

CVDPREVENT Master Indicator Guide



(covering all 57 indicators in the audit, as at September 2026)
Using data to drive cardiovascular disease prevention



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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 each of the indicators in the audit, as well as the national level position and alignment with national guidance. The Round 5 indicators have been introduced to the audit and have been published on the Data & Improvement Tool from the March 2026 data extract onwards.

All 57 active indicators in the audit are listed below, grouped by clinical area. The outcome indicators are grouped together at the end of the list and at the end of this guide.

Indicator list

Code	Indicator
ATRIAL FIBRILLATION	
CVDP001AF	Prevalence of GP recorded atrial fibrillation in patients aged 18 and over
CVDP002AF	Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy
CVDP004AF	Percentage of patients aged 18 and over with GP recorded atrial fibrillation (AF) whose latest CHADS2 or CHA2DS2-VASc is less than 2 or there is no CHADS2 or CHA2DS2-VASc score recorded, in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients currently receiving oral anticoagulants).

Code	Indicator
CVDP005AF	Percentage of patients aged 18 and over, with GP recorded AF and with a CHA2DS2-VASc score of 2 or more, who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.
HYPERTENSION	
CVDP001HYP	Prevalence of GP recorded hypertension in patients aged 18 and over
CVDP002HYP	Percentage of patients aged 18 to 79 years with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is equal to 140/90 mmHg or less
CVDP003HYP	Percentage of patients aged 80 years or over with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is 150/90 mmHg or less
CVDP004HYP	Percentage of patients aged 18 and over with GP recorded hypertension, who have had a blood pressure reading within the preceding 12 months
CVDP005HYP	Percentage of patients aged 18 and over, whose latest blood pressure value is in the at risk range for hypertension with no GP recorded hypertension
CVDP006HYP	Percentage of patients aged 18 and over with GP recorded hypertension, prescribed at least one anti-hypertensive treatment with last systolic BP 100mmHg or less and a subsequent antihypertension medication prescription date
CVDP007HYP	Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold.
CVDP009HYP	Percentage of patients aged 18 and over, with GP recorded hypertension, with a record of a urine albumin: creatinine ratio (or protein: creatinine ratio) testing in preceding 12 months.
CVDP010HYP	Patients with GP recorded CVD (narrow definition), whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months
FAMILIAL HYPERCHOLESTEROLAEMIA	
CVDP002FH	Prevalence of GP recorded possible, probable or confirmed familial hypercholesterolaemia, all ages (rate per 1,000 patients)
CVDP003FH	Prevalence of GP recorded genetically confirmed familial hypercholesterolaemia, all ages (rate per 100,000 patients)
CVDP004FH	Percentage of GP registered patients of all ages whose cholesterol values are in the at risk range for FH, with no GP record of FH diagnosis or investigation
CHOLESTEROL	
CVDP003CHOL	Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy
CVDP006CHOL	Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 10% or more, on lipid lowering therapy
CVDP008CHOL	Percentage of patients aged 18 and over, with no GP recorded CVD and a GP recorded QRISK score of 10% or more, CKD (G3a to G5), T1 diabetes (aged 40 and over) or T2 diabetes aged 60 and over, who are currently treated with lipid lowering therapy.
CVDP009CHOL	Percentage of patients aged 18 and over with GP recorded CVD (narrow definition), who are currently treated with lipid lowering therapy.

Code	Indicator
CVDP010CHOL	Percentage of patients aged 18 and over with GP recorded CKD (G3a to G5), who are currently treated with lipid lowering therapy.
CVDP011CHOL	Percentage of patients aged 18 and over, with GP recorded CVD (narrow definition), who have had a cholesterol test (non-HDL-C or LDL-C) within the preceding 12 months.
CVDP012CHOL	Patients with GP recorded CVD (narrow definition), 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
CHRONIC KIDNEY DISEASE	
CVDP001CKD	Prevalence of GP recorded CKD (G3a to G5) in patients aged 18 and over
CVDP002CKD	Percentage of GP registered patients aged 18 and over, with 2 low eGFRs with no GP recorded CKD (G3a to G5)
CVDP003CKD	Percentage of GP registered patients aged 18 and over, where the latest eGFR reading is low with no GP recorded CKD (G3a to G5)
CVDP004CKD	Percentage of patients aged 18 and over with GP recorded CKD (G3a to G5), with a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 12 months
CVDP005CKD	Percentage of patients aged 18 and over with GP recorded CKD (G3a to G5), hypertension and proteinuria, currently treated with renin-angiotensin system antagonists
CVDP006CKD	Percentage of patients aged 18 and over with GP recorded CKD (G3a to G5), with a record of an eGFR test in the preceding 12 months
CVDP007CKD	Percentage of patients aged 18 and over with GP recorded CKD (G3a to G5) with an ACR of less than 70 mg/mmol, in whom the last blood pressure reading (measured in the preceding 12 months) is less than 140/90 mmHg.
CVDP008CKD	Patients with GP recorded CKD (G3a to G5), who are currently treated with an SGLT2 inhibitor
CARDIOVASCULAR DISEASE	
CVDP001CVD	Prevalence of GP recorded cardiovascular disease (wide definition) in patients aged 18 and over
CVDP002CHD	Percentage of patients aged 18 and over, with GP recorded coronary heart disease (CHD), in whom the last blood pressure reading or equivalent home/ambulatory blood pressure reading (measured in the preceding 12 months) is below the age- appropriate treatment threshold.
CVDP002STRK	Percentage of patients aged 18 and over, with GP recorded stroke or TIA, in whom the last blood pressure reading or equivalent home/ambulatory blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold.
SMOKING	
CVDP001SMOK	Percentage of patients aged 18 and over with GP recorded CVD or CVD risk factors who are GP recorded current smokers or have no smoking status recorded, whose notes record smoking status in the preceding 12 months.
CVDP002SMOK	Percentage of patients aged 18 and over with GP recorded CVD or CVD risk factors who are GP recorded current smokers, who have a record of an offer of support or treatment within the preceding 12 months.
DIABETES MELLITUS AND NON-DIABETIC HYPERGLYCAEMIA	

Code	Indicator
CVDP002NDH	Percentage of patients aged 18 and over, whose last HbA1c record is 42mmol/mol or more but less than 48mmol/mol, who do not have a GP record of NDH or diabetes.
CVDP003DM	Percentage of patients aged 18 and over, whose last two HbA1c records are 48mmol/mol or more (uncoded diabetes), who do not have a GP record of diabetes.
CVDP005DM	Percentage of patients aged 18 and over, whose last single HbA1c record is 48 mmol/mol or more (possible diabetes), who do not have a GP record of diabetes or have uncoded diabetes.
CVDP006DM	Patients with GP recorded Type 2 Diabetes Mellitus, who are currently treated with an SGLT2 inhibitor
BMI	
CVDP001BMI	Percentage of patients aged 18 and over, with GP recorded CVD or CVD risk factors (excluding AAA), whose notes record BMI status in the preceding 12 months
HEART FAILURE	
CVDP001HF	Prevalence of GP recorded heart failure in patients aged 18 and over
CVDP002HF	Percentage of patients aged 18 and over, with GP recorded heart failure, with a record of an eGFR test in the preceding 6 months.
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
CARDIOVASCULAR-KIDNEY-METABOLIC (CVKM)	
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
OUTCOMES	
CVDP001MORT	All cause mortality among patients with GP recorded cardiovascular disease (wide definition) in patients aged 18 and over (Age standardised rate per 100,000 person years)
CVDP002MORT	Mortality from cardiovascular disease among patients with GP recorded cardiovascular disease (wide definition) in patients aged 18 and over (Age standardised rate per 100,000 person years)
CVDP003MORT	Mortality from stroke among patients with GP recorded cardiovascular disease (wide definition) in patients aged 18 and over (Age standardised rate per 100,000 person years)
CVDP004MORT	Mortality from heart attacks (MI) among patients with GP recorded cardiovascular disease (wide definition) in patients aged 18 and over (Ages standardised rate per 100,000 person years)
CVDP005MORT	All cause mortality among patients with GP recorded hypertension in patients aged 18 to 79 (Age standardised rate per 100,000 person years)

Code	Indicator
CVDP006MORT	Mortality from cardiovascular disease among patients with GP recorded hypertension in patients aged 18 to 79 (Age standardised rate per 100,000 person years)
CVDP007MORT	All cause mortality among patients with GP recorded high risk conditions for cardiovascular disease (Age standardised rate per 100,000 person years).
CVDP008MORT	Mortality from cardiovascular disease among patients with GP recorded high risk conditions for cardiovascular disease (Age standardised rate per 100,000)
CVDP001ADMN	Proportion of patients with GP recorded hypertension aged 18 to 79, who had a hospital admission with stroke as the primary cause (Age standardised proportion %)
CVDP002ADMN	Proportion of patients with GP recorded hypertension aged 18 to 79, who had a hospital admission with heart attack (MI) as the primary cause (Age standardised proportion %)

ATRIAL FIBRILLATION INDICATORS

Atrial fibrillation (AF) is a heart rhythm disorder in which the heart beats irregularly and often abnormally fast. AF increases the risk of stroke, because blood can collect in the heart and form clots. Many people with AF have no symptoms, so the condition may only be found during a routine pulse check or electrocardiogram (ECG).

Stroke risk in people with AF is assessed using a risk score. The CVDPREVENT AF indicators use the CHA2DS2-VASc score, which takes account of factors such as age, sex, hypertension, diabetes and previous stroke. Anticoagulation reduces the risk of AF-related stroke, and direct-acting oral anticoagulants (DOACs) are recommended as the first-line treatment for most eligible patients.

CVDP001AF: Prevalence of GP recorded atrial fibrillation in patients aged 18 and over

This indicator measures the recorded prevalence of atrial fibrillation (AF) in patients aged 18 and over. Many people with AF have no symptoms, so the condition may go undetected. Identifying AF allows stroke risk to be assessed and anticoagulation to be offered where appropriate.

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

Associated guidance: [NICE guidance NG196](#) (Atrial fibrillation: diagnosis and management), recommendations on the detection and diagnosis of AF.

Using this indicator: Differing levels of recorded AF prevalence can reflect differences in the age and risk profile of the local population as well as differences in case finding. Lower than expected recorded prevalence may indicate opportunities to improve detection, for example through opportunistic pulse checks. This indicator should be interpreted alongside local population characteristics.

Data breakdowns: Data for this indicator are published at England, region, ICB and sub-ICB level. Results can be broken down by age group, deprivation and sex at all levels, and by deprivation and sex (age standardised) from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP002AF: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy

This indicator measures the proportion of patients with AF and a CHA2DS2-VASc score of 2 or more who are currently treated with anticoagulation drug therapy. Anticoagulation reduces the risk of AF-related stroke in patients at increased risk.

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

Associated guidance: [NICE guidance NG196](#) (Atrial fibrillation: diagnosis and management), recommendations on stroke prevention and anticoagulation in AF.

Using this indicator: Differing levels of anticoagulation in eligible AF patients can be an indicator of variation in the quality of care. Higher proportions of eligible patients treated with anticoagulation represent better quality of care. Lower proportions may indicate opportunities to review patients who are not currently treated, taking account of bleeding risk and patient choice.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP004AF: Percentage of patients aged 18 and over with GP recorded atrial fibrillation (AF) whose latest CHADS2 or CHA2DS2-VASc is less than 2 or there is no CHADS2 or CHA2DS2-VASc score recorded, in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients currently receiving oral anticoagulants).

This indicator measures the proportion of AF patients whose latest stroke risk score is less than 2, or who have no score recorded, and who are not currently receiving oral anticoagulants, who have had their stroke risk assessed using the CHA2DS2-VASc score in the preceding 12 months. Stroke risk can change over time, for example as patients get older or develop new conditions, so regular reassessment helps to identify patients who have become eligible for anticoagulation.

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

Associated guidance: [NICE guidance NG196](#) (Atrial fibrillation: diagnosis and management), recommendations on assessing stroke risk in people with AF.

Using this indicator: Higher proportions of patients with an up to date stroke risk assessment represent better quality of care. Lower proportions may indicate that some patients whose stroke risk has increased are not being identified for anticoagulation. This indicator can be used to identify areas of good practice and areas for improvement.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP005AF: Percentage of patients aged 18 and over, with GP recorded AF and with a CHA2DS2-VASc score of 2 or more, who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.

This indicator measures the proportion of AF patients with a CHA2DS2-VASc score of 2 or more who were prescribed a direct-acting oral anticoagulant (DOAC), or a vitamin K antagonist where a DOAC was declined or clinically unsuitable. DOACs are recommended as the first-line anticoagulant for most eligible patients with AF.

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

Associated guidance: [NICE guidance NG196](#) (Atrial fibrillation: diagnosis and management), recommendations on the choice of anticoagulant.

Using this indicator: Differing levels of DOAC prescribing in eligible AF patients can be an indicator of variation in the quality of care. Higher proportions represent better alignment with current guidance on anticoagulant choice. Lower proportions may indicate opportunities to review anticoagulant treatment with patients.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[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.

CVDP001HYP: Prevalence of GP recorded hypertension in patients aged 18 and over

This indicator measures the recorded prevalence of hypertension in patients aged 18 and over. Hypertension rarely causes symptoms, so many people are unaware that they have it. Identifying hypertension allows treatment to be started to reduce the risk of heart attack and stroke.

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

Associated guidance: [NICE guidance NG136](#) (Hypertension in adults: diagnosis and management), recommendations on diagnosing hypertension.

Using this indicator: Differing levels of recorded hypertension prevalence can reflect differences in the age and risk profile of the local population as well as differences in case finding. Lower than expected recorded prevalence may indicate opportunities to improve detection, for example through opportunistic blood pressure checks. This indicator should be interpreted alongside local population characteristics.

Data breakdowns: Data for this indicator are published at England, region, ICB and sub-ICB level. Results can be broken down by age group, deprivation and sex at all levels, and by deprivation and sex (age standardised) from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP002HYP: Percentage of patients aged 18 to 79 years with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is equal to 140/90 mmHg or less

This indicator measures the proportion of patients aged 18 to 79 with hypertension whose last blood pressure reading in the preceding 12 months is 140/90 mmHg or less. Treating blood pressure to the appropriate threshold reduces the risk of heart attack and stroke.

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 for people aged under 80.

Using this indicator: Differing levels of blood pressure control in patients with hypertension aged 18 to 79 can be an indicator of variation in the quality of care. Higher proportions of patients with blood pressure treated to the appropriate threshold represent better quality of care and reduced risk of 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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP003HYP: Percentage of patients aged 80 years or over with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is 150/90 mmHg or less

This indicator measures the proportion of patients aged 80 and over with hypertension whose last blood pressure reading in the preceding 12 months is 150/90 mmHg or less. A higher treatment threshold applies for people aged 80 and over.

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 for people aged 80 and over.

Using this indicator: Differing levels of blood pressure control in patients with hypertension aged 80 and over can be an indicator of variation in the quality of care. Higher proportions of patients with blood pressure treated to the appropriate threshold represent better quality of care and reduced risk of 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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP004HYP: Percentage of patients aged 18 and over with GP recorded hypertension, who have had a blood pressure reading within the preceding 12 months

This indicator measures the proportion of patients with hypertension who have had a blood pressure reading in the preceding 12 months. Regular monitoring, at least annually, allows treatment to be reviewed and adjusted so that blood pressure is kept within the appropriate threshold.

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

Associated guidance: [NICE guidance NG136](#) (Hypertension in adults: diagnosis and management), recommendations on monitoring and reviewing treatment.

Using this indicator: Differing levels of blood pressure monitoring can be an indicator of variation in the quality of care. Higher proportions of patients with a recent blood pressure reading represent better quality of care. Lower proportions may indicate opportunities to improve recall and review processes.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP005HYP: Percentage of patients aged 18 and over, whose latest blood pressure value is in the at risk range for hypertension with no GP recorded hypertension

This indicator measures the proportion of patients aged 18 and over whose latest blood pressure reading is in the at risk range for hypertension, but who do not have a GP record of hypertension. These patients may have undiagnosed hypertension and could benefit from further assessment to confirm or rule out a diagnosis.

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

Associated guidance: [NICE guidance NG136](#) (Hypertension in adults: diagnosis and management), recommendations on confirming a diagnosis of hypertension.

Using this indicator: Lower proportions represent better quality of care, as fewer patients with readings in the at risk range are without a diagnosis or follow-up. Higher proportions may indicate opportunities for case finding and review. The at risk range is set out in the indicator metadata.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and deprivation from England down to sub-ICB level, and by deprivation and sex (age standardised) from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP006HYP: Percentage of patients aged 18 and over with GP recorded hypertension, prescribed at least one anti-hypertensive treatment with last systolic BP 100mmHg or less and a subsequent antihypertension medication prescription date

This indicator identifies patients with hypertension, prescribed at least one antihypertensive treatment, whose last systolic blood pressure was 100 mmHg or less and who have been issued a subsequent antihypertensive prescription. Low blood pressure in patients on antihypertensive treatment can cause dizziness and increase the risk of falls, so these patients may benefit from a medication review.

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

Associated guidance: [NICE guidance NG136](#) (Hypertension in adults: diagnosis and management), recommendations on reviewing antihypertensive treatment.

Using this indicator: Lower proportions may represent better quality of care, as fewer patients continue on antihypertensive treatment despite low blood pressure. Higher proportions may indicate opportunities to review treatment and reduce the risk of overtreatment. Individual circumstances should be considered, as some patients may have a clinical reason for continued treatment.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP007HYP: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold.

This indicator measures the proportion of patients with hypertension whose last blood pressure reading in the preceding 12 months is below the age appropriate treatment threshold. It brings together the age-specific thresholds used in CVDP002HYP and CVDP003HYP to give an overall measure of blood pressure control in hypertension.

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

Associated guidance: [NICE guidance NG136](#) (Hypertension in adults: diagnosis and management), recommendations on age-specific blood pressure targets.

Using this indicator: Differing levels of blood pressure control in patients with hypertension can be an indicator of variation in the quality of care. Higher proportions of patients with blood pressure treated to the appropriate threshold represent better quality of care and reduced risk of 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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP009HYP: Percentage of patients aged 18 and over, with GP recorded hypertension, with a record of a urine albumin: creatinine ratio (or protein: creatinine ratio) testing in preceding 12 months.

This indicator measures the proportion of patients with hypertension who have had a urine albumin:creatinine ratio (ACR) or protein:creatinine ratio test in the preceding 12 months. Urine ACR testing detects protein in the urine, which can be an early sign of kidney damage. Identifying kidney damage early allows treatment to be adjusted to protect kidney function and reduce cardiovascular risk.

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

Associated guidance: [NICE guidance NG136](#) (Hypertension in adults: diagnosis and management), recommendations on assessing target organ damage, and [NICE guidance NG203](#) (Chronic kidney disease: assessment and management), recommendations on testing for CKD.

Using this indicator: Higher proportions of patients with hypertension who have had a urine ACR test represent better quality of care. Lower proportions may indicate opportunities to improve testing, so that kidney damage is identified and managed earlier. This indicator can be used to identify areas of good practice and areas for improvement.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

FAMILIAL HYPERCHOLESTEROLAEMIA INDICATORS

Familial hypercholesterolaemia (FH) is an inherited condition that causes high cholesterol levels from birth. Without treatment, people with FH are at increased risk of developing heart disease at a young age.

Most people with FH have not been diagnosed. Because FH is inherited, identifying one person with the condition allows their relatives to be offered testing (cascade testing), so early detection can benefit whole families.

CVDP002FH: Prevalence of GP recorded possible, probable or confirmed familial hypercholesterolaemia, all ages (rate per 1,000 patients)

This indicator measures the recorded prevalence of possible, probable or confirmed familial hypercholesterolaemia (FH) across all ages, as a rate per 1,000 patients. Recording FH supports appropriate treatment and allows relatives to be offered testing.

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

Associated guidance: [NICE guidance CG71](#) (Familial hypercholesterolaemia: identification and management), recommendations on identifying and diagnosing FH.

Using this indicator: Differing levels of recorded FH prevalence can reflect differences in the age and risk profile of the local population as well as differences in case finding. Lower than expected recorded prevalence may indicate opportunities to improve detection, for example by reviewing patients with very high cholesterol levels. This indicator should be interpreted alongside local population characteristics.

Data breakdowns: Data for this indicator are published at England, region, ICB and sub-ICB level. Results can be broken down by sex at all levels, and by age group and deprivation from England down to region level.

[Click here to find the metadata for this indicator.](#)

CVDP003FH: Prevalence of GP recorded genetically confirmed familial hypercholesterolaemia, all ages (rate per 100,000 patients)

This indicator measures the recorded prevalence of genetically confirmed FH across all ages, as a rate per 100,000 patients. Genetic testing confirms the diagnosis and allows the specific variant to be used for cascade testing of relatives.

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

Associated guidance: [NICE guidance CG71](#) (Familial hypercholesterolaemia: identification and management), recommendations on DNA testing and cascade testing.

Using this indicator: Differing rates of genetically confirmed FH can reflect differences in access to and uptake of genetic testing, as well as differences in local populations. Lower rates may indicate opportunities to refer patients with a clinical diagnosis of FH for genetic testing. This indicator should be interpreted alongside CVDP002FH.

Data breakdowns: Data for this indicator are published at England, region and ICB level. Results can be broken down by deprivation and sex from England down to region level, and by age group at England level.

[Click here to find the metadata for this indicator.](#)

CVDP004FH: Percentage of GP registered patients of all ages whose cholesterol values are in the at risk range for FH, with no GP record of FH diagnosis or investigation

This indicator measures the proportion of patients of all ages whose cholesterol values are in the at risk range for FH, with no GP record of an FH diagnosis or investigation. These patients may have undiagnosed FH and could benefit from further assessment.

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

Associated guidance: [NICE guidance CG71](#) (Familial hypercholesterolaemia: identification and management), recommendations on identifying people with possible FH.

Using this indicator: Lower proportions represent better quality of care, as fewer patients with cholesterol in the at risk range are without an FH diagnosis or investigation. Higher proportions may indicate opportunities for case finding and referral. The at risk range is set out in the indicator metadata.

Data breakdowns: Data for this indicator are published at England, region, ICB and sub-ICB level. Results can be broken down by age group, deprivation and sex at all levels.

[Click here to find the metadata for this indicator.](#)

CHOLESTEROL INDICATORS

Cholesterol is a fatty substance carried in the blood. High levels of non-HDL cholesterol, which includes low-density lipoprotein (LDL) cholesterol, contribute to the build-up of fatty deposits in the arteries and increase the risk of heart attack and stroke.

Lipid lowering therapy, most commonly statins, reduces the risk of cardiovascular events. It is recommended for people with established CVD (secondary prevention), and for people without CVD who are at increased risk, for example those with a QRISK score of 10% or more or with chronic kidney disease (primary prevention). QRISK estimates a person's risk of having a heart attack or stroke over the next ten years.

For secondary prevention, NICE guidance NG238 recommends aiming for an LDL-cholesterol level of 2.0 mmol/l or less, or a non-HDL cholesterol level of 2.6 mmol/l or less.

CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy

This indicator measures the proportion of patients without CVD who have a QRISK score of 20% or more and are on lipid lowering therapy. A QRISK score estimates a person's risk of having a heart attack or stroke over the next ten years, and a score of 20% or more indicates a high risk.

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

Associated guidance: [NICE guidance NG238](#) (Cardiovascular disease: risk assessment and reduction, including lipid modification), recommendations on lipid lowering therapy for primary prevention.

