Department of Health & Social Care

NHS Health Check Best Practice Guidance

For commissioners and providers

3 November 2026

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Section 1: Overview

1.1 The NHS Health Check Programme

The NHS Health Check for adults aged 40 to 74 is a core component of England's cardiovascular disease (CVD) prevention programme. It supports earlier identification and management of major CVD risk factors, aiming to prevent heart disease, stroke, type 2 diabetes, kidney disease and reduce the chance of developing some cases of dementia, which can contribute to premature death, disability and health inequalities.

The NHS Health Check appointment is made up of three elements:

1. Risk assessment, where the top seven risk factors for CVD: blood pressure, cholesterol, smoking, alcohol consumption, physical activity, body mass index (BMI) and blood sugar are measured; and a person's risk of developing CVD in the next 10 years is calculated.

2. Risk communication, where results are used to raise awareness of cardiovascular risk factors and support individuals to understand what their risk means for them; and

3. Risk management, where individuals are supported to reduce their risk of CVD, for example, by referring people to weight management services or, where appropriate, referring for further clinical assessment to access treatment for hypertension, enabling them to take better control of their health and live longer, healthier lives.

As set out in the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, local authorities are legally responsible for ensuring that everyone in the eligible population is offered an NHS Health Check every five years and that the programme is delivered in accordance with the regulations. When discharging this duty, they must also act with a view to securing continuous improvement in the percentage of eligible people in their local authority area who receive an NHS Health Check.

1.2 Purpose and how to use this guidance

This guidance sets out the legal requirements and recommended best practice for commissioners and providers delivering and improving the NHS Health Check programme. It replaces Public Health England's NHS Health Check Best Practice Guidance (2020), brings relevant programme standards together in one document, and should be used alongside relevant legislation and NICE guidance. It supports consistent, evidence-based and equitable delivery, effective onward pathways, and the use of data for assurance and continuous improvement. It also includes practical tools and learning from local authorities that can be adapted to local needs.

Sections can be read independently according to the reader's role and area of focus:

- Section 2 is primarily for commissioners and covers legal requirements, service design, contracting, workforce, quality assurance and improvement.

- Section 3 is primarily for providers and sets out the end-to-end delivery pathway, including clinical requirements, risk communication and next steps. Commissioners should also be familiar with this section to ensure services are commissioned appropriately.

- Section 4 is relevant to both commissioners and providers and covers data recording, information transfer, reporting and assurance.

Annex 1 provides a catalogue of practical resources to support the commissioning, delivery, improvement and promotion of NHS Health Checks. The annex brings together guidance, tools and supporting materials for both commissioners and providers. These have been developed alongside regional colleagues, local authorities and behavioural scientists.

1.3 Why is the NHS Health Check important?

CVD remains one of the leading causes of preventable ill health, premature mortality and health inequality in England. It affects the everyday lives of at least 7 million people in England living with the condition. CVD is the second leading cause of death in England. Each year, there are around 33,000 early deaths from heart disease and stroke in people under the age of 75.

People living in England's most deprived areas are four times more likely to die prematurely than someone in the least deprived. Currently, it is estimated that in England, the healthcare cost of CVD is approximately £7.4 billion each year, with cost to the wider economy estimated at £15.8 billion annually.

Up to 80% of premature deaths from CVD are preventable, as modifiable risk factors, including high blood pressure, high cholesterol, poor diet, obesity, physical inactivity and smoking, account for the vast majority of CVD cases.

Therefore, the programme provides a significant opportunity to improve the health and wellbeing of adults aged 40 to 74 years through the promotion of early awareness, assessment, and management of the major risk factors for CVD.

Each year the programme engages over 1.3 million people and is estimated to prevent around 500 heart attacks or strokes[1]. Recent studies evaluating the effectiveness of NHS Health Checks in reducing all-cause mortality suggests significant long-term benefit[2][3].

[1] Robson J., Dostal I., Sheikh A. et al. The NHS Health Check in England: an evaluation of the first 4 years. *BMJ Open*, 6(1) (2016).
[2] Saund J., Dodhia H., Vanoli J., Masselot P. and O'Neill S. Association of the NHS Health Check with all-cause mortality: a longitudinal cohort study in primary care. *British Journal of General Practice* (2026).
[3] Nakhare S., Re F., Young H. et al. Ten-year clinical and health economic impact of NHS Health Check attendance: a linked population cohort study. *The Lancet Primary Care* (2026), in press.

1.4 A renewed national commitment to CVD prevention

In July 2025, the government published *Fit for the Future: the 10 Year Health Plan for England*, setting out three shifts for the health system, including from sickness to prevention. It committed to a modern service framework for cardiovascular disease, published in July 2026, which aims to reduce premature mortality from heart disease and stroke by 25% within 10 years.

The CVD MSF takes a cardiovascular-kidney-metabolic approach and identifies 12 priority areas, including improved case finding for key risk factors. The NHS Health Check is the pragmatic, proximal metric for this priority. The published CVD MSF sets out the standard, equity metric, baseline, and 3- and 10-year ambitions.

1.5 Reaching inclusion health groups and underserved communities

The core goal of the 10 Year Health Plan is to halve the gap in healthy life expectancy (HLE) between England's richest and poorest regions while increasing HLE for everyone. HLE disparities are largely driven by differences in long-term health condition prevalence and cardiovascular disease is strongly associated with health inequalities.

Commissioning of the NHS Health Check should be considered alongside local health inequalities and health improvement plans which respond to the disparities faced in local communities including where people may not be registered with a GP practice or are experiencing periods of homelessness or rough sleeping. More detail on this can be found in section 2.1.5.

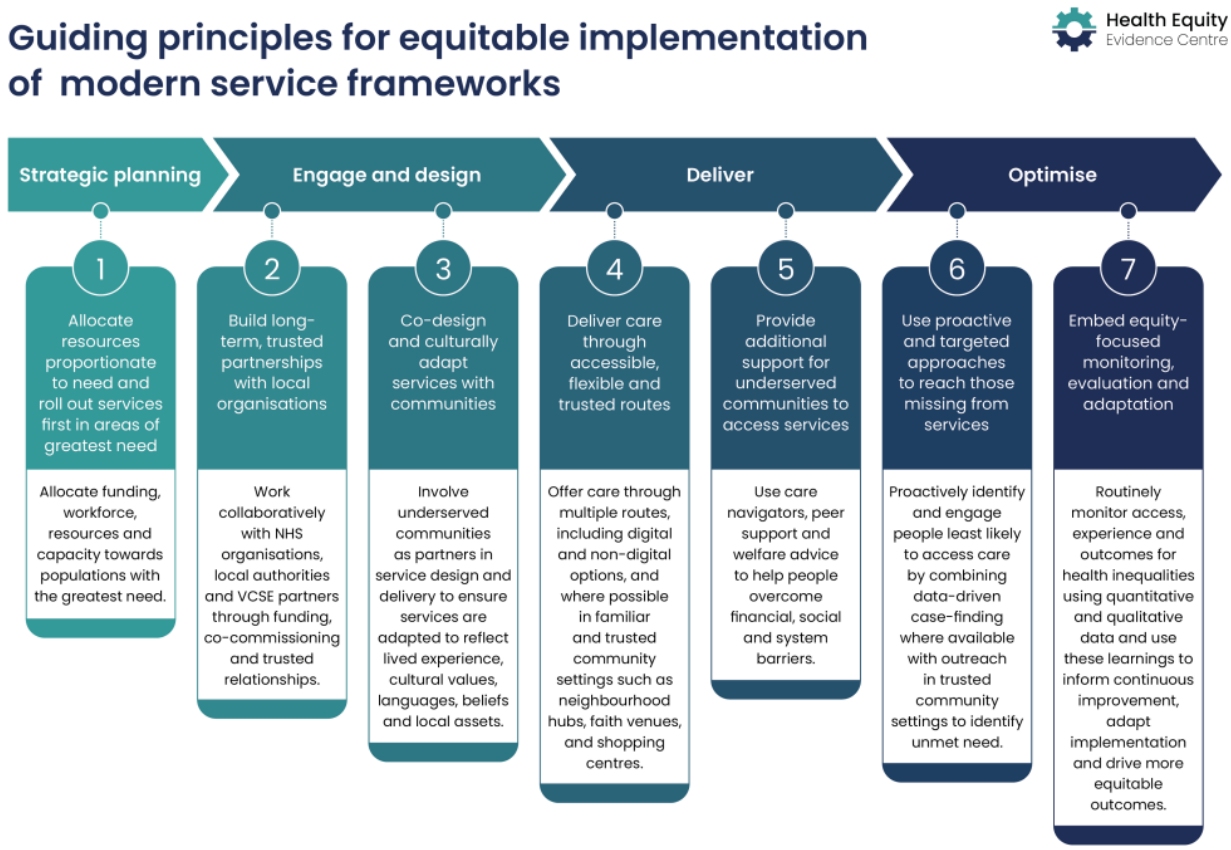
The NHS England Core20PLUS5 framework may be a helpful tool for commissioners and providers to consider when delivering their programme. It targets healthcare inequalities by encouraging outreach in the most deprived 20% of the population alongside locally identified vulnerable groups, using prioritised clinical areas like cardiovascular and respiratory health to drive up uptake for preventative checks.

If action is delivered in a one-size-fits-all manner, there is a risk that the already persistent inequalities could widen. Local areas should therefore consider how greater and more innovative efforts to reach and engage higher-risk and underserved groups could support more equitable uptake, while maintaining the offer for all eligible people. Researchers at Health Equity Evidence Centre, Queen Mary University of London, developed evidence-informed guiding principles for equitable implementation of the CVD MSF based on a library of Health Equity Evidence Centre evidence briefs and these principles are transferable to the commissioning and delivery of NHS Health Checks.[4]

Diagram 1 provides a visual display of the guiding principles for equitable implementation of modern service frameworks.

[4] https://www.heec.co.uk/equitable-implementation-of-modern-service-frameworks/

Diagram 1: Guiding principles for equitable implementation of modern service frameworks



1.6 Working system-wide to deliver CVD prevention

The successful delivery of NHS Health Checks relies on the NHS, local authorities and local delivery partners working together closely in partnership so they can make the most effective contribution to improving population health, regardless of where the Health Check takes place. The CVD MSF provides an opportunity to align commissioning across NHS and local authority public health routes where relevant to other case finding services to promote join up and efficiencies. Health and wellbeing boards should play an important strategic and system leadership role in shaping how NHS Health Checks are prioritised, targeted and delivered locally. The reforms set out in the neighbourhood health planning framework will create the conditions for delivering services that are centred around the needs of local communities Neighbourhood health framework - GOV.UK. Local partners should continue to work together through Health and Wellbeing Boards to develop a joint strategic needs assessment and produce a plan for delivering services and joining up resources at a local level, so that these can best serve agreed shared outcomes and priorities. A focus on prevention and proactive care management, including by using data to effectively manage risk and target high-risk cohorts earlier, is highlighted as a key element of the neighbourhood health approach.

Prevention Accelerators (PAs) were a commitment in the 10 Year Health Plan with the aim to demonstrate scaling up of preventative interventions that reduce demand for urgent and emergency care and elective care. PA sites have been launched to test innovative community-led models for secondary prevention, including the detection, treatment and management of clinical CVD risk factors and demonstrate how collaboration within local areas can accelerate progress on prevention.

1.7 NHS Health Check Online

To support the delivery of the ambitions set out above, the government is piloting an online version of the NHS Health Check with the vision being to increase the flexibility and reach of the programme through the creation of an innovative and accessible national digital service that people can complete at home.

This is currently in the private Beta testing phase which enables continuous assessment and improvement of the digital service based on the experiences of users and providers. More information can be found on the NHS Health Check website.

We will continue to keep Directors of Public Health and local authorities updated with the progress and opportunities to use the service in their areas.

Section 2: Commissioning and service design

2.1 Legal requirements for the NHS Health Check

2.1.1 Overview of local authority responsibility

Commissioners should ensure that contracts reflect requirements within The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (S.I. 2013/35116) (as amended) ("the Regulations").

These mandate that local authorities are required to make arrangements to:

- provide, or secure the provision of, health checks to be offered to eligible people in their area.

- ensure each eligible person aged 40 - 74 in their area is offered an NHS Health Check within 5 years of becoming an eligible person and to offer a further check within each subsequent period of 5 years from the date of the previous check.

- ensure certain information (provided this can be obtained) is recorded as part of the NHS Health Check (listed in section 2.1.3), where the health check is conducted outside the individual's GP practice, for a record of the health check containing required information to be forwarded to the individual's GP

- ensure the individual having their NHS Health Check is informed of their cardiovascular risk score, and other results are communicated to them

When providing or securing the provision of health checks to be offered to eligible people in their area, local authorities must act with a view to securing continuous improvement in the percentage of eligible individuals participating in the NHS Health Check.

There are also 'health checks' for people with severe mental illness and checks for people with learning disabilities. These checks differ from the NHS Health Check in scope, target audience and frequency. They also do not form part of the legal requirements of the 2013 Regulations. Individuals (aged between 40 and 74) who are eligible for those checks are also eligible for the NHS Health Check unless they are excluded based on NHS Health Check exclusion criteria.

2.1.2 Eligibility criteria

The Regulations set out the criteria for an eligible person (who should be offered an NHS Health Check as set out above). An eligible person is a person aged 40 - 74 years who:

a) has not been diagnosed with the following:

- coronary heart disease
- chronic kidney disease (CKD), being CKD which has been classified as stage 3, 4 or 5 CKD within the meaning of the National Institute for Health and Clinical Excellence clinical guideline 73 on Chronic Kidney Disease, published September 2008.

