CVDP ANNUAL AUDIT REPORT 2025

Department of Health & Social Care

CVDPREVENT

(For the audit period to March 2025)

Using data to drive cardiovascular disease prevention

HQIP
Healthcare Quality Improvement Partnership

The CVDPREVENT audit is commissioned by the **Healthcare Quality Improvement Partnership (HQIP)** and funded by NHS England as part of the **National Clinical Audit and Patient Outcomes Programme.**

The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations, and crown dependencies. The CVDPREVENT audit aims to support quality improvement in the prevention of cardiovascular disease (CVD) in primary care in England. The audit is delivered in partnership between NHS England, the Office for Health Improvement and Disparities (OHID) within the Department for Health & Social Care (DHSC), and the NHS Benchmarking Network (NHSBN).

Authors: Office for Health Improvement and Disparities (OHID) and NHS Benchmarking Network, December 2025

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CONTENTS

INTRODUCTION

Cardiovascular disease (CVD) remains the leading cause of premature mortality in England and continues to place a substantial burden on patients, communities, and the health system. Key modifiable risk factors such as hypertension, high cholesterol, and chronic kidney disease (CKD), are well recognised, yet too often underdiagnosed or suboptimally managed. Strengthening the systematic detection and treatment of these conditions is therefore critical to improving outcomes, reducing inequalities, and delivering on national priorities for cardiovascular health. The CVDPREVENT audit was established to support this ambition, providing robust and consistent data to help local systems monitor performance and drive targeted quality improvement in primary care.

By offering reliable insights across practices, Primary Care Networks (PCNs), Integrated Care Boards (ICBs), and regions, the audit empowers clinicians and system leaders to focus resources where they can have the greatest impact. For patients, this means earlier diagnosis, improved management of long-term conditions, and reduced risk of serious cardiovascular events such as heart attacks and strokes.

NHSBN were awarded the contract to deliver workstream three of the CVDPREVENT audit by HQIP from February 2021 to January 2024, covering the reporting and quality improvement elements of the programme. The three-year contract was extended for an additional two years covering 2024 and 2025. OHID deliver the analysis and indicator development for the project and NHSE are responsible for the data collection.

ADDITIONAL LINKS AND BACKGROUND INFORMATION:

- **Background, aims, scope**
- **Acknowledgements**
- **Methodology**
- **Line of sight document**

The Fifth Annual Report presents analysis of GP recorded data for the relevant patient cohorts up to March 2025. In this latest report, results from data audited on 31st March 2025 are compared to previous iterations of the audit and comparisons are made between demographic groups to identify health inequalities. This report also looks at results compared to the **NHS priorities and operational planning guidance** ambitions set out for 2024/25 and focuses on patients with hypertension, lipid management and patients with CKD.

To access the full dataset and understand local achievement on the CVDPREVENT indicators, go to the **CVDPREVENT Data & Improvement Tool** for all breakdowns at national, regional, ICB, sub-ICB, PCN and practice levels.

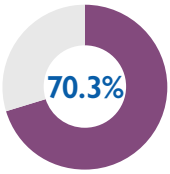
50 indicators are now calculated and published by the CVDPREVENT audit, not all of which are included in this report. Indicators highlighted in this report have been selected, with support from the CVDPREVENT Clinical Lead, QI Lead and CVDPREVENT Steering Group, in order to align with key national priorities and improvement opportunities.

KEY FINDINGS SUMMARY

HYPERTENSION

Key finding 1:

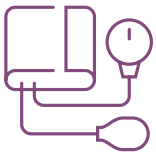
70.3% treated to Quality & Outcomes Framework (QOF) threshold, **2.7m** still not optimally managed.



Nearly 3 million patients with hypertension not treated to target.

Key finding 2:

Younger adults **less likely** to meet thresholds.



Working-age adults are **falling behind** in blood pressure control.

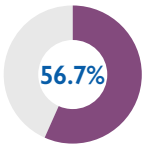
Key finding 3:

Patients with very high BP face **higher risk** of further complications, including heart attack, stroke and death.

CHOLESTEROL

Key finding 4:

56.7% of people at risk of CVD are on lipid-lowering therapy **(up 498k patients from 2024).**



Uptake of lipid therapy is improving – but still only **just over half** of high-risk patients.

Key finding 5:

Less than half of CVD patients at cholesterol target.

Over 1.4 million CVD patients are not treated to NICE cholesterol target.

