 2.

Indicator achievement and thresholds

In terms of indicator achievement and thresholds, one GP proposed that if these indicators were introduced, a lower achievement target (such as 50%) could be set initially, and for this to be increased over time. In their view this would be more effective than setting a high target where practices may consider generating CVD risk scores based on actual and estimated values from the clinical system to achieve this rather than undertaking CVD risk assessments. Another practice suggested the possibility of indicator achievement (and payment) being based upon the practice demonstrating that they had attempted to obtain the measurements from patients to

achieve the indicator, even if they were unsuccessful and no CVD risk score was available.

Supporting guidance

The majority of survey respondents (between 63.5% and 65.4%) did not think any improvements needed to be made to the supporting guidance provided in the pilot handbook for the three indicators (Table 6), with a further 11 respondents (21.2%) being unsure for each. A small number of respondents thought the guidance needed to be improved (but did not provide any further detail) and two respondents asked for further clarification regarding the CVD risk tools that would be suitable to use. Views from respondents were relatively consistent across the indicators.

Table 6: Views on indicator guidance changes for the CVD-related indicators (survey)

Could the supporting indicator guidance provided in the handbook be improved for any of the indicators?

	Yes	No	Unsure	Total
Indicator 1: CVD prevention: Risk assessment (general population)	7 (13.5%)	34 (65.4%)	11 (21.2%)	52
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	8 (15.4%)	33 (63.5%)	11 (21.2%)	52
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	7 (13.5%)	34 (65.4%)	11 (21.2%)	52

Please note where percentages do not total 100%, this is as a result of rounding.

6. Practices' views on implementation issues and impact

This section covers practice views on: training requirements; workload, resource utilisation (including which healthcare professionals would be involved) and costs (including impact on appointment times); any changes required to practice organisation (e.g. setting up and use of clinical system protocols, recall systems, and templates); any barriers to implementation; assessment of overlap with and/or impact on existing QOF indicators or local schemes; assessment of the impact on health inequalities; and any other overall views on implementation of the indicators (including unintended consequences).

6.1. Training requirements

Practices were asked in the survey whether staff would need any additional training to implement the indicators. Just under half of the survey respondents (47.1%, 24/51) thought that administrative staff would need additional training if these indicators were introduced. A higher proportion (52.9%, 27/51) reported that clinical staff would need additional training.

6.2. Workload, resource utilisation and costs

6.2.1. Workload

Most survey respondents thought the requirements relating to the CVD-related indicators would generate additional clinical workload, either 'definitely' or 'to some extent' (Table 7), with indicator 3 being suggested as generating the most additional clinical workload (88.5%, 46/52).

The survey showed varying views as to which staff groups would be most affected by the clinical requirements of the CVD-related indicators (Table 8). Many respondents reported that 'GPs' would be most affected (ranging from 37 of the 52 respondents for indicator 1 (71.2%) to 38 respondents for indicators 2 and 3 (73.1%). Over half of respondents thought that 'nursing' would be affected, with a higher proportion of respondents considering this for indicator 1 (59.6%, 31/52) than indicators 2 and 3 (55.8%, 29/52). Approximately 30% of respondents across the three indicators thought that pharmacists would also be affected.

Three practices at interview thought that these indicators would lead to an increase in the number of NHS Health Checks done if additional funding was available. A

further GP raised concerns about potential future clinical staffing requirements and the need to further train existing staff if the indicators were introduced and more if patient reviews became more frequent than five years. This view was also stated by four survey respondents.