  Given changes to NICE guidelines, this should be interpreted as chronic kidney disease (stage G3a to G5, previously stage 3-5) in line with NICE guideline NG203. We intend to update legislation to reflect this in the future.
- diabetes
- hypertension
- atrial fibrillation
- transient ischaemic attack
- hypercholesterolemia

  This should be defined as familial hypercholesterolemia and we intend to update legislation to reflect this in the future.
- heart failure
- peripheral arterial disease
- stroke

b) is not being prescribed statins for the purpose of lowering cholesterol

Following queries and developments in clinical practice, this should be interpreted as currently prescribed statins (or other lipid lowering therapies) for the purpose of lowering cholesterol. We intend to update legislation in the future with this wording.

c) has not previously been assessed either through an NHS Health Check, or any other check undertaken through the health service in England, as having a 20% or higher risk of having a cardiovascular event during the ten years following the check.

Where someone has a moderate CVD risk of 10-19%, they remain an eligible person provided none of the other exclusions listed above apply, for example, if the individual is being prescribed a statin.

Diabetes insipidus is not an exclusion.

The eligible cohort includes residents within a local authority area who are not registered with a GP Practice. More detail on reaching these individuals can be found in section 2.1.5.

Local authorities are not responsible for offering eligible prisoners or people in detained settings an NHS Health Check. Under a delegation agreement made between the Secretary of State and NHS England (made under s.7A of the National Health Service Act 2006), NHSE are currently responsible for all public health services for children and adults in secure detained settings. The NHS Health Check programme is a public health service.

If an NHS Health Check provider communicates to a GP practice that further clinical assessment is required as a result of the NHS Health Check, it is the responsibility of the GP to ensure this is carried out. For instance, if an individual has a very high blood pressure, a high CVD risk score, or a cholesterol or blood glucose test which requires further investigation.

Protocols underpinning the delivery of the NHS Health Check should be in line with NICE Clinical Guidance 238 Cardiovascular disease: risk assessment and reduction, including lipid modification and other relevant NICE Clinical Guidance which is detailed in section 3.

2.1.3 Data required in the NHS Health Check

The Regulations set out the information that must be recorded and communicated as part of every NHS Health Check. This data supports the risk assessment, enables the person to understand their results and ensures relevant information can be included in the patient record.

It is a statutory duty that specified health check data (as per regulation 5(3) of the Regulations) must be recorded at the time of the health check; this data should be recorded in the individual's GP record. As well as the required data which must be recorded, it is best practice to include in the record any behavioural advice given, referrals where relevant and if further clinical assessment is needed. If the check is conducted outside of the GP practice, the record of the health check containing the required recorded information must be sent to the individual's GP practice. This should enable them to code it the data into the record, rather than just attaching it as a PDF to the consultation record. Structured, coded and extractable information is important for clinical continuity and to support delivery of the NHS Health Check pathway, including identifying people for call and recall, recording the outcome of a check, and enabling clinicians to undertake any required further clinical assessment.

Section 3 of this guidance provides detailed information on the collection of this data, clinical thresholds, and useful resources and guidance for delivering the NHS Health Check.

As set out in the Regulations. the following information relating to the person undergoing the NHS Health Check must be recorded as part of the health check:

- age
- gender (being the person's reported or phenotypical gender)

  While the Regulations state gender must be recorded, it is recommended that biological sex is used for the CVD risk score calculation, as outlined in section 3.7.3
- smoking status
- family history of coronary heart disease in any parent or sibling when the parent or sibling was aged under sixty years
- ethnicity
- body mass index (BMI)
- cholesterol level
- blood pressure
- physical activity level
- alcohol use disorders identification test (AUDIT) score
- cardiovascular risk score.

The duty to record the above information does not apply in respect of any information which cannot be obtained because the person undergoing the check is unable or refuses to provide the information or does not consent to any test or procedure necessary to obtain that information.

The individual undergoing the NHS Health Check must be told their cardiovascular risk score along with their BMI, cholesterol level, blood pressure and AUDIT score (which may help understand the risk) as soon as reasonably practicable after the test has taken place.

For people aged 65 to 74, the NHS Health Check must also include giving information to the individual to raise their awareness of dementia and of the availability of memory services which offer further advice and assistance to people who may be experiencing memory difficulties, including making the diagnosis of dementia. It is also best practice for providers to make all attendees aware that the risk factors for CVD are the same as those for dementia.

Additional assessments to be included in the check

The NHS Health Check should also include a risk assessment for diabetes and, if an individual is high-risk, a blood glucose test. More detail on the diabetes risk assessment can be found in section 3.5.2.

All women aged 40-55 should be asked if they know where to go for further information and support on the menopause. The decrease in oestrogen during menopause increases the risk of CVD by increasing cholesterol levels, fat accumulation around the waist, and potentially higher blood pressure. These changes can narrow arteries and raise the risk of heart attacks and strokes. Perimenopause symptoms also can often start from the age of 40, with most women starting the menopause between the ages of 45 and 55, so NHS Health Checks provide a key opportunity to reach and support these women. The question which should be asked in the NHS Health Check and resources to signpost women to is in the table in section 3.3.

The purpose of the menopause content is to signpost to trusted resources, not to initiate a discussion about symptoms during the check. The method of sharing the resources could be verbally, by email, via the NHS App, by SMS or through a combination of approaches. This should be in line with usual local processes for sharing resources with patients. The resources cover menopause symptoms, treatment options and wider health impacts, including information on the relationship between menopause and CVD, alongside advice on mental wellbeing, bone health, premature ovarian insufficiency, and support for women from different ethnic groups.

2.1.4 Local authority data collection

Local authorities are required to submit information on the number of NHS Health Checks offered and the number of NHS Health Checks received each quarter and return this data to the Department of Health and Social Care (DHSC). This data collection requirement is set out in the single data list (ref 254-00), which lists the datasets that local government must routinely submit to central government.

More information on data collection and reporting can be found in section 4.

2.1.5 Equity Act 2010 and addressing health inequalities

NHS Health Checks should be commissioned and delivered in a way that promotes equitable access, experience and outcomes, in accordance with the Equality Act 2010. This means recognising that equality of opportunity cannot always be achieved by treating everyone in the same way. Commissioners and providers should consider whether people with protected characteristics face particular barriers to accessing or benefiting from the programme and take proportionate action to address those barriers. This may include adapting how people are invited, where and how checks are delivered, how information is communicated, and making reasonable adjustments for disabled people.

Commissioners should consider health equity throughout the design and delivery of the NHS Health Check programme. National health equity guidance, such as the Health Equity Assessment Tool (HEAT), can support consideration of whether programme resources, opportunities and access are being fairly distributed according to need, by the principles of proportionate universalism. HEAT provides a practical framework that enables systematic action on health inequalities and equalities, with online training for the programme accessible through e-Learning for Health.

Examples of proportionate universalist approaches include using tailored communications and engagement approaches for underserved populations, targeting outreach activity towards communities with the greatest need, and delivering NHS Health Checks in in locations and settings that are accessible and trusted by those underserved or most at risk of poor health outcomes, while maintaining a universal offer for all those eligible for the NHS Health Check. These approaches may be particularly important for people who are not registered with a GP practice and others who face barriers to accessing preventative services. In line with the ambitions of the Neighbourhood Health Service and relevant NICE guidance, including NICE guideline NG214 on integrated health and social care for people experiencing homelessness, commissioners and providers should consider how they can make NHS Health Checks available to these groups.

For those struggling to access a GP service, the Register with a GP Surgery service is a digital registration service that was developed with input from organisations working with marginalised groups, including Doctors of the World, Groundswell, and Friends, Families and Travellers. The service was introduced in 2022 to simplify and standardise GP registration, making it easier for all patients to register without requiring proof of address, ID, or immigration status. The service is free, compulsory for all NHS GP practices in England, and available 24/7. For those without access to a digital device, GP practices can still accept paper-based registrations, and work is ongoing to ensure paper and digital registration processes are aligned for consistency.

Learning from local delivery: outreach support for people who are experiencing periods of homelessness or rough sleeping.

In one local authority a small public health team seek to reach people who are experiencing periods of homelessness or rough sleeping through delivering NHS Health Checks in temporary accommodation, specialist clinics and at community events for people experiencing homelessness. Practitioners build trust gradually, offer participants choice and work closely with primary care, housing and voluntary organisations.

The service reaches approximately 160 people each month, identifying conditions such as hypertension and diabetes while improving engagement with healthcare. One participant who initially declined screening later accepted an NHS Health Check after attending wellbeing sessions. The intervention led to diagnoses and treatment, smoking cessation, weight loss, improved blood-sugar levels and eventual permanent housing.

The programme shows that flexible, trauma-informed outreach can make preventive healthcare a gateway to wider health, housing and wellbeing support.

2.2 Workforce and training

The workforce delivering the NHS Health Checks need to use a mix of clinical competencies (proficiency in taking accurate measurements such blood pressure, pulse and BMI as well as interpreting blood cholesterol and glucose results), digital proficiency

(ability to calculate QRISK scores), communication skills (ability to clearly explain QRISK scores and 'heart age') and behaviour-change techniques (e.g. open questions, affirmations and reflective listening).

The NHS Health Check competency framework (2020) outlines the core and technical competencies needed by people carrying out NHS Health Checks. The NHS Health Check Learner and Assessor Workbook accompanies the competency framework and supports commissioners and providers to assess and evidence their staff's competence against the competencies and identify any training needs. Free e-learning courses on how to conduct an NHS Health Check and support behaviour change are available at All Our Health: NHS Health Check.

NHS Health Check trainers and practitioners can also use additional resources to improve the quality of their delivery of the dementia component of the check. These can be found on the NHS Health Check website (NHS Health Check - Dementia training) An updated dementia competency framework sets out core skills and knowledge which is applicable to different types of service provision (Dementia (2018, updated 2026) | Skills for Health).

Further training is available on delivering brief advice:

- Alcohol Identification and Brief Advice (ALC) training module
- Alcohol and tobacco brief interventions training modules
- Videos on delivering brief advice

2.3 Designing an impactful NHS Health Check service

Local authorities should use this guidance to commission NHS Health Check services in line with the legislative requirements and best practice set out in this document. The delivery model should be shaped by local population need, patterns of cardiovascular disease risk, health inequalities, existing clinical and public health pathways, and local opportunities to improve reach and quality.

There is no single delivery model that will be right for every local area. However, all models should be designed to invite all eligible people and deliver the three elements of the NHS Health Check: risk assessment, risk awareness and risk management. Increasing awareness of risk alone is unlikely to lead to sustained behaviour change. Commissioners should therefore ensure that individuals identified as being at increased risk are given practical support and opportunities to act on their results, including access to appropriate behavioural support, further clinical assessment or onward referral.

Commissioners should apply the proportionate universalism principles in section 2.1.5, maintaining a universal offer while prioritising attendance among higher-risk and underserved groups. Where available, data extraction software and GP clinical systems can support targeted delivery.

Commissioners and providers should also use the evidence-based NHS Health Check market segmentation to inform how they communicate, design and deliver NHS Health Checks. The segmentation provides insight into the attitudes, awareness and needs of 30- to 74-year-olds towards their health and NHS Health Checks. This can help commissioners and providers tailor their approach to the different segments with the aim of reaching those who are underrepresented and at greater risk of having a heart attack or stroke in the next 10 years. For ease of reference in day-to-day practice, a one-page summary is available here: NHSHC Market Segmentation provider resource.

Learning from local delivery: applying proportionate universalism to delivery

Some local authorities have designed payment arrangements that pay different amounts for completed NHS Health Checks depending on the characteristics of the individual receiving the check. Systematically identifying those who may be at higher risk and most likely to need an intervention through a cohorting approach allows invitation methods and any follow-up engagement to be tailored to need.

In some areas, providers receive higher payments for checks completed with individuals identified as being at increased cardiovascular risk. In others, higher payments may be linked to factors such as smoking, obesity, deprivation or other locally identified priorities. This helps align provider incentives with local prevention goals and encourages additional focus on groups most likely to benefit from intervention, while maintaining a universal offer for all the eligible population.

Commissioners should consider whether a mix of providers and delivery settings would maximise opportunities to reach people at higher risk and increase uptake. Examples from local areas show local authorities funding increased capacity where needed, either by offering additional evening and weekend appointments through existing providers or by commissioning providers able to deliver checks outside standard working hours.

Some areas also deliver the programme in community settings or workplaces to improve access for groups less likely to attend appointments in a healthcare setting. These are sometimes done on a drop-in, or opportunistic, basis where they may find people who are eligible without sending an invite.

Learning from local delivery: building strong relationships with providers and the local health system

A strong and consistent theme across discussions with local authorities who have high NHS Health Check coverage was the importance of investing time in provider relationships. Rather than relying solely on formal contract management processes, local authorities described having regular contact with providers throughout the year and viewing relationship-building as a core part of programme delivery.

Examples from local practice included local authority staff meeting regularly with providers to discuss challenges, share learning and provide practical support at different stages of the delivery cycle. This included helping providers identify eligible cohorts, sharing effective invitation approaches, clarifying local processes, supporting training needs and helping resolve operational issues before they became barriers to delivery. Several local authorities also highlighted the value of working closely with ICBs and primary care colleagues to support communication, data flows and joined up working across the local system.

This approach helps build trust, strengthen partnership working and creates a shared commitment to improving delivery. Local authorities should consider provider engagement as an ongoing function of programme management, ensuring providers have access to regular support and opportunities to discuss challenges throughout the year, rather than only through formal contract review processes.

Commissioners should ensure that GP practices understand how delivering the NHS Health Check or acting on the results can support achievement of relevant Quality and Outcomes Framework (QOF) indicators which explicitly refer to clinical activities carried out with respect to the NHS Health Checks eligible population. This should help encourage GP practices to prioritise and/or support the delivery of NHS Health Checks in their area. A document showing where the NHS Health Check provides a mechanism for supporting primary care in achieving 2026/27 QOF indicators can be found here. It also shows how the NHS Health Check activity relates to other performance frameworks.