Key finding 6:

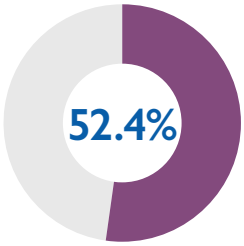
Persistent **ethnic disparities** in treatment and monitoring.

Black and mixed ethnic groups remain **least likely** to get optimal cholesterol care.

CHRONIC KIDNEY DISEASE (CKD)

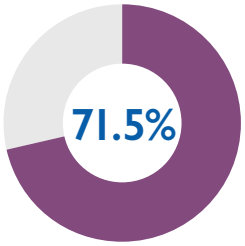
Key finding 7:

52.4% of CKD patients had urine ACR tests in past 12 months **(up 13.5% points since June 2023).** Monitoring for kidney damage is improving – but **nearly half** of CKD patients are still not tested annually.



Key finding 8:

71.5% of people living with CKD + hypertension + proteinuria are treated with RAS antagonists.



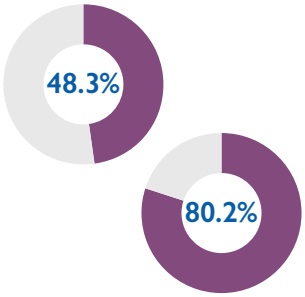
OPPORTUNITIES

Key finding 9:

Missed diagnosis remains a major risk – **over 1 million** patients may have not been properly coded which could result in **a possible missed diagnosis** for hypertension, CKD or diabetes.

Key finding 10:

48.3% of patients with CVD met NICE recommended cholesterol targets. Among patients with CHD **80.2%** had blood pressure within the appropriate treatment threshold.



KEY FINDINGS AND RECOMMENDATIONS

HYPERTENSION

Key finding 1:

In March 2025, CVDPREVENT data showed that 70.3% of patients with hypertension were treated to the QOF age-appropriate threshold. This means that almost 30% of patients with diagnosed hypertension (2.7 million patients) are still not treated to the QOF target for hypertension, or we have no current record of the blood pressure.

Key finding 2:

CVDPREVENT data shows that younger age groups with hypertension are still less likely to be treated to the QOF threshold than older groups. For instance, younger working-age adults (18–59) make up roughly a quarter of people with hypertension, yet they were still less likely to be treated to the QOF threshold compared with older groups in March 2025. It is hoped that self-reporting and enhancements to the NHS App, as outlined in the NHS Fit for the Future plan, will help address this gap.

Key finding 3:

Between 1st January 2024 and 31st December 2024, people with hypertension whose latest blood pressure was in the 'high' or 'very high' risk groups had markedly worse outcomes than those with lower blood pressures. The mortality rate from cardiovascular disease was 536.2 per 100,000 in the high risk group and 941.5 per 100,000 in the very high risk group, compared with 343.0 per 100,000 in the moderate risk group. Similarly, hospital admissions for heart attack or stroke occurred in 0.55% of patients in the high risk group and 0.87% in the very high risk group, compared with 0.37% in the moderate risk group. Even though the risk in these high risk blood pressure groups is highlighted, it is also important to note that there may still be substantial health gain available through targeting patients with moderate risk blood pressure, as even though the elevated risk is less extreme, the number of people in this group is much larger than the 'high' and 'very high' risk groups.

CHOLESTEROL

Key finding 4:

Looking at patients with no recorded Atherosclerotic Cardiovascular Disease (ASCVD), in March 2025 56.7% of patients with a QRISK score over 10% or CKD or higher risk diabetes had a current prescription for lipid lowering therapy. This represented a total of 4.6 million patients and was an improvement of 2.1 percentage points (495,823 patients) from the figure reported in March 2024. While this trend is positive there remains scope for further improvement.

Key finding 5:

In March 2025, fewer than half of patients (48.3%) with CVD had their blood cholesterol level treated to threshold. This meant that 51.7% (1,474,280 patients) were not treated to target or have no current record of treatment or management. Achievement across ICBs varied from 37.5% to 57.2%.

Key finding 6:

Despite **Core20PLUS5** being launched in November 2021 we still see large ethnic disparities in care. The black and mixed ethnic groups were least likely to be prescribed appropriate drug therapy, receive regular monitoring, or be treated to threshold across multiple conditions and indicators. In March 2025, 37.5% of patients from the black ethnic group had their cholesterol treated to threshold compared to 53.3% and 48.5% in the Asian and White ethnic groups.

