Public Health England

Action notes

Title of meeting:	NHS Health Heck Expert Scientific and Clinical Advisory Panel (7)
Date:	Monday 11 May 2015
Time:	13:30 – 15:30
Venue:	Board Room, Wellington House SE1 8UG

Attendees:

Chair	John Newton, Chief Knowledge Officer, PHE Kevin Fenton, Director of Health and Wellbeing, PHE Jamie Waterall, NHS Health Check, National Lead, PHE Ann Mackie, Director of Programmes, UKNSC Michael Soljak, Clinical Research Fellow, Imperial College John Deanfield, Director of National Centre for Cardiovascular Prevention Jonathan Valabhji, National Clