Public Health England

Meeting Notes

Title of meeting:	NHS Health Check Expert Scientific and Clinical Advisory Panel
Date:	Thursday 7 March 2019
Time:	14:00 – 16:00
Venue:	Room 501, Wellington House, 133-155 Waterloo Road, London
Dial in details:	→ Join Skype Meeting Join by phone +44 208 495 3300 Conference ID: 9663483

Attendees:

Gillian Fiumicelli,	Head of Vascular Disease Prevention, London Borough of Bromley
Jamie Waterall,	National Lead CVD Prevention and Deputy Chief Nurse, PHE
John Deanfield,	Senior advisor to Public Health England on cardiovascular disease prevention & UCL professor of cardiology **(Chair)**
Rachel Clark	Head of Evidence and Evaluation, PHE
Matt Kearney,	National Clinical Director for CVD prevention NHS England
Huon Gray,	National Clinical Director for Heart Disease, NHS England
Nick Wareham	Director of the MRC Epidemiology Unit and co-Director of the Institute of Metabolic Science, Cambridge
Rebecca Willans (on behalf of Monica Desai)	Specialty Public Health Registrar National Institute for Health and Care Excellence
Peter Kelly	Centre Director North East, PHE
Lynda Seery	Public Health Specialist, Newcastle City Council
Anthony Rudd	National Clinical Director for Stroke, NHS England
Alf Collins	Clinical Director, Personalised Care, NHS England
Julia Hippisley-Cox	Professor of Clinical Epidemiology and General Practice in the Division of Primary Care, University of Nottingham

Secretariat

Katherine Thompson	Deputy National Lead CVD Prevention, PHE
Hannah Rees	Senior Support Manager CVD Prevention, PHE

Guests

Chris Kypridemos	University of Liverpool
Martin O'Flaherty	University of Liverpool
Chryssa Stefanidou	Behavioural Science Team, PHE
Andrea Hewins	Product Lead, Digital, PHE
Eleanor Wilkinson	NHS Health Check digital exemplar lead, PHE

Apologies

John Newton,	Director of Health Improvement, PHE
Annmarie Connolly,	Director of Health Equity and Place, PHE
Anne Mackie	Director of Programmes UK National Screening Committee, PHE
Ash Soni,	Vice Chair, English Pharmacy Board
Martin Vernon,	National Clinical Director for Older People, NHS England
Felix Greaves,	Deputy Director, Science and Strategic Information, PHE
Michael Soljak,	Clinical Research Fellow, Imperial College London
Jonathan Valabhji,	National Clinical Director for Obesity and Diabetes, NHS England
Alistair Burns,	National Clinical Director for Dementia, NHS England
Richard Fluck,	Chair of the Internal Medicine Programme of Care board
Charles Alessi,	Senior Advisor and Lead for Preventable Dementia, PHE
Zafar Iqbal	Associate Medical Director Public Health; Midlands Partnership NHS Foundation Trust

Timings	Item Description	Paper	Lead
14:00 – 14:05	**1. Welcome and apologies** Chair welcomed new members, Alf Collins, Clinical Director of Personalised Care at NHS England and Rachel Clark, Head of Evidence and Evaluation, PHE.		Chair
14:05 – 14:15	**2. Actions from the last meeting** **Action 29** – picking this up under item 4 The panel noted that the discussion in the last meeting on QRISK and erectile dysfunction was not concluded. It was confirmed that work is still progressing on this. JHC recommended in the last meeting that QRISK 3 is used rather than 2, even if don't use the extra components. A conversation with MHRA is still needed. A discussion followed on what difference is between conversation needed with service user for QRISK 2 and for QRISK3. More work is needed on this. From a risk point of view, it was asked whether an opportunity is being missed if people don't know e.g. erectile dysfunction being a risk factor. JHC stated that if you ignore extra risk factors then might be underestimating risk, so could push the service user under the threshold for treatment with statins for example. All agreed that there are	Paper 1 – ESCAP action notes	KT

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	several dimensions of complexity that need to be worked through on this issue. **Action 1**: Revisit the introduction of QRISK3 at a future meeting KT confirmed that all other actions from the last meeting were complete.		
14:15 – 14:25	**3. NHS Health Check update** KT provided a summary of data, as set out in Paper 2. Recently published Q3 data shows an overall decline in activity, with a continued downward trend in number of checks offered. Potentially a symptom of pressures that local Public Health departments are under. PHE have been doing work to drive up numbers, with behavioural insights and going forward with digital. Overall around 85% people invited and around 48% taking up offer. KT highlighted that this decline in activity is why linking the NHS HC to the national CVD ambitions is important. JW followed with an update on the CVD ambitions and the CVD Prevention Conference on 14 February, which was attended by almost 500 people. JW confirmed that the NHS Long Term Plan has a commitment for NHS to work more closely with PHE and Local Govt on improving the NHS Health Check programme. PHE have established a CVD system leadership forum, with broad membership from partners, charities and royal colleges. JW discussed the secondary prevention ambitions, and highlighted the recent CVD Health Matters issue including a blog and resources. **Action 2:** Share link to National Ambitions and CVD Health Matters with ESCAP members **Action 3**: ESCAP members to help promote the national ambitions and resources Discussion followed on the NHS HC and how to engage those least engaged with their health. AC	Paper 2 – NHS HC 2018-19 Q 3 data	KT