2.3.1 What to include in the service specification or contract

In commissioning the NHS Health Check programme, commissioners should refer to the Provider Selection Regime statutory guidance.

The service specification or contract should translate the legislation and best practice set out in this guidance into clear expectations for providers. It should describe what the service must deliver, who the service is for, how quality will be assured, what data must be recorded and shared, and how the commissioner and providers will work together to improve performance. It should specify that all equipment used to deliver the NHS Health Check should be fully functional and where appropriate that devices are compliant with Medicines and Healthcare products Regulatory Agency (MHRA) requirements.

As a minimum, commissioners should consider including the following areas in their service specification or contract:

1. Eligible population identification

The specification should set out the exclusion and inclusion criteria as listed in section 2.1.2 above and the Regulations. The commissioner should specify in each provider's contract the minimum number or proportion of eligible people they are expected to invite over a given period, so the commissioner is confident the whole eligible population is covered across the programme.

Providers should have a systematic approach to identifying and inviting all eligible people for an NHS Health Check every 5 years, starting at the age of 40 years. This could be through a birth month scheduling system or through a bespoke cohorting approach that assesses prior knowledge of a person's risk status e.g. smoking status, including where there is no recent recorded check of e.g. blood pressure or BMI. This allows engagement and the health check offer to be tailored to individual need.

Where appropriate, the specification should identify cohorts to be assigned to the provider based on its delivery model and set out targeted outreach requirements to encourage uptake, so that services are delivered at a scale and intensity proportional to the level of need or disadvantage.

Where the provider is outside general practice, commissioners should facilitate agreements between the provider and organisations holding the relevant data, such as GP practices or the ICB, to enable the provider to identify and invite the eligible population. Commissioners should support the establishment of any necessary data-sharing or data-processing arrangements and ensure the provider can access the required data securely and lawfully.

2. Invitations and maximising reach

The specification should set out how providers should invite their eligible population, encourage uptake of the invitation and wider activities to maximise reach. The specification should also set out the data recording requirements for first invitations and reminders.

In line with proportionate universalism, the universal invitation offer should be maintained, while the timing, frequency, method and intensity of engagement may be tailored to improve uptake among priority groups. For instance, this may include individuals with certain risk factors, such as current smokers or those with a high BMI, people living in areas of higher deprivation, or those with missing risk factor information in their record, such as no recorded blood pressure.

The specification could include, but is not limited to:

- Sending a message to raise awareness of the programme and its importance around two weeks before sending an invitation. This could be via SMS or the NHS App. These are referred to as 'warm-up' messages, so the individual is ready to act on the invite when they receive it.

- Sending an invitation around 2 weeks after the warm-up message.

- Agreeing the range of invitation methods to be used, for instance SMS, NHS App message, letter, email, phone call

- Ensuring the booking route within the invitation is clear, simple and accessible, with as few steps as possible.

- Sending at least two reminders if there is no activity following the initial invitation and which method should be used for these. Commissioners may want to suggest using phone calls for those likely to be at high-risk of CVD who have not responded to align with a proportionate universalist approach.

- Maximising opportunities to encourage individuals to book an NHS Health Check if they interact with the provider on other occasions

- Utilising and displaying marketing materials to raise awareness of the importance of the NHS Health Check

The evidence-based NHS Health Check market segmentation could be used to develop content to encourage uptake, such as utilising different messages for those who have previously not attended the NHS Health Check.

Templates for warm-up messages, reminders and invitations which have been developed using behavioural science expertise can be found here.

3. Elements to include within the NHS Health Check

The specification should set out the data that needs to be recorded within the NHS Health Check as set out in section 2.1.3 above and in the Regulations. It should make clear that any checks delivered which do not include this data should not be coded as a complete NHS Health Check.

It should also specify if there are any templates within clinical systems which should be used.

If the commissioner decides to include further questions or assessments in the NHS Health Check, they should ensure these do not detract from the delivery of the required elements of the check.

4. Risk communication and onward pathways

The specification should require providers to communicate results and support next steps in accordance with section 3.4, including advice, signposting, referral and further clinical assessment.

The specification should set out the locally agreed pathways providers are expected to use, including where and how referrals to local programmes or requests for further clinical assessment should be made, what information should be shared, how this should be documented both for individuals records and to enable programme evaluation, and what the individual should be told about next steps.

Local authorities should agree these arrangements with providers and engage relevant partners across the local health system, such as GP practices, Integrated Care Boards, community pharmacy, local authority-commissioned services and voluntary and community sector organisations so that they understand the programme, their role in the pathway and what happens following a check.

Where NHS Health Checks are delivered outside general practice, local authorities should ensure GP practices across the area are aware of the programme, understand how results and requests for further clinical assessment will be communicated, and are prepared to act on them. Local authorities should also monitor the extent to which there is effective communication with, and appropriate action following the NHS Health Check by general practice.

Learning from local delivery: moving from a single check to a prevention pathway

A strong example of how the NHS Health Check can be part of a wider prevention pathway is how some areas have integrated NHS Health Check templates directly into the GP clinical system to enable automated referrals to a locally commissioned behaviour-change service.

In one example, built-in triggers identify people whose data from the NHS Health Checks indicate that behavioural support may be beneficial such as a high BMI, alcohol consumption or smoking status. It automatically transfers the data to the public health team to review, enabling an easier way for the team to know which individuals require a call to offer and encourage them to access behavioural support programmes. Individuals are then provided ongoing support against their agreed behaviour-change goals.

This reduces the number of manual steps required of providers and creates a clearer route from the NHS Health Check into ongoing behaviour change support. The system has helped to achieve improvements in the number of individuals offered behavioural support, and the quality of the follow-up provided to patients.

5. Data recording and information transfer

The specification should set out what data must be recorded during an NHS Health Check, how data should be transferred to the patient record when the check is delivered outside general practice, and how the commissioner should receive data for monitoring and assurance.

Where GP clinical systems and data extraction software are used to support NHS Health Check delivery, the specification should set out expectations for implementation and assurance processes to ensure consistency and accuracy across providers. This may include additional data requests alongside the required quarterly data return, or SNOMED code expectations for invitations to improve data quality.

Contracts should make clear that all NHS Health Check data should be recorded and where the health check is conducted outside of the individual’s GP practice, the provider should forward it to them. Where checks are delivered within general practice, data should be coded directly into the patient record. Where checks are delivered by a community or third-party provider, information should be shared with the individual's GP practice in a clear and structured format that will enable the practice to code the data into the patient

record. This should be done as soon as possible and no later than two working days after the check.

Commissioners should engage with the ICB, local GP practices and other relevant system partners to agree effective information-transfer processes and build the relationships needed to support consistent coding, rather than information being attached solely as a PDF. This is to ensure the patient's record is clinically accurate, and for reporting and quality improvement. More information and examples of data recording and information transfer processes can be found in section 4.

Commissioners should also consider what outcome data could be collected from providers or elsewhere across the local health system to understand the impact of the programme, for example referrals to primary care or behavioural change services, identification of hypertension, and identification of people with a high cardiovascular risk score.

Learning from local delivery: using data extraction systems to improve NHS Health Check delivery

A group of three local authorities working together have transitioned from manual invoicing and data management processes to a real-time NHS Health Check data management and extraction system created significant opportunities for quality improvement, assurance, relationship building, and payment accuracy.

The system has provided valuable insight into NHS Health Check delivery, how data is recorded, and local risk management pathways, enabling an evidence-based approach to improving quality across the programme. Working closely with the software provider to troubleshoot and shape dashboard development has ensured the data meets commissioner needs and has supported effective use of the software beyond our locality.

Access to real-time data has helped identify training needs, particularly around clinical template completion, alcohol screening, and QRISK assessments, allowing for targeted support through training, specification refinement, and commissioner-provider discussions.

Additional benefits include improved payment assurance, eligibility validation, health equity auditing, and a shared understanding of performance and improvement priorities between commissioners and providers.

Initial challenges included provider engagement, confidence in the software, and data extraction across different templates and delivery models. These were overcome through effective change management, collaboration, and open communication with both NHS Health Check providers and the software supplier.

Learning from local delivery: using data to drive targeted action and reduce health inequalities

In one local area, a local data dashboard provides an overview of NHS Health Check invitations and delivery across eligible populations. This is extracted directly from clinical records by an ICB data team and contains functionality to exclude patients who have opted out of data aggregation. The dashboard allows data to be analysed by age, ethnicity and gender.

Routine analysis of dashboard data helped identify lower NHS Health Check uptake among Caribbean communities compared with other population groups. This insight informed a collaborative response involving health services, neighbourhood teams and voluntary and community sector partners to develop a tailored engagement approach aimed at increasing participation. The data also helped inform decisions about where investment and resources can be most effectively directed, supporting efforts to reduce health inequalities and improve access to the programme.

The transition to a more integrated data collection process has brought additional operational benefits, including access to benchmarking information which allows performance to be compared across practices and localities, helping to identify variation and opportunities to share best practice.

6. Payment and incentives

Payment mechanisms should support the outcomes the commissioner wants to achieve and should not create incentives to prioritise activity that is easiest to deliver over activity that is most needed. Commissioners should regularly review payment arrangements to ensure they promote year-on-year improvement, delivery of a high-quality service, and support proportionate universalism.

Depending on local contracting arrangements, payment may be linked to invitations, completed checks, data completeness, quality requirements, improvement actions or agreed equity measures.

Commissioners should only remunerate NHS Health Checks where the required data listed in section 2.1.3 has been recorded and this should be made clear to providers. NHS Health Checks without the required data should not be coded as complete. If the information cannot be obtained because the person undergoing the check is unable or refuses to provide it or does not consent to any test or procedure necessary to obtain that information, these should not be coded as complete and the local authority should decide how to remunerate in these circumstances.

Learning from local delivery: designing a payment model which incentivises delivery

Discussions with local authorities who have achieved relatively high NHS Health Check coverage, or demonstrated significant recent improvement, highlighted the importance of payment models in influencing provider behaviour. Rather than relying solely on a flat payment per completed NHS Health Check, these areas used payment mechanisms to encourage continuous improvement in delivery.

Examples from local practice show a range of approaches. In one area, providers receive bonus payments for achieving coverage thresholds, with an additional payment available when 75% coverage is achieved and a larger bonus available when 100% coverage is achieved. This creates an incentive to continue improving performance rather than simply delivering activity up to a minimum level.

Another local authority refined its payment model following the pandemic, moving away from a simple payment-per-check approach and introducing graduated payments linked to 60%, 75% and 85% of NHS Health Check coverage in the eligible population. Local leaders reported that this approach helped maintain motivation across GP practices by ensuring providers at different stages of improvement all had an achievable stretch target. This payment model change formed part of a wider improvement programme that contributed to sustained increases in delivery, including setting clear KPIs, risk-based prioritisation tools and providing direct support to providers. This wider programme was associated with a significant improvement of the area's coverage, with the area moving from below-average performance to becoming one of the highest-performing local authorities in England.

These examples demonstrate how payment models can be designed to encourage continuous improvement while keeping providers engaged at different levels of performance.

7. Workforce and training

The specification should set out what training is expected of those delivering the NHS Health Check and the responsibilities of the commissioner and providers in relation to training. The NHS Health Check Competency Framework (2020) provides a guide for commissioners and providers on the competencies staff need to have to deliver NHS Health Checks.

8. Performance monitoring and contract management

Commissioners should ensure that contracts support delivery of the statutory requirements and national ambitions for the NHS Health Check programme and include KPIs to align with this. This includes offering an NHS Health Check to all eligible individuals every five years and supporting continuous improvement in the proportion of eligible individuals receiving an NHS Health Check. Contracts should also aim to support progress towards the NHS Health Check ambitions set out in the CVD MSF.

Commissioners should also consider including additional KPIs within contracts to reflect local priorities and population need. These may include the number of eligible people invited, completed checks, completion by population group or geography, data completeness, any locally agreed improvement priorities, and monitoring of NHS Health Check outcomes such as referrals, diagnoses made, treatment offered and outcomes from behavioural interventions such as weight reduction or smoking quits. Analysis of NHS Health Check outcomes enables commissioners to understand and communicate the effectiveness and impact of the programme on CVD prevention.

Contract management meetings should be used to review performance, identify issues, and agree and monitor improvement actions. Commissioners could also use clinical system searches to assess the quality and completeness of delivered checks, including whether all required fields were completed, whether information was recorded at the time of the check, and whether appropriate onward referrals were made.

Learning from local delivery: using contract management as an improvement tool

High-performing local authorities described using contract management as a mechanism for continuous improvement rather than solely for performance monitoring or payment reconciliation.

Examples from local practice included using practice-level dashboards and contract review templates to compare invitations, completed checks, conversion rates, quality indicators and progress against agreed targets. These discussions enabled commissioners and providers to identify variation in performance, understand barriers to delivery and agree practical actions for improvement. It also displayed how much money the provider had made and how much they were missing out on if they had low delivery rates. A template of a dashboard which could be used can be found here.

Several areas also used contract review meetings to assure the quality of completed checks by reviewing whether key elements of the NHS Health Check, including QRISK completion, coding and required data collection, had been completed and recorded appropriately.

This approach helps make missed opportunity and quality issues visible, while keeping the focus on improvement.

2.4 Providing a quality service and continuous improvement

The Regulations set out that in discharging the requirements in respect of the NHS Health Check offer, local authorities must act with a view to securing continuous improvement in the percentage of eligible individuals in its area participating in an NHS Health Check.

