NHS Health Checks and links to wider system frameworks

Section 1: Quality and Outcomes Framework (QOF)

The table below sets out the 2026/27 QOF indicators for which the NHS Health Check provides a mechanism to support primary care in achieving them.

Indicator area	QOF indicator	QOF ID code
Blood pressure	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years.	BP002
Obesity	The percentage of patients aged 18 or over living with obesity, appropriately adjusted for ethnicity in line with NICE guidelines (either with a BMI ≥30 kg/m² recorded in the preceding 12 months, or a BMI ≥27.5 kg/m² recorded in the preceding 12 months for patients with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background) who have been referred to a weight management programme within 90 days of the BMI being recorded.	OB004
Obesity	Percentage of eligible patients (per NICE TA1026 Funding Variation cohorts, accounting for ethnicity and comorbidity status) who have a recorded shared decision-making discussion about the management of obesity and are offered NICE approved medicines management (pharmacotherapy) for use in a primary care setting with accompanying referral to suitable behavioural support programme, in the preceding 12 months.	OB005
Smoking	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months.	SMOK002
Smoking	The percentage of patients aged 15 or over who are recorded as current smokers who have a	SMOK004

	record of an offer of support and treatment within the preceding 24 months.	
Non-diabetic hyperglycaemia	The percentage of patients with non-diabetic hyperglycaemia or a previous diagnosis of gestational diabetes who have had an HbA1c or fasting blood glucose performed in the preceding 12 months.	NDH003
Mental health	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months.	MH003
Mental health	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months.	MH006
Mental health	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months.	MH007
Mental health	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight (BMI of ≥23 kg/m² or ≥25 kg/m² if ethnicity is recorded as White)) or preceding 24 months for all other patients.	MH011
Mental health	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months.	MH012

The table below sets out wider 2026/27 QOF indicators relevant to cardiovascular disease prevention, detection and management. These provide broader context for activity that may involve further assessment, diagnosis, referral or ongoing management following a health check.

Indicator area	**QOF indicator**	**QOF ID code**
Atrial fibrillation	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more).	AF006
Atrial fibrillation	Percentage of patients on the QOF Atrial Fibrillation register and with a CHA2DS2-VASc	AF008

	score of 2 or more, who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	
Diabetes	The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or microalbuminuria who are currently treated with an ACE-I (or ARBs).	DM006
Diabetes	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register.	DM014
Diabetes	The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months.	DM020
Diabetes	The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months.	DM021
Diabetes	The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years) or where a statin is declined or if clinically unsuitable, another lipid-lowering therapy.	DM034
Diabetes	The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin or where a statin is declined or if clinically unsuitable, another lipid-lowering therapy.	DM035
Diabetes	The percentage of patients with diabetes, on the register aged 79 years and under, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading).	DM036
Diabetes	The percentage of patients with diabetes who have had the following care processes performed in the preceding 12 months: BMI measurement, BP measurement, HbA1c measurement, cholesterol measurement, record of smoking status, foot examination, albumin:creatinine ratio, and eGFR creatinine measurement.	DM037
Secondary prevention of	The percentage of patients with coronary heart disease with a record in the preceding 12 months	CHD005

coronary heart disease	that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken.	
Cardiovascular disease	The percentage of patients with coronary heart disease, stroke or TIA, aged 79 years or under, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less, (or equivalent home blood pressure reading).	CD001
Cardiovascular disease	The percentage of patients with coronary heart disease, stroke or TIA, aged 80 years or over, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent home blood pressure reading).	CD002
Cholesterol control and lipid management	Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy.	CHOL003
Cholesterol control and lipid management	Percentage of patients on the QOF Coronary Heart Disease (CHD), Peripheral Arterial Disease (PAD), or Stroke/Transient Ischaemic Attack (TIA) Register, with the most recent cholesterol measurement in the preceding 12 months, showing as ≤ 2.0 mmol/L if it was an LDL cholesterol reading or ≤ 2.6 mmol/L if it was a non-HDL cholesterol reading. For multiple readings on the latest date the LDL reading takes priority.	CHOL004
Heart failure	The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses.	HF007
Heart failure	The percentage of patients with a diagnosis of heart failure on or after 1 April 2023 which: (1) has been confirmed by an echocardiogram or by specialist assessment in the 6 months before entering on to the register; or (2) if registered at the practice after diagnosis, with no record of the diagnosis originally being confirmed either by echocardiogram or by specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration.	HF008
Heart failure	The percentage of patients with a current diagnosis of heart failure with reduced ejection fraction, who are currently treated with: an ACE inhibitor or ARNI or ARB; and a beta blocker; and	HF009

	a mineralocorticoid receptor antagonist; and an SGLT2 inhibitor.	
Hypertension	The percentage of patients with hypertension aged 79 years or under, without moderate or severe frailty, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading).	HYP010
Hypertension	The percentage of patients with hypertension aged 80 years or over, without moderate or severe frailty, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (or equivalent home blood pressure reading).	HYP011
Stroke and TIA	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anticoagulant is being taken.	STIA007
Dementia	The percentage of patients diagnosed with dementia whose care plan has been reviewed in the preceding 12 months.	DEM004

Section 2: Network Contract DES

Below is a summary of provisions within the Network Contract DES 2026/27 that are relevant to the policy context and delivery environment for the NHS Health Check programme.

- **8.1 Core primary care network (PCN) service requirements 8.1.1:** Core functions of PCNs include improving health outcomes for patients through effective population health management and reducing health inequalities, targeting resources and efforts in the most effective way to meet patient need, which includes delivering proactive care.
- **8.3 Improving health outcomes & reducing health inequalities 8.3.1:** PCNs must seek to improve health outcomes for its population using a data-driven approach and population health management techniques in line with guidance and the CORE20PLUS5 approach. This includes working with partners, including community pharmacy, to proactively identify and manage CVD risk, hypertension and raised lipids in line with nationally agreed guidance and pathways.
- **8.4 Targeting resource and efforts 8.4.1:** PCNs must contribute to the delivery of multi-disciplinary proactive care for complex patients at greatest risk of deterioration and hospital admission, by risk stratifying patients and offering care in accordance with the guidance. This must be done as part of an integrated neighbourhood team, with the aim of reducing avoidable exacerbations of ill health, improving quality of care and patient experience, and reducing unnecessary hospital admission.
- **Annex B minimum requirements for additional roles reimbursement scheme**: Includes requirement for nursing associates to promote health and well-

being to all patients, for example undertaking the NHS Health Check; advise patients on general healthcare and promote self-management.

Section 3: NHS Oversight Framework

The NHS Health Check is relevant to metrics from the NHS Oversight Framework 2026/27. The tables below set out metrics that are relevant to activity which may occur during or following an NHS Health Check.

Domain 1 – Population health, prevention and reducing inequality

Subject area	Metric	Applies to	Status
Population health	Under 75s cardiovascular disease mortality rate	ICBs	Contextual
Preventing ill health	% of eligible people supported by obesity prevention programmes	ICBs	Scoring
Reducing inequality	Deprivation gap in lipid management	ICBs	Scoring
Reducing inequality	Deprivation gap in hypertension management	ICBs	Scoring

Domain 4 – Effectiveness of care

Subject area	Metric	Applies to	Status
Managing long term conditions	% of patients who receive all 8 diabetes care processes	ICBs	Scoring

Managing long term conditions	Number of patients with GP recorded cardiovascular disease whose cholesterol is managed to NICE guidance	ICBs	Scoring
Managing long term conditions	Number of patients with GP recorded hypertension whose blood pressure is managed to NICE guidance	ICBs	Scoring