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# Cardiovascular Disease Prevention Audit Directions Specification

**This data collection is known  
as CVDPREVENT Audit**

# Document management

## Revision History

Version	Date	Summary of Changes
1.1	25/05/2021	Updated with information on HQIPs commissioned provider, frequency of collection and GP System Suppliers. Refresh of Annex A to align with amendments made to the current business rules following extraction and analysis of data requirements. These are reviewed and signed off by clinicians.
1.2	12/07/2022	<p>The change made to the CVD Prevent extract is that we are now collecting all blood pressure (BP) records in the 15 months up to and including the Reporting period end date (RPED) rather than from the Audit period start date (APSD) up to and including the reporting period end date. The last collection in the year will be the same as previously as the period between the APSD and RPED is 15 months. This will mean more BP records are returned in earlier collections where the period between the APSD and RPED is less than 15 months.</p> <p>This change is due to NHSE's mid-year reporting of a BP indicator that requires a measurement in the last 12 months. Changing the time period as above for BP records allows for this indicator to be reported on and also results in the latest collection capturing the full 15 months of BP records as previously.</p> <p>Updated with information on PHE's transfer of functions, HQIPs commissioned provider, frequency of collection and GP System Suppliers. Refresh of Annex A to align with amendments made to the current business rules following extraction and analysis of data requirements. These are reviewed and signed off by clinicians.</p>
1.3	14/11/2022	Updated to state PHE's functions relating to the audit transferred to the Office for Health Improvement and Disparities (OHID).

## Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility
Dave Roberts	Head of Product for Arm's-length Bodies
Lucy Verlander	Senior Business and Operational Delivery Manager
Busola Awani	Higher Information Governance Specialist

## Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Dave Roberts		Head of Product for Arm's-length Bodies	27/07/2020	1.0

Dave Roberts	Head of Product for Arm's-length Bodies	17/08/2021	1.1
Dave Roberts	Head of Product for Arm's-length Bodies	12/07/2022	1.2
Kathryn Salt	Head of Service: Open Data and Publications Workforce & Estates, Adult Social Care, Secondary Care and Primary Care Domain	14/11/2022	1.3

## Glossary of Terms

Term / Abbreviation	What it stands for
CVD	Cardiovascular Disease
DARS	Data Access Request Service
DCB	Data Coordination Board
DPN	Data Provision Notice
HES	Hospital Episode Statistics
Audit Partners	Audit Partners means the group of organisations involved in this project, namely NHS England, the Office for Health Improvement and Disparities (OHID), The Healthcare Quality Improvement Partnership (HQIP), and HQIP's commissioned provider – NHS Benchmarking Network.

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# Purpose of document

This document sets out the requirements for the Cardiovascular Disease Prevention Audit Directions and should be read alongside the Directions issued by NHS England. This data collection is known as the CVDPREVENT Audit.

## Introduction

The NHS Long Term Plan identifies cardiovascular disease (**CVD**) as a clinical priority and the single biggest condition where lives can be saved by the NHS over the next 10 years. CVD causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas.

The CVDPREVENT Audit is a new national primary care audit that will support the implementation of the NHS Long Term Plan, the annually negotiated General Medical Services contract and the [national CVD Prevention programme](#). The CVDPREVENT Audit will be commissioned and delivered by several partners (hereafter referred to as the **Audit Partners**<sup>1</sup>) including NHS England, the Office for Health Improvement and Disparities (OHID) the Healthcare Quality Improvement Partnership (**HQIP**) and HQIP's commissioned provider – NHS Benchmarking Network.

The aim of the audit is to support professionally led quality improvement, optimising diagnosis and treatment of high-risk conditions to prevent heart attacks and strokes at scale. The audit also aims to evaluate the national CVD Prevention programme and inform better decisions on its delivery.

To deliver the audit, routinely recorded General Practice (**GP**) data will be extracted by NHS Digital via the General Practice Extraction Service (**GPES**). The data will help clinicians to understand how well they are performing in the diagnosis and management of six high-risk conditions for CVD.

## Data Collection

### Scope

Under section 259(1)(a) of the Health and Social Care Act 2012 (**the 2012 Act**), a Data Provision Notice will be served in accordance with the procedure published as part of the NHS Digital duty under section 259(8) on the following persons:

- General Practices in England, covering the three core GP system suppliers:
  - TPP
  - EMIS
  - Cegedim Health Solutions
  - (Eva Health Technologies were part of the original data collection. They subsequently ceased to be a GP system supplier and patients migrated by 2 March 2021.

Under section 259(5) of the 2012 Act, the organisation types specified in the above Scope must comply with the Form, Manner and Period of the data collection requirements.

In line with the national data opt-out operational policy guidance, national data opt-outs will not apply to the collection. However, Type 1 objections will be upheld in collecting this data from General

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<sup>1</sup> NHS Improvement were an Audit Partner until they became part of [NHS England](#) in July 2022. Public Health England (PHE) were an Audit Partner until 30/09/2021 when the functions related to the Audit passed to the Office for Health Improvement and Disparities (OHID). Further information is here: [Public health system reforms: location of Public Health England functions from 1 October - GOV.UK \(www.gov.uk\)](#)

Practices and therefore the data for those patients who have registered a Type 1 objection with their GP will not be collected. The Type 1 objection prevents an individual's personal identifiable confidential information from being shared outside of their GP Practice except when it is being used for the purposes of their direct care.

## Source

The data will be collected from GPs using the GPES.

## Category

The audit will collect identifiable patient level data, which will be held by NHS Digital. A full list of the data items to be collected can be found at [Annex A](#). The specification is reviewed each year by the CVD prevent audit partners in line with the standard GP extract specification review process of new and ongoing extracts, the audit partner group contains both clinicians and analysts. This is managed through fortnightly meetings held between the audit partner group and NHS Digital. The SNOMED CT codes used within the specification are regularly reviewed throughout the year following SNOMED UK and International releases.

There will be three patient cohorts:

**Cohort 1** – Patients registered in a GP practice that have been diagnosed with at least one of the six high-risk conditions who have not dissented to their data being used for national audit or collections:

- hypertension
- familial hypercholesterolaemia or other hyperlipidaemias, including possible or probable diagnosis and those patients with Simon Broome score or a Dutch lipid score in their patient record
- chronic kidney disease ([grades 3 to 5](#))
- non-diabetic hyperglycaemia, glucose intolerance or pre-diabetes
- a diagnosis of diabetes mellitus (Type 1 and Type 2)
- atrial fibrillation

**Cohort 2** – Patients registered in a GP practice with cardiovascular disease diagnosed who have not dissented to their data being used for national audit or collections.

**Cohort 3** – Patients registered in a GP practice who have entries in their record that suggest they may have an undiagnosed high-risk condition (listed below) or undiagnosed existing CVD and who have not dissented to their data being used for national audit or collections.

- hypertension
- familial hypercholesterolaemia or other hyperlipidaemias, including possible or probable diagnosis and those patients with Simon Broome score or a Dutch lipid score in their patient record
- chronic kidney disease ([grades 3 to 5](#))
- non-diabetic hyperglycaemia or glucose intolerance or pre-diabetes
- a diagnosis of diabetes mellitus (Type 1 and Type 2)
- atrial fibrillation

A data minimisation exercise has been undertaken to ensure that the data taken on each individual is kept to a minimum.

There are seven different groups of data items included in this data extraction. All of these data items will be extracted for patients included in all three of the cohorts listed above.

- **Patient characteristics – demographic and key data items:** This group includes the identifiers (for example: date of birth, NHS Number and postcode) and demographic information (for example: sex and ethnicity) for each patient, as well as the other key data items (for example: patient's registered GP practice) that are required
- **Patient characteristics – inequalities data items:** The Audit Partners require these data items to estimate the reach to disadvantaged populations. These data items cover both high-risk and vulnerable patients, for example patients with severe mental illness or learning disabilities, and it is critical that the Audit Partners are able to monitor the access/provision of CVD prevention services by these patients and attainment of optimal treatment of high risk conditions
- **CVD risk factor data items:** Required so that the Audit Partners can estimate the following:
  - if the necessary CVD risk factor checks are being recorded at appropriate times within the patient journey (for example smoking, CHA<sub>2</sub>DS<sub>2</sub>-VASc, QRisk2)
- **CVD risk factor test (and accompanying value) data items:** Required so that the Audit Partners can estimate the following:
  - if the necessary CVD risk factor tests are being undertaken at appropriate times within the patient journey and that patients are receiving optimal preventive treatment (for example BP, cholesterol, eGFR tests and medications)
- **CVD diagnosis data items:** Required so that the Audit Partners can estimate:
  - if patients who have an existing CVD diagnosis are already receiving the appropriate secondary prevention treatment and monitoring through existing care pathways (the use of lipid lowering therapy such as statins)
  - to look for other associated high-risk factors which can be managed to prevent disease progression (for example blood pressure, cholesterol, smoking)
- **Advice, signposting, information, brief intervention and referral data items:** Required so that the Audit Partners can estimate the following:
  - whether or not a patient received the appropriate advice, signposting, information, brief intervention and referrals (lifestyle, smoking and alcohol)
  - whether or not the appropriate advice, signposting, information, brief intervention and referrals led to a change (ideally a positive change) in the patient's health (for example smoking, BMI, cholesterol)
- **Prescribed CVD medication data items:** Required so that the Audit Partners can estimate the following:
  - whether patients who are prescribed an existing CVD medication are already receiving the appropriate management and monitoring of their care pathway (for example monitoring blood tests in CKD, high cholesterol)
  - whether or not a patient is receiving the appropriate preventive CVD medication (for example statins, PCSK9 inhibitors, blood pressure treatment, anticoagulants)

## Frequency

The first extract took place 27 November 2020. The Audit Partners received an initial full-year extract of data covering financial year 2019-20. Future extracts are on a quarterly basis.

# Analysis

## Internal processing

Once the data is collected from GP system suppliers (**GPSS**), validation on the file structure and contents will be carried out before files are accepted by NHS Digital's GP Data Collector system. The data will then be processed by the Data Management Service (DMS) to create a data asset. The processing involves loading the files from GPSS into a secure database and linking to corporate reference data to provide additional demographic information. This process also removes any Personal Identifiable Data (PID) from the data asset.

Data quality will be checked against the standard six data quality characteristics, which are coverage, completeness, validity, default, integrity and timeliness, as per the requirements of the Audit Partners.

Many of the SNOMED CT codes used to specify the data items listed are also used in the Quality and Outcomes and Framework (QOF) and other payment extractions and therefore the data quality of these codes is expected to be high. For other SNOMED CT codes that are not used in payment extractions, the data quality may not be as high. Analysis conducted by the Audit Partners will determine this.

Other non-coded information will be validated against standard NHS Digital protocols. For example: patient NHS Number will be validated against the Modulus 11 algorithm<sup>2</sup> and GP practice code will be validated against reference data held by NHS Digital.

## Data linkage

As described above, data collected under these Directions will be linked by NHS Digital to corporate reference data to provide additional demographic information.

The Audit Partners wish to link the primary care General Practice data with secondary care Hospital Episode Statistics (HES) data and mortality data, in order to track the monitoring and evaluation of national programme delivery across the life course and care pathway, and to determine impact on outcomes and health inequalities. This will be managed by the NHS Digital Data Access Request Service (**DARS**) with oversight from Independent Group Advising on Data Release<sup>3</sup> (**IGARD**) where appropriate.

Subject to the Audit Partners gaining appropriate authorisation via DARS/IGARD, data collected under these Directions may also be linked to other data sets held by NHS Digital to provide richer information, enhance existing publications, develop new publications, and to respond to requests from the Audit Partners. More information about the data sets and collections that NHS Digital hold and that may be used for linkage can be found on the [NHS Digital Data Collections and Data Sets webpage](#).

# Consultation

Consultation, as required by section 258 of the 2012 Act, has been completed by NHS Digital. In addition, and as part of the assurance process, the Data Coordination Board requests appropriate consultation is undertaken with the members of the Joint GP IT Committee (JGPITC) to obtain feedback on the technical design of the extraction.

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<sup>2</sup> [http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/n/nhs/nhs\\_number\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/n/nhs/nhs_number_de.asp?shownav=1)

<sup>3</sup> <https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/independent-group-advising-on-the-release-of-data>

A targeted stakeholder consultation exercise with members of the JGPITC took place between 23 December 2019 – 31 January 2020. The findings of the targeted stakeholder consultation have been reflected in the final data specification which has ensured data minimisation of the extraction.

In reflection of the extensive professional and other stakeholder involvement in developing the CVDPREVENT audit, few objections or challenges were raised in response to this consultation exercise.

NHS England have also consulted with relevant clinical advisors in deciding which data items should be included in this extract. The SNOMED codes that make up the data items have been reviewed and agreed by NHS Digital Clinical Informatics Advisors.

A CVDPREVENT Implementation Steering Group was established over 18 months ago. It is chaired by GP and former National Clinical Director, Dr Matt Kearney, and includes several GPs and other primary care practitioners from across England. It has national representation from the Royal College of General Practitioners (RCGP), The National Institute for Health and Care Excellence (NICE), British Heart Foundation, NHS England, and NHS Digital to oversee the project. The Steering Group provides the leadership for the development of the CVDPREVENT national audit programme and has also been instrumental in developing the supporting business rule set.

## Dissemination/Sharing

### Regular Dissemination/Sharing

Regular dissemination of data obtained by complying with these Directions will be restricted to the Audit Partners, therefore, NHS Digital has been directed not to exercise its powers under section 261(1) and 261(4) of the 2012 Act other than to disseminate information to the Audit Partners where it would be lawful for NHS Digital to do so.

The information that will be disseminated to the Audit Partners will be anonymised in line with the Information Commissioner's Office (ICO) Anonymisation Code of Practice<sup>4</sup>.

The Audit Partners require record level data and certain potential identifiers (for example: year of birth, gender, ethnicity, and indices of deprivation) in order to perform their analysis. However, all key patient identifiers will be removed (e.g. postcode, date of birth and NHS number) and data will be disseminated in the least identifiable form where possible (e.g. year of birth will be used instead of date of birth).

### Data Access Request Service (DARS)

Requests from the Audit Partners for information obtained by complying with the Directions will be via successful application to DARS supported by appropriate data sharing agreements and with oversight from IGARD where appropriate.

National data opt-outs will be applied to dissemination of CVDPREVENT audit data by NHS Digital that are in scope of the national data opt-out operational policy guidance.

## Publication

### Data to be published

NHS Digital must not publish information other than anonymous statistical data (with small numbers suppressed), this form and manner has been agreed with NHS England pursuant to section 260(4)(a)

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<sup>4</sup> <https://ico.org.uk/media/for-organisations/documents/1061/anonymisation-code.pdf> or any subsequent document, guidance or code on the same topic published by the ICO

of the 2012 Act. NHS Digital may also consult with the other Audit Partners on such publications, where NHS Digital and NHS England consider it appropriate for those Audit Partners to be consulted.

## Data prohibited from publication

NHS Digital is directed not to publish information it obtains under these Directions, except for the anonymous statistical data (with small numbers suppressed) referred to above.

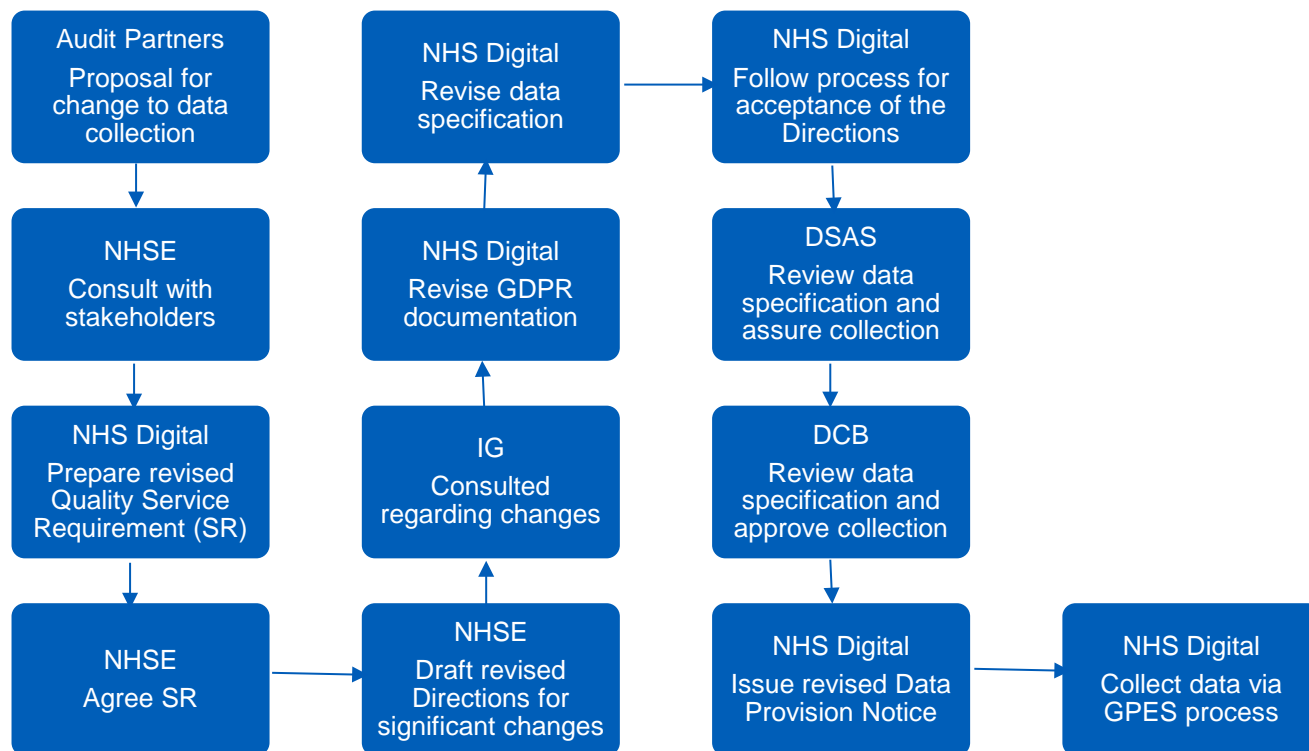
## System Delivery Function

There is no requirement for NHS Digital to create or procure a system delivery function to facilitate this work. It is expected that NHS Digital will utilise its existing strategic toolset to meet this requirement.

## Change control process

Changes to the data specification are managed via the governance structure and follow a defined path, which includes liaising with external stakeholders.