Therefore, commissioners should regularly review how the NHS Health Check is commissioned to ensure the service continues to meet local population need and assess CVD risk. This should include using programme data, provider and patient feedback, local intelligence and learning from contract management to identify what is working well, where improvements are needed and whether the current delivery model, provider mix, payment arrangements and pathways remain appropriate.

Commissioners and their providers are both responsible for establishing and clearly setting out the level of data access required to achieve this, adhering to information governance and privacy requirements. See section 4.1 for more information.

Equity should also be considered as part of ongoing service quality and improvement plans. Commissioners should regularly assess whether NHS Health Check resources, access and outcomes are equitable, and take action where inequalities are identified. As mentioned in section 2.1.5, the Health Equity Assessment Tool (HEAT), can support this assessment. For more detailed guidance on assessing equality of access and outcomes, please refer to the NHS Health Check Health Equality Audit Guidance.

The NHS Health Check Systematic Approach to Raising Standards (StARS) framework is a national quality improvement tool (published in 2015) that local authorities can use to provide a structured, systematic approach to reviewing and improving programme quality and delivery. More recently, some regions have developed their own version of this framework, an example of which can be found here.

A national primary care audit (CVDPREVENT) is available to support primary care and local partners to identify variation in the identification, diagnosis and management of CVD conditions.

Section 3: NHS Health Check end-to-end pathway

3.1 Overview

This section of the guidance sets out the end-to-end pathway which all NHS Health Checks should follow, regardless of where they are delivered. It explains what each stage should entail, including the assessment tools which can be used, the data which should be collected, relevant clinical guidance and best practice actions.

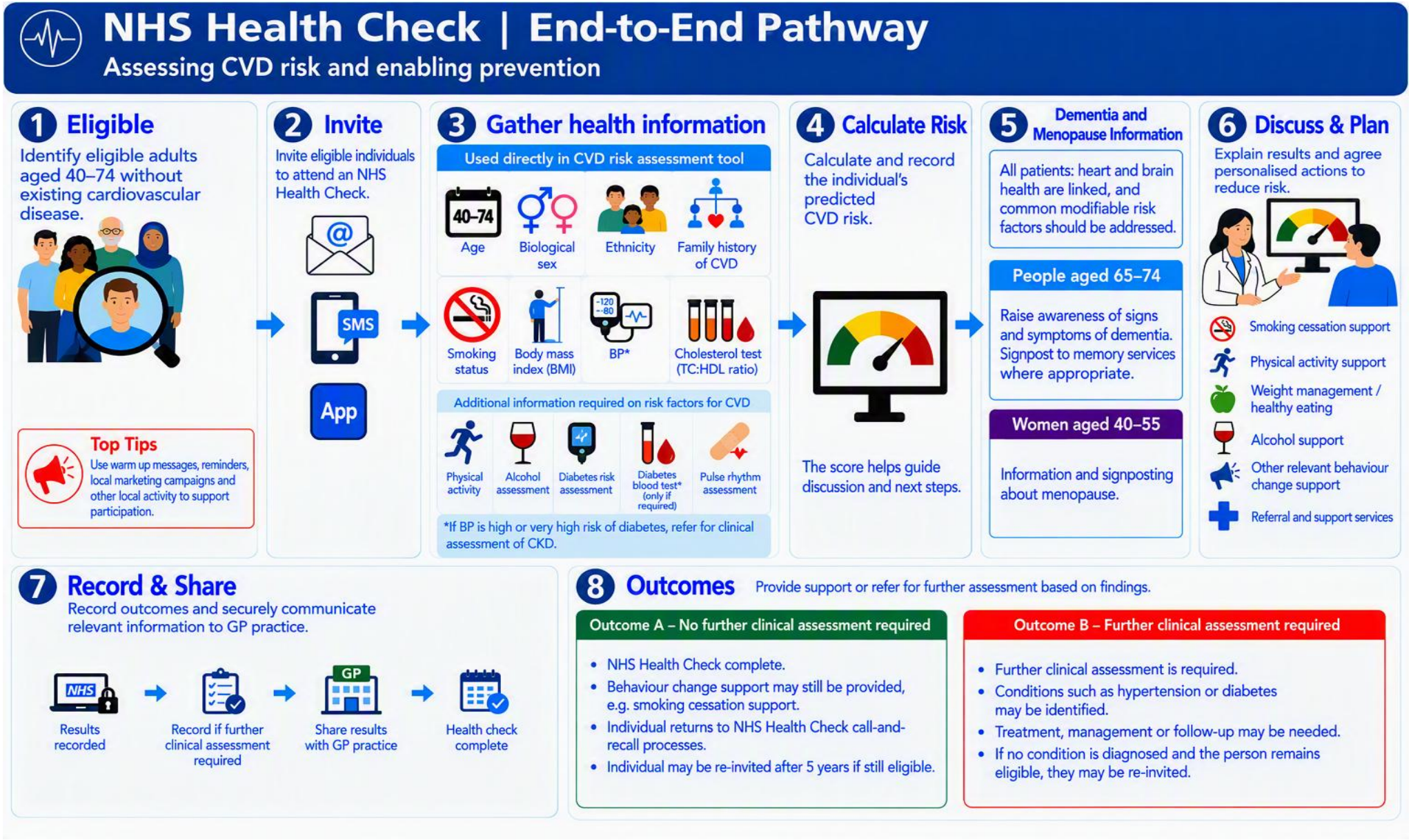
NHS Health Checks should be carried out by appropriately trained, culturally competent staff and include the following components:

- identifying and inviting the eligible population, considering local health inequalities and providing appointment opportunities to suit population access requirements.
- collecting data on behavioural risk factors and family history of CVD to input into a CVD risk assessment algorithm.
- performing a pulse rhythm and blood pressure check, referring to the patient's GP for further assessment as required.
- undertaking the GPPAQ and AUDIT questionnaires to further understand behavioural risk factors
- conducting a cholesterol test to input into the CVD risk assessment algorithm
- using a diabetes risk filter to determine if a blood test for diabetes is needed and conducting this test if required
- providing information to all that the risk factors for CVD are the same as those for dementia and for those aged 65-74 make them aware of the signs and symptoms of dementia and be signposted to memory services if appropriate.
- for women aged 40-55, asking if they know where to get information about the menopause and if they do not, provide relevant signposting.
- communicating the results of the CVD risk assessment to the patient, discussing modifiable risk factors and agreeing personalised actions, signposting or referring to behavioural change support services where appropriate.

- ensuring all data, results and whether further clinical assessment is needed is communicated to the GP practice to allow for coding in the patient's record and appropriate action.

Diagram 2 provides a visual representation of the NHS Health Check pathway.

Diagram 2: NHS Health Check end-to-end pathway



3.2 Identifying and inviting individuals to the NHS Health Check

3.2.1 Identifying and cohorting the eligible population

Commissioners should set out who is responsible for identifying the eligible population and sending invitations. In most cases, this will be the provider. Where NHS Health Checks are delivered outside general practice, commissioners should ensure appropriate data-sharing and data-processing arrangements are in place to enable providers to securely and lawfully access the information required to identify and invite the eligible population.

Providers should use GP clinical system searches, data extraction systems or other locally agreed methods to identify eligible individuals in line with the eligibility criteria set out in section 2.1.2 and the Regulations.

Commissioners may specify in their contracts that certain cohorts within the eligible population should receive invitations before others or be invited through certain communication routes. Prioritising these groups allows more time for tailored engagement which can improve uptake. Providers should follow the commissioner's guidance on how to identify and prioritise these groups. Where no priority cohorts have been specified, providers should consider focusing more assertive follow-up invites for those most likely to benefit first, for example by refining eligibility searches to identify people with missing risk factor data or recent recordings that suggest higher cardiovascular risk, such as BMI or smoking status.

Pregnancy could influence key metrics such as blood pressure and BMI, which in turn will affect the individual's CVD risk score. Therefore, the advice is to defer the NHS Health Check and re-offer from around 12 months post-partum.

There are also 'health checks' for people with severe mental illness and checks for people with learning disabilities. These checks differ from the NHS Health Check in scope, target audience and frequency. Individuals (aged between 40 and 74) who are eligible for those checks are also eligible for the NHS Health Check unless they are excluded based on NHS Health Check exclusion criteria.

3.2.2 Inviting the eligible population

Once the cohort has been determined, the provider should engage the population in line with the approach agreed between the commissioner and provider. Local arrangements may vary and different organisations may be responsible for different stages, for example, sending the initial invitation and subsequent reminders, so commissioners should ensure that responsibilities are clearly agreed.

However, regardless of who is responsible for the activity, it is best practice that all of those in the eligible population are sent a warm-up message, followed by an invitation and at least two reminders if the individual has not engaged. This is to maximise the likelihood someone will take up the invitation. Table 1 below provides more detail on this.

Providers should use the templates provided in the table which have been developed using behavioural science input. These should also be considered alongside the evidence-based NHS Health Check market segmentation tool which describes tailoring messaging to different population groups. A summary of this work can be found here.

Table 1 also sets out how the activity should be coded. Using these will reduce the risk of double counting of first invites when reporting figures to DHSC. More information can be found in section 4.2.

Table 1: NHS Health Check communications and coding

	Description	**Coding**
Warm-up message	Warm-up messages are messages sent prior to an invite to raise awareness of the programme so an individual is more likely to act when they receive their invite.	This should not be coded as an invitation.
First invite/ offer	Following the warm-up message, individuals should be invited using the method agreed with the commissioner, for example by SMS, the NHS App, email or letter. We advise that providers should send the invite within two weeks of the warm-up message.	All first invitations to the NHS Health Check, regardless of the method, should be coded with *523281000000104 | National Health Service Health Check invitation first letter (procedure)*
Reminders	Reminders are any invites or offers sent after the initial one in the 5-year period, using this term will avoid confusion when it comes to data collection. Reminders should be sent to individuals who have not booked an appointment to encourage them to take up the offer.	First reminders should be coded with *523301000000103 | National Health Service Health Check invitation second letter (procedure),* and any further reminders or offers should be coded with *523321000000107 | National Health Service Health Check invitation third letter (procedure).*

Some suggested wording for communications can be found here.

3.3 Conducting the check

The NHS Health Check involves asking specific questions to gather data to calculate an individual's CVD risk and consider if any behaviour change advice should be given. Providers may wish to consider collecting some of this data via a questionnaire prior to the appointment.

Table 2 below lists the information which needs to be collected during all NHS Health Checks, how it should be used and suggested actions for the different elements. NHS Health Checks are carried out in a range of settings, but irrespective of mode of delivery all the specified information must be recorded.

There is an expectation that providers of the NHS Health Check should follow relevant NICE guidance and other national guidance on the different elements of the check. Table 2 provides links to relevant guidance and other useful resources for providers to signpost to.

More detail on the clinical assessment tools is provided below the table in section 3.5.

A one-page summary is available here to support those delivering the check during the appointment.

It is a statutory duty that specified information obtained during the NHS Health Check data must be recorded. This data should be recorded in the individual's GP record. It is also best practice to include in the record any behavioural advice given, referrals where relevant and if further clinical assessment is needed.

If the check is conducted outside the relevant GP practice, a record of the health check containing the required information set out in the Regulations must be sent to the individual's GP practice. This should be done as soon as possible and no later than two working days after the check. The receiving GP practice should code the data in the relevant individual's record- the practice should not just attach a PDF to the consultation record. Structured, coded and extractable information is needed for clinical continuity and management of the end-to-end pathway, including call and recall and for clinicians conducting any further clinical assessment.

The relevant codes for the NHS Health Check can be found in the information standard: NHS Health Check Information Standard - Update to ISB 1080 - NHS Standards Directory. For more information, see section 4.1.

The information standard does not yet include the menopause content. If signposting on menopause is given during the check, the following code should be recorded on the patient record: *313207002 | Menopause education (procedure)*.

NHS Health Check templates available within GP clinical systems can support consistent programme delivery, standardise data entry and improve data quality. Where available, providers may wish to use these to conduct an NHS Health Check. Unless any additions to the NHS Health Check are specified by commissioners, providers may disregard optional items listed in NHS Health Check templates within GP clinical systems and should prioritise the required components of the NHS Health Check. For more information, see section 4.2.

3.4 Communicating results and next steps

Table 2 below provides recommended actions for the different elements of the NHS Health Check and useful resources to share with or signpost individuals to according to their results and identified risk factors.

Once the CVD risk score has been calculated, the provider must communicate the score to the person as soon as practicable after the test. The provider should explain the individual's results clearly including whether the individual's 10-year CVD risk is low, moderate or high, what this means and the factors contributing to it. Results should be discussed in plain language, with an opportunity for the individual to ask questions and confirm their understanding.

The results should then inform a personalised conversation about reducing future risk, consistent with principles from Making Every Contact Count, Healthy Conversation Skills, and NICE guidance on behaviour change (PH49) and shared decision making (NG197). This should include recognising positive behaviours, identifying potential barriers to change and discussing practical strategies or sources of support to overcome them, and agreeing realistic actions based on the individual's circumstances and confidence. This may include offering brief advice, information, signposting or referral to local services. Relevant resources in Table 2 should be shared with the individual using usual local communication methods, such as by SMS, email, leaflets or NHS App message. Providers may also wish to populate and share the NHS Health Check results card template with the individual, alongside any supporting resources. This can be found here.

Where further clinical assessment, repeat testing or consideration of treatment is needed, the provider should follow the locally agreed pathway and explain to the individual what will happen next. If the NHS Health Check is delivered outside the individual's GP practice, the information required to be recorded during the check must be communicated to them.

Information on any need for further clinical assessment should also be included, and the individual's GP practice would be responsible for ensuring that this is completed.

If further clinical assessment does not result in a diagnosis of a condition within the exclusion criteria, they remain eligible for another NHS Health Check five years after their previous check, provided they continue to meet the eligibility criteria.