Using this indicator: Higher proportions of high risk patients on lipid lowering therapy represent better quality of care. Lower proportions may indicate opportunities to discuss treatment with patients at high risk. This indicator should be considered alongside CVDP006CHOL, which uses the lower QRISK threshold of 10%.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP006CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 10% or more, on lipid lowering therapy

This indicator measures the proportion of patients without CVD who have a QRISK score of 10% or more and are on lipid lowering therapy. NICE guidance recommends offering lipid lowering therapy for primary

prevention to people with a QRISK score of 10% or more, following a discussion about the risks and benefits.

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

Associated guidance: [NICE guidance NG238](#) (Cardiovascular disease: risk assessment and reduction, including lipid modification), recommendations on lipid lowering therapy for primary prevention.

Using this indicator: Higher proportions of eligible patients on lipid lowering therapy represent better alignment with current guidance. Lower proportions may indicate opportunities to discuss treatment with eligible patients. Patient choice following an informed discussion should be taken into account when interpreting this indicator.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP008CHOL: Percentage of patients aged 18 and over, with no GP recorded CVD and a GP recorded QRISK score of 10% or more, CKD (G3a to G5), T1 diabetes (aged 40 and over) or T2 diabetes aged 60 and over, who are currently treated with lipid lowering therapy.

This indicator measures the proportion of patients without CVD who are eligible for lipid lowering therapy for primary prevention (QRISK score of 10% or more, CKD (G3a to G5), type 1 diabetes aged 40 and over, or type 2 diabetes aged 60 and over) and who are currently treated with lipid lowering therapy.

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

Associated guidance: [NICE guidance NG238](#) (Cardiovascular disease: risk assessment and reduction, including lipid modification), recommendations on lipid lowering therapy for primary prevention.

Using this indicator: Higher proportions of eligible patients currently treated with lipid lowering therapy represent better alignment with current guidance. Lower proportions may indicate opportunities to discuss treatment with eligible patients. Patient choice following an informed discussion should be taken into account when interpreting this indicator.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP009CHOL: Percentage of patients aged 18 and over with GP recorded CVD (narrow definition), who are currently treated with lipid lowering therapy.

This indicator measures the proportion of patients with CVD (narrow definition) who are currently treated with lipid lowering therapy.

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

Associated guidance: [NICE guidance NG238](#) (Cardiovascular disease: risk assessment and reduction, including lipid modification), recommendations on lipid lowering therapy for secondary prevention.

Using this indicator: Differing levels of current lipid lowering treatment in CVD patients can be an indicator of variation in the quality of care. Higher proportions represent better quality of secondary prevention care. Lower proportions may indicate opportunities to review patients who have stopped or never started treatment.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP010CHOL: Percentage of patients aged 18 and over with GP recorded CKD (G3a to G5), who are currently treated with lipid lowering therapy.

This indicator measures the proportion of patients with CKD (G3a to G5) who are currently treated with lipid lowering therapy.

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

Associated guidance: [NICE guidance NG238](#) (Cardiovascular disease: risk assessment and reduction, including lipid modification) and [NICE guidance NG203](#) (Chronic kidney disease: assessment and management), recommendations on lipid lowering therapy in CKD.

Using this indicator: Differing levels of current lipid lowering treatment in CKD patients can be an indicator of variation in the quality of care. Higher proportions represent better quality of care. Lower proportions may indicate opportunities to review patients who have stopped or never started treatment.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP011CHOL: Percentage of patients aged 18 and over, with GP recorded CVD (narrow definition), who have had a cholesterol test (non-HDLC or LDL-C) within the preceding 12 months.

This indicator measures the proportion of patients with CVD (narrow definition) who have had a cholesterol test (non-HDL cholesterol or LDL-cholesterol) in the preceding 12 months. Regular testing allows the response to treatment to be monitored and treatment to be adjusted where needed.

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

Associated guidance: [NICE guidance NG238](#) (Cardiovascular disease: risk assessment and reduction, including lipid modification), recommendations on monitoring lipid lowering therapy.

Using this indicator: Higher proportions of CVD patients with a recent cholesterol test represent better quality of care. Lower proportions may indicate opportunities to improve recall and review processes. This indicator can be used alongside CVD012CHOL, which relies on a recent cholesterol test.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVD012CHOL: Patients with GP recorded CVD (narrow definition), 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 patients with CVD (narrow definition) whose most recent cholesterol level in the preceding 12 months 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. These thresholds reflect the secondary prevention targets in NICE guidance NG238.

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

Associated guidance: [NICE guidance NG238](#) (Cardiovascular disease: risk assessment and reduction, including lipid modification), recommendations on lipid targets for secondary prevention.

Using this indicator: Higher proportions of CVD patients with cholesterol treated to these thresholds represent better quality of secondary prevention care. Lower proportions may indicate opportunities to review and optimise lipid lowering treatment. This indicator can be used to identify areas of good practice and areas for improvement.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[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.

CVDP001CKD: Prevalence of GP recorded CKD (G3a to G5) in patients aged 18 and over

This indicator measures the recorded prevalence of CKD (G3a to G5) in patients aged 18 and over. CKD is often asymptomatic in its earlier stages, so it may not be recorded even where test results indicate the condition.

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

Associated guidance: [NICE guidance NG203](#) (Chronic kidney disease: assessment and management), recommendations on identifying and classifying CKD.

Using this indicator: Differing levels of recorded CKD prevalence can reflect differences in the age and risk profile of the local population as well as differences in case finding. Lower than expected recorded prevalence may indicate opportunities to improve detection, for example by reviewing patients with low eGFR results who do not have CKD recorded (see CVDP002CKD and CVDP003CKD). This indicator should be interpreted alongside local population characteristics.

Data breakdowns: Data for this indicator are published at England, region, ICB and sub-ICB level. Results can be broken down by age group, deprivation and sex at all levels, and by deprivation and sex (age standardised) from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP002CKD: Percentage of GP registered patients aged 18 and over, with 2 low eGFRs with no GP recorded CKD (G3a to G5)

This indicator measures the proportion of patients aged 18 and over with two low eGFR readings who do not have CKD (G3a to G5) recorded. These patients may have undiagnosed or uncoded CKD and could benefit from review.

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

Associated guidance: [NICE guidance NG203](#) (Chronic kidney disease: assessment and management), recommendations on diagnosing CKD.

Using this indicator: Lower proportions represent better quality of care, as fewer patients with test results indicating CKD are without a diagnosis. Higher proportions may indicate opportunities to review and code patients, so that they can be offered appropriate monitoring and treatment.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and deprivation from England down to sub-ICB level, and by deprivation and sex (age standardised) from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP003CKD: Percentage of GP registered patients aged 18 and over, where the latest eGFR reading is low with no GP recorded CKD (G3a to G5)

This indicator measures the proportion of patients aged 18 and over whose latest eGFR reading is low and who do not have CKD (G3a to G5) recorded. A single low reading does not confirm CKD, but these patients may benefit from a repeat test to confirm or rule out a diagnosis.

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

Associated guidance: [NICE guidance NG203](#) (Chronic kidney disease: assessment and management), recommendations on diagnosing CKD.

Using this indicator: Lower proportions represent better quality of care, as fewer patients with a low eGFR are without follow-up. Higher proportions may indicate opportunities to arrange repeat testing. This indicator should be considered alongside CVDP002CKD.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and deprivation from England down to sub-ICB level, and by deprivation and sex (age standardised) from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP004CKD: Percentage of patients aged 18 and over with GP recorded CKD (G3a to G5), with a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 12 months

This indicator measures the proportion of patients with CKD (G3a to G5) who have had a urine ACR (or protein:creatinine ratio) test in the preceding 12 months. ACR testing is used alongside eGFR to classify CKD and to assess the risk of disease progression.

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

Associated guidance: [NICE guidance NG203](#) (Chronic kidney disease: assessment and management), recommendations on monitoring CKD.