This process flow is shown below:



## Annex A – Data Specification

Extract ID	Description	Applied to population:
<b>CVDP001</b>	<b>CVDPREVENT audit extract specification for patients with one of the six conditions putting them at risk of cardiovascular disease.</b>	<b>CVDPCX001</b>

<i>Item Number</i>	<i>Description</i>
1	Patient's date of birth.
2	Patient's NHS number.
3	Postcode of patient's CURRENT address only.
4	The national practice code for the practice.
5	Patient's sex.
6	The latest date and ethnicity code of the patient.
7	Latest date, code and value of the BMI recorded up to and including the reporting period end date.
8	Latest date, code and value associated with the height recordings up to and including the reporting period end date.
9	Latest date, code and value associated with the weight recordings up to and including the reporting period end date.
10	The code and date of the earliest severe mental health diagnosis recorded up to and including the reporting period end date.
11	The code and date of the earliest learning disability (including autism) diagnosis recorded up to and including the reporting period end date.
12	The code and date of the earliest cancer diagnosis recorded up to and including the reporting period end date.
13	The code and date of the earliest palliative care recorded on the patients record up to and including the reporting period end date.
14	Date and code of the first type 1 diabetes diagnosis up to and including the reporting period end date.
15	Date and code of the first type 2 diabetes diagnosis up to and including the reporting period end date.
16	Date of the most recent diabetes diagnosis resolved code recorded after the most recent diabetes diagnosis and up to and including the reporting period end date.
17	Date of the latest non type 1 or 2 diabetes diagnosis recorded up to and including the reporting period end date.
18	Date and code of the first diagnosis of hypertension recorded up to and including the reporting period end date.
19	Date and code of the most recent hypertension diagnosis resolved code recorded after the most recent hypertension diagnosis and up to and including the reporting period end date.
20	Date and code of the most recent severe hypertension diagnosis up to and including the reporting period end date.
21	Date and code of the first familial hypercholesterolaemia or other hyperlipidaemias diagnosis recorded up to and including the reporting period end date.
22	Date and code of the earliest possible or probable familial hypercholesterolaemia or other hyperlipidaemias recorded up to and including the reporting period end date.
23	ALL dates and codes of the earliest genetic familial hypercholesterolaemia or other hyperlipidaemias diagnosis recorded up to and including the reporting period end date.

<i>Item Number</i>	<i>Description</i>
24	Date and code of the earliest chronic kidney disease (3-5) diagnosis recorded up to and including the reporting period end date.
25	Date and code of the most recent chronic kidney disease resolved code recorded after the latest chronic kidney disease (3-5) diagnosis and up to and including the reporting period end date.
26	The code and date of the latest CKD diagnosis recorded up to and including the reporting period end date.
27	Date and code of the earliest diagnosis of pre-diabetes, impaired glucose tolerance or non-diabetic hyperglycaemia up to and including the reporting period end date.
28	Date and code of the earliest diagnosis of atrial fibrillation (including atrial flutter) recorded up to and including the reporting period end date.
29	Date and code of the most recent atrial fibrillation diagnosis resolved code recorded after the most recent atrial fibrillation (including atrial flutter) diagnosis and up to and including the reporting period end date.
30	Date and code of the latest gestational diabetes diagnosis recorded up to and including the reporting period end date.
31	All dates, codes, value 1's and value 2's associated with the blood pressure recordings in the 15 months up to and including the reporting period end date.
32	All codes, dates and value 1's and value 2's of home blood pressure readings in the 3 months leading up to and including a new diagnosis of hypertension (where the diagnosis is within 12 months of the reporting period end date).
33	All codes, dates and value 1's and value 2's of ambulatory blood pressure readings in the 3 months leading up to and including a new diagnosis of hypertension (where the diagnosis is within 12 months of the reporting period end date).
34	Date and code of the latest smoking habit code recorded up to and including the reporting period end date.
35	The code, date and value of the earliest high cholesterol reading defined as any of the following recorded up to and including the reporting period end date: <ul style="list-style-type: none"> <li>• A total cholesterol or total cholesterol HDL ratio of greater than or equal to 5 mmol/L</li> <li>• An LDL-C cholesterol reading of greater than or equal to 3 mmol/L</li> <li>• A non-HDL-C cholesterol reading of greater than or equal to 5.9 mmol/L</li> </ul>
36	ALL dates, codes, values for total cholesterol recorded either: <ul style="list-style-type: none"> <li>• within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>• on or after the initial high reading</li> </ul>
37	ALL dates, codes, values for total cholesterol HDL ratio recorded either: <ul style="list-style-type: none"> <li>• within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>• on or after the initial high reading</li> </ul>
38	ALL dates, codes, values for LDLC cholesterol recorded either: <ul style="list-style-type: none"> <li>• within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>• on or after the initial high reading</li> </ul>
39	ALL dates, codes, values for NON-HDLC cholesterol recorded either: <ul style="list-style-type: none"> <li>• within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>• on or after the initial high reading</li> </ul>
40	ALL dates, codes, values for HDLC cholesterol recorded either: <ul style="list-style-type: none"> <li>• within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>• on or after the initial high reading</li> </ul>

<i>Item Number</i>	<i>Description</i>
41	ALL dates and codes for all the cholesterol findings without associated values recorded either: <ul style="list-style-type: none"> <li>• within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>• on or after the initial high reading</li> </ul>
42	ALL dates, codes, values for triglyceride cholesterol recorded either: <ul style="list-style-type: none"> <li>• within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>• on or after the initial high reading</li> </ul>
43	Date, code and value of the most recent total cholesterol or total cholesterol HDL recorded up to and including the reporting period end date.
44	Date, code and value of the most recent LDL-C cholesterol with an associated value recorded up to and including the reporting period end date.
45	Date, code and value of the most recent non-HDL-C cholesterol with an associated value recorded up to and including the reporting period end date.
46	Date, code and value of the most recent HDL-C cholesterol recorded up to and including the reporting period end date.
47	Date and code for the most recent cholesterol finding without an associated value recorded up to and including the reporting period end date.
48	Date, code and value of the latest triglyceride cholesterol up to and including the reporting period end date.
49	Date, code and value of the most recent eGFR reading with an associated value recorded up to and including the reporting period end date.
50	Date, code and value of the penultimate eGFR reading with an associated value recorded up to and including the reporting period end date.
51	Date, code and value of a single eGFR reading, where this is the only eGFR reading in the patient's record, taken up to and including the reporting period end date and where the reading is less than 60ml per minute.
52	All codes, dates and values of the eGFR readings in the preceding 15 months up to the end of the reporting period.
53	Date and code of the latest mild frailty diagnosis recorded up to and including the reporting period end date.
54	Date and code of the latest moderate frailty diagnosis recorded up to and including the reporting period end date.
55	Date and code of the latest severe frailty diagnosis recorded up to and including the reporting period end date.
56	Date and code of the latest excessive alcohol consumption code recorded up to and including the reporting period end date.
57	Date and code of the latest alcohol intervention recorded up to and including the reporting period end date.
58	Date and code of the latest diet intervention (advice or referral) recorded up to and including the reporting period end date.
59	Date and code of the latest smoking intervention recorded up to and including the reporting period end date.
60	Date and code of the latest activity/exercise intervention recorded up to and including the reporting period end date.
61	Date and code of the latest lifestyle intervention/education recorded up to and including the reporting period end date.
62	Date and code of the most recent referral to the diabetes prevention programme recorded up to and including the reporting period end date.
63	Date, code and value of the latest HbA1c reading with an associated value recorded up to and including the reporting period end date.
64	The code, date and value of the penultimate HbA1c reading recorded up to and including the reporting period end date.
65	Date and code of the latest recording of evidence of nephropathy up to and including the reporting period end date.