Table 2: NHS Health Check components, thresholds, actions and supporting resources

Category	Measure	Categories / Thresholds	Action	Relevant guidance	Resources to share with patients
CVD risk assessment tool inputs	**Age**	40-74 years inclusive	Confirm eligibility and record for CVD risk assessment calculation.		
	Sex See section 3.7.3 for further information on sex and gender	Biological sex	Record for CVD risk assessment calculation.		
	Ethnicity	White/not stated; Indian; Pakistani; Bangladeshi; Other Asian; Black African; Black Caribbean; Chinese; Other ethnic group	Record using CVD risk assessment ethnicity categories and include in diabetes risk assessment if applicable.		
	Family history of coronary heart disease (CHD)	First-degree relative with heart attack or angina under 60 years. 'First-degree' relative means father, mother, brother or sister.	Record for CVD risk assessment calculation		Family history of heart and circulatory conditions - BHF
		Non-smoker			

Category	Measure	Categories / Thresholds	Action	Relevant guidance	Resources to share with patients
	Smoking status	Ex-smoker Light smoker (<10/day) Moderate smoker (10-19/day) Heavy smoker (≥20/day)	Record for CVD risk assessment calculation. Deliver verbal brief advice (VBA) to all current smokers and offer referral to local stop smoking services.	NICE guidance NG209: Tobacco: preventing uptake, promoting quitting and treating dependence | Guidance | NICE	Quit smoking - Better Health - NHS Find stop smoking support services - NHS
	Body Mass Index (BMI) *Lower thresholds apply for people with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean background	**Underweight:** less than 18.5 kg/m^2 **Healthy weight:** 18.5 to 24.9 kg/m^2 **Overweight**: 25 to 29.9kg/m^2 (*23 to 27.4kg/m^2) **Obese:** 30 kg/m^2 or more (*27.5kg/m^2 or more)	Record BMI for CVD risk assessment and use for diabetes risk assessment if required. Offer weight management advice and referral/signposting if the person is overweight or obese. Consider referral for clinical assessment if person is underweight	NICE guidance NG 246: Overweight and obesity management NICE quality standard QS 212: Overweight and obesity management	How to lose weight | Weight loss tips and advice - Better Health - NHS Couch to 5k | Better Health - NHS Healthy recipes | Better Health - NHS
	Blood pressure (BP)	**Normal**: <140/90mmHg	Record BP for CVD risk assessment calculation and use for diabetes risk assessment if required. Where BP is high (140/90mmHg or higher), the individual requires an assessment by primary care.	NICE guideline NG136: Hypertension in adults: diagnosis and management	High blood pressure | NHS Signposting should focus on managing the relevant behavioural risk factors.

Category	Measure	Categories / Thresholds	Action	Relevant guidance	Resources to share with patients
		High: Systolic BP≥140mmHg and/or Diastolic BP≥90mmHg	Where an individual is diagnosed with hypertension, they should also be **assessed for chronic kidney disease (CKD)**, which includes a venous blood test (urea and electrolytes) to determine eGFR and a urine sample for albumin-to-creatinine ratio (ACR) (see section 3.5.6) Same-day referral for clinical assessment if the individual has very high blood pressure (180/120mmHg or higher)		
	Cholesterol See section 3.5.4 for further information	Total cholesterol: High Density Lipoprotein (TC:HDL) ratio	Input TC:HDL ratio into CVD risk assessment tool to determine overall long term CVD risk Follow NICE and national guidance for lipid management, offering healthy lifestyle advice and/or referral for clinical assessment as applicable to results In line with NICE recommendations (CG71), individuals with very high TC levels (>7.5mmol/L) should be referred on for clinical assessment of suspected familial	NICE guideline NG238: Cardiovascular disease: risk assessment and reduction, including lipid modification NHS Accelerated Access Collaborative » Summary of national guidance for lipid management	Low HDL cholesterol levels - Heart UK Understanding your cholesterol results - Heart UK How to eat less saturated fat - NHS UK 5 cholesterol-lowering foods - British Heart Foundation Tips to reduce your cholesterol levels - British Heart Foundation Cholesterol Smart Home - Heart UK

Category	Measure	Categories / Thresholds	Action	Relevant guidance	Resources to share with patients
			hypercholesterolaemia irrespective of the CVD risk score.	NICE guideline CG71: Familial hypercholesterolaemia Identification and Management	
Other behavioural risk factors	**Physical activity level using GPPAQ**	Active	Reinforce positive physical activity behaviour and consider signposting to local support where appropriate.	NICE guideline PH44: Physical activity: brief advice for adults in primary care UK CMO physical activity guidelines UK CMO physical activity life stage infographics	Get active - Better Health - NHS Couch to 5k | Better Health - NHS NHS Active 10, walking app Exercise - NHS How to improve your strength and flexibility - NHS Helping you move more - Sport England Home workout videos | Better Health - NHS Be More Active Whilst Living With A Health Condition
		Moderately active	Provide physical activity advice and consider referral to local support where appropriate.		
		Moderately inactive	All adults should aim for at least 150 minutes a week. Support those doing none or little physical activity to build more movement into everyday routines – this is where the greatest health benefits are achieved. Consider referral to local support.		
		Inactive			
	Alcohol risk assessment	**Low risk:** AUDIT-C <5, FAST <3, AUDIT score 0-7	Reinforce positive behaviour	Guidance on the 5 alcohol use	Structured advice tool – designed as a guide for practitioners giving brief interventions and as a

Category	Measure	Categories / Thresholds	Action	Relevant guidance	Resources to share with patients
	If AUDIT-C ≥5 or FAST ≥3, then a full AUDIT needs to be completed. See section 3.5.1 for further information	**Increasing risk:** 8-15 AUDIT score	Deliver alcohol brief intervention and signpost to tools to support reducing alcohol consumption.	screening tests - GOV.UK Clinical guidelines for alcohol treatment - Guidance - GOV.UK E-learning module for giving alcohol brief advice or referring to treatment- NHSE elfh Hub	takeaway patient information leaflet Drink less alcohol - Better Health - NHS NHS Drink Free Days app The risks of drinking too much - NHS Tips on cutting down on alcohol - NHS A guide to alcohol units (and signs of alcohol dependence) | NHS For people who might need specialist support to reduce alcohol consumption: Alcohol support- NHS
		Higher risk: 16-19 AUDIT score	Deliver alcohol brief advice and signpost to tools to support reducing alcohol consumption. The individual should also have further clinical assessment and onward referral for tests as appropriate and as per local pathway.		
		Possible dependence: 20 or higher AUDIT score	Refer to alcohol treatment services and further clinical assessment and onward referral for tests as appropriate and as per local pathway.		
CVD risk assessment result	**CVD risk assessment score** See section 3.5.5 for further information	**Low risk:** <10% QRISK score	Regardless of the risk score, communicate risk score clearly, reinforce positive behaviour, and support behaviour change through providing advice and signposting.	NICE guidance NG238: Cardiovascular disease: risk assessment and reduction, including lipid modification.	Signposting should focus on managing the relevant behavioural risk factors.
		Moderate risk: 10-19.9% QRISK score			
		High risk: ≥20% QRISK score			

Category	Measure	Categories / Thresholds	Action	Relevant guidance	Resources to share with patients
			if QRISK ≥10%, refer for clinical assessment		
Other clinical measurements	**Pulse rhythm at radial or brachial pulse before measuring BP**	Regular pulse	If **irregular pulse**, the individual should be referred for clinical assessment for atrial fibrillation.	NICE guidance NG196: Atrial fibrillation: diagnosis and management	Atrial fibrillation - NHS
		Irregular pulse			
Diabetes risk assessment and testing	**Diabetes risk filter** See section 3.5.2 for further information	Use a validated diabetes risk assessment tool and offer blood test for diabetes for individuals meeting risk assessment levels as set out in section 3.5.2. When no risk assessment tool is available, offer a blood test for diabetes for individuals with high blood pressure or obesity.	Offer a blood test for diabetes.	NICE guidance PH38: Type 2 diabetes: prevention in people at high risk	
	Blood test for diabetes	**Moderate risk (if high risk on assessment tool**	Consider brief advice and referral to structured weight loss programme, if relevant	NICE guidance PH38: Type 2 diabetes:	Diabetes - NHS

Category	Measure	Categories / Thresholds	Action	Relevant guidance	Resources to share with patients
	See section 3.5.3 for further information	**but blood test for diabetes in normal range)**: HbA1c <42mmol/mol (6.0%) or FPG <5.5mmol/L (100mg/dL)		prevention in people at high risk NHS Diabetes Prevention Programme	10 tips for healthy eating | Type 2 diabetes risk | Diabetes UK How to prevent type 2 diabetes | Diabetes UK Healthier You | Diabetes Prevention
		High risk (pre diabetes): HbA1c 42-47 mmol/mol (6.0-6.4%) or FPG 5.5-6.9mmol/L (100-125mg/dL)	Discuss modifiable risk factors and refer (or signpost) to the NHS Diabetes Prevention Programme		
		Very high risk: HbA1c ≥ 48mmol/mol (≥ 6.5%) or FPG ≥7 mmol/L (>=126mg/dL)	Refer to GP practice team for clinical assessment, repeat blood test. The GP practice team should also assess for **CKD,** which includes a venous blood test (urea and electrolytes) to determine eGFR and a urine sample for albumin-to-creatinine ratio (ACR) (see 3.5.6)		

Category	Measure	Categories / Thresholds	Action	Relevant guidance	Resources to share with patients
Additional NHS Health Check elements	**Dementia**	**All attendees**	Make attendees aware that the risk factors for CVD are the same as those for dementia. The person delivering the check should explain that: • What is good for the heart is good for the brain • Up to 45% of cases of dementia could be prevented or delayed by targeting modifiable risk factors[5]. • Modifiable risk factors, which increase the risk of dementia and are addressed through the NHS Health Check include high blood pressure, alcohol consumption, obesity, smoking, and physical inactivity.	NICE guidance NG16: Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset NICE quality standard QS184: dementia NHS Health Check - Dementia training	What is dementia - NHS
		Attendees aged 65-74	Make the individual aware of the signs and symptoms of dementia and signpost to memory services through local pathways if appropriate		

[5] Livingston G, Huntley J, Liu K et al. **Dementia prevention, intervention, and care: 2024 report of the *Lancet* standing Commission**. The Lancet, 2024; 404, 572-628

Category	Measure	Categories / Thresholds Action	Relevant guidance	Resources to share with patients
	Menopause	Women aged 40-55 should be asked the following: *Menopause can cause periods to change or stop. You may feel sudden hot feelings (hot flushes) and nighttime sweating, poor sleep, and mood changes. Treatment can help with symptoms and support your long-term health.* *Do you know where to get more information about the menopause?* If the individual says they do not know where to go for information, providers should share the relevant resources from the last column. These provide more information and detail on where the individual can go for support.	The content has been designed so no specific menopause training is required. However, if the individual delivering the check would like more information, the following e-learning resource may be helpful: NHSE elfh Hub	**Link between menopause and CVD risk:** Menopause and heart and circulatory conditions - BHF **General resources on menopause:** Menopause - NHS The menopause - Women's Health Concern Self-Care Forum -Menopause Fact Sheet Menopause Support- Understanding Menopause **More specific resources on menopause:** Mind- How can menopause affect mental health? British Menopause Society: Menopause and weight gain Royal Osteoporosis Society - What's the menopause got to do with bone health? Daisy Network - Supporting women with Premature Ovarian Insufficiency

Category	Measure	Categories / Thresholds	Action	Relevant guidance	Resources to share with patients
					British Menopause Society: Menopause in ethnic minority women

3.5 Further information on assessment tools

As set out in the table above, within the NHS Health Check, different risk filters or assessment tools need to be used for different elements of the check. This section provides more detail on these tools and how they should be used.

3.5.1 Alcohol risk assessment

The Regulations set out that the Alcohol Use Disorder Identification Test-Consumption score (AUDIT) must be recorded as part of the NHS Health Check. The Regulations define AUDIT as 'a score categorising the level of risk associated with the person's alcohol consumption'. This AUDIT tool identifies health risks from alcohol use and enables brief interventions to provide timely advice, support, or referral to specialist alcohol services.

To deliver this section of the NHS Health Check, the provider should begin with conducting AUDIT-C or FAST. This is to determine whether the full AUDIT questions need to be asked.

AUDIT-C consists of the three consumption questions from the full AUDIT. These questions and information on how to calculate the score can be found here: Alcohol use disorders identification test for consumption (AUDIT-C).

Providers could also use FAST instead of AUDIT-C. This is another alcohol harm assessment tool which consists of a subset of questions from the full AUDIT questionnaire. The questions and information on how to calculate the score can be found here: Fast alcohol use screening test

If AUDIT-C ≥5 or FAST ≥3, the provider will need to ask the remaining AUDIT questions and calculate the full AUDIT score to determine the person's risk.

An AUDIT score of 8-15 indicates increasing-risk drinking,16-19 is higher risk and 20 or higher suggests possible dependence.

People whose score is 8 or over should be advised of their level of risk and be given advice on reducing it and signposted to resources provided in Table 2.

NICE National guidance NG50 recommends that people with a score >15 on AUDIT are in the group at elevated risk of cirrhosis and should be referred for further clinical assessment as per local pathway,

3.5.2 Diabetes risk filter

The diabetes risk filter is used to decide whether an individual should be offered a blood test for diabetes as part of the NHS Health Check. It is not itself a diagnostic test for diabetes.