Three practices expressed concerns as to whether this could lead to a disproportionate amount of clinical time providing preventative medicine rather than dealing with acute care, and the amount of clinical time this indicator could take:

"There's an assumption that I have 30 minutes to spend with every patient and also that people will be engaged in this conversation given that this is not why they have come to see me, and we would all like to think that we're offering holistic care and we're doing as much as we can, but we can only do so much." [GP, interview]

As with clinical workload, most survey respondents thought that the indicator would 'definitely' or 'to some extent' generate additional administrative workload (Table 9), with indicators 2 and 3 suggested as generating the most additional administrative workload. One survey respondent highlighted that due to the lack of patient engagement, a substantial amount of time was already taken 'chasing and calling' patients to attend, which would increase if the proposed indicators were introduced. This view was also reflected by an interviewee:

"We don't have time to see people who've actually got symptoms […], and that leads to a lot of frustration, and a lot of political angst because actually people want to see us when they've got symptoms. They don't really necessarily want to see us when they've got a primary prevention problem." [GP, interview]

At interview one GP highlighted that current practice processes and patient letters may need to be redesigned to meet the requirements of these indicators but considered that this would be of overall benefit to the patients.

Table 7: Views on additional clinical workload generated by the CVD-related indicators (survey)

Will the requirements relating to the indicators generate additional CLINICAL workload?

	Yes, definitely	Yes, to some extent	No	Unsure	Total
Indicator 1: CVD prevention: Risk assessment (general population)	23 (44.2%)	19 (36.5%)	6 (11.5%)	4 (7.7%)	52
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	22 (42.3%)	23 (44.2%)	3 (5.8%)	4 (7.7%)	52
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	21 (40.4%)	25 (48.1%)	2 (3.8%)	4 (7.7%)	52

Please note where percentages do not total 100%, this is as a result of rounding.

Table 8: Views on staff groups affected by the clinical requirements (survey)

Which staff group(s) would be most affected by the clinical requirements of the indicators? *Respondents selecting 'Yes'*

	GP	Nursing	Pharmacist	Other Clinical	Unsure	Total Respondents* (n)
Indicator 1: CVD prevention: Risk assessment (general population)	37 (71.2%)	31 (59.6%)	15 (28.8%)	14 (26.9%)	7 (13.5%)	52
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	38 (73.1%)	29 (55.8%)	17 (32.7%)	14 (26.9%)	6 (11.5%)	52
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	38 (73.1%)	29 (55.8%)	15 (28.8%)	14 (26.9%)	6 (11.5%)	52

* This is a multiple response question, so the number of responses totals more than 52, as respondents could select more than one response

Table 9: Views on additional administrative workload generated by the CVD-related indicators (survey)

Will the requirements relating to the indicator generate additional ADMINISTRATIVE workload?

	Yes, definitely	Yes, to some extent	No	Unsure	Total
Indicator 1: CVD prevention: Risk assessment (general population)	28 (53.8%)	10 (19.2%)	10 (19.2%)	4 (7.7%)	52
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	25 (48.1%)	16 (30.8%)	7 (13.5%)	4 (7.7%)	52
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	24 (46.2%)	17 (32.7%)	7 (13.5%)	4 (7.7%)	52

Please note where percentages do not total 100%, this is as a result of rounding.

6.2.2. Time pressure, appointment capacity and appointment type/length

Just over half of survey respondents (between 53.8% and 55.8%) thought there would be time pressure issues relating to these three indicators (Table 10) with between 28.8% (indicators 2 and 3) and 34.6% (for indicator 1) of respondents stating there would be no time pressure issues.

Approximately half of respondents (between 50.0% and 51.9%) thought that the three indicators could be associated with appointment capacity issues, and around one third of respondents did not think this would be an issue (Table 11). At least five survey respondents suggest that these indicators would require additional appointments to be created.

Table 10: Views on time pressure issues in the practice relating to the indicators (survey)

Can you foresee any other time pressure issues in the practice relating to the indicators?

	Yes	No	Unsure	Total

Indicator 1: CVD prevention: Risk assessment (general population)	28 (53.8%)	18 (34.6%)	6 (11.5%)	52
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	29 (55.8%)	15 (28.8%)	8 (15.4%)	52
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	29 (55.8%)	15 (28.8%)	8 (15.4%)	52

Please note where percentages do not total 100%, this is as a result of rounding.