<i>Item Number</i>	<i>Description</i>
66	Date and code of the latest evidence of retinopathy screening up to and including the reporting period end date.
67	Date, code and value of the latest liver function test recorded up to and including the reporting period end date.
68	Date, code and value of the latest gamma-glutamyl transferase level recorded up to and including the reporting period end date.
69	Date, code and value of the latest thyroid function test recorded up to and including the reporting period end date.
70	Date and code of the latest referral to metabolic or endocrine clinic recorded up to and including the reporting period end date.
71	Date, code and value of the latest serum creatinine result recorded up to and including the reporting period end date.
72	Date, code and value of the latest urine albumin/creatinine ratio with an associated value recorded up to and including the reporting period end date.
73	The code, date and value of the penultimate Urine albumin/creatinine ratio reading with an associated value up to and including the reporting period end date.
74	ALL dates, codes and values of the urine albumin/creatinine ratio results recorded within the reporting period or after the first 3mg/mmol reading.
75	Date, code and value of the latest persistent proteinuria diagnosis up to and including the reporting period end date.
76	Date, code and value of the latest fasting plasma glucose test with an associated value recorded up to and including the reporting period end date.
77	Date, code and value of the most recent random blood glucose test with an associated value recorded up to and including the reporting period end date.
78	Date, code and value of the latest haemoglobin (full blood count) test result recorded up to and including the reporting period end date.
79	Date and code of the latest referral to a diabetes structured education programme recorded where the event occurred after the diabetes diagnosis and up to and including the reporting period end date.
80	Date and code of the latest attendance or completion of a diabetes structured education programme where the event occurred after the diabetes diagnosis and up to and including the reporting period end date.
81	Date and code of the latest recent foot risk classification recorded up to and including the reporting period end date.
82	Date, code and value of the latest Simon Broome score recorded up to and including the reporting period end date.
83	Date, code and value of the latest Dutch lipid score recorded up to and including the reporting period end date.
84	Date and code of the latest pulse rhythm assessment recorded up to and including the reporting period end date.
85	Date, code and value of the most recent QRISK score with an associated value recorded up to and including the reporting period end date.
86	Date, code and value of the latest therapeutic treatment range recorded up to and including the reporting period end date.
87	Date, code and value of the latest INR blood test recorded up to and including the reporting period end date.
88	Date, code and value of the most recent calcium blood test following the first low eGFR reading of less than or equal to 30ml per minute up to and including the reporting period end date.
89	Dates, code and value of the most recent phosphate blood test from the first low eGFR reading of less than or equal to 30ml per minute up to and including the reporting period end date.
90	Date, code and value of the most recent parathyroid hormone blood test from the first low eGFR reading of less than or equal to 30ml per minute up to and including the reporting period end date.
91	Date, code and value of the latest CVD risk assessment recorded up to and including the reporting period end date.
92	Date and code of the latest code indicating that the patient has chosen not to receive a CVD risk assessment recorded up to and including the reporting period end date.

<i>Item Number</i>	<i>Description</i>
93	Date, code and value of the latest CHADS2 score recorded up to and including the reporting period end date.
94	Date, code and value of the latest CHADSVASC score recorded up to and including the reporting period end date.
95	Date, code and value of the latest has bled score recorded up to and including the reporting period end date.
96	Date, code and value of the latest renal function blood test recorded up to and including the reporting period end date.
97	The latest date and code of the patient's choice not to be prescribed antihypertension medication up to and including the reporting period end date.
98	Date, code and prescription value of the latest antihypertension medication prescribed recorded up to and including the reporting period end date.
99	The latest date and code of the patient's choice not to be prescribed a statin medication up to and including the reporting period end date.
100	Date, code and prescription value of the latest statin medication prescribed recorded up to and including the reporting period end date.
101	The latest date and code of the offer of a statin medication up to and including the reporting period end date.
102	The latest date and code of the patient's choice not to be prescribed an angiotensin-converting enzyme (ACE) inhibitor medication up to and including the reporting period end date.
103	The date, code and prescription value of the latest an angiotensin-converting enzyme (ACE) inhibitor medication prescribed recorded up to and including the reporting period end date.
104	The latest date and code of the patient's choice not to be prescribed an Angiotensin II receptor blockers (ARB) medication up to and including the reporting period end date.
105	The date, code and prescription value of the latest an Angiotensin II receptor blockers (ARB) medication prescribed recorded up to and including the reporting period end date.
106	The latest date and code of the patient's choice not to be prescribed an angiotensin antagonist medication up to and including the reporting period end date.
107	The date, code and prescription value of the latest an angiotensin antagonist medication prescribed recorded up to and including the reporting period end date.
108	The latest date and code of the patient's choice not to be prescribed an oral anticoagulant medication up to and including the reporting period end date.
109	Date of the most recent oral anticoagulant prophylaxis code up to and including the reporting period end date.
110	The date, code and prescription value of the latest an oral anticoagulant medication prescribed recorded up to and including the reporting period end date.
111	The latest date and code of the patient's oral anticoagulant medication review recorded up to and including the reporting period end date.
112	The latest date and code of the patient's discussion regarding the type of oral anticoagulant medication available to choose from recorded up to and including the reporting period end date.
113	The latest date and code of the patient's adverse reaction to an oral anticoagulant medication recorded up to and including the reporting period end date.
114	The date, code and prescription value of the latest Ezetimibe medication prescribed up to and including the reporting period end date.
115	The date, code and prescription value of the latest PCSK9i medication prescribed up to and including the reporting period end date.
116	The latest dates and prescription value associated with the diabetes prescriptions recorded up to and including the reporting period end date.
117	The latest date and prescription value associated with metformin prescriptions recorded up to and including the reporting period end date.
118	The latest date, code and value of the latest C-Peptide test result recorded up to and including the reporting period end date.
119	The date and prescription value of the latest smoking cessation medication prescribed up to and including the reporting period end date.
120	The most recent ECG indicating a possible or probable atrial fibrillation diagnosis up to and including the reporting period end date.
121	The most recent date and code to determine if there is an irregular pulse or supraventricular tachycardia recorded up to and including the reporting period end date.

<u>Item Number</u>	<u>Description</u>
122	The most recent date and code of atrial fibrillation monitoring recorded up to and including the reporting period end date.
123	The most recent date and code of a history of atrial fibrillation recorded up to and including the reporting period end date.

