Provider line of sight table on report recommendations for submission to the funders							
Please can the provider complete the following details to allow for ease of access and rapid review							
Project and Title of report, including HQIP Ref. ***e.g., Ref. XXX, Project and report title***			**REF 690, National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPREVENT) Workstream 3, Fifth Annual Audit Report**				
1. What is the report looking at/what is the project measuring?			**Measuring the variation in identification, diagnosis and management of people at risk of CVD across dimensions of potential health inequity including deprivation, age, sex and ethnicity, as well as outcomes (including mortality and admissions for stroke/heart attack) for patients collected by the audit.**				
2. What countries are covered?			**England**				
3. The number of previous projects (e.g., whether it is the 4th project or if it is a continuous project)			**This is the fifth round of CVDPREVENT**				
4. The date the data is related to (please include the start and end points – e.g., from 1 January 2016 to 1 October 2016)			**The data included in the fifth report is GP recorded data up to the end of March 2025 and outcomes measured between 1st January 2024 and 31st December 2024.**				
5. Any links to NHS England objectives or professional work-plans (only if you are aware of any)							
Please can the provider complete the below for each recommendation in the report							
No.	**Recommendation**	**Intended audience for recommendation**	**Evidence in the report which underpins the recommendation** *(including page number)*	**Current national audit benchmarking standard if there is one**	**Associated NHS payment levers or incentives'**	**Guidance available (for example, NICE guideline)**	**% project result if the question previously asked by the project (date asked and result). If not asked before please denote N/A. This is so that there is an indication of whether the result has increased or decreased and over what period of time**
Rec 1	NHS England should keep blood pressure treatment to target as a national priority, consistent with the 10 Year Health Plan and the 2025/26 Priorities and Operational Planning Guidance. Integrated Care Systems should reduce variation and	NHS England, Integrated Care Systems	Key Finding 1 – Annual Report, Hypertension, page 8 Key Finding 2 – Annual Report, Hypertension – Health	CVDP007HYP: Percentage of patients aged 18 and over, with GP-recorded hypertension, in whom the last blood	QOF	NICE guideline [NG136], Hypertension in adults: diagnosis and management, 21 November 2023	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

	prioritise patients at greatest risk by: • Targeting patients with high blood pressure (>160/100mmHg), at greatest risk of CVD events (**key findings 1, 3**). • Strengthening monitoring and treatment of working-age adults aged 18–59 years, who remain less likely to be monitored and / or treated to threshold (**key finding 2**). • Expanding use of self-monitoring and digital reporting through the NHS App to support earlier intervention (**key findings 2, 3**).		Inequalities, page 8 – 9 Key Finding 3, Hypertension – Outcomes, page 9	pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold has an ambition of 80% in 2024/25 NHS priorities and operational planning guidance			March 2024: 70.92% March 2025: 70.31% (decrease by 0.61%) March 2024, 18-59 years: 60.3% March 2025, 18-59 years: 58.6% (decrease by 1.7%) March 2024, 60-79 years: 72.7% March 2025, 60-79 years: 71.9% (decrease by 0.8%) March 2024, 80+ years: 80.3% March 2025, 80+ years: 81.6% (increase by 1.3%)
Rec 2	Integrated Care Systems should work to deliver cholesterol management improvement locally by: • Ensuring all eligible patients have had a QRISK score recorded	Integrated Care Systems	Key Finding 4 – Annual Report, Cholesterol – Primary Prevention, page 10 Key Finding 5 – Annual Report,	NA	NA	NICE Guideline [NG238] Cardiovascular disease: risk assessment and reduction including lipid modification, 14 December 2023	CVDP008CHOL: Patients with no GP recorded CVD and either a GP recorded QRISK score of 10% or more, or CKD and diabetes, who are currently treated with lipid lowering therapy. March 2024: 54.6%