Using this indicator: Higher proportions of CKD patients with a recent ACR test represent better quality of care. Lower proportions may indicate opportunities to improve monitoring, so that patients at higher risk of progression are identified. This indicator can be used to identify areas of good practice and areas for improvement.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP005CKD: Percentage of patients aged 18 and over with GP recorded CKD (G3a to G5), hypertension and proteinuria, currently treated with renin-angiotensin system antagonists

This indicator measures the proportion of patients with CKD (G3a to G5), hypertension and proteinuria who are currently treated with a renin-angiotensin system antagonist, such as an ACE inhibitor or angiotensin receptor blocker. In these patients, renin-angiotensin system antagonists reduce blood pressure and slow the progression of kidney disease.

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

Associated guidance: [NICE guidance NG203](#) (Chronic kidney disease: assessment and management), recommendations on blood pressure control and renin-angiotensin system antagonists in CKD.

Using this indicator: Higher proportions of eligible patients treated with a renin-angiotensin system antagonist represent better quality of 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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP006CKD: Percentage of patients aged 18 and over with GP recorded CKD (G3a to G5), with a record of an eGFR test in the preceding 12 months

This indicator measures the proportion of patients with CKD (G3a to G5) who have had an eGFR test in the preceding 12 months. Regular eGFR testing allows changes in kidney function to be identified and treatment to be adjusted.

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

Associated guidance: [NICE guidance NG203](#) (Chronic kidney disease: assessment and management), recommendations on monitoring CKD.

Using this indicator: Higher proportions of CKD patients with a recent eGFR test represent better quality of care. Lower proportions may indicate opportunities to improve recall and review processes. This indicator can be used to identify areas of good practice and areas for improvement.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP007CKD: Percentage of patients aged 18 and over with GP recorded CKD (G3a to G5) with an ACR of less than 70 mg/mmol, in whom the last blood pressure reading (measured in the preceding 12 months) is less than 140/90 mmHg.

This indicator measures the proportion of patients with CKD (G3a to G5) and an ACR of less than 70 mg/mmol whose last blood pressure reading in the preceding 12 months is less than 140/90 mmHg. Blood pressure control in CKD reduces cardiovascular risk and slows disease progression.

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

Associated guidance: [NICE guidance NG203](#) (Chronic kidney disease: assessment and management) and [NICE guidance NG136](#) (Hypertension in adults: diagnosis and management), recommendations on blood pressure targets in CKD.

Using this indicator: Differing levels of blood pressure control in patients with CKD can be an indicator of variation in the quality of care. Higher proportions of patients with blood pressure treated to the appropriate threshold represent better quality of care and reduced risk of 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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CARDIOVASCULAR DISEASE INDICATORS

Cardiovascular disease (CVD) is a general term for conditions affecting the heart or blood vessels, including coronary heart disease (CHD), stroke and transient ischaemic attack (TIA), and peripheral arterial disease.

CVDPREVENT uses two definitions of CVD. The narrow definition covers coronary heart disease, peripheral arterial disease, non-haemorrhagic stroke and transient ischaemic attack. The wide definition covers a broader set of cardiovascular conditions, as set out in the indicator metadata. For people with established CVD, managing risk factors such as blood pressure and cholesterol (secondary prevention) reduces the risk of further events.

CVDP001CVD: Prevalence of GP recorded cardiovascular disease (wide definition) in patients aged 18 and over

This indicator measures the recorded prevalence of cardiovascular disease (wide definition) in patients aged 18 and over. The conditions included in the wide definition are set out in the indicator metadata.

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

Associated guidance: [NICE guidance NG238](#) (Cardiovascular disease: risk assessment and reduction, including lipid modification), recommendations on secondary prevention in people with CVD.

Using this indicator: Differing levels of recorded CVD prevalence can reflect differences in the age and risk profile of the local population as well as differences in recording. This indicator provides context for the other CVD indicators in this guide and should be interpreted alongside local population characteristics.

Data breakdowns: Data for this indicator are published at England, region, ICB and sub-ICB level. Results can be broken down by age group, deprivation and sex at all levels, and by deprivation and sex (age standardised) from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP002CHD: Percentage of patients aged 18 and over, with GP recorded coronary heart disease (CHD), in whom the last blood pressure reading or equivalent home/ambulatory blood pressure reading (measured in the preceding 12 months) is below the age- appropriate treatment threshold.

This indicator measures the proportion of patients with coronary heart disease (CHD) whose last blood pressure reading in the preceding 12 months, or equivalent home or ambulatory reading, is below the age appropriate treatment threshold. Blood pressure control is a key element of secondary prevention in CHD.

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.

Using this indicator: Differing levels of blood pressure control in CHD patients can be an indicator of variation in the quality of care. Higher proportions of patients with blood pressure treated to the appropriate threshold represent better quality of care and reduced risk of 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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP002STRK: Percentage of patients aged 18 and over, with GP recorded stroke or TIA, in whom the last blood pressure reading or equivalent home/ambulatory blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold.

This indicator measures the proportion of patients with a history of stroke or TIA whose last blood pressure reading in the preceding 12 months, or equivalent home or ambulatory reading, is below the age appropriate treatment threshold. Blood pressure control reduces the risk of a further stroke.

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.

Using this indicator: Differing levels of blood pressure control in stroke and TIA patients can be an indicator of variation in the quality of care. Higher proportions of patients with blood pressure treated to the appropriate threshold represent better quality of care and reduced risk of 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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

SMOKING INDICATORS

Smoking is one of the main modifiable risk factors for CVD. Stopping smoking at any age reduces the risk of heart attack and stroke. Recording smoking status and offering support to stop are key parts of CVD prevention for people who have CVD or risk factors for it.

CVDP001SMOK: Percentage of patients aged 18 and over with GP recorded CVD or CVD risk factors who are GP recorded current smokers or have no smoking status recorded, whose notes record smoking status in the preceding 12 months.

This indicator measures the proportion of patients with CVD or CVD risk factors, who are recorded as current smokers or have no smoking status recorded, whose smoking status has been recorded in the preceding 12 months. An up to date smoking status allows patients who smoke to be offered support to stop.

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

Associated guidance: [NICE guidance NG209](#) (Tobacco: preventing uptake, promoting quitting and treating dependence), recommendations on asking about and recording smoking status.

Using this indicator: Higher proportions of patients with a recent smoking status recorded represent better quality of care. Lower proportions may indicate opportunities to ask about smoking at routine reviews. This indicator can be used to identify areas of good practice and areas for improvement.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England

down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP002SMOK: Percentage of patients aged 18 and over with GP recorded CVD or CVD risk factors who are GP recorded current smokers, who have a record of an offer of support or treatment within the preceding 12 months.

This indicator measures the proportion of patients with CVD or CVD risk factors who are recorded as current smokers and who have a record of an offer of support or treatment to stop smoking in the preceding 12 months. Stopping smoking at any age reduces the risk of heart attack and stroke.

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

Associated guidance: [NICE guidance NG209](#) (Tobacco: preventing uptake, promoting quitting and treating dependence), recommendations on offering stop smoking support.

Using this indicator: Higher proportions of current smokers with a recorded offer of support represent better quality of care. Lower proportions may indicate opportunities to offer support or referral to stop smoking services. This indicator can be used to identify areas of good practice and areas for improvement.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

DIABETES MELLITUS AND NON-DIABETIC HYPERGLYCAEMIA 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.

Non-diabetic hyperglycaemia (NDH), sometimes called prediabetes, describes raised blood glucose levels that are not in the diabetic range (an HbA1c of 42 to 47 mmol/mol). People with NDH are at increased risk of developing type 2 diabetes, and this risk can be reduced through lifestyle change. An HbA1c of 48

mmol/mol or above is consistent with diabetes. Patients whose results fall in these ranges but who have no corresponding record may be missing out on appropriate care.

CVDP002NDH: Percentage of patients aged 18 and over, whose last HbA1c record is 42mmol/mol or more but less than 48mmol/mol, who do not have a GP record of NDH or diabetes.

This indicator measures the proportion of patients aged 18 and over whose last HbA1c is 42 mmol/mol or more but less than 48 mmol/mol, who do not have a GP record of non-diabetic hyperglycaemia (NDH) or diabetes. These patients may not have been identified as at increased risk of type 2 diabetes.