Extract ID	Description	Applied to population:
<b>CVDP002</b>	<b>CVD PREVENT audit extract specification for patients diagnosed with cardiovascular disease.</b>	<b>CVDPCX002</b>

<u>Item Number</u>	<u>Description</u>
1	Patient's date of birth.
2	Patient's NHS number.
3	Postcode of patient's CURRENT address only.
4	The national practice code for the practice.
5	Patient's sex.
6	The latest date and ethnicity code of the patient.
7	Latest date, code and value of the BMI recorded up to and including the reporting period end date.
8	Latest date, code and value associated with the height recordings up to and including the reporting period end date.
9	Latest date, code and value associated with the weight recordings up to and including the reporting period end date.
10	The code and date of the earliest severe mental health diagnosis recorded up to and including the reporting period end date.
11	The code and date of the earliest learning disability (including autism) diagnosis recorded up to and including the reporting period end date.
12	The code and date of the earliest cancer diagnosis recorded up to and including the reporting period end date.
13	The code and date of the earliest palliative care recorded on the patients record up to and including the reporting period end date.
14	Date and code of the first type 1 diabetes diagnosis up to and including the reporting period end date.
15	Date and code of the first type 2 diabetes diagnosis up to and including the reporting period end date.
16	Date of the most recent diabetes diagnosis resolved code recorded after the most recent diabetes diagnosis and up to and including the reporting period end date.
17	Date of the latest non type 1 or 2 diabetes diagnosis recorded up to and including the reporting period end date.
18	Date and code of the first diagnosis of hypertension recorded up to and including the reporting period end date.
19	Date and code of the most recent hypertension diagnosis resolved code recorded after the most recent hypertension diagnosis and up to and including the reporting period end date.
20	Date and code of the most recent severe hypertension diagnosis up to and including the reporting period end date.
21	Date and code of the first familial hypercholesterolaemia or other hyperlipidaemias diagnosis recorded up to and including the reporting period end date.
22	Date and code of the earliest possible or probable familial hypercholesterolaemia or other hyperlipidaemias recorded up to and including the reporting period end date.
23	ALL dates and codes of the earliest genetic familial hypercholesterolaemia or other hyperlipidaemias diagnosis recorded up to and including the reporting period end date.
24	Date and code of the earliest chronic kidney disease (3-5) diagnosis recorded up to and including the reporting period end date.
25	Date and code of the most recent chronic kidney disease resolved code recorded after the latest chronic kidney disease (3-5) diagnosis and up to and including the reporting period end date.
26	The code and date of the latest CKD diagnosis recorded up to and including the reporting period end date.
27	Date and code of the earliest diagnosis of pre-diabetes, impaired glucose tolerance or non-diabetic hyperglycaemia up to and including the reporting period end date.

<i>Item Number</i>	<i>Description</i>
28	Date and code of the earliest diagnosis of atrial fibrillation (including atrial flutter) recorded up to and including the reporting period end date.
29	Date and code of the most recent atrial fibrillation diagnosis resolved code recorded after the most recent atrial fibrillation (including atrial flutter) diagnosis and up to and including the reporting period end date.
30	Date and code of the first coronary heart disease diagnosis recorded up to and including the reporting period end date.
31	Date and code of the first stroke diagnosis recorded up to and including the reporting period end date.
32	Date and code of the first transient ischaemic attack diagnosis recorded up to and including the reporting period end date.
33	Date and code of the first heart failure diagnosis recorded up to and including the reporting period end date.
34	Date and code of the first abdominal aortic aneurysm recorded up to and including the reporting period end date.
35	Date and code of the first peripheral arterial disease diagnosis recorded up to and including the reporting period end date.
36	Date and code of the latest gestational diabetes diagnosis recorded up to and including the reporting period end date.
37	All dates, codes, value 1's and value 2's associated with the blood pressure recordings in the 15 months up to and including the reporting period end date.
38	All codes, dates and value 1's and value 2's of home blood pressure readings in the 3 months leading up to and including a new diagnosis of hypertension (where the diagnosis is within 12 months of the reporting period end date).
39	All codes, dates and value 1's and value 2's of ambulatory blood pressure readings in the 3 months leading up to and including a new diagnosis of hypertension (where the diagnosis is within 12 months of the reporting period end date).
40	Date and code of the latest smoking habit code recorded up to and including the reporting period end date.
41	The code, date and value of the earliest high cholesterol reading defined as any of the following recorded up to and including the reporting period end date: <ul style="list-style-type: none"> <li>• A total cholesterol or total cholesterol HDL ratio of greater than or equal to 5 mmol/L</li> <li>• An LDL-C cholesterol reading of greater than or equal to 3 mmol/L</li> <li>• A non-HDL-C cholesterol reading of greater than or equal to 5.9 mmol/L</li> </ul>
42	ALL dates, codes, values for total cholesterol recorded either: <ul style="list-style-type: none"> <li>• within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>• on or after the initial high reading</li> </ul>
43	ALL dates, codes, values for total cholesterol HDL ratio recorded either: <ul style="list-style-type: none"> <li>• within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>• on or after the initial high reading</li> </ul>
44	ALL dates, codes, values for LDL-C cholesterol recorded either: <ul style="list-style-type: none"> <li>• within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>• on or after the initial high reading</li> </ul>
45	ALL dates, codes, values for NON-HDL-C cholesterol recorded either: <ul style="list-style-type: none"> <li>• within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>• on or after the initial high reading</li> </ul>