	at least once every 5 years. • Offering lipid-lowering therapy to patients with QRISK scores ≥10%, (**key finding 4**). • Promoting effective utilisation of lipid-lowering therapies, including combination therapy where needed, to improve achievement of cholesterol targets. • Optimising therapy for people with established CVD to achieve NICE-defined LDL and non-HDL cholesterol thresholds, ensuring lipids are monitored as well as lowered, aligned with the NHS Priorities and Operational Planning Guidance (**key findings 5, 10**).		Cholesterol – Secondary Prevention, page 10 – 11 Key Finding 10 – Annual Report, Opportunities, page 13				March 2025: 56.7% (increase by 2.1%) 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 June 2024: 45.5% March 2025: 48.3% (increase by 2.8%)
Rec 3	Integrated Care Systems should address health inequalities in CVD prevention, focusing on groups with the poorest	Integrated Care Systems	Key Finding 6 – Annual Report, Cholesterol – Health Inequalities, page 11	NA	NA	Core20PLUS5 NICE Guideline [NG238] Cardiovascular disease: risk assessment and	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-

	outcomes. Actions should include: • Improving access to hypertension treatment and lipid-lowering therapies for patients with Black and Mixed ethnic backgrounds **(key finding 6)**. • Using data to identify and reduce gaps in care across ethnicity, sex, and deprivation quintiles **(key finding 6)**.					reduction including lipid modification, 14 December 2023	HDL cholesterol less than or equal to 2.6 mmol/l, in the preceding 12 months June 2024, black ethnic group: 35.6% March 2025, black ethnic group: 37.5% (increase by 1.9%) June 2024, mixed ethnic group: 39.4% March 2025, mixed ethnic group: 41.3% (increase by 1.9%)
Rec 4	Alongside blood pressure and cholesterol management, Integrated Care Systems should prioritise CKD care by increasing uptake of annual ACR testing for patients with CKD (G3a–G5) **(key finding 7)**, and reviewing those with CKD, hypertension and proteinuria to ensure appropriate initiation or optimisation of RAS antagonist therapy **(key finding 8).**	Integrated Care Systems	Key Finding 7 – Annual Report, Chronic Kidney Disease, page 11 Key Finding 8 – Annual Report Chronic Kidney Disease, page 11	NA	NA	NA	CVDP004CKD: Patients with GP recorded CKD (G3a to G5) with a record of a urine ACR test in the preceding 12 months March 2024: 44.6% March 2025: 52.4% (increase by 7.8%) Patients with GP recorded CKD (G3a to G5) and hypertension and proteinuria, who are currently treated with renin-angiotensin system antagonists March 2024: 71.0%

							March 2025: 71.5% (increase by 0.5%)
Rec 5	As part of their statutory responsibilities for improving population health, and in line with the NHS Plan, ICBs should strengthen the use of available patient record data to drive targeted case finding for undiagnosed cardiovascular-related conditions. Plans should set out how routinely recorded indicators — such as elevated blood pressure, reduced eGFR, or raised HbA1c levels — will be used to identify individuals with potential undiagnosed hypertension, CKD, or diabetes **(key findings 4, 9)**	Integrated Care Boards	Key Finding 4 – Annual Report, Cholesterol – Primary Prevention, page 10 Key Finding 9 – Annual Report, Opportunities, page 13	NA	NA	NA	CVDP005HYP: Patients with single blood pressure reading of systolic >=140mmHg and diastolic >=90mmHg (at risk of hypertension), who do not have a record of GP recorded hypertension. March 2024: 1.98% March 2025: 2.03% (increase by 0.05%) CVDP002CKD: Patients whose last two eGFRs are less than 60ml/min/1.73m2 (uncoded CKD), who do not have a record of GP recorded CKD (G3a to G5) March 2024: 0.56% March 2025: 0.45% (decrease by 0.11%) CVDP003DM: Patients whose last two HbA1c records are 48mmol/mol or more (uncoded diabetes), who do not have a GP record of diabetes. March 2024: 0.1% March 2025: 0.05% (decrease by 0.05%)