Where available, providers should use one of the following validated diabetes risk assessment tools:

- **Cambridge Diabetes Risk Score:** a tool which uses information such as age, sex, BMI, family history, smoking history and prescribed medication to assess diabetes risk. ***A score above 0.2 indicates a blood test for diabetes is needed.***

- **QDiabetes**: a computer-based risk assessment tool which estimates a person's risk of developing type 2 diabetes over the next 10 years. It asks about family history, smoking status, medical history and prescribed medication. ***A score above 5.6 indicates a blood test for diabetes is needed.***

- **Leicester Practice Risk Score:** a practice-based tool which can be used with data from GP records. It uses routinely recorded information including age, sex, BMI, ethnicity, family history of diabetes and anti-hypertensive use. ***A score above 4.8 indicates a blood test for diabetes is needed.***

- **Leicester Risk Assessment Score**: a questionnaire-based tool suitable for use in community or outreach settings where GP record access is limited. It includes questions on age, sex, ethnicity, family history, waist measurement, BMI and high blood pressure. **A score of 16 or above indicates a blood test for diabetes is needed.**

The choice of tool will depend on the local delivery model and the information and assessment tool available in the setting. For example, QDiabetes and the Leicester Practice Score are more suited to settings where information can be drawn from GP records or a structured clinical system, while questionnaire-based approaches such as the Leicester Risk Assessment Score may be more practical in community or outreach settings where record access is limited.

If a validated tool is not available, if **any of the following apply** a blood test for diabetes should be offered:

- BMI of 30 kg/m² or above

- BMI of 27.5 kg/m² or above for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African Caribbean backgrounds

- blood pressure of 140/90 mmHg or above, systolic blood pressure above 140 mmHg, or diastolic blood pressure above 90 mmHg

The person delivering the check should also consider offering a blood test for diabetes to the following even if a risk filter does not indicate it is needed as they will still be at significant risk:

- people with first-degree relatives with type 2 diabetes or heart disease

- people with tissue damage known to be associated with diabetes, such as retinopathy, kidney disease or neuropathy
- women with past gestational diabetes
- those with conditions or illnesses known to be associated with diabetes, such as polycystic ovarian syndrome or severe mental health disorders
- those on current medication known to be associated with diabetes, such as oral corticosteroids

Where the filter indicates increased risk, the provider should offer a blood test for diabetes as part of the NHS Health Check, as outlined in the next section.

The diabetes risk filter should also be used to support prevention conversations. People identified as being at high risk should be told that their risk of developing type 2 diabetes can be reduced, and should be offered appropriate lifestyle advice, signposting and referral to an evidence-based diabetes prevention programme where they meet the local referral criteria.

3.5.3 Blood testing for diabetes

There is no single universally recognised blood test for high risk of diabetes, or for diabetes itself. HbA1c is most often used, with fasting plasma glucose and oral glucose tolerance test (OGTT) as alternative options.

3.5.3.1 HbA1c (glycated haemoglobin)

HbA1c testing does not require fasting, so can be more convenient for patients. HbA1c is formed when glucose binds to haemoglobin in red blood cells. The higher the plasma glucose over the past two or three months, the higher the HbA1c. Even within the non-diabetic range, HbA1c has been shown to be a risk marker for vascular events and can be used to assess the risk of diabetes. HbA1c is not a reliable measure in certain conditions, such as severe anaemia (including caused by glucose-6-phosphate dehydrogenase deficiency) or haemoglobinopathies such as sickle cell anaemia or thalassemia.

NICE guidance PH38 advises that HbA1c values between 42 and 47mmol/mol (6.0-6.4%) indicate that the individual is at high risk of type 2 diabetes, with scores above that suggesting very high risk.

If the values are less than 42 mmol/mol but the risk filter suggested that the individual was at high risk of diabetes, they should still be classified as at moderate risk.

3.5.3.2 Fasting plasma glucose and oral glucose tolerance tests

A fasting plasma glucose (FPG) and oral glucose tolerance test (OGTT) are alternative tests which can be used to identify diabetes risk.

To undertake these tests, the individual being tested should be informed of the fasting requirement in writing or over the phone. If possible, the appointment should be scheduled for no later than 11am, to make fasting easier.

NICE guidance PH38 advises that FPG value between 5.5 and 6.9mmol/l indicate that the individual is at high risk of type 2 diabetes, with scores above that suggesting very high risk.

3.5.3.3 Interpreting results

The result should be interpreted alongside symptoms and clinical judgement. If the individual has an abnormal diabetes blood test result, they should be referred for clinical assessment and repeat bloods in line with NICE guidance PH38 section 1.5. This should be recorded in their patient record.

Any individual identified as high risk from the filter or the blood test, should be advised on how to reduce modifiable risk factors. The provider should also consider a referral to the NHS Diabetes Prevention Programme (NHS DPP) if they are able to do so or suggest this to the individual's GP when communicating results.

Any individual identified as very high risk from the blood test, with results in the diabetic range, should be referred for clinical assessment by the GP practice team. This should include a repeat blood test to confirm diabetes and an assessment for chronic kidney disease (see section 3.5.6).

Results, test type and any referral or advice should be recorded in the individual's GP record or communicated clearly to the GP practice where the NHS Health Check is delivered outside general practice. The individual's GP practice is responsible for further clinical assessment and risk management.

More detail is provided in section 3.6.2 below on the appropriate use of point of care testing.

3.5.4 Blood testing for cholesterol

In the NHS Health Check, the ratio of total cholesterol (TC) to high-density lipoprotein cholesterol (HDL) is used to calculate the CVD risk score. In line with NICE recommendations (CG71), practitioners should be aware that people with very high total cholesterol (> 7.5 mmol per litre) should be referred for clinical assessment for suspected familial hypercholesterolaemia, irrespective of their CVD risk score.

A cholesterol reading from the previous six months does not need to be repeated and can be used in the NHS Health Check.

Further detail is outlined in this summary of national guidance for lipid management for primary and secondary prevention of cardiovascular disease.

3.5.5 CVD risk assessment tool

QRISK is the recommended cardiovascular disease risk assessment tool used to estimate an individual's risk of having a cardiovascular event over the next 10 years. Within the NHS Health Check, the QRISK calculation brings together information collected during the check, including age, sex, ethnicity, smoking status, blood pressure, total cholesterol/HDL ratio, BMI and relevant family history.

NICE guidance NG238 recommends the use of QRISK3 for CVD risk assessments, however it acknowledges an ongoing need to use QRISK2 where QRISK3 is not available. Providers should continue to use QRISK2 where it is the only available version that is integrated into GP IT systems. The web-based version of QRISK3 is not suitable for clinical use.

Providers should ensure that all required inputs are recorded accurately before calculating the score. The result should be communicated clearly to the individual during the NHS Health Check, including whether their 10-year risk is low, moderate or high, and what the result means for their personal risk. Table 2 above outlines the following risk categories: low risk is less than 10%; moderate risk is 10% to 19.9%; and high risk is 20% or above.

Regardless of the risk score, providers should use the results to identify modifiable behavioural risk factors, such as smoking, physical inactivity, alcohol consumption or obesity, and support meaningful behaviour change. This should include agreeing realistic actions with the individual and, where appropriate, providing brief advice, signposting to further resources or referring them to behavioural change programmes.

People with a score of 20% or above should be referred to the locally agreed high-risk pathway. People with scores of 10% or above should be referred for consideration of lipid lowering therapy. There may be situations when lipid lowering therapy is considered for people with scores less than 10% (see NICE NG238). If lipid lowering therapy is prescribed, the individual will no longer be eligible for an NHS Health Check. However, if it is not prescribed and in five years no other exclusion criteria are met, they will remain eligible.

The QRISK score and the data used to calculate it should be recorded in the individual's GP record. Where the check is delivered outside general practice, commissioners and providers should agree how the result, risk category, advice given and any referral or further clinical assessment will be communicated to the GP practice for coding and action.

3.5.6 Chronic kidney disease (CKD) assessment

The CVD Modern Service Framework highlights the benefits of a cardiovascular-kidney-metabolic (CVKM) approach. The NHS Health Check provides a good opportunity to identify people who have risk factors for CKD, such as hypertension and diabetes.

Individuals with blood pressure above 140/90 mmHg or a diabetes blood test result in the very-high-risk range should be referred for further clinical assessment of CKD, which

involves a venous blood test for urea and electrolytes to determine estimated glomerular filtration rate (eGFR), together with a urine albumin-to-creatinine ratio (ACR).

3.6 Use of equipment

3.6.1 General principles

All equipment used to deliver the NHS Health Check should be fully functional, used regularly, CE marked, validated, maintained and recalibrated in line with the manufacturer's instructions. This includes height and weight measuring devices, blood pressure monitors and point of care testing equipment (more detail on point of care testing below). Where appropriate, providers should ensure that devices are compliant with Medicines and Healthcare products Regulatory Agency (MHRA) requirements.

Any adverse incident involving medical equipment should be reported to the manufacturer and to the MHRA and managed in line with the provider's governance arrangements. An adverse incident is an event that causes, or has the potential to cause, unexpected or unwanted effects involving the accuracy or safety of device users, including patients, staff or other people.

Examples of adverse incidents include injury caused by medical device failure or misuse, a consultation being interrupted or compromised by equipment failure, an incorrect CVD risk score being calculated because of equipment failure, or a patient's health deteriorating as a result of medical device failure.

Correct use and maintenance of equipment is important because inaccurate readings affect the individual's CVD risk score and may lead to inappropriate clinical management. Incidents should be reported as soon as possible, as apparently minor incidents may have greater significance when considered alongside other similar reports.

3.6.2 Point of care testing

Point of care testing (POCT), also known as near patient testing, means medical testing carried out at or near the place where care is delivered, with the aim of producing accurate results quickly. In the NHS Health Check, venous blood samples sent for laboratory analysis are considered gold standard and the preferred approach, but it is recognised that some providers may undertake POCT. When deciding whether to use POCT, local systems should balance the potential benefits (such as convenience and increased access), with the trade-offs (such as potential inaccuracy of results), and ensure this balance is acceptable in their operating context.

Where POCT is used, particular attention should be paid to quality assurance (internal quality control and external quality assessment). The accuracy of results depends on both the device itself and how it is used. This means staff training and compliance around device use and maintenance are critical. Caution should be exercised when using POCT results alone for threshold-based decisions, such as diagnosis of non-diabetic hyperglycaemia by HbA1c level. Providers should consider confirming POCT results that

would influence diagnosis or management with venous blood samples sent to a laboratory. Please refer to the MHRA guidance on management and use of POCT for further details and any upcoming recommendations made by the National Institute of Health and Care Excellence (NICE) on point of care lipid test for cardiovascular disease prevention in primary and community care.

3.7 Guidance on frequent queries

3.7.1 NHS Health Check in pregnancy

The NHS Health Check should be deferred for pregnant people and those responsible for sending invitations should re-offer the check from around 12 months post-partum. This is because pregnant people require specialist antenatal care and physiological changes in pregnancy may impact test results within the NHS Health Check.

3.7.2 Approach to missing components of CVD risk assessment tool

In line with the principles of Making Every Contact Count (MECC), practitioners should use the opportunity to provide tailored healthy behaviour advice and make appropriate referrals wherever possible, even where one or more components of the NHS Health Check are missing. This includes situations where a person:

- is unable or unwilling to provide the required information;
- does not consent to a test or procedure needed to obtain that information; or
- cannot provide enough information to complete a fully personalised QRISK3 or other CVD risk score.

Where possible, a QRISK score should be calculated even with incomplete information, but the individual should be advised that this is no longer a personalised score. This should be clearly documented and interpreted with caution and clinical judgement. If the score is 10% or above, providers should proceed with appropriate risk management and further clinical assessment in line with the usual pathway. This should not be coded as a complete NHS Health Check. Local authorities should decide how providers may be remunerated in these circumstances.

Missing components should be recorded, and the individual should not be excluded from being offered a future NHS Health Check solely because the check was incomplete.

3.7.3 Gender vs sex for CVD risk calculation

It is recommended that biological sex is inputted into the CVD risk assessment tool. This is because biological sex, or sex assigned at birth, affects heart age, as well as risk of diabetes and cardiovascular disease. In cases where the individual's gender may be different to their biological sex or they may not identify with the sex on their medical record, biological sex should be used to calculate the CVD risk score.

However, it is recognised that gender reassignment may lead to changes in cardiovascular risk, for example as a result of hormone therapy, therefore clinical judgement should be applied on an individual basis.

3.7.4 Smokeless tobacco and QRISK

People who use smokeless tobacco should only be categorised as a smoker in QRISK if they also smoke or as an ex-smoker if they have previously smoked. If they only use smokeless tobacco and have never smoked, they should be categorised as non-smokers.

However, people who use smokeless tobacco should be advised about the health risks associated with using smokeless tobacco and still be offered referral to tobacco cessation services, as outlined in NICE guidance NG 209.

Smokeless tobacco includes heat-not-burn tobacco products for the purpose of this guidance.

3.7.5 Information for people who vape and CVD risk assessment

People who vape may do so to support quitting smoking. They should only be included as smokers in QRISK if they also smoke or as ex-smokers if they have previously smoked.

If they do not smoke and have never smoked, they should be included as non-smokers. Information to support stopping vaping is available on: How to quit vaping - Better Health - NHS.

If a person reports that they vape, this should be recorded separately and, where the NHS Health Check takes place outside the GP practice, communicated to the GP alongside other NHS Health Check data.

Section 4: Data and reporting

4.1 Information governance and programme data flows

4.1.1 Government standards and information governance requirements

All organisations involved in the delivery of the NHS Health Check programme must comply with:

- UK General Data Protection Regulation (GDPR) and the Data Protection Act 2018
- Locally agreed information sharing agreements and data processing arrangements
- Appropriate confidentiality, consent, security and access controls for patient information

4.1.2 Patient identifiable data

Using and sharing patient-identifiable data is an important component of efforts to improve population health. Patient-identifiable data should only be shared where there is a lawful basis to do so and must be transferred securely.