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

Associated guidance: [NICE guidance PH38](#) (Type 2 diabetes: prevention in people at high risk), recommendations on identifying people at high risk and offering intensive lifestyle support.

Using this indicator: Lower proportions represent better quality of care, as fewer patients with HbA1c results in the NDH range are without a record. Higher proportions may indicate opportunities to code patients and offer lifestyle support, including referral to the NHS Diabetes Prevention Programme where eligible.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and deprivation from England down to sub-ICB level, and by deprivation and sex (age standardised) from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP003DM: Percentage of patients aged 18 and over, whose last two HbA1c records are 48mmol/mol or more (uncoded diabetes), who do not have a GP record of diabetes.

This indicator measures the proportion of patients aged 18 and over whose last two HbA1c results are 48 mmol/mol or more, who do not have a GP record of diabetes. These patients may have diabetes that has not been recorded (uncoded diabetes).

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

Associated guidance: [NICE guidance NG28](#) (Type 2 diabetes in adults: management), recommendations on the management of type 2 diabetes.

Using this indicator: Lower proportions represent better quality of care, as fewer patients with test results in the diabetic range are without a diagnosis. Higher proportions may indicate opportunities to review and code patients, so that they can be offered appropriate treatment and monitoring.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and deprivation from England down to sub-ICB level, and by deprivation and sex (age standardised) from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP005DM: Percentage of patients aged 18 and over, whose last single HbA1c record is 48 mmol/mol or more (possible diabetes), who do not have a GP record of diabetes or have uncoded diabetes.

This indicator measures the proportion of patients aged 18 and over whose last single HbA1c result is 48 mmol/mol or more, who do not have a GP record of diabetes and do not meet the uncoded diabetes definition in CVDP003DM. A single raised result does not confirm diabetes, but these patients may benefit from a repeat test.

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

Associated guidance: [NICE guidance NG28](#) (Type 2 diabetes in adults: management), recommendations on the management of type 2 diabetes.

Using this indicator: Lower proportions represent better quality of care, as fewer patients with a raised HbA1c are without follow-up. Higher proportions may indicate opportunities to arrange repeat testing. This indicator should be considered alongside CVDP003DM.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and deprivation from England down to sub-ICB level, and by deprivation and sex (age standardised) from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

BMI INDICATORS

Obesity is a risk factor for CVD, type 2 diabetes, hypertension and chronic kidney disease. Body mass index (BMI) is a measure of whether a person is a healthy weight for their height. Regular recording of BMI supports the identification of patients who may benefit from weight management support.

CVDP001BMI: Percentage of patients aged 18 and over, with GP recorded CVD or CVD risk factors (excluding AAA), whose notes record BMI status in the preceding 12 months

This indicator measures the proportion of patients with CVD or CVD risk factors (excluding AAA) whose BMI has been recorded in the preceding 12 months. An up to date BMI supports the identification of patients who may benefit from weight management support.

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

Associated guidance: [NICE guidance NG246](#) (Overweight and obesity management), recommendations on measuring and recording BMI.

Using this indicator: Higher proportions of patients with a recent BMI recorded represent better quality of care. Lower proportions may indicate opportunities to record BMI at routine reviews. This indicator can be used to identify areas of good practice and areas for improvement.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

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.

CVDP001HF: Prevalence of GP recorded heart failure in patients aged 18 and over

This indicator measures the recorded prevalence of heart failure in patients aged 18 and over. Symptoms of heart failure can be mistaken for other conditions, so accurate diagnosis and recording supports access to treatment.

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

Associated guidance: [NICE guidance NG106](#) (Chronic heart failure in adults: diagnosis and management), recommendations on diagnosing heart failure.

Using this indicator: Differing levels of recorded heart failure prevalence can reflect differences in the age and risk profile of the local population as well as differences in case finding. Lower than expected recorded prevalence may indicate opportunities to improve detection, for example through timely assessment of patients with symptoms such as breathlessness. This indicator should be interpreted alongside local population characteristics.

Data breakdowns: Data for this indicator are published at England, region, ICB and sub-ICB level. Results can be broken down by age group, deprivation and sex at all levels, and by deprivation and sex (age standardised) from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

CVDP002HF: Percentage of patients aged 18 and over, with GP recorded heart failure, with a record of an eGFR test in the preceding 6 months.

This indicator measures the proportion of patients with heart failure who have had an eGFR test in the preceding 6 months. Heart failure and its treatments can affect kidney function, so regular monitoring supports safe use of medication.

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

Associated guidance: [NICE guidance NG106](#) (Chronic heart failure in adults: diagnosis and management), recommendations on monitoring, including renal function.

Using this indicator: Higher proportions of heart failure patients with a recent eGFR test represent better quality of care. Lower proportions may indicate opportunities to improve monitoring. This indicator can be used to identify areas of good practice and areas for improvement.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[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.

Data breakdowns: Data for this indicator are published at England, region, ICB, sub-ICB, PCN and GP practice level. Results can be broken down by sex at all levels, by age group and ethnicity from England down to PCN level, by deprivation from England down to sub-ICB level, and by learning disability and severe mental illness from England down to ICB level.

[Click here to find the metadata for this indicator.](#)

OUTCOME INDICATORS

The CVDPREVENT outcome indicators measure health outcomes for patients in the audit by linking CVDPREVENT data to hospital and death records. They report mortality and hospital admission rates for patients with GP recorded CVD, hypertension or high risk conditions for CVD. Outcome indicators are reported for separate time periods from the other indicators in this guide.

Outcome rates are age standardised. This adjusts for differences in the age profile of populations, so that areas with older or younger populations can be compared. Outcomes are influenced by many factors, including deprivation, wider determinants of health and secondary care, as well as primary care. They should be interpreted alongside the detection, monitoring and treatment indicators in this guide, and differences between areas should not be taken to show cause and effect.

CVDP001MORT: All cause mortality among patients with GP recorded cardiovascular disease (wide definition) in patients aged 18 and over (Age standardised rate per 100,000 person years)

This indicator measures the age standardised rate of death from any cause among patients aged 18 and over with GP recorded CVD (wide definition), per 100,000 person years. It provides an overall measure of outcomes for patients with established CVD.

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

Associated guidance: There is no single guideline for this outcome measure. It reflects the combined effect of the detection, monitoring and treatment covered elsewhere in this guide, including [NICE guidance NG238](#) (Cardiovascular disease: risk assessment and reduction, including lipid modification).

Using this indicator: Lower rates represent better outcomes. Because the rates are age standardised, they can be compared between areas with different age profiles. Outcomes are influenced by many factors beyond primary care, including deprivation and secondary care, so this indicator should be used alongside the detection, monitoring and treatment indicators in this guide. Differences between areas should not be taken to show cause and effect.

Data breakdowns: Data for this indicator are published at England, region and ICB level. Results can be broken down by sex at all levels, and by age group, deprivation and ethnicity from England down to region level.

[Click here to find the metadata for this indicator.](#)

CVDP002MORT: Mortality from cardiovascular disease among patients with GP recorded cardiovascular disease (wide definition) in patients aged 18 and over (Age standardised rate per 100,000 person years)

This indicator measures the age standardised rate of death from cardiovascular disease among patients aged 18 and over with GP recorded CVD (wide definition), per 100,000 person years.

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

Associated guidance: There is no single guideline for this outcome measure. It reflects the combined effect of secondary prevention activity covered elsewhere in this guide, including [NICE guidance NG238](#) (Cardiovascular disease: risk assessment and reduction, including lipid modification).

Using this indicator: Lower rates represent better outcomes. Because the rates are age standardised, they can be compared between areas with different age profiles. Outcomes are influenced by many factors beyond primary care, including deprivation and secondary care, so this indicator should be used alongside the detection, monitoring and treatment indicators in this guide. Differences between areas should not be taken to show cause and effect.

Data breakdowns: Data for this indicator are published at England, region and ICB level. Results can be broken down by sex at all levels, and by age group, deprivation and ethnicity from England down to region level.

