CVDPREVENT 2026 new Indicator Guide

Arden&GEM

NHS Benchmarking Network

(for new indicators introduced to the audit in August 2026)
Using data to drive cardiovascular disease prevention

HQIP
Healthcare Quality Improvement Partnership

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BACKGROUND

The CVDPREVENT audit is part of a broader strategic objective outlined in the NHS Long Term Plan to prevent 150,000 strokes, heart attacks and cases of dementia over the next ten years. The audit captures primary care data to drive cardiovascular disease (CVD) quality improvement at individual general practice (GP), primary care network (PCN), and integrated care board (ICB) level.

The CVDPREVENT Data & Improvement Tool allows you to benchmark national findings and support system change in your local area by viewing data at all system levels from national down to individual practice level. As the audit develops, new indicators are introduced to add to the insights into CVD prevention in primary care, as primary care teams will be able to assess their status and progress against national CVD quality improvement objectives. The indicators have been selected and developed by key stakeholders, including: the CVD Intelligence team that sits within the Office for Health Improvement and Disparities (OHID), NHS Benchmarking Networking (NHSBN), the CVDPREVENT Clinical Lead, Steering Group, Primary Care Clinical Panel and CVDPREVENT Patient Panel.

In July 2026, NHS England published the CVD Modern Service Framework (MSF), which sets out twelve priorities for improving cardiovascular disease prevention and treatment over the next ten years. The framework establishes standards and ambitions for each priority, along with equity metrics designed to reduce variation in care between primary care networks. Three of the new Round 5 indicators - CVDP001CVKM, CVDP010HYP and CVDP003HF - provide the primary measures for priorities within the MSF, supporting local systems to track progress against its ambitions.

This guide is intended to give insight to the rationale behind the new indicators as well as the national level position and alignment with national guidance. These indicators have been introduced to the audit and have been published on the Data & Improvement Tool from the March 2026 data extract onwards.

The Round 5 indicators, published in August 2026, are listed below.

Indicator list

CVDP003HF - Patients with GP recorded heart failure with reduced ejection fraction, who are currently treated using the four pillar model.
CVDP004HF - Patients with GP recorded heart failure, who are currently treated with an SGLT2 inhibitor.
CVDP010HYP - Patients with GP recorded CVD (narrow definition), whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.
CVDP008CKD - Patients with GP recorded CKD (G3a to G5), who are currently treated with an SGLT2 inhibitor.
CVDP006DM - Patients with GP recorded Type 2 Diabetes Mellitus, who are currently treated with an SGLT2 inhibitor.
CVDP001CVKM - Patients with GP recorded CKD (G3a to G5), heart failure or type 2 Diabetes Mellitus who are currently treated with an SGLT2 inhibitor.
CVDP002CVKM - Patients with GP recorded CVD (narrow definition) whose last blood pressure reading is to the appropriate treatment threshold AND whose most recent blood cholesterol level is LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l, in the preceding 12 months.

HEART FAILURE INDICATORS

Heart failure (HF) is a condition in which the heart is unable to pump blood around the body efficiently. It can occur at any age but is more common in older people. Symptoms can include breathlessness, extreme fatigue, and ankle swelling, although the severity of symptoms can vary considerably between individuals.

Heart failure with reduced ejection fraction (HFrEF) is a specific form of heart failure where the heart muscle does not contract effectively, reducing the amount of blood pumped out with each heartbeat. Effective treatment of HFrEF can significantly reduce the risk of hospitalisation and death.

Guideline-directed medical therapy for HFrEF is based on a four pillar model, comprising four classes of medication that have each demonstrated significant benefits in clinical trials. The four pillars are: an ACE inhibitor, angiotensin receptor blocker (ARB), or angiotensin receptor-neprilysin inhibitor (ARNI); a licensed beta-blocker; a mineralocorticoid receptor antagonist (MRA); and, for patients without type 1 diabetes, an SGLT2 inhibitor (SGLT2i). Optimising patients on all four pillars, where clinically appropriate, reduces hospitalisation and mortality.