CHRONIC KIDNEY DISEASE

Key finding 7:

52.4% of patients GP recorded CKD (G3a to G5) had a record of a urine ACR test in the preceding 12 months. This is an increase of 7.8 percentage points from March 2024 and 13.5 percentage points from June 2023 when the audit first began to measure this indicator.

Key finding 8:

Looking at patients with CKD (G3a to G5) and hypertension and proteinuria, 71.5% are currently treated with renin-angiotensin system (RAS) antagonists. This was a minor improvement of 0.5 percentage points from the 71.0% reported in March 2024 and 3.8 percentage points from March 2021 when the audit first began to measure this indicator. When looking at achievement across ICBs we see variation of 11 percentage points from 65.2% to 76.2%.

OPPORTUNITIES

Key finding 9:

In March 2025, the data revealed levels of potential missed diagnosis for cardiovascular related conditions in the population. 2% of patients (over 1 million individuals) were reported as having a blood pressure reading of systolic >=140mmHg and diastolic >=90mmHg but no GP-recorded hypertension diagnosis. Similarly, 0.45% (over 225,000 patients) whose last two eGFRs are less than 60ml/min/1.73m2 did not have a GP record of CKD (G3a to G5).

Key finding 10:

In March 2025, 48.3% of patients with cardiovascular disease (CVD) met NICE recommended cholesterol targets. Among patients with GP-recorded coronary heart disease (CHD), 80.2% had blood pressure within the appropriate treatment threshold.

NATIONAL RECOMMENDATIONS

CVDPREVENT – Round 5 Recommendations

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 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**).
2. Integrated Care Systems should work to deliver cholesterol management improvement locally by:
    - Ensuring all eligible patients have had a QRISK score recorded 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**).
3. Integrated Care Systems should address health inequalities in CVD prevention, focusing on groups with the poorest 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**).
4. Alongside blood pressure and cholesterol management, Integrated Care Systems should prioritise CKD care by increasing uptake of annual urine 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**).
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**).

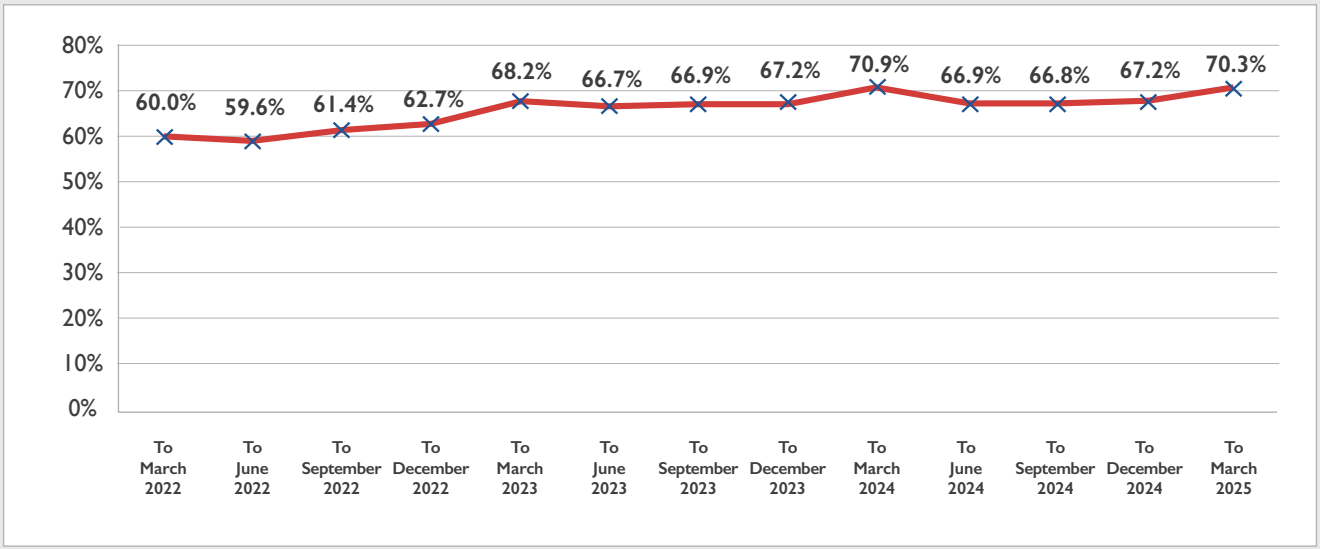
HYPERTENSION

KEY FINDING 1:

In March 2025, CVDPREVENT data showed that 70.3% of patients with hypertension were treated to the QOF age-appropriate threshold **(Figure 1).** This compares to 70.9% in March 2024. Nationally, the achievement was 9.7 percentage points below the national ambition of 80% set out in the **2024/25 NHS priorities and operational planning guidance** for achievement by end of March 2025. The drop in achievement from June 2024 onwards can be partially explained by the incorporation of revised thresholds for home and ambulatory BP readings. The number of patients treated to the QOF threshold has increased by 485,158 patients since June 2024

Figure 1:

Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.



According to the data, 29.7% of patients with diagnosed hypertension (2.7 million patients) are either not being treated to the QOF target or have not had a recent blood pressure recorded. CVDPREVENT figures also indicate that the number of patients with diagnosed hypertension in the audit sample is rising. This highlights that the scale of the task to manage hypertension is increasing in primary care **(Figure 1).**

HEALTH INEQUALITIES

KEY FINDING 2:

CVDPREVENT data shows that younger age groups with hypertension are still less likely to be treated to the QOF threshold than older groups. For instance, younger working-age adults (18–59) make up roughly a quarter of people with hypertension, yet they were still less likely to be treated to the QOF threshold compared with older groups in March 2025 **(Figure 2).** It is hoped that self-reporting and enhancements to the NHS App, as outlined in the **NHS Fit for the Future plan,** will help address this gap.

Figure 2:

Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.

	March 2025		
Age (years)	18-59	60-79	80+
Proportion treated to threshold	58.6%	71.9%	81.6%
Numerator (no. of patients treated)	1,442,443	3,436,243	1,545,414
Denominator (total no. of patients with diagnosed hypertension)	2,461,212	4,782,373	1,893,150

OUTCOMES

The audit uses outcomes indicators to measure admissions and mortality rates for patients collected by CVDPREVENT. For detail on the indicators and how they have been calculated, please refer to the **CVDPREVENT Outcomes Indicators Guide.**

KEY FINDING 3:

Between 1st January 2024 and 31st December 2024, people with hypertension whose latest blood pressure was in the 'high' or 'very high' risk groups had markedly worse outcomes than those with lower blood pressures **(Figure 3).** The mortality rate from cardiovascular disease was 536.2 per 100,000 in the high risk group and 941.5 per 100,000 in the very high risk group, compared with 343.0 per 100,000 in the moderate risk group. Similarly, hospital admissions for heart attack or stroke occurred in 0.55% of patients in the high risk group and 0.87% in the very high risk group, compared with 0.37% in the moderate risk group. Even though the risk in these high risk blood pressure groups is highlighted, it is also important to note that there may still be substantial health gain available through targeting patients with moderate risk blood pressure, as even though the elevated risk is less extreme, the number of people in this group is much larger than the 'high' and 'very high' risk groups.

Figure 3:

January 2024 - December 2024	No measurement	Treated to target	Moderate risk	High risk	Very high risk
Mortality from cardiovascular disease among patients with GP recorded hypertension in patients aged 18 to 79 (Age standardised rate per 100,000 person years)	371.0	316.8	343.0	536.2	941.5
Proportion of patients with GP recorded hypertension aged 18 to 79, who had a hospital admission with stroke as the primary cause (Age standardised)	0.36%	0.30%	0.41%	0.63%	1.22%
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)	0.30%	0.31%	0.37%	0.55%	0.87%

Definitions:

- No measurement: no valid blood pressure recorded in the last 12 months
- Treated to target: less than 140/90mmHg
- Moderate raised BP: over 140/90mmHg and under 160/100mmHg
- High raised BP: over 160/100mmHg and under 180/120mmHg
- Very high raised BP: over 180/120mmHg

Patients who have readings that could place them in more than one category (due to the systolic and diastolic readings sitting in two different categories) are assigned to the highest-risk group. For example, a patient with a reading of 165/95mmHg would be included in the 'high raised BP' group.