[Click here to find the metadata for this indicator.](#)

CVDP003MORT: Mortality from stroke among patients with GP recorded cardiovascular disease (wide definition) in patients aged 18 and over (Age standardised rate per 100,000 person years)

This indicator measures the age standardised rate of death from stroke among patients aged 18 and over with GP recorded CVD (wide definition), per 100,000 person years.

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

Associated guidance: There is no single guideline for this outcome measure. It reflects the combined effect of activity covered elsewhere in this guide, including blood pressure control ([NICE guidance NG136](#)) and anticoagulation in AF ([NICE guidance NG196](#)).

Using this indicator: Lower rates represent better outcomes. Because the rates are age standardised, they can be compared between areas with different age profiles. Outcomes are influenced by many factors beyond primary care, including deprivation and secondary care, so this indicator should be used

alongside the detection, monitoring and treatment indicators in this guide. Differences between areas should not be taken to show cause and effect.

Data breakdowns: Data for this indicator are published at England, region and ICB level. Results can be broken down by sex at all levels, by age group and deprivation from England down to region level, and by ethnicity at England level.

[Click here to find the metadata for this indicator.](#)

CVDP004MORT: Mortality from heart attacks (MI) among patients with GP recorded cardiovascular disease (wide definition) in patients aged 18 and over (Ages standardised rate per 100,000 person years)

This indicator measures the age standardised rate of death from heart attack (myocardial infarction, MI) among patients aged 18 and over with GP recorded CVD (wide definition), per 100,000 person years.

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

Associated guidance: There is no single guideline for this outcome measure. It reflects the combined effect of activity covered elsewhere in this guide, including lipid management ([NICE guidance NG238](#)) and blood pressure control ([NICE guidance NG136](#)).

Using this indicator: Lower rates represent better outcomes. Because the rates are age standardised, they can be compared between areas with different age profiles. Outcomes are influenced by many factors beyond primary care, including deprivation and secondary care, so this indicator should be used alongside the detection, monitoring and treatment indicators in this guide. Differences between areas should not be taken to show cause and effect.

Data breakdowns: Data for this indicator are published at England, region and ICB level. Results can be broken down by sex at all levels, by age group and deprivation from England down to region level, and by ethnicity at England level.

[Click here to find the metadata for this indicator.](#)

CVDP005MORT: All cause mortality among patients with GP recorded hypertension in patients aged 18 to 79 (Age standardised rate per 100,000 person years)

This indicator measures the age standardised rate of death from any cause among patients aged 18 to 79 with GP recorded hypertension, per 100,000 person years.

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

Associated guidance: There is no single guideline for this outcome measure. It reflects the combined effect of activity covered elsewhere in this guide, including [NICE guidance NG136](#) (Hypertension in adults: diagnosis and management).

Using this indicator: Lower rates represent better outcomes. Because the rates are age standardised, they can be compared between areas with different age profiles. Outcomes are influenced by many

factors beyond primary care, including deprivation and secondary care, so this indicator should be used alongside the detection, monitoring and treatment indicators in this guide. Differences between areas should not be taken to show cause and effect.

Data breakdowns: Data for this indicator are published at England, region and ICB level. Results can be broken down by sex at all levels, and by deprivation and ethnicity from England down to region level.

[Click here to find the metadata for this indicator.](#)

CVDP006MORT: Mortality from cardiovascular disease among patients with GP recorded hypertension in patients aged 18 to 79 (Age standardised rate per 100,000 person years)

This indicator measures the age standardised rate of death from cardiovascular disease among patients aged 18 to 79 with GP recorded hypertension, per 100,000 person years.

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

Associated guidance: There is no single guideline for this outcome measure. It reflects the combined effect of activity covered elsewhere in this guide, including [NICE guidance NG136](#) (Hypertension in adults: diagnosis and management).

Using this indicator: Lower rates represent better outcomes. Because the rates are age standardised, they can be compared between areas with different age profiles. Outcomes are influenced by many factors beyond primary care, including deprivation and secondary care, so this indicator should be used alongside the detection, monitoring and treatment indicators in this guide. Differences between areas should not be taken to show cause and effect.

Data breakdowns: Data for this indicator are published at England, region and ICB level. Results can be broken down by sex at all levels, and by deprivation and ethnicity from England down to region level.

[Click here to find the metadata for this indicator.](#)

CVDP007MORT: All cause mortality among patients with GP recorded high risk conditions for cardiovascular disease (Age standardised rate per 100,000 person years).

This indicator measures the age standardised rate of death from any cause among patients with GP recorded high risk conditions for CVD, per 100,000 person years. The conditions included are set out in the indicator metadata.

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

Associated guidance: There is no single guideline for this outcome measure. It reflects the combined effect of primary prevention activity covered elsewhere in this guide, including [NICE guidance NG238](#) (Cardiovascular disease: risk assessment and reduction, including lipid modification).

Using this indicator: Lower rates represent better outcomes. Because the rates are age standardised, they can be compared between areas with different age profiles. Outcomes are influenced by many

factors beyond primary care, including deprivation and secondary care, so this indicator should be used alongside the detection, monitoring and treatment indicators in this guide. Differences between areas should not be taken to show cause and effect.

Data breakdowns: Data for this indicator are published at England, region and ICB level. Results can be broken down by sex at all levels, and by age group, deprivation and ethnicity from England down to region level.

[Click here to find the metadata for this indicator.](#)

CVDP008MORT: Mortality from cardiovascular disease among patients with GP recorded high risk conditions for cardiovascular disease (Age standardised rate per 100,000)

This indicator measures the age standardised rate of death from cardiovascular disease among patients with GP recorded high risk conditions for CVD. The conditions included are set out in the indicator metadata.

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

Associated guidance: There is no single guideline for this outcome measure. It reflects the combined effect of primary prevention activity covered elsewhere in this guide, including [NICE guidance NG238](#) (Cardiovascular disease: risk assessment and reduction, including lipid modification).

Using this indicator: Lower rates represent better outcomes. Because the rates are age standardised, they can be compared between areas with different age profiles. Outcomes are influenced by many factors beyond primary care, including deprivation and secondary care, so this indicator should be used alongside the detection, monitoring and treatment indicators in this guide. Differences between areas should not be taken to show cause and effect.

Data breakdowns: Data for this indicator are published at England, region and ICB level. Results can be broken down by sex at all levels, and by age group, deprivation and ethnicity from England down to region level.

[Click here to find the metadata for this indicator.](#)

CVDP001ADMN: Proportion of patients with GP recorded hypertension aged 18 to 79, who had a hospital admission with stroke as the primary cause (Age standardised proportion %)

This indicator measures the age standardised proportion of patients aged 18 to 79 with GP recorded hypertension who had a hospital admission with stroke as the primary cause.

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

Associated guidance: There is no single guideline for this outcome measure. It reflects the combined effect of activity covered elsewhere in this guide, including [NICE guidance NG136](#) (Hypertension in adults: diagnosis and management).

Using this indicator: Lower proportions represent better outcomes. Because the proportions are age standardised, they can be compared between areas with different age profiles. Outcomes are influenced by many factors beyond primary care, including deprivation and secondary care, so this indicator should be used alongside the detection, monitoring and treatment indicators in this guide. Differences between areas should not be taken to show cause and effect.

Data breakdowns: Data for this indicator are published at England, region and ICB level. Results can be broken down by sex at all levels, and by deprivation and ethnicity from England down to region level.

[Click here to find the metadata for this indicator.](#)

CVDP002ADMN: Proportion of patients with GP recorded hypertension aged 18 to 79, who had a hospital admission with heart attack (MI) as the primary cause (Age standardised proportion %)

This indicator measures the age standardised proportion of patients aged 18 to 79 with GP recorded hypertension who had a hospital admission with heart attack (MI) as the primary cause.

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

Associated guidance: There is no single guideline for this outcome measure. It reflects the combined effect of activity covered elsewhere in this guide, including [NICE guidance NG136](#) (Hypertension in adults: diagnosis and management).