SGLT2 inhibitors are a more recent addition to heart failure treatment guidelines. Evidence from large clinical trials has demonstrated significant reductions in cardiovascular death and hospitalisation for worsening heart failure in patients treated with SGLT2i, and they are now recommended as part of guideline-directed medical therapy for HFrEF in NICE guidance.

CVDP003HF: Patients with GP recorded heart failure with reduced ejection fraction, who are currently treated using the four pillar model.

This indicator counts the percentage of patients with HFrEF who are currently being treated using the four pillar model of guideline-directed medical therapy, where clinically appropriate. Optimising patients on all four pillars reduces hospitalisation and mortality in HFrEF. Identifying the proportion of patients receiving this therapy can highlight opportunities to improve treatment and outcomes.

Type of indicator: This indicator is a CVDPREVENT treatment indicator.

Associated guidance: NICE guidance NG106 (Chronic heart failure in adults: diagnosis and management), recommendations on pharmacological treatment of HFrEF. This indicator provides the measure for Priority 8 of the CVD Modern Service Framework (NHS England, 2026), which sets a 10-year ambition of 75% of eligible HFrEF patients treated using the four pillar model.

Using this indicator: Differing levels of four pillar treatment can be an indicator of variation in the quality of care. Higher proportions of patients on all four pillars of guideline-directed medical therapy, where clinically appropriate, represent better quality of care. Lower proportions could indicate opportunities to review and optimise treatment. This indicator can be used to identify areas of good practice and areas for improvement. Patients with a clinical contraindication to one or more pillars should not be included in the denominator for that pillar.

National position: Data on the proportion of HFrEF patients receiving all four pillars of guideline-directed medical therapy will be available from the CVDPREVENT audit from July 2026 onwards.

Click here to find the metadata for this indicator.

CVDP004HF: Patients with GP recorded heart failure, who are currently treated with an SGLT2 inhibitor

This indicator measures the proportion of eligible heart failure patients who are currently treated with an SGLT2 inhibitor. SGLT2 inhibitors are recommended as part of guideline-directed medical therapy for patients with HFrEF, reducing the risk of hospitalisation and cardiovascular death. This indicator is in early development.

Type of indicator: This indicator is a CVDPREVENT treatment indicator

Associated guidance: NICE guidance NG106 (Chronic heart failure in adults: diagnosis and management), recommendations on pharmacological treatment of HFrEF, including the use of SGLT2 inhibitors.

Using this indicator: Differing levels of SGLT2i prescribing in heart failure patients can be an indicator of variation in the quality of care. Higher proportions of eligible HFrEF patients treated with an SGLT2i represent better quality of care. Lower proportions may indicate opportunities to review and optimise treatment in line with current guidance. This indicator is in early development and should be interpreted with caution.

National position: Data on the proportion of heart failure patients treated with an SGLT2i will be available from the CVDPREVENT audit from July 2026 onwards. This indicator is in early development.

Click here to find the metadata for this indicator.

HYPERTENSION INDICATORS

High blood pressure, or hypertension, rarely has noticeable symptoms. If untreated, hypertension increases the risk of serious health problems such as heart attacks and strokes.

The only way to know if your blood pressure is high is to measure it. Blood pressure (BP) is recorded with two numbers. The systolic pressure (higher number) is the force at which the heart pumps blood around the body. The diastolic pressure (lower number) is the resistance to the blood flow in the blood vessels. They are both measured in millimetres of mercury (mmHg).

Following a diagnosis of hypertension, regular monitoring (at least annually) and a reduction of BP to specific treatment thresholds is recommended, to reduce the risk of developing problems such as heart attacks or strokes. BP can be managed through lifestyle changes, medications, or both of these. There are different treatment thresholds for blood pressure depending on a person's age and whether they have other comorbidities such as diabetes or chronic kidney disease. The CVDPREVENT blood pressure treatment threshold indicators only uses the treatment thresholds depending on age and not level of comorbidity.