CHOLESTEROL

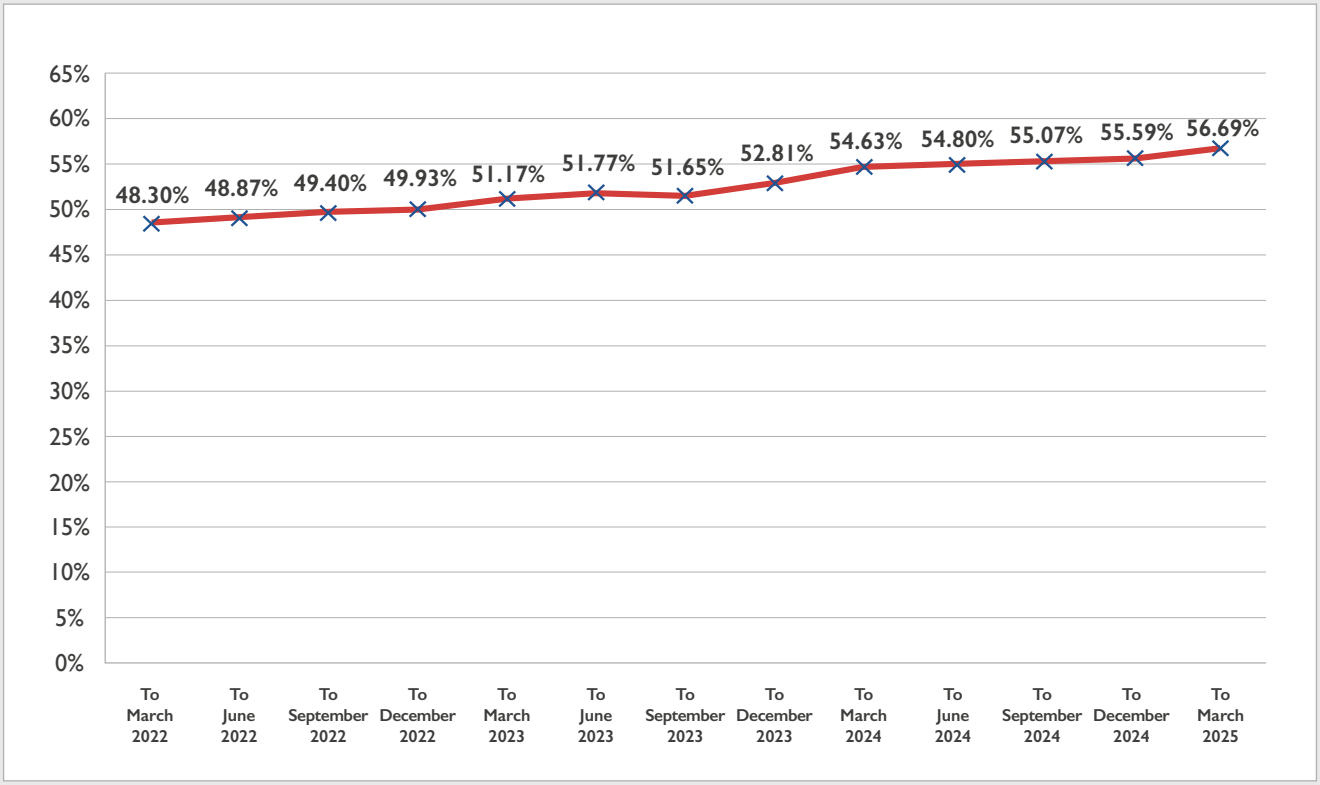
PRIMARY PREVENTION

KEY FINDING 4:

Looking at patients with no recorded Atherosclerotic Cardiovascular Disease (ASCVD), in March 2025 56.7% of patients with a QRISK score over 10% or CKD or higher risk diabetes had a current prescription for lipid lowering therapy **(Figure 4).** This represented a total of 4.6 million patients and was an improvement of 2.1 percentage points (495,823 patients) from the figure reported in March 2024. While this trend is positive there remains scope for further improvement.

Figure 4:

Patients with no GP recorded CVD and either a GP recorded QRISK score of 10% or more, or CKD or higher risk diabetes, who are currently treated with lipid lowering therapy.