Using this indicator: Lower proportions represent better outcomes. Because the proportions are age standardised, they can be compared between areas with different age profiles. Outcomes are influenced by many factors beyond primary care, including deprivation and secondary care, so this indicator should be used alongside the detection, monitoring and treatment indicators in this guide. Differences between areas should not be taken to show cause and effect.

Data breakdowns: Data for this indicator are published at England, region and ICB level. Results can be broken down by sex at all levels, and by deprivation and ethnicity from England down to region level.

[Click here to find the metadata for this indicator.](#)

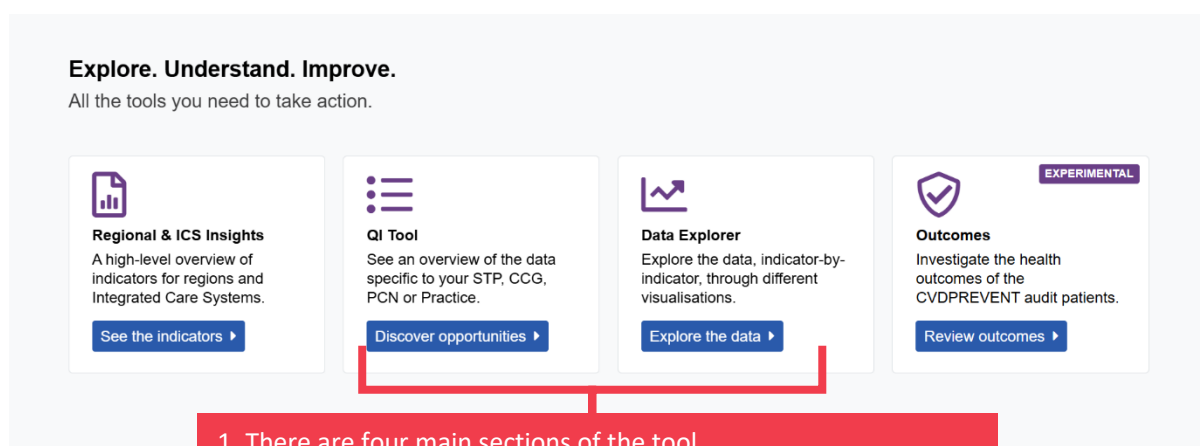
CVDPREVENT DATA & IMPROVEMENT TOOL

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.

Select a time period:

A time period displays all available data up to the end of that month.

To March 2026

To December 2025

To September 2025

To June 2025

To March 2025

To December 2024

To September 2024

To June 2024

To March 2024

To December 2023

To September 2023

To June 2023

To March 2023

To December 2022

To September 2022

To June 2022

To March 2022

To September 2021

To March 2021

To March 2020

Update ▲

Select an area:

Search all system levels and areas by name.

e.g. Birmingham

Browse system levels

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.

Data Explorer

Explore the data, indicator-by-indicator, through different visualisations.

Select an indicator:

Switch between available indicators

CVD: Treated to BP threshold (CVDP010HYP)

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

Proportion %

Quality Improvement

Data Extract

Metadata

All Persons Data

81.32 %

Area value

— %

System median

81.32 %

National value

Inequalities Markers

Area Comparison

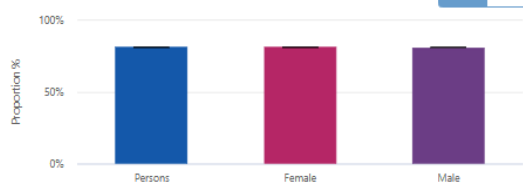
Learning Disabilities

Data Extract (.csv)

System median National value ?

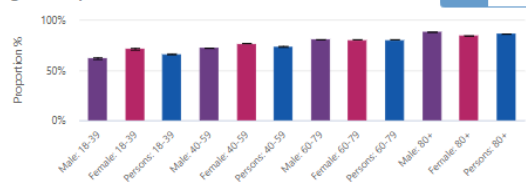
Markers showing national values but no area values means that the area value has been suppressed for disclosure control due to small count.

Sex



Show system/national values Download chart (.png)

Age Group



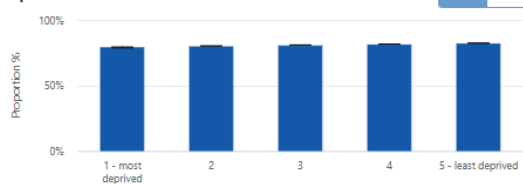
Show system/national values Download chart (.png)

Ethnicity



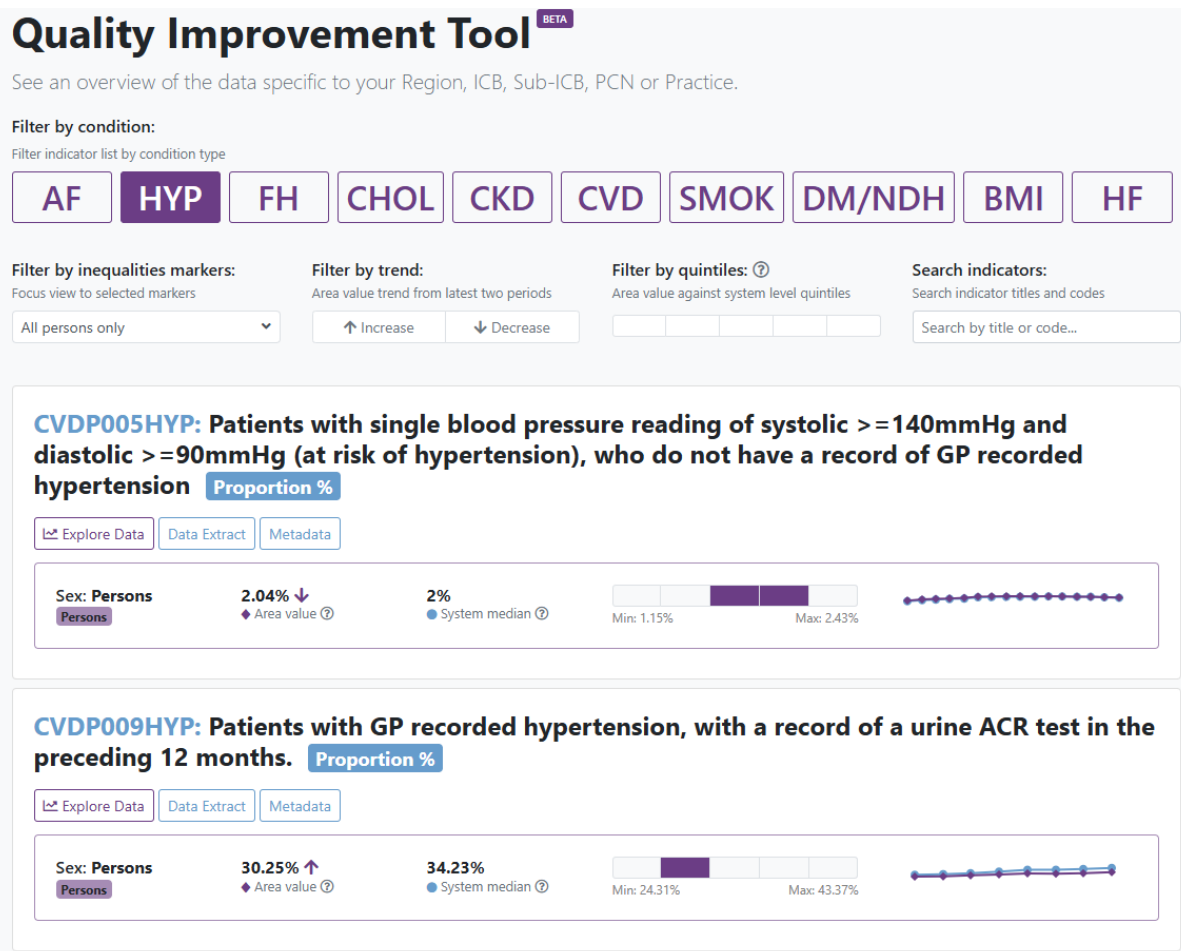
Show system/national values Download chart (.png)

Deprivation Quintile



Show system/national values Download chart (.png)

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.