CVDP010HYP: Patients with GP recorded CVD (narrow definition), whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months

This indicator measures the proportion of CVD patients (narrow definition: coronary heart disease, peripheral arterial disease, non-haemorrhagic stroke or transient ischaemic attack) whose blood pressure is within the QOF treatment threshold (treated to target), based on a blood pressure reading recorded in the preceding 12 months. Blood pressure control is a key element of secondary prevention in patients with established cardiovascular disease, reducing the risk of further events.

Type of indicator: This indicator is a CVDPREVENT treatment indicator.

Associated guidance: NICE guidance NG136 (Hypertension in adults: diagnosis and management), recommendations on blood pressure targets in patients with cardiovascular disease. This indicator provides the measure for Standard 1 of Priority 7 of the CVD Modern Service Framework (NHS England, 2026), which sets a 10-year ambition of 85% of CVD patients with blood pressure treated to the appropriate threshold.

Using this indicator: Differing levels of blood pressure control in CVD patients can be an indicator of variation in the quality of care. Higher proportions of patients with blood pressure treated to the QOF target represent better quality of care and reduced risk of further cardiovascular events. Lower proportions may indicate opportunities to review and optimise antihypertensive treatment. This indicator can be used to identify areas of good practice and areas for improvement.

National position: Data on the proportion of CVD patients with blood pressure within the QOF treatment threshold will be available from the CVDPREVENT audit from July 2026 onwards.

Click here to find the metadata for this indicator.

CHRONIC KIDNEY DISEASE INDICATORS

Chronic kidney disease (CKD) is a condition where there is a gradual loss of kidney function over time, it is classified as grades G1 to G5 (G5 being the most severe). Patients with CKD have an increased risk of developing CVD. CKD can be asymptomatic but early identification and management can reduce the risk of CKD progression as well as the risk of developing CVD.

Kidney function can be assessed by measuring an estimated glomerular filtration rate (eGFR). This is a blood test which measures how much blood (in millilitres) is 'cleaned' by the kidneys in one minute.

CKD is defined as abnormalities of kidney structure or function, present for >3 months. The presence of two low eGFR values (less than 60 ml/min/1.73 m2) more than three months apart in the GP record, is diagnostic of CKD.

CVDP008CKD: Patients with GP recorded CKD (G3a to G5), who are currently treated with an SGLT2 inhibitor

This indicator measures the proportion of CKD stage 3-5 patients who are currently treated with an SGLT2 inhibitor. SGLT2 inhibitors slow the progression of chronic kidney disease and reduce cardiovascular risk in patients with CKD, and are recommended in eligible patients as per NICE guidance.

Type of indicator: This indicator is a CVDPREVENT treatment indicator.

Associated guidance: NICE guidance NG203 (Chronic kidney disease: assessment and management) and NICE technology appraisal TA775 (Dapagliflozin for treating chronic kidney disease), recommendations on the use of SGLT2 inhibitors in CKD.

Using this indicator: Differing levels of SGLT2i prescribing in CKD patients can be an indicator of variation in the quality of care. Higher proportions of eligible CKD stage 3-5 patients treated with an SGLT2i represent better quality of care and may help to slow disease progression and reduce cardiovascular risk. Lower proportions may indicate opportunities to review and optimise treatment. This indicator can be used to identify areas of good practice and areas for improvement.

National position: Data on the proportion of CKD stage 3-5 patients treated with an SGLT2i will be available from the CVDPREVENT audit from July 2026 onwards.

Click here to find the metadata for this indicator.

DIABETES MELLITUS INDICATORS

Type 2 diabetes is a long-term condition in which the body does not produce enough insulin or does not use it effectively, resulting in high blood glucose levels. Patients with type 2 diabetes are at significantly increased risk of developing cardiovascular disease, including heart attack and stroke, as well as kidney disease and other complications. SGLT2 inhibitors are recommended for patients with type 2 diabetes who have or are at high risk of cardiovascular or renal disease, providing cardiovascular and renal protection in addition to glycaemic control.

CVDP006DM: Patients with GP recorded Type 2 Diabetes Mellitus, who are currently treated with an SGLT2 inhibitor

This indicator measures the proportion of type 2 diabetes patients who are currently treated with an SGLT2 inhibitor. SGLT2 inhibitors are recommended for patients with type 2 diabetes who have or are at high risk of cardiovascular or renal disease. This indicator is in early development.