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	asked about the invitation letter and raised the point that those least engaged often demonstrate fear and avoidance behaviour; if use words such as risk/harm/disease, they're not going to engage. If you use more positive language, the disengaged are more likely to engage. KT highlighted the work PHE have done with Behavioural Insights colleagues on the Invitation letter, and more widely. AC noted that it is as much about health psychology as behavioural insights. KT acknowledged that there is still a cohort of people that don't engage and noted that there may be opportunities through the digital programme.		
14:25 – 14:55	**4. NHS Health Check digital exemplar and behavioural science** AH, CS and EW provided an update on the digital exemplar project, including details on the use of behavioural science in the project. Some key points included: - Used people centred research and applied behavioural insights to how interviewed people. - Interviewed 30 people – providers, commissioners and end users, from around country. - Once analysed data and held concept workshop, identified 16 areas of opportunity. From those distilled down to 2 areas to explore further. - Commissioned a systematic literature review from UCL. Majority of literature focuses on specific behaviours. Absence of evidence on referrals; whether attend referrals and repeat checks. Now planning to move into Alpha phase, focusing on two areas; - Looking at whole NHS HC end to end journey and opportunities for doing this digitally. - Focus in on what happens after assessment. How can we help users make and sustain a change. In discussion that followed, panel asked what the metrics of success are for project. Presenters	Item 4 Presentation	CS, AH, KB

Timings	Item Description	Paper	Lead
	confirmed they've not yet defined metrics of success for Alpha. They will run usability testing and use number of validated scales, including patient activation, to understand and measure participants' experience and engagement with prototypes in Alpha. AC noted he has patient activation measure team in his team, so happy to connect colleagues. **Action 4:** Chryssa to speak to Alf about incorporating the patient activation tool into the development of the digital concepts. As there is such variability in types of end users, presenters were asked how they ensure to capture different views, particularly with such small sample size. They confirmed through the literature review and using number of validated measures, and also that they won't stop testing and engaging with end users. Panel also questioned how they are factoring in the benefit of digital on those least likely to or able to engage in the HCs and/or in digital resources. AH noted that the benefit is a knock-on effect; those capable engage with digital, which frees up resources for those most in need and/or unlikely to engage. It was suggested that this knock-on effect is more explicitly set out in project. Finally, it was noted that there may be learning that can be taken from the success of the Heart Age tool and confirmed that they are developing an evaluation framework for the project.		
14:55 – 15:25	**5. WorkHORSE** CK and MO ran a demonstration of the alpha version of the WorkHORSE model. In developing the model, they have run 3 workshops with NHS HC stakeholders, including PHE, LA commissioners, academics etc: 1: Getting to know each other 2: Gathering input from participants 3: Testing some assumptions and early versions	Item 5 Presentation	MF and CK

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	Will run 4th workshop with validated model to demonstrate how they envision the tool working The microsimulation takes one through how people interact through the life course of the NHC HC. The user enters simulation parameters into the model, for example location, time period, effectiveness, cost effectiveness, and the model then goes into scenarios. **Action 5**: Martin to share some screen shots of the tool **Action 6:** Martin to share the WorkHORSE poster from the CVD prevention conference The intention is for the model to be open source and open access, developing a forum of users. The model is quite flexible, for example where an LA doesn't have the relevant data, they can enter ambitions. One can save the scenario and compare to other scenarios, e.g. where no one receives an NHS HC, and use it, for example, to refine the invitation strategy. The model has not yet been validated. Users told them that they needed a thinking tool, not just a cost-effectiveness tool. MK was part of the workshop and noted that many commissioners warmed to the tool, the potential to model different scenarios and use it in local area. It was confirmed that some support and training will be required with end users on how to engage with and use the tool. A discussion followed on feasibility of including Dementia as an outcome in the tool. Assumption that by modifying risk CVD will modify the risk of Dementia but need the evidence for this to enter into the model. **Action 7:** National CVD prevention team, Matt Kearney to meet with the WorkHORSE team to discuss the dementia element and potentially bring Alistair Burns into the conversation. Panel also noted that the model doesn't reflect that if intervene later in disease then will have different impact. MO confirmed that their model works with lag times, so has quite different effects over shorter vs longer time horizons.		

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	It was discussed what ESCAP's role is in relation to the model, as not sure to what extent can comment on user feedback on model and/or academic validity of evidence underpinning model. **Action 8:** ESCAP to revisit how best to support the roll out of the tool at a future meeting Finally, it was noted that there is more evidence/data coming out this year so more data/assumptions that can go in to the model.		
15:25 – 15:55	**6. NHS Health Check aims and objectives** JW highlighted that more work was needed in positioning the NHS HC as not only a CVD prevention programme, but a broader Non-Communicable Disease (NCD) programme. Discussion followed on how to embrace the idea of NCDs with patients and professionals. It was noted that knowledge of what NCDs are and use of the term is limited outside of professional groupings. One suggestion was to spell out what diseases it covers, e.g. cancer, diabetes etc, whenever use the term NCD. Discussion followed on the best way to communicate and use the term NCD with different audiences, with suggestions raised to look to the healthy ageing, predictive prevention and targeted smoking packages examples. It was also raised whether, in addition to behavioural and physiological risk, there is anything on psychological risk in the Check, particularly as predictors of the end users' future mental health. It was confirmed that mental health has been considered in the content review process in the past, but it has not met all the criteria. **Action 9:** National team to share historical content review proposals with ESCAP members and the current guidance and proposal form. Panel also discussed how to understand the frame of mind of a person when they come in for a Check. People will be at different stages of self-efficacy so no one size fits all approach. It was confirmed that work has been done with Behavioural Insights to test two different leaflets using different language/frames, but it had no effect.	Paper 3 – NHS HC aims and objectives	JW

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15:55 – 16:00	**7. AOB** **Action 10:** Members to comment on the realist evidence review and send comments back to Geoffry Wong by 25 March		All
Dates of 2019 meetings	Thursday 23 May 10 – 12:00		