It is the responsibility of commissioners and providers to ensure that their local arrangements comply with the law, including by taking independent legal advice as appropriate. Commissioners should state in relevant contracts the specific rights and responsibilities that apply to data processors delivering the programme.

Further information on the data protection responsibilities of organisations processing personal data can be found on the Information Commissioner's Office website.

4.1.3 Main data flows for the NHS Health Check programme

There are three main data flows for the NHS Health Check, necessary for the effective running of the programme:

- **Identifying and inviting the eligible population:** GP clinical systems and/or data extraction software should be used to identify eligible individuals through eligibility searches based on national inclusion and exclusion criteria. These criteria are specified in section 2.1. Eligible individuals should be invited to an NHS Health Check using locally agreed processes, aligning with the best practice set out in section 3.2.
- **Transfer of NHS Health Check data to GP clinical systems:** It is a statutory duty that specified NHS Health Check data must be recorded, and this should be recorded in the individual's patient record. Where NHS Health Checks are delivered

outside general practice, the completed NHS Health Check dataset should be transferred back to the individual's GP record in a secure and structured format as soon as possible and no later than two working days after the check. The NHS Health Check dataset should consist of all data listed as part of the required dataset for an NHS Health Check, specified in section 3, to be considered complete. Where an NHS Health Check is delivered in the individual's GP practice, timely and structured data transfer into the individual's patient record is still expected.

Commissioners have a legal duty to ensure that information related to each health check is recorded and processed in accordance with the Regulations. This includes the forwarding of health check information to the individual's GP where the check has been conducted outside of their GP. A local protocol should be in place for the timely transfer of NHS Health Check data and the referral of individuals where abnormal clinical parameters are identified. As part of this protocol, commissioners should engage with the ICB, local GP practices and other relevant system partners to agree effective information-transfer processes and build the relationships needed to support consistent coding, rather than information being attached solely as a PDF within the consultation record. Structured, coded and extractable information is needed for clinical continuity and management of the end-to-end pathway, including call and recall and for clinicians conducting any required further clinical assessment.

- **Monitoring, evaluation and quality assurance:** Data is extracted from GP clinical systems to support local performance monitoring, quality assurance, equity and service evaluations and statutory data returns. This is usually completed using specific GP clinical system searches and/or data extraction software. Commissioners should ensure data collection and reporting requirements are clearly reflected within service specifications, contracts and provider monitoring arrangements. High-quality data is essential for programme monitoring, performance management, service improvement, evaluating inequalities and reporting.

4.1.4 NHS Health Check data collection roles and responsibilities

Data collection requirements are set out in The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, which state that each local authority shall make arrangements to secure that information related to each check should be recorded and processed in accordance with regulation.

Commissioners should:

- ensure robust data-sharing and information governance arrangements are in place across all providers

- ensure local systems support the identification and invitation of eligible individuals

- ensure third-party providers can securely transfer NHS Health Check data back to general practice or directly into the individual's clinical record
- specify and support local monitoring, evaluation and quality assurance processes
- ensure timely and accurate national reporting

Providers should:

- record and report NHS Health Check data accurately, timely and consistently
- transfer NHS Health Check data securely, promptly and in a structured format
- maintain appropriate audit trails and governance controls
- ensure staff understand information governance responsibilities

4.2 Data recording requirements and processes

4.2.1 NHS Health Check required dataset

The specified information which must be recorded for a complete NHS Health Check is set out in the Regulations (at regulation 5) and in section 2.1.

Any check which does not contain the all the required information should not be considered a completed NHS Health Check, should not be included in any national reporting, and should not be renumerated as an NHS Health Check.

4.2.2 Using eligibility searches

Local authorities have a statutory duty to provide, or make arrangements to secure the provision of, health checks to be offered to eligible persons in their area. An eligible person is a person in the local authority's area who is aged 40-74 and does not meet exclusion criteria set out in the Regulations. Each eligible person must be offered an NHS Health Check once every 5 years, and, where people remain eligible, within 5 years of the date of the previous check. after that. In order to meet this duty, local authorities will need to ensure systems are in place to consistently and accurately identify the eligible population.

Most GP clinical systems and data extraction software provide search and reporting functionality to support NHS Health Check delivery. Where available, eligibility searches can be used by commissioners and providers to identify eligible individuals for an NHS Health Check. Where unavailable, commissioners should take appropriate action to ensure that they and the providers can accurately identify the eligible population, engaging with DHSC regional colleagues required.

Eligibility searches should be run routinely for quality assurance and to identify those:

- aged 40-74
- who have not yet received an NHS Health Check within the previous 5 years

Eligibility searches should apply the eligibility and exclusion criteria set out in section 2.1.2 and the Regulations.

All eligibility searches used by commissioners and providers should be reviewed regularly to ensure all those eligible for the NHS Health Check are captured to enable the legislative requirements to be met. Where searches are found to not fully capture all those eligible for the NHS Health Check, commissioners and providers should seek appropriate support to improve the accuracy of search results, engaging DHSC regional colleagues or the NHS Health Check central team as required.

If commissioners or providers have access to, and use, eligibility searches where outputs contain patient-identifiable data, it is the responsibility of those organisations to ensure that appropriate information governance and data protection are in place.

4.2.3 NHS Health Check offer data recording terminology

- **First invite/invitation:** the first invite an eligible individual receives for an NHS Health Check within a five-year period.
- **First reminder:** the first reminder an eligible individual receives to attend an NHS Health Check. This is sent after a ‘first invite’ and therefore not the first contact an eligible individual receives to receive a check.
- **Further reminders:** any subsequent reminders an eligible individual to attend an NHS Health Check within a five-year period. This is sent after a ‘first reminder’.

4.2.4 Using SNOMED codes

SNOMED codes are used to record NHS Health Check activity in GP clinical systems and any connected systems used by providers. Accurate SNOMED coding is essential for identifying eligible individuals, sending invites and reminders, recording activity, transferring information between systems, providing timely further clinical assessment and producing reliable local and national reports.

Inaccurate, inconsistent or incomplete SNOMED coding can lead to eligible people being missed, ineligible people being invited for a check, clinical risk or activity being counted inaccurately.

To achieve accurate and consistent SNOMED coding, commissioners are encouraged to establish standard SNOMED coding expectations with their NHS Health Check providers to support the accurate identification of eligible populations, maintaining accurate patient records and consistent reporting across providers.

Invitation codes

Providers should use appropriate NHS Health Check SNOMED codes to record when an eligible person is first invited to an NHS Health Check within a five-year cycle, and when an eligible person receives reminders within the same five-year cycle. The parent SNOMED CT concept for this activity is:

- 523241000000107 | National Health Service Health Check invitation (procedure)

Annex 2 lists the 8 child codes for this parent SNOMED CT concept. These child codes are e intended to describe the invite method. However, dependent on the invite method, there is limited ability to discern between first invitations and reminders. This means that reminders can often be incorrectly counted as first invites, resulting in inaccurate activity and national reporting.

Commissioners and providers should therefore ensure that local coding processes distinguish, as far as possible, between a first invitation and any reminders. A simple way to do this is described below.

To improve data quality, commissioners and providers should consider using the following codes regardless of the invite method:

First invitation*: 523281000000104 | National Health Service Health Check invitation first letter (procedure)

First reminder within a five-year period: 523301000000103 | National Health Service Health Check invitation second letter (procedure)

All further reminders within a five-year period: 523321000000107 | National Health Service Health Check invitation third letter (procedure)

Where local contract specifications require specific codes to be used to describe first invites and reminders for payment, or other, purposes, commissioners and providers are responsible for ensuring that appropriate systems and guidance are in place to enable accurate, consistent reporting.

*Please see 'digital-only codes' for guidance when a first invite includes the NHS Health Check Online service.

For quarterly data returns, **it is important that commissioners and providers report only the first invitation made to an eligible individual within the five-year cycle as an offer**.

If warm-up messages (messages sent to raise awareness prior to sending an invite) are used, these should not be considered as the 'first invitation', nor coded as an NHS Health Check invite. For more information, see section 4.3.

When sending invites or reminders to an NHS Health Check, providers should ensure that delivery reports are used to assess how many patients did not receive the message. This is usually marked as 'undeliverable' or 'unsent'. For these patients, providers should ensure that their clinical record does not contain an NHS Health Check invitation SNOMED code, that this invitation is not reported in national statistics, and that the patient is invited to a check via an alternative route.

Where no previous invitation has been made to the patient and the patient has completed an NHS Health Check opportunistically, providers and admin staff coding NHS Health Check data should make sure to record the first invitation SNOMED code alongside the appropriate completion SNOMED code.

Attendance codes

It is important to ensure that NHS Health Check attendance is recorded consistently and accurately. Where a patient does not respond to the locally agreed maximum number of invitations/reminders, the appropriate SNOMED code listed below should be used.

- 522401000000101 | Failed to respond to National Health Service Health Check invitation (finding)

Where a patient fails to attend a pre-booked NHS Health Check appointment, the appropriate SNOMED code listed below should be used.

- 522351000000107 | Did not attend National Health Service Health Check (finding)

Commissioners and providers should ensure that there is a process in place to ensure any patients who fail to attend an NHS Health Check are not excluded from being offered a future NHS Health Check should they remain eligible.

Completion codes

Ensuring that completion status is accurately recorded is essential to accurate reporting and timely further clinical assessment where required. **Where an NHS Health Check is completed within general practice,** the appropriate SNOMED code listed below should be used.

- 523221000000100 | National Health Service Health Check completed (situation)

Where an NHS health Check is completed outside of general practice, the appropriate SNOMED code listed below should be used.

- 840391000000101 | National Health Service Health Check completed by third party (situation)

Where a patient explicitly declines an NHS Health Check invitation, the appropriate SNOMED code listed below should be used.

- 758661000000102 | National Health Service Health Check declined (situation)

Where several stages have already been completed, but the patient declines to complete an NHS Health Check, the appropriate SNOMED codes listed below should be used to record that a patient has started but declined to complete their NHS Health Check.

- 1034771000000106 | National Health Service Health Check commenced (situation)

- 758661000000102 | National Health Service Health Check declined (situation)

Commissioners and providers should ensure that there is a process in place to ensure any patients who complete or decline an NHS Health Check are not excluded from being offered a future NHS Health Check should they remain eligible.

Codes for the NHS Health Check Online

Several SNOMED codes were introduced specifically for the NHS Health Check Online service to identify where a patient has been invited to undertake a check via the digital service, where a patient has completed or not completed their check via the digital service, and where the digital service flagged that a patient required further clinical assessment.

The digital service specific codes should only be used to record NHS Health Check activity via the NHS Health Check Online service. Commissioners and providers should ensure that the digital service specific codes are not used to record any face-to-face NHS Health Check delivery activity.

The relevant digital-only codes are:

- 2406501000000101 | Digital National Health Service Health Check invitation (procedure)

- 2242631000000104 | Digital National Health Service Health Check completed (situation)

- 2242641000000108 | Digital National Health Service Health Check stopped (situation)

- 2242651000000106 | Digital National Health Service Health Check requires follow-up (finding)

- 2242661000000109 | Digital National Health Service Health Check requires urgent follow-up (finding)

Where a first invitation within a five-year cycle includes an invite to complete the NHS Health Check through the digital service, the relevant digital-only code should be used. For any reminders or further invitations including the digital service, providers should use appropriate codes to ensure there is no risk of double counting 'first offers'. A simple way to do this is outlined below.

First invitation: 2406501000000101 | Digital National Health Service Health Check invitation (procedure)

First reminder within a five-year period: 523301000000103 | National Health Service Health Check invitation second letter (procedure)

All further reminders within a five-year period: 523321000000107 | National Health Service Health Check invitation third letter (procedure)

The digital-only code should not be used for invitations to attend an in-person NHS Health Check appointment.

Coding clinical data from an NHS Health Check

It is a legal requirement that specified health check data must be recorded at the time of the health check; this data should be recorded in the individual's GP record. The NHS Health Check Information Standard describes the relevant codes for the NHS Health Check, and providers should ensure that all data entries align with the information standard to ensure consistency.

The information standard does not yet include the menopause content. If signposting on menopause is given during an NHS Health Check, the following code should be recorded on the patient record.

- 313207002 | Menopause education (procedure)

4.2.5 Using NHS Health Check templates within GP clinical systems

NHS Health Check templates can support consistent programme delivery by helping providers to record the required information in a structured way. Using NHS Health Check templates, either via GP clinical systems or locally created, can help standardise data entry, support SNOMED coding and improve data quality for further clinical assessment where required and future reporting.

Where NHS Health Check templates are available, commissioners and providers should ensure that they are configured to reflect information required to be recorded during an NHS Health Check under the Regulations, as outlined in section 2.1. Any templates used by providers should also support accurate SNOMED coding, aligned with the codes set out in the NHS Health Check Information Standard.

NHS Health Check templates should make a clear distinction between:

- information which must be recorded as part of the NHS Health Check
- locally requested additions
- optional prompts or wider prevention messages

Unless any additional components to the NHS Health Check are specified by commissioners, providers may disregard **optional** items within NHS Health Check templates which are not part of the required dataset and should prioritise the required components of the NHS Health Check. Therefore, providers should ensure staff are aware of the NHS Health Check's required dataset to avoid inadvertently expanding the scope of the programme during a check. Any additional elements should not detract from recording the information which must be recorded as part of the NHS Health Check under the Regulations.

Where possible, providers should also minimise the use of free-text recording within NHS Health Check templates and use structured coding to ensure consistency.

Where NHS Health Check templates are supplied by a third-party system or created locally, it is the responsibility of both commissioners and providers to ensure that a system is in place to both train staff to accurately deliver an NHS Health Check using the template, and to routinely evaluate the accuracy and completeness of the template. The latter should include a process for reviewing any changes to template content, SNOMED coding and reporting outputs.