Type of indicator: This indicator is a CVDPREVENT treatment indicator.

Associated guidance: NICE guidance NG28 (Type 2 diabetes in adults: management) and NICE technology appraisals on SGLT2 inhibitors, recommendations on their use for cardiovascular and renal protection in type 2 diabetes.

Using this indicator: Differing levels of SGLT2i prescribing in type 2 diabetes patients can be an indicator of variation in the quality of care. Higher proportions of eligible patients treated with an SGLT2i may reflect better alignment with current guidance and improved cardiovascular and renal outcomes. Lower proportions may indicate opportunities to review and optimise treatment. This indicator is in early development and should be interpreted with caution.

National position: Data on the proportion of type 2 diabetes patients treated with an SGLT2i will be available from the CVDPREVENT audit from July 2026 onwards. This indicator is in early development.

Click here to find the metadata for this indicator.

CARDIOVASCULAR-KIDNEY-METABOLIC (CVKM) INDICATORS

The cardiovascular-kidney-metabolic (CVKM) indicators bring together patients across multiple high-risk conditions – chronic kidney disease, heart failure and type 2 diabetes – who are eligible for treatment with SGLT2 inhibitors. These composite indicators support a holistic view of SGLT2i prescribing across these overlapping and interrelated conditions, reflecting the cardioprotective and renoprotective benefits of SGLT2 inhibitors across this broader patient population.

CVDP001CVKM: Patients with GP recorded CKD (G3a to G5), heart failure or type 2 Diabetes Mellitus who are currently treated with an SGLT2 inhibitor

This indicator brings together patients with chronic kidney disease (stage 3-5), heart failure (with reduced ejection fraction), or type 2 diabetes who are eligible for treatment with an SGLT2 inhibitor, and measures the proportion who are currently being treated with an SGLT2i. This composite indicator reflects the broad cardiovascular and renal benefits of SGLT2 inhibitors across these conditions. This indicator is in early development.

Type of indicator: This indicator is a CVDPREVENT treatment indicator.

Associated guidance: NICE guidance NG106 (heart failure), NG203 (CKD) and NG28 (type 2 diabetes), and relevant NICE technology appraisals on SGLT2 inhibitors across these conditions. This indicator provides the measure for Priority 3 of the CVD Modern Service Framework (NHS England, 2026), which sets a 10-year ambition of 80% of eligible patients treated with an SGLT2 inhibitor.

Using this indicator: Differing levels of SGLT2i prescribing across CKD, HF and type 2 diabetes patients can be an indicator of variation in the quality of care. Higher proportions of eligible patients treated with an SGLT2i represent better alignment with current guidance and may indicate improved cardiovascular and renal outcomes across this high-risk population. Lower proportions may identify opportunities to review and optimise treatment. This indicator is in early development and should be interpreted with caution.

National position: Data on the proportion of CKD, HF or type 2 diabetes patients eligible for SGLT2i treatment who are currently treated will be available from the CVDPREVENT audit from July 2026 onwards. This indicator is in early development.

Click here to find the metadata for this indicator.

CVDP002CVKM: Patients with GP recorded CVD (narrow definition) whose last blood pressure reading is to the appropriate treatment threshold AND whose most recent blood cholesterol level is LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l, in the preceding 12 months

This indicator measures the proportion of CVD patients (narrow definition: coronary heart disease, peripheral arterial disease, non-haemorrhagic stroke or transient ischaemic attack) whose blood pressure and cholesterol are both within the QOF treatment threshold (treated to target), based on readings recorded in the preceding 12 months. Achieving both blood pressure and cholesterol targets is a key element of secondary prevention in patients with established cardiovascular disease.

Type of indicator: This indicator is a CVDPREVENT treatment indicator.

Associated guidance: NICE guidance NG136 (hypertension), NG238 (cardiovascular disease: risk assessment and reduction, including lipid modification), recommendations on blood pressure and cholesterol targets in patients with cardiovascular disease.