Table 11: Views on potential capacity issues in the practice relating to the indicators (survey)

Can you foresee any appointment capacity issues in the practice relating to the indicators?

	Yes	No	Unsure	Total
Indicator 1: CVD prevention: Risk assessment (general population)	27 (51.9%)	18 (34.6%)	7 (13.5%)	52
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	26 (50.0%)	18 (34.6%)	8 (15.4%)	52
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	27 (51.9%)	17 (32.7%)	8 (15.4%)	52

Practices were asked in the survey about changes to appointment type and length that may be required to implement these indicators.

Just over half of respondents to the survey did not think that any changes would be required to the appointment type if the indicator was introduced (Table 12a). Suggestions from respondents who did think changes would be needed included an increase in nurse appointments and additional appointments to provide follow up care or discuss test results.

One survey respondent proposed that 'Making every contact count' needed to be built into the indicators, where services in the whole system 'work smarter not harder' to capture different types of information during a single patient appointment, a view that was also proposed by a GP interviewee.

Most respondents thought that a standard appointment would be required, with the remaining respondents suggesting an extended appointment was required (Table 12b). The rationale for needing extended appointments was to recognise the

additional complexity of the consultation (including risk score calculation and relevant subsequent actions), and for additional clinical coding time.

Table 12a: Views on any changes needed to appointment type relating to the indicator (survey)

Do you think there would need to be any changes to appointment TYPE for the following indicators?

	Yes	No	Unsure	Total
Indicator 1: CVD prevention: Risk assessment (general population)	12 (23.1%)	29 (55.8%)	11 (21.2%)	52
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	14 (26.9%)	27 (51.9%)	11 (21.2%)	52
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	14 (26.9%)	27 (51.9%)	11 (21.2%)	52

Please note where percentages do not total 100%, this is as a result of rounding.

Table 12b: Views on any changes needed to appointment length relating to the indicator (survey)

Do you think there would need to be any changes to appointment LENGTH for the indicators?

	Standard appointment	Extended appointment	Total
Indicator 1: CVD prevention: Risk assessment (general population)	41 (78.8%)	11 (21.2%)	52
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	38 (73.1%)	14 (26.9%)	52
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	38 (73.1%)	14 (26.9%)	52

6.3.   Barriers to implementation

This report has previously highlighted potential barriers to implementation of the indicator, such as patient engagement, staff workload and time pressures. This section includes an additional potential barrier to implementation which relates to limits on Health Check numbers by Public Health teams due to lack of funding. This issue may need to be addressed at system or national level.

Limits on Health Check activity

Four of the twelve practices interviewed mentioned that their local Public Health team had put a limit or 'cap' on the amount of NHS Health Checks activity that they would fund in a financial year and therefore this would have an impact on the ability of practices to undertake more Health Checks and increase the number of people with a CVD risk score. This view was also mentioned by a survey respondent in their comments.

"If you have a cap on activity that we're effectively having to stop despite our public health team being worried about our CVD mortality, it doesn't quite fit together with that overall. So I guess that's one of the things to think about, is the resource behind the health checks." [GP, interview]

"But (local council) have been very mean and they limit the number of Health Checks we can do. They're starting to relax a little bit but across the country you might find that some public health teams are not funding Health Checks at the same level as other areas. So you've got a problem there with the consistency nationally. You won't be able to compare one region with another unless you know the health checks are consistent." [Practice manager, interview]

6.4. Impact on health inequalities

Practices were asked in the interviews and in the survey to consider whether the three indicators would have any impact on health inequalities. There were mixed views from the survey (Table 13) for all three indicators, with just over half of respondents suggesting that there would be a positive impact, with indicator 3 (modifiable risk factors) having the strongest view (54.9%, 28/51) and indicator 1 (general population) with the lower response (51.0%, 26/51).

Almost 40% of respondents (20/51) were unsure of the impact or considered there to be a mixed impact of these indicators on health inequalities. One survey respondent raised concerns that health screening could take up too much time and resource.