All providers should ensure that any checks completed using a template which contains missing data entries for the required NHS Health Check dataset are not considered a completed NHS Health Check and are not included in any national reporting. Where NHS Health Checks are incomplete, any data gathered should still be recorded and communicated to the patient record. Where a pre-saved answer exists from a previous appointment, the same data should still be actively recorded by the provider, even where the patient's response remains unchanged. Behavioural advice and clinical results should also still be provided to patients in these circumstances and recorded in the clinical record, see section 3.3 for more information on communicating results.

4.3 Reporting duties and mandatory data collection processes

Commissioners are required to submit information on the number of NHS Health Checks offered and the number of NHS Health Checks received each quarter and return this to DHSC. This data collection requirement is set out in The Single Data List (ref 254-00), which lists that central government requires from local government relating to their function as a local authority.

4.3.1 Quarterly data return

The NHS Health Check quarterly data return is included within The Single Data List (ref 254-00). At the end of each financial quarter, local authorities need to submit:

- the number of NHS Health Checks **offered**
- the number of NHS Health Checks **received**

The quarterly data return is submitted via the reporting portal on the NHS Health Check website and is published as official statistics on Fingertips, where the data is used to calculate national and local performance indicators. Quarterly data returns are also published on the Public Health Outcomes Framework and used to update three of the framework's indicators annually (C26a to C26c).

Definition - NHS Health Checks offered

The number of NHS Health Checks **offered** is defined as the total number of **first** NHS Health Check invitations made to eligible individuals within a single quarter, either via sending an invitation or them having a check opportunistically.

To accurately report this data, commissioners should ensure that only the following data is included and reported:

- any instances during the quarter where an eligible individual has been invited to an NHS Health Check for the first time within a five-year period, regardless of the method.
- any instances during the quarter where an eligible individual has requested and receives an NHS Health Check without receiving a previously reported invite within a five-year period.
- any instances during the quarter where an eligible individual has received an NHS Health Check opportunistically and has not received a previously reported invite within a five-year period.

Commissioners should ensure that data reported on the number of NHS Health Checks offered **does not** include the following:

- any instances during the quarter where an eligible individual has received a warmup message, before an initial invite, or a reminder, after an initial invite, within a 5-year period.

- any instances during the quarter where an eligible individual has received an NHS Health Check opportunistically and has received a previously reported invite within a five-year period.

- any instances during the quarter where an individual not eligible for the NHS Health Check has been incorrectly invited to a check.

Definition - NHS Health Checks received

The number of NHS Health Checks **received** is defined as the total number of NHS Health Checks delivered by providers to eligible individuals within a single quarter.

To accurately report this data, commissioners should ensure that only the total number of NHS Health Checks delivered to eligible individuals is reported. This should include checks delivered outside primary care. These should be identified with the following SNOMED codes **only**.

- 523221000000100 | National Health Service Health Check completed (situation)

- 840391000000101 | National Health Service Health Check completed by third party (situation)

Commissioners should ensure that data reported for each quarter on the number of NHS Health Checks received **does not** include the following:

- any instances during the quarter where an individual not eligible for the NHS Health Check has received a check.

- any instances during the quarter where an eligible individual has wrongly received an additional NHS Health Check within a five-year period.

- any instances during the quarter where an incomplete NHS Health Check, missing any components of the required data set, has been reported.

Nominated individuals

Each local authority should nominate at least one individual to submit the authority's NHS Health Check quarterly data return. This nomination should be approved by the relevant

Director of Public Health (DPH). To apply to be a nominated individual in your local authority, please use the form on the NHS Health Check website.

A single local authority can have more than one nominated individual, and this should be coordinated via the process outlined above. Where possible, this approach is encouraged to ensure that local authorities have a robust data management process and to support reliable and timely reporting.

Where public health functions are shared between multiple local authorities, one individual may submit quarterly data returns for multiple local authorities.

Data return timetable

Quarter	**Portal Opens**	**Submission Deadline**	**Amendments***
Q1 (April - June)	July	First week of August	N/A
Q2 (July - September)	October	First week of November	Q1
Q3 (October - December)	January	First week of February	Q1 & Q2
Q4 (January - March)	April	Mid-May	Q1, Q2 & Q3

*Local authorities can amend data entered for previous quarters in the same financial year during each submission window until the Q4 submission deadline, at which point all data is final.

Data submission and quality assurance

Nominated individuals for each local authority will be notified once the reporting portal opens and will be sent reminders during the return-period to encourage timely reporting.

To ensure that the data submitted for the quarterly data return is accurate and of good quality, commissioners should establish clear data collection processes across all providers and ensure that providers are aware of the exact definitions of the data being requested. As part of this, commissioners should introduce a standardised SNOMED coding format for providers to record activity against when they offer and deliver an NHS Health Check. Guidance on appropriate and effective SNOMED coding can be found in section 4.2.

Upon receipt of the data from providers, and before submission, commissioners should assess the data against the following checks:

General validation checks:

- are the number of offers and NHS Health Checks received broadly consistent with the previous quarters and the same quarter last year? If not, can the difference be explained?

- have all providers submitted data for the reporting quarter?

- have there been any changes to the provider landscape? For example, are there any new providers or has the service specification changed?

- have there been any planned changes to programme delivery that could explain variations?

- is either figure higher than the total eligible population?

If the number of NHS Health Check offers is higher than expected:

- have reminders been incorrectly counted as offers?

- have the figures for NHS Health Checks offered and received been transposed?

- do providers typically send a large proportion of NHS Health Check offers during a particular quarter?

If the number of NHS Health Check offers is lower than expected:

- has all provider activity been counted?

- have the figures for NHS Health Checks offered and received been transposed?

If the number of NHS Health Checks received is higher than expected:

- have the figures for NHS Health Checks offered and received been transposed?

- have any ineligible individuals or repeat NHS Health Checks within a 5-year period been included?

- has activity for more than one quarter been reported together?

If the number of NHS Health Checks received is lower than expected:

- have the figures for NHS Health Checks offered and received been transposed?

- has activity for all providers been aggregated?

- have quarters historically followed a similar trend?

Commissioners who still have concerns regarding the data collected for submission after conducting quality assurance checks in-line with the checks outlined above should facilitate discussion with their NHS Health Check providers and/or quality assurance leads in local networks where possible.

Please note, nominated individuals should still submit a quarterly data return in the absence of any activity during the quarter, entering '0' in both the offered and received fields in the reporting portal. Likewise, nominated individuals should still submit a quarterly data return if the data is incomplete at the deadline. This can be updated at the next quarterly return, but not for not Q4.

If any issues are encountered while trying to submit data, nominated individuals should alert their NHS Health Check Regional Lead or the nhshealthcheck@dhsc.gov.uk inbox.

After submitting

Following submission of the quarterly data return, nominated individuals may amend the data until the submission deadline via the reporting portal on the NHS Health Check website. Please note, following the submission deadline for Q4, no further amendments can be made to the figures submitted for the financial year.

Once the data portal closes following the submission deadline, DHSC conducts validation and quality checks. Submitted figures are compared against:

- expected values
- previous submissions
- national averages

Should any unexpected trends or changes be identified, local authorities may be contacted to resolve any data queries. It is important that local authorities respond to these queries as soon as possible to ensure the data is contextualised and/or amended prior to the publication deadline.

Data publication and Fingertips

As an official statistic, the exact dates of the NHS Health Check quarterly data publication are publicly announced in advance on the UK national statistics publication hub. Publication dates are also announced on the reporting portal.

Annual and cumulative performance is published on Fingertips and cumulative five-yearly performance is published on the Public Health Outcomes Framework. These publications provide national and local benchmarking data, trend analysis, and cumulative performance measures.

The programme uses a rolling reporting approach rather than being treated as a fixed five-year programme. This means that the five-year indicator is rolled on year-on-year (for example, April 2021 to March 2025, April 2022 to March 2026).

4.3.2 Total eligible population (TEP)

Total Eligible Population (TEP) estimates are used as a denominator for NHS Health Check performance indicators. TEP is estimated annually, calculated by DHSC using the latest available Office of National Statistics population estimates, minus the estimated number of people on existing disease registers. TEP estimates also exclude prisoners serving a sentence of at least 6 months. This is because local authorities are not responsible for offering eligible prisoners or people in detained settings an NHS Health Check.

TEP estimates for the next financial year are sent to Directors of Public Health and commissioners during the final quarter of each financial year and are finalised prior to the Q1 data submission of each financial year.

Recognising that some areas can identify their local eligible population through specific searches within GP clinical systems, commissioners are offered the opportunity to submit alternative TEP figures. These should be submitted via the reporting portal on the NHS Health Check website.

Alternative TEP estimates

Prior to the Q1 data submission period each year, commissioners should:

- review the TEP estimate provided by DHSC
- where available, compare the TEP estimate against local intelligence and utilising local GP clinical system searches

Alternative TEP estimates should only be submitted with supporting records which clearly document the methodology and evidence used to challenge the original estimate. **Requests need to be submitted by the mid-June deadline each year.** DHSC will then consider the alternative estimates against set criteria:

- the alternative TEP estimate covers the local authority geographical footprint
- the approach used to create the alternative TEP estimate is clearly defined, and GP clinical system searches are evidenced accurately
- the criteria used to determine eligibility/ineligibility is in line with the criteria set out in the Local Authorities Regulations 2013

TEP estimates are used on Fingertips as the denominator for some NHS Health Check metrics, including PHOF indicators. TEP estimates cannot be changed once Q1 data is submitted.

4.4 Data and reporting top tips and common pitfalls

All commissioners and staff delivering the NHS Health Check programme should regularly check the NHS Health Check Forum on NHS Health Check website. The forum contains years of threads detailing local learning, discussions and advice which can help deliver a more efficient service and improve data reporting and quality.

4.4.1 Top tips for commissioners

- set clear data expectations within service specifications and contracts
- ensure third-party systems reflect eligibility criteria and coding requirements
- check all providers have submitted data before reporting quarterly data
- count only the first invite in each five-year cycle in reporting
- compare activity with previous quarters and the same quarter last year
- ensure opportunistic checks are reported in both offered and received totals
- use data to identify equity gaps and improve service delivery

4.4.2 Top tips for NHS Health Check providers

- review eligibility searches regularly
- use the agreed SNOMED codes consistently
- transfer all data back to the GP record in coded form, minimising free text
- ensure staff are trained to distinguish mandatory and optional NHS Health Check elements in templates
- regularly review data quality and SNOMED coding to ensure accurate reporting

4.4.3 Common pitfalls

- relying on PDF attachments instead of coded GP record entries
- assuming NHS Health Check templates only include national requirements and inadvertently expanding the scope of the programme

- counting reminders as offers
- counting partial assessments as completed checks
- including ineligible individuals or undelivered invites in activity totals
- transposing offered and received figures when reporting activity figures
- reporting activity from more than one quarter

Annex 1: Useful resources

A number of these resources are based on local authority examples of best practice and have been developed into templates to be shared at national level.

NHS Health Check on a page

This document provides a high-level summary of NHS Health Check delivery and should be used alongside this best national guidance document, local clinical pathways and local protocols. It is not a substitute for the full Best Practice Guidance. Staff delivering NHS Health Checks should familiarise themselves with the guidance, particularly section 3, which includes additional information on assessment tools, common clinical queries, and signposting resources.

Marketing materials

This document provides some marketing materials for use by local authorities and local providers of the NHS Health Check. These have been created with behavioural scientist advice. A useful how to guide is included to help use these resources.

The materials provided are for:

- Office printing
- Professional printing
- Landscape screen display
- Portrait screen display

Communication templates

This document gives providers some suggested wording to use when inviting users to their NHS Health Check. Templates include potential warm up messages, various formats of invites and reminder messages.

Contract management tool

This document offers a concise quarterly tool to support constructive commissioner-provider conversations about their NHS Health Check programme activity, quality and impact it has on cardiovascular disease prevention. The template can be used quarterly to support a constructive discussion between commissioners and providers about improving cardiovascular disease prevention via the NHS Health Check, including the programme's reach, quality and impact on outcomes.

NHS Health Checks and links to wider system frameworks

This document includes links to wider system frameworks and a table that sets out the 2026/27 QOF indicators for which the NHS Health Check provides a mechanism to support primary care in achieving them.

Market segmentation overview

This document provides a simple summary of the market segmentation work. The Department published seven evidence-based audience segments in 2023, based on mixed-methods research with over 1,800 adults aged 30–74, to help local authorities tailor NHS Health Check communications, service design and delivery to improve uptake. This practical resource helps local authorities use market segmentation insights to target, engage and support people at greater risk of heart attack and stroke. The full report can be found on our website.

Systematic Approach to Raising Standards (StARS) framework

This document provides a shorter self-audit resource intended to sit alongside the existing full StARS framework, a national quality improvement and self-assessment tool for commissioners and their delivery partners. It provides a structured approach to reviewing programme quality, identifying gaps, recognising effective practice and agreeing priorities for continuous improvement. It supports review against current legislation, national best practice guidance, programme requirements and relevant NICE guidance. It is planned that the full StARS framework will be updated, and this lite version will be revised alongside that.

Annex 2: NHS Health Check offer SNOMED Code Index

- 2406501000000101 | Digital National Health Service Health Check invitation (procedure)
- 980621000000105 | National Health Service Health Check invitation email (procedure)
- 523281000000104 | National Health Service Health Check invitation first letter (procedure)
- 523301000000103 | National Health Service Health Check invitation second letter (procedure)
- 980641000000103 | National Health Service Health Check invitation short message service text message (procedure)
- 523321000000107 | National Health Service Health Check invitation third letter (procedure)
- 523261000000108 | National Health Service Health Check telephone invitation (procedure)
- 522261000000101 | National Health Service Health Check verbal invitation (procedure)