Using this indicator: Differing levels of combined blood pressure and cholesterol control in CVD patients can be an indicator of variation in the quality of care. Higher proportions of patients with both measures treated to the QOF target represent better quality of secondary prevention care. Lower proportions may indicate opportunities to review and optimise treatment. This indicator can be used to identify areas of good practice and areas for improvement.

National position: Data on the proportion of CVD patients with both blood pressure and cholesterol within the QOF treatment threshold will be available from the CVDPREVENT audit from July 2026 onwards.

Click here to find the metadata for this indicator.

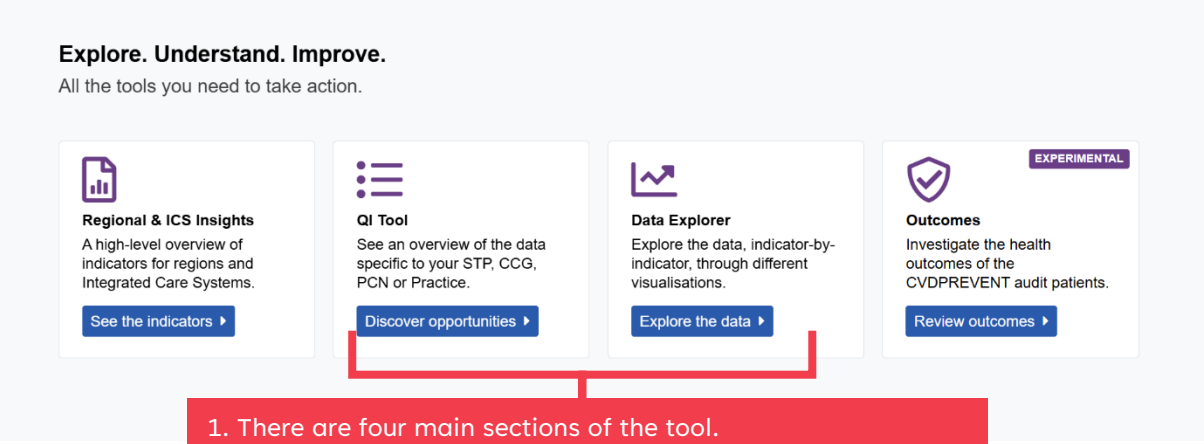
CVDPREVENT DATA & IMPROVEMENT TOOL

Go to the Data & Improvement Tool to find out how your organisation is performing against these new indicators. This Data & Improvement Tool enables you to drill down into the data, showing information at National, ICS, PCN and individual practice levels to enable teams to understand the performance of their services and potential improvement opportunities.

The tool is split into 4 mains sections (see screenshot below):

1. **Regional & ICS Insights** – A high-level overview of a curated list of indicators for regions and Integrated Care Systems. Data is displayed comparing your selected system or area to the national position. Select 'open indicator' to view time series data, inequalities time series data and area breakdowns for selected system or area.
2. **QI Tool** – An overview of all the data specific to your Region, ICB, Sub-ICB, PCN or Practice for QI purposes. Data is displayed comparing your selected system or area to the national position in time series format showing selected area's value trend from last two periods. **New indicators can be found here.**
3. **Data Explorer** – Allows users to explore all of the data, indicator-by-indicator, through different visualisations including inequality markers and area comparison. **New indicators can be found here.**
4. **Outcomes** – Investigate the health outcomes of CVDPREVENT audit patients by accessing this combined dataset that links CVDPREVENT data to hospital and death records.