SECONDARY PREVENTION

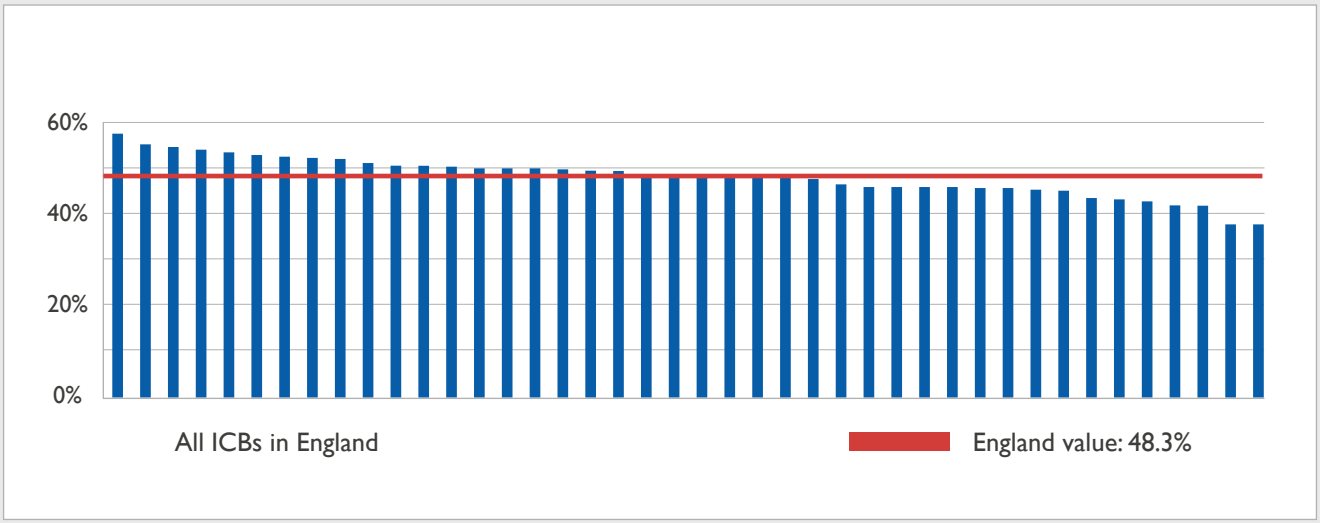
KEY FINDING 5:

In March 2025, less than half of patients (48.3%) with CVD had their blood cholesterol level treated to threshold or have no current record of treatment or management. This meant that 51.8% (1,474,280 patients) were not treated to target or have no current record of treatment or management. June 2024 data, which is when this indicator was updated to measure against the newer NICE recommended thresholds of LDL and non-HDL cholesterol levels, showed a 45.5% achievement. Achievement across ICBs varied from 37.5% to 57.2% **(Figure 5).**

The March 2025 data also showed that 81.4% of patients had a record of an LDL or non-HDL cholesterol level in the preceding 12 months compared to 79.2% in March 2024, representing a modest improvement of 2.2 percentage points showing progress in cholesterol monitoring.

Figure 5:

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 – All ICBs in England.



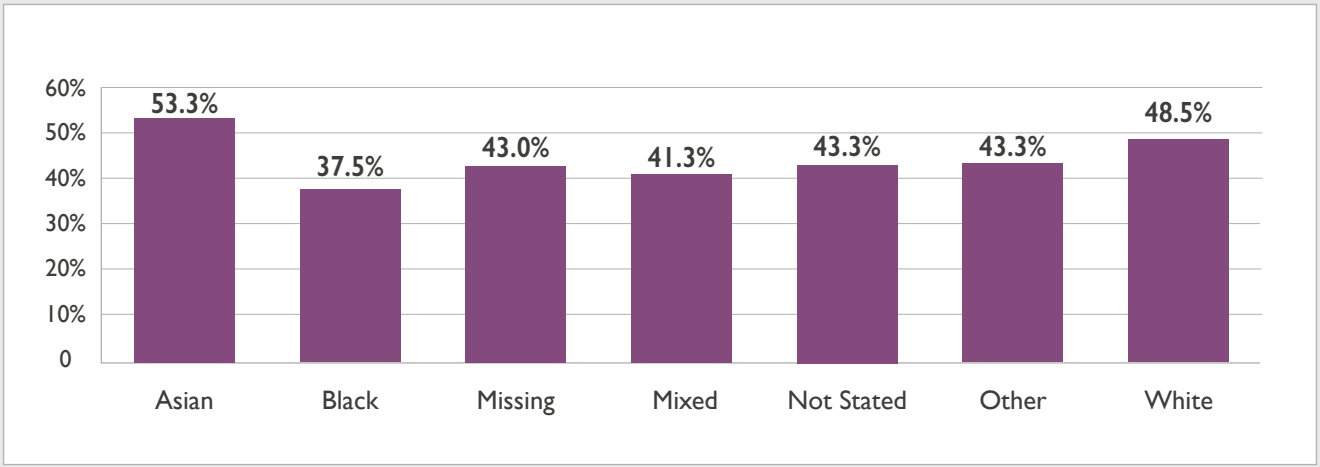
HEALTH INEQUALITIES

KEY FINDING 6:

Despite **Core20PLUS5** being launched in November 2021 we still see large ethnic disparities in care. The black and mixed ethnic groups were least likely to be prescribed appropriate drug therapy, receive regular monitoring or be treated to threshold across multiple conditions and indicators. In March 2025, 37.5% of patients from the black ethnic group had their cholesterol treated to threshold compared to 53.3% and 48.5% in the Asian and White ethnic groups **(Figure 6).**

Figure 6:

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 by ethnic group.



Confidence intervals:

- Asian: 53.06- 53.49
- Black: 37.1- 37.91
- Missing: 42.57- 43.45
- Mixed: 40.64- 42.01
- Not stated: 42.94- 43.6
- Other: 42.71-43.81
- White: 48.42- 48.55

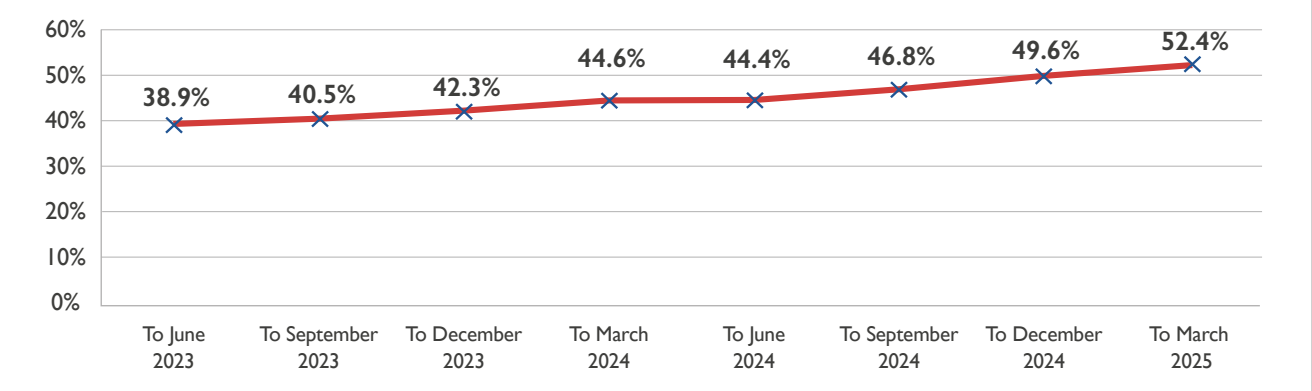
CHRONIC KIDNEY DISEASE

KEY FINDING 7:

52.4% of patients GP recorded CKD (G3a to G5) had a record of a urine ACR test in the preceding 12 months **(Figure 7).** This is an increase of 7.8 percentage points from March 2024 and 13.5 percentage points from June 2023 when the audit first began to measure this indicator. By comparison, improvements from March 2024 to March 2025 were 2.2 percentage points for cholesterol monitoring and 1.4 percentage points for hypertension monitoring.

Figure 7:

Patients with GP recorded CKD (G3a to G5) with a record of a urine ACR test in the preceding 12 months.



KEY FINDING 8:

Looking at patients with CKD (G3a to G5) and hypertension and proteinuria, 71.5% are currently treated with renin-angiotensin system (RAS) antagonists. This was a minor improvement of 0.5 percentage points from the 71.0% reported in March 2024 and 3.8 percentage points from March 2021 when the audit first began to measure this indicator. When looking at achievement across ICBs we see variation of 11 percentage points from 65.2% to 76.2%. This compares to a gap of almost 20 percentage points for secondary prevention of CVD (**key finding 5**).