Table 13: Views on the impact of the indicators on health inequalities (survey)

What do you consider the impact will be on health inequalities for the indicators?

	Positive impact	Negative impact	Unsure or mixed impact	Total

Indicator				
Indicator 1: CVD prevention: Risk assessment (general population)	26 (51.0%)	5 (9.8%)	20 (39.2%)	51
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	27 (52.9%)	4 (7.8%)	20 (39.2%)	51
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	28 (54.9%)	3 (5.9%)	20 (39.2%)	51

Please note where percentages do not total 100%, this is as a result of rounding.

Five practices expressed their views in the interviews, raising further concerns about lack of engagement in some patient cohorts and that health inequalities existed based on deprivation:

"If you give each practice the same amount of funding for their health checks, the leafy suburbs, people will come in requesting their health checks whereas actually if you work in a deprived area, it's actually a lot of work dragging people in and trying to get them engaged." [GP, interview]

And the same GP then added:

"I think we risk treating the worried well very well and actually [...] so there is a risk of increasing inequalities and it's because some of those patients in deprived areas, actually they take more effort to go and get in for the health checks and more invitations and more work." [GP, interview]

This view was upheld by another GP from a different interview:

All that happens is the worried will attend and have a nice check and we send them away. It's like the deprived [...] they're the hard to reach, those are the ones we need to get, and we are not getting to those. [...] we are just measuring things for the well, [...] and it takes so much time to do all that." [GP, interview]

One GP described how they had tried to overcome the inequalities in their practice:

"We've been relatively innovative, and we've tried to risk assess the people that we've been inviting in for the Health Check. So, we've concentrated on areas of deprivation, patients that have previously had a smoking history. Those sort of groups, older males. Particularly when we were coming back after COVID and restarting the health checks we really tried to prioritise those health groups, but obviously we can't do a health check on everyone as it stands at present." [GP, interview]

6.5. Other overall views on implementation of the indicators (including unintended consequences)

There were mixed views on whether there would be unintended consequences as a result of introducing any of the three indicators. Between 37.3% (indicators 2 and 3) and 39.2% (indicator 1) of survey respondents did not think there would be any unintended (positive or negative) consequences if they were introduced and just over 20% were unsure (Table 14).

Between 13 and 14 respondents (25.5% and 27.5%, respectively) thought any unintended consequences of the indicators would be positive, and the remaining six to seven respondents anticipated negative unintended consequences. (Table 14).

Table 14: Views on potential unintended consequences relating to the indicators (survey)

Are there any unintended positive or negative consequences that you can think of that could be experienced locally if these indicators were introduced nationally?

	Yes, positive	Yes, negative	No	Unsure	Total
Indicator 1: CVD prevention: Risk assessment (general population)	13 (25.5%)	7 (13.7%)	20 (39.2%)	11 (21.6%)	51
Indicator 2: CVD prevention: Risk assessment (modifiable risk factors or comorbidities)	14 (27.5%)	7 (13.7%)	19 (37.3%)	11 (21.6%)	51
Indicator 3: CVD prevention: Risk assessment (modifiable risk factors)	14 (27.5%)	6 (11.8%)	19 (37.3%)	12 (23.5%)	51

Please note where percentages do not total 100%, this is as a result of rounding.

There were a number of comments from the survey, with three respondents highlighting that these indicators could have a positive impact by reducing the long-term effects of cardiovascular disease.

"Any extra CVD risk assessment would be a benefit to patients and the health service in the long term." [Admin, survey]

Another three respondents raised concerns relating to the risk of focusing too much resource on the older age group, with a further two respondents highlighting that the indicators could lead to increased demand for appointments.

"Inappropriate focus on well elderly patients instead of those younger patients at high risk and in real need of intervention for CVD." [GP, survey]

One respondent raised the issue of the potential impact and additional burden on phlebotomy services and could lead to capacity issues in services available for onward referral of patients.