How to use the Data & Improvement Tool to find new indicators



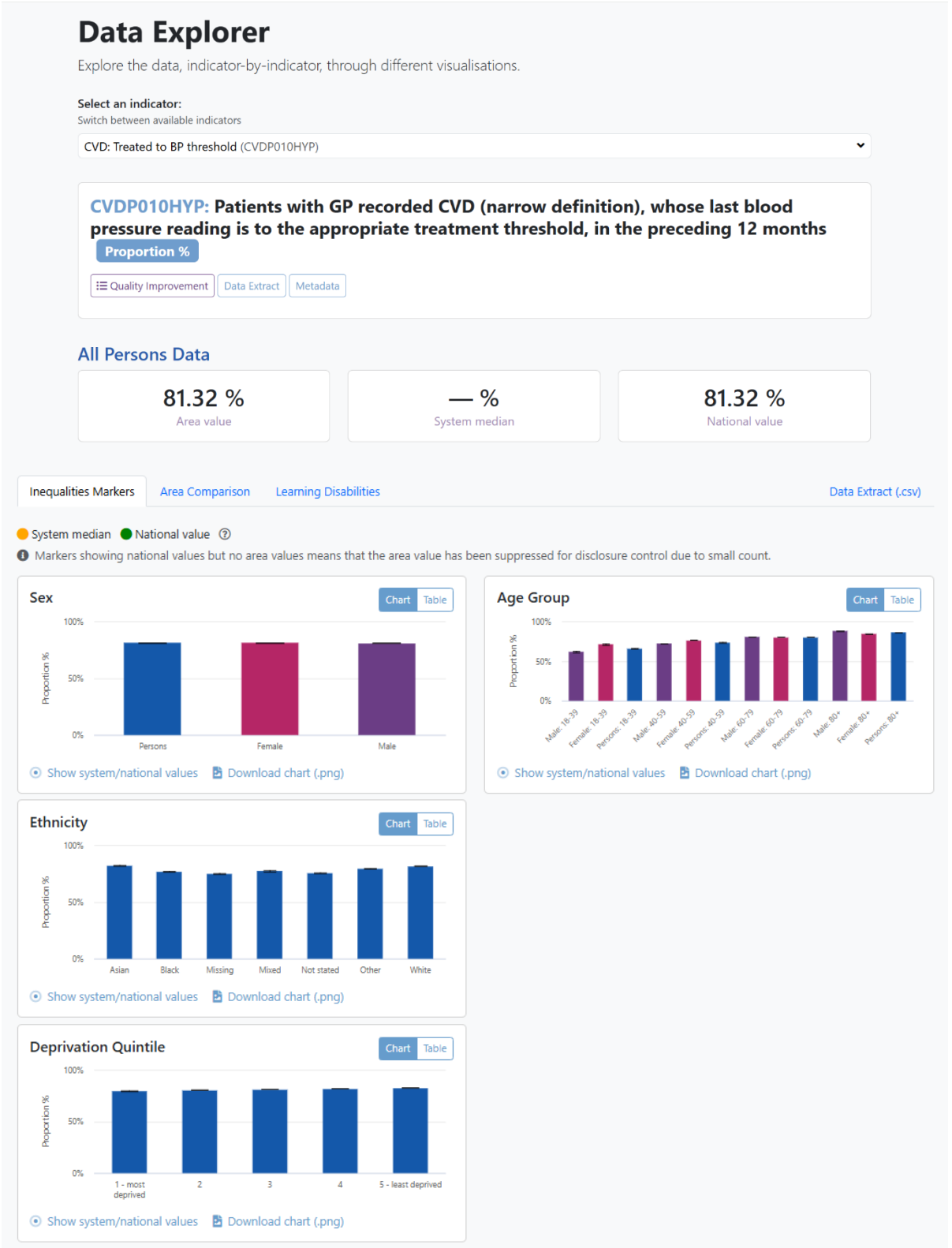
1. There are four main sections of the tool.

When initially published new indicators can be found on the QI tool and Data Explorer section.