OPPORTUNITIES

KEY FINDING 9:

In March 2025, the data revealed levels of potential missed diagnosis for cardiovascular related conditions in the population. 2% of patients (over 1 million individuals) were reported as having a blood pressure reading of systolic >=140mmHg and diastolic >=90mmHg but no GP-recorded hypertension diagnosis. Similarly, 0.45% (over 225,000 patients) whose last two eGFRs are less than 60ml/min/1.73m2 did not have a GP record of CKD (G3a to G5) **(Figure 8).**

Figure 8:

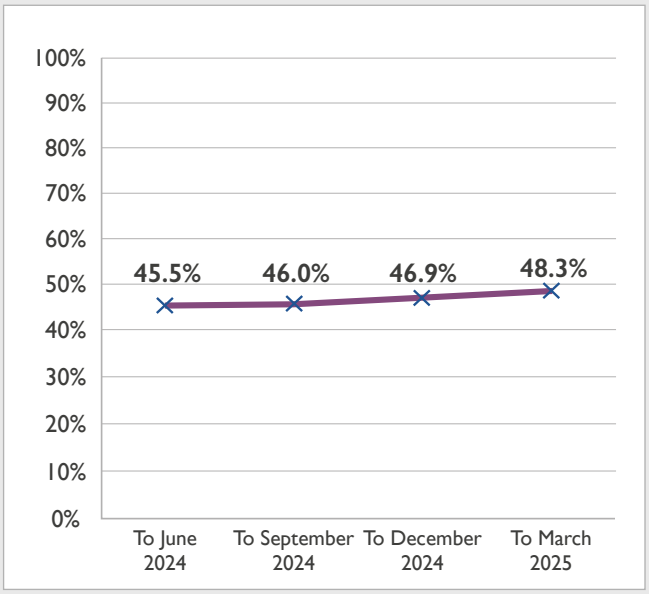
Patients with single blood pressure reading of systolic >=140mmHg and/or diastolic >=90mmHg (at risk of hypertension), who do not have a record of GP recorded hypertension		2.03%
Numerator: 1,030,161	Denominator: 50,677,460	
Patients whose last two eGFRs are less than 60ml/min/1.73m2 (uncoded CKD), who do not have a record of GP recorded CKD (G3a to G5)		0.45%
Numerator: 228,319	Denominator: 50,677,460	
Patients whose last two HbA1c records are 48mmol/mol or more (uncoded diabetes), who do not have a GP record of diabetes.		0.05%
Numerator: 25891	Denominator: 50,677,460	

KEY FINDING 10:

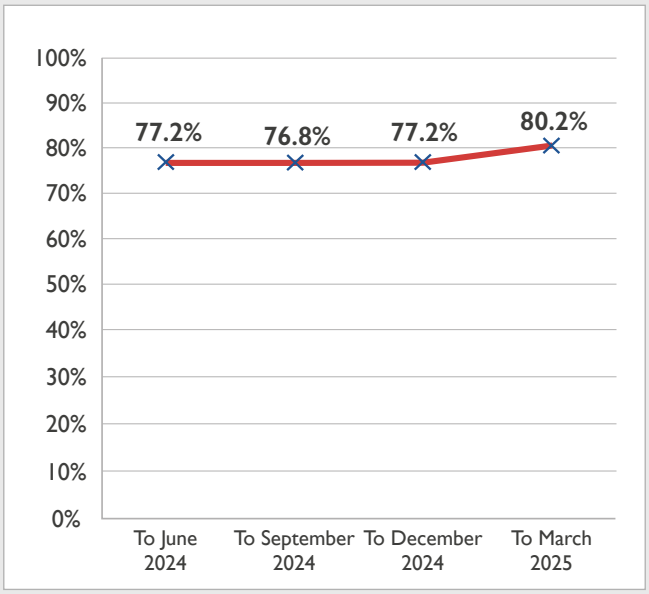
In March 2025, 48.3% of patients with cardiovascular disease (CVD) met NICE recommended cholesterol targets. Among patients with GP-recorded coronary heart disease (CHD), 80.2% had blood pressure within the appropriate treatment threshold.

Figure 9:

Cholesterol control in CVD patients (narrow definition) and blood pressure control in CHD patients.



Patients with CVD (narrow definition) whose most recent blood cholesterol level is treated to threshold



Patients with GP recorded coronary heart disease (CHD), whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.

AUDIT RESOURCES

REGIONAL AND ICS INSIGHTS

A high level overview of indicators for regions and Integrated Care Systems.

See the indicators

QI TOOL

See an overview of the data specific to your STP, CCG, PCN or Practice.

Discover opportunities

DATA EXPLORER

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

Explore the data

OUTCOMES

Investigate the health outcomes of the CVDPREVENT audit patients.

Review outcomes