



# Increasing NHS Health Check Uptake in Walsall

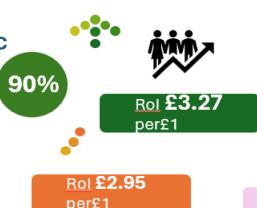
## Sub Theme: Targeting care and investment for better impact and value

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### Introduction & Aims

The NHS Health Check Programme (NHSHP) is a free health check-up every 5 years for adults aged 40 to 74 who do not already have a pre-existing Cardiovascular Disease related condition. It aims to identify early signs of stroke, kidney disease, heart disease, type 2 diabetes, and dementia risk. The goal is early detection and prevention, helping people make lifestyle changes or receive medical support to lower their risk of serious health conditions. Because of the programme's potential to save lives, reduce inequalities and reduce health and social care costs by return on investment, there is an objective to increase NHS health check 'uptake of offers' which will in turn, improve health and wellbeing outcomes in Walsall.

**Increasing the uptake of NHSHP is estimated to achieve higher ROI by 2040**



**Return on Investment:** By 2040 the current NHSHP is likely to reduce absolute health inequalities and is estimated to yield a Return on Investment (ROI) of £2.93 for every £1 spent from a societal perspective, compared to no programme

**Cost-Effectiveness:** Investing further in improving follow-up interventions is estimated to achieve an additional ROI of £5.18 for every £1 spent from a societal perspective, compared to current programme

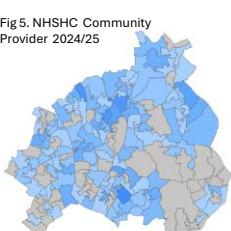
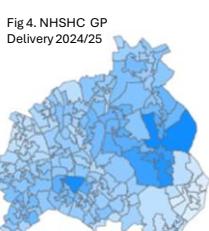
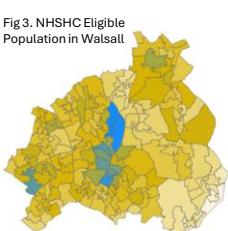
### Walsall's biggest risk factors



### Data Results – Impact & Influence

In Walsall, 45.5% of the eligible population were offered an NHS Health Check between Q1 2020 and Q4 2025, with 31.5% completing a check. The uptake rate of 69.2% places Walsall 13th highest out of 153 local authorities. In 2024/25, Walsall achieved the largest growth in completed checks in the West Midlands—an 81.5% increase from 2023/24. A total of 10,150 checks were completed, reaching 84.6% of those invited, far exceeding England (37.5%) and the West Midlands (36.8%). Despite this progress, under-75 cardiovascular mortality in Walsall remains significantly higher than the national rate (107.7 vs. 77.1 per 100,000).

Most GP practices are located in deprived areas, improving access for residents, while the community/workplace provider focuses on harder-to-reach individuals who may struggle to attend traditional appointments. Data shows the commissioning model is working. The community provider consistently meets targets for ethnicity and deprivation, delivering checks in areas where GP activity is lowest or where target populations live. This demonstrates that combining GP and community provision, guided by real-time mapping, can reduce inequalities and extend programme reach. It also highlights how health checks can be strategically targeted rather than uniformly commissioned.



### Why is increasing uptake so important?

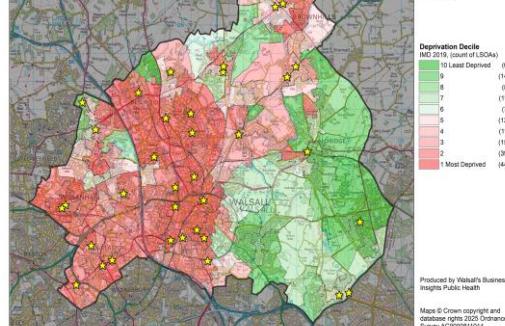
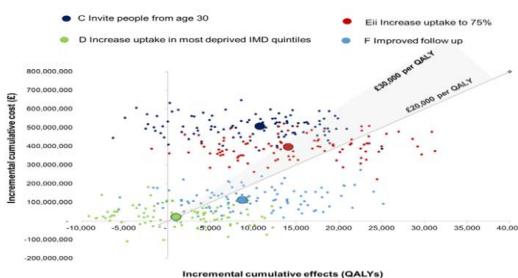


### Approach

Cardiovascular disease prevention is a key public health priority, and the NHS Health Check (NHSHP) programme is central to identifying those at highest risk. Nationally, 100% of eligible patients should be offered a health check, with 75% receiving one. In Walsall, a proportionate universal approach supports health equity. Data analysis helps identify and prioritise the most at-risk groups by using local insights and targeting vulnerable populations.

Although GP practices offer broad coverage, uptake is highest in groups more likely to attend, creating inequalities for vulnerable communities with greater health risks. To address this, a community provider was commissioned to reach higher-risk individuals, particularly in deprived areas and minority ethnic groups. Using a data-driven approach, including heat-mapping GP activity, areas with low uptake were identified, enabling more targeted delivery of NHSHPs.

**Figure 1. Cost-effectiveness plane from a health and social care perspective for scenarios C, D, Eii and F**



### Outcomes and Next Steps

- Increase invitations aiming for 100% of the eligible population
- Analyse invitation patterns and implement targeted invitation strategies, prioritising those most in need and/or at risk e.g. males, ethnic minority groups, and residents living in IMD decile 1 areas.
- Develop a Power BI analytical tool that integrates data from the community provider, GP systems, including legacy and new ICB data reports.
- Analyse lifestyle change outcomes, including how many people quit smoking, lost weight, or sustained other lifestyle changes after receiving an NHS Health Check.
- Produce an annual outcomes report tracking follow-up diagnoses such as statin prescribing, new diabetes cases, stroke diagnoses, and other key indicators.