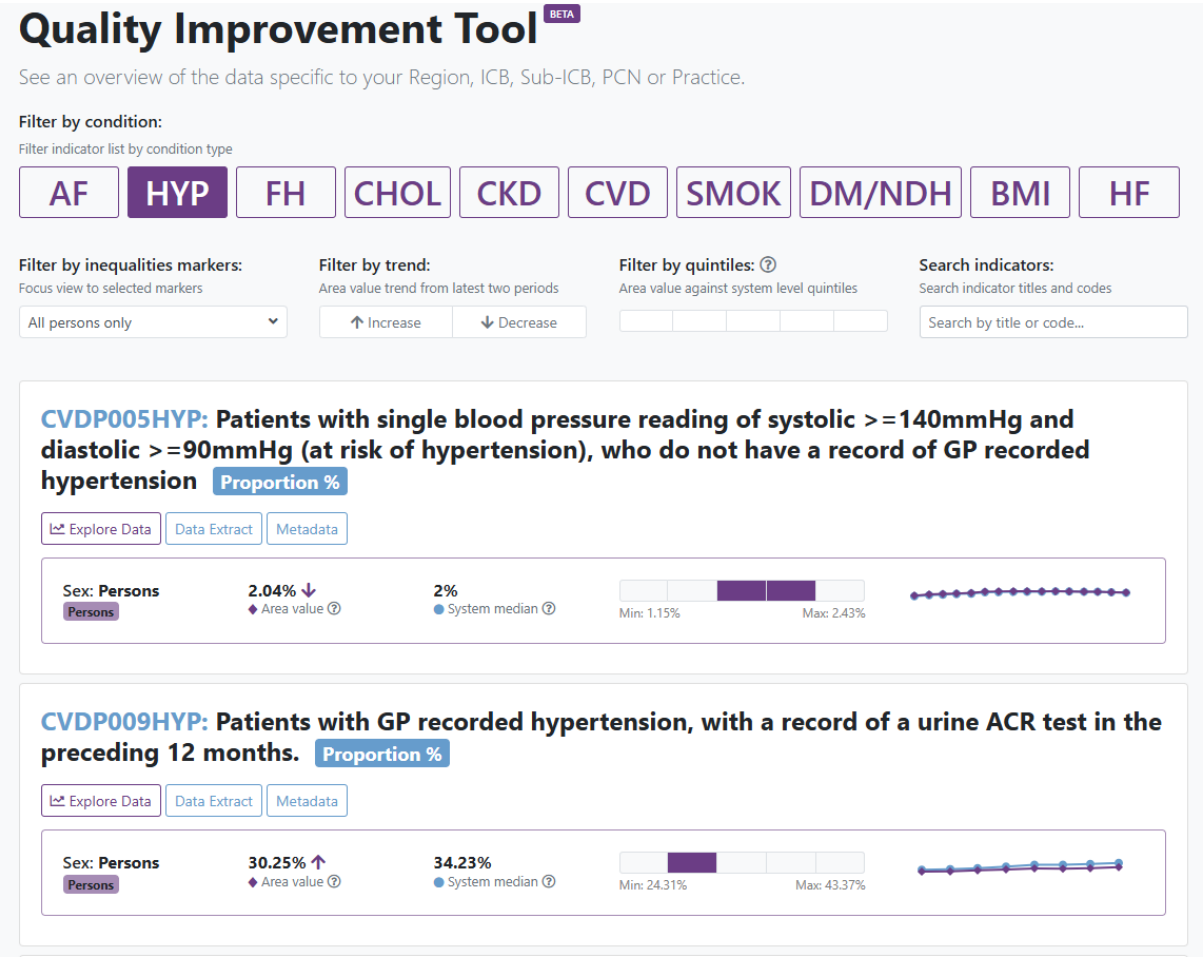
2. Use the blue bar to find the information that is relevant to you.

Choose the time period and type in your chosen system or area, or 'browse system levels' to choose your ICB, region, sub-ICB PCN or practice.

3a. For the data explorer view you can navigate through the charts health inequalities markers and benchmarked area comparative charts. These charts can also be viewed in table format providing information on the numerators and denominators behind each figure. Please select 'Metadata' if you wish to find out further information about each indicator.



3a. For the QI tool view you can navigate through the charts displaying time series data as well as selected area trend information. Selecting 'explore data' will take you to the data explorer view for the selected indicator, time period and area. Please select 'Metadata' if you wish to find out further information about each indicator.



Further information on how to navigate our data and improvement tool please watch our demonstration video which can be found **here**.

Please contact the CVDPREVENT support team via **nhsbn.cvdprevent@nhs.net** if you have any queries regarding this document or the navigation of the data and improvement tool.