<i>Item Number</i>	<i>Description</i>
46	ALL dates, codes, values for HDLC cholesterol recorded either: <ul style="list-style-type: none"> <li>within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>on or after the initial high reading</li> </ul>
47	ALL dates and codes for all the cholesterol findings without associated values recorded either: <ul style="list-style-type: none"> <li>within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>on or after the initial high reading</li> </ul>
48	ALL dates, codes, values for triglyceride cholesterol recorded either: <ul style="list-style-type: none"> <li>within the reporting period if the high cholesterol reading occurs prior to the start of the audit period</li> </ul> OR <ul style="list-style-type: none"> <li>on or after the initial high reading</li> </ul>
49	Date, code and value of the most recent total cholesterol or total cholesterol HDL recorded up to and including the reporting period end date.
50	Date, code and value of the most recent LDL-C cholesterol with an associated value recorded up to and including the reporting period end date.
51	Date, code and value of the most recent non-HDL-C cholesterol with an associated value recorded up to and including the reporting period end date.
52	Date, code and value of the most recent HDL-C cholesterol recorded up to and including the reporting period end date.
53	Date and code for the most recent cholesterol finding without an associated value recorded up to and including the reporting period end date.
54	Date, code and value of the latest triglyceride cholesterol up to and including the reporting period end date.
55	Date, code and value of the most recent eGFR reading with an associated value recorded up to and including the reporting period end date.
56	Date, code and value of the penultimate eGFR reading with an associated value recorded up to and including the reporting period end date.
57	Date, code and value of a single eGFR reading, where this is the only eGFR reading in the patient's record, taken up to and including the reporting period end date and where the reading is less than 60ml per minute.
58	All codes, dates and values of the eGFR readings in the preceding 15 months up to the end of the reporting period.
59	Date and code of the latest mild frailty diagnosis recorded up to and including the reporting period end date.
60	Date and code of the latest moderate frailty diagnosis recorded up to and including the reporting period end date.
61	Date and code of the latest severe frailty diagnosis recorded up to and including the reporting period end date.
62	Date and code of the latest excessive alcohol consumption code recorded up to and including the reporting period end date.
63	Date and code of the latest alcohol intervention recorded up to and including the reporting period end date.
64	Date and code of the latest diet intervention (advice or referral) recorded up to and including the reporting period end date.
65	Date and code of the latest smoking intervention recorded up to and including the reporting period end date.
66	Date and code of the latest activity/exercise intervention recorded up to and including the reporting period end date.
67	Date and code of the latest lifestyle intervention/education recorded up to and including the reporting period end date.
68	Date and code of the most recent referral to the diabetes prevention programme recorded up to and including the reporting period end date.

<i>Item Number</i>	<i>Description</i>
69	Date, code and value of the latest HbA1c reading with an associated value recorded up to and including the reporting period end date.
70	The code, date and value of the penultimate HbA1c reading recorded up to and including the reporting period end date.
71	Date and code of the latest recording of evidence of nephropathy up to and including the reporting period end date.
72	Date and code of the latest evidence of retinopathy screening up to and including the reporting period end date.
73	Date, code and value of the latest liver function test recorded up to and including the reporting period end date.
74	Date, code and value of the latest gamma-glutamyl transferase level recorded up to and including the reporting period end date.
75	Date, code and value of the latest thyroid function test recorded up to and including the reporting period end date.
76	Date and code of the latest referral to metabolic or endocrine clinic recorded up to and including the reporting period end date.
77	Date, code and value of the latest serum creatinine result recorded up to and including the reporting period end date.
78	Date, code and value of the latest urine albumin/creatinine ratio with an associated value recorded up to and including the reporting period end date.
79	The code, date and value of the penultimate Urine albumin/creatinine ratio reading with an associated value up to and including the reporting period end date.
80	ALL dates, codes and values of the urine albumin/creatinine ratio results recorded within the reporting period or after the first 3mg/mmol reading.
81	Date, code and value of the latest persistent proteinuria diagnosis up to and including the reporting period end date.
82	Date, code and value of the latest fasting plasma glucose test with an associated value recorded up to and including the reporting period end date.
83	Date, code and value of the most recent random blood glucose test with an associated value recorded up to and including the reporting period end date.
84	Date, code and value of the latest haemoglobin (full blood count) test result recorded up to and including the reporting period end date.
85	Date and code of the latest referral to a diabetes structured education programme recorded where the event occurred after the diabetes diagnosis and up to and including the reporting period end date.
86	Date and code of the latest attendance or completion of a diabetes structured education programme where the event occurred after the diabetes diagnosis and up to and including the reporting period end date.
87	Date and code of the latest recent foot risk classification recorded up to and including the reporting period end date.
88	Date, code and value of the latest Simon Broome score recorded up to and including the reporting period end date.
89	Date, code and value of the latest Dutch lipid score recorded up to and including the reporting period end date.
90	Date and code of the latest pulse rhythm assessment recorded up to and including the reporting period end date.
91	Date, code and value of the most recent QRISK score with an associated value recorded up to and including the reporting period end date.
92	Date, code and value of the latest therapeutic treatment range recorded up to and including the reporting period end date.
93	Date, code and value of the latest INR blood test recorded up to and including the reporting period end date.
94	Date, code and value of the most recent calcium blood test following the first low eGFR reading of less than or equal to 30ml per minute up to and including the reporting period end date.
95	Dates, code and value of the most recent phosphate blood test from the first low eGFR reading of less than or equal to 30ml per minute up to and including the reporting period end date.
96	Date, code and value of the most recent parathyroid hormone blood test from the first low eGFR reading of less than or equal to 30ml per minute up to and including the reporting period end date.

<i>Item Number</i>	<i>Description</i>
97	Date, code and value of the latest CVD risk assessment recorded up to and including the reporting period end date.
98	Date and code of the latest code indicating that the patient has chosen not to receive a CVD risk assessment recorded up to and including the reporting period end date.
99	Date, code and value of the latest CHADS2 score recorded up to and including the reporting period end date.
100	Date, code and value of the latest CHADSVASC score recorded up to and including the reporting period end date.
101	Date, code and value of the latest has bled score recorded up to and including the reporting period end date.
102	Date, code and value of the latest renal function blood test recorded up to and including the reporting period end date.
103	The latest date and code of the patient's choice not to be prescribed antihypertension medication up to and including the reporting period end date.
104	Date, code and prescription value of the latest antihypertension medication prescribed recorded up to and including the reporting period end date.
105	The latest date and code of the patient's choice not to be prescribed a statin medication up to and including the reporting period end date.
106	Date, code and prescription value of the latest statin medication prescribed recorded up to and including the reporting period end date.
107	The latest date and code of the offer of a statin medication up to and including the reporting period end date.
108	The latest date and code of the patient's choice not to be prescribed an angiotensin-converting enzyme (ACE) inhibitor medication up to and including the reporting period end date.
109	The date, code and prescription value of the latest an angiotensin-converting enzyme (ACE) inhibitor medication prescribed recorded up to and including the reporting period end date.
110	The latest date and code of the patient's choice not to be prescribed an Angiotensin II receptor blockers (ARB) medication up to and including the reporting period end date.
111	The date, code and prescription value of the latest an Angiotensin II receptor blockers (ARB) medication prescribed recorded up to and including the reporting period end date.
112	The latest date and code of the patient's choice not to be prescribed an angiotensin antagonist medication up to and including the reporting period end date.
113	The date, code and prescription value of the latest an angiotensin antagonist medication prescribed recorded up to and including the reporting period end date.
114	The latest date and code of the patient's choice not to be prescribed an oral anticoagulant medication up to and including the reporting period end date.
115	The date and code of the most recent oral anticoagulant prophylaxis code up to and including the reporting period end date.
116	The date, code and prescription value of the latest an oral anticoagulant medication prescribed recorded up to and including the reporting period end date.
117	The latest date and code of the patient's oral anticoagulant medication review recorded up to and including the reporting period end date.
118	The latest date and code of the patient's discussion regarding the type of oral anticoagulant medication available to choose from recorded up to and including the reporting period end date.
119	The latest date and code of the patient's adverse reaction to an oral anticoagulant medication recorded up to and including the reporting period end date.
120	The date, code and prescription value of the latest Ezetimibe medication prescribed up to and including the reporting period end date.
121	The date, code and prescription value of the latest PCSK9i medication prescribed up to and including the reporting period end date.
122	The latest dates and prescription value associated with the diabetes prescriptions recorded up to and including the reporting period end date.
123	The latest date and prescription value associated with metformin prescriptions recorded up to and including the reporting period end date.
124	The latest date, code and value of the latest C-Peptide test result recorded up to and including the reporting period end date.
125	The date and prescription value of the latest smoking cessation medication prescribed up to and including the reporting period end date.

<i>Item Number</i>	<i>Description</i>
126	The most recent ECG indicating a possible or probable atrial fibrillation diagnosis up to and including the reporting period end date.
127	The most recent date and code to determine if there is an irregular pulse or supraventricular tachycardia recorded up to and including the reporting period end date.
128	The most recent date and code of atrial fibrillation monitoring recorded up to and including the reporting period end date.
129	The most recent date and code of a history of atrial fibrillation recorded up to and including the reporting period end date.

Extract ID	Description	Applied to population:
<b>CVDP003</b>	<b>Cardiovascular disease prevention audit primary care extraction- CVD PREVENT audit extract specification for patients who have entries in their record that suggest they may have an undiagnosed high-risk condition.</b>	<b>CVDP003</b>

<i>Item Number</i>	<i>Description</i>
1	Patient's date of birth.
2	Patient's NHS number.
3	Postcode of patient's CURRENT address only.
4	The national practice code for the practice.
5	Patient's sex.
6	The latest date and ethnicity code of the patient.
7	Latest date, code and value of the BMI recorded up to and including the reporting period end date.
8	Latest date, code and value associated with the height recordings up to and including the reporting period end date.
9	Latest date, code and value associated with the weight recordings up to and including the reporting period end date.
10	The code and date of the earliest severe mental health diagnosis recorded up to and including the reporting period end date.
11	The code and date of the earliest learning disability (including autism) diagnosis recorded up to and including the reporting period end date.
12	The code and date of the earliest cancer diagnosis recorded up to and including the reporting period end date.
13	The code and date of the earliest palliative care recorded on the patients record up to and including the reporting period end date.
14	Date of the latest non type 1 or 2 diabetes diagnosis recorded up to and including the reporting period end date.
15	Date and code of the latest gestational diabetes diagnosis recorded up to and including the reporting period end date.
16	All dates, codes, value 1's and value 2's associated with the blood pressure recordings in the 15 months up to and including the reporting period end date.
17	Date, code and value of the most recent total cholesterol or total cholesterol HDL with an associated value recorded up to and including the reporting period end date.
18	Date, code and value of the most recent LDL-C cholesterol with an associated value recorded up to and including the reporting period end date.
19	Date, code and value of the most recent non-HDL-C cholesterol with an associated value recorded up to and including the reporting period end date
20	Date, code and value of the most recent HDL-C cholesterol recorded up to and including the reporting period end date
21	Date and code for all the cholesterol findings without associated values recorded up to and including the reporting period end date.
22	Date, code and value of the latest triglyceride cholesterol up to and including the reporting period end date.
23	Date, code and value of the most recent eGFR reading with an associated value recorded up to and including the reporting period end date.
24	Date, code and value of the penultimate eGFR reading with an associated value recorded up to and including the reporting period end date.
25	Date, code and value of a single eGFR reading, where this is the only eGFR reading in the patient's record, taken up to and including the reporting period end date and where the reading is less than 60ml per minute.

<i>Item Number</i>	<i>Description</i>
26	Date, code and value of the latest HbA1c reading with an associated value recorded up to and including the reporting period end date.
27	The code, date and value of the penultimate HbA1c reading recorded up to and including the reporting period end date.
28	Date, code and value of the latest urine albumin/creatinine ratio with an associated value recorded up to and including the reporting period end date.
29	The code, date and value of the penultimate Urine albumin/creatinine ratio reading with an associated value up to and including the reporting period end date.
30	ALL dates, codes and values of the urine albumin/creatinine ratio results recorded within the reporting period or after the first 3mg/mmol reading.
31	Date, code and value of the latest fasting plasma glucose test with an associated value recorded up to and including the reporting period end date.
32	Date, code and value of the most recent random blood glucose test with an associated value recorded up to and including the reporting period end date.
33	Date, code and value of the most recent QRISK score with an associated value recorded up to and including the reporting period end date.
34	Date, code and value of the latest CVD risk assessment recorded up to and including the reporting period end date.
35	Date and code of the latest code indicating that the patient has chosen not to receive a CVD risk assessment recorded up to and including the reporting period end date.
36	Date, code and value of the latest CHADS2 score recorded up to and including the reporting period end date.
37	Date, code and value of the latest CHADSVASC score recorded up to and including the reporting period end date.
38	The latest date and code of the patient's choice not to be prescribed a statin medication up to and including the reporting period end date.
39	Date, code and prescription value of the latest statin medication prescribed recorded up to and including the reporting period end date.
40	The latest date and code of the offer of a statin medication up to and including the reporting period end date.
41	The latest date and code of the patient's choice not to be prescribed an oral anticoagulant medication up to and including the reporting period end date.
42	Date of the most recent oral anticoagulant prophylaxis code up to and including the reporting period end date.
43	The date, code and prescription value of the latest an oral anticoagulant medication prescribed recorded up to and including the reporting period end date.
44	The latest date and code of the patient's oral anticoagulant medication review recorded up to and including the reporting period end date.
45	The latest date and code of the patient's discussion regarding the type of oral anticoagulant medication available to choose from recorded up to and including the reporting period end date.
46	The latest date and code of the patient's adverse reaction to an oral anticoagulant medication recorded up to and including the reporting period end date.
47	The most recent ECG indicating a possible or probable atrial fibrillation diagnosis up to and including the reporting period end date.
48	The most recent date and code to determine if there is an irregular pulse or supraventricular tachycardia recorded up to and including the reporting period end date.
49	The most recent date and code of atrial fibrillation monitoring recorded up to and including the reporting period end date.
50	The most recent date and code of a history of atrial fibrillation recorded up to and including the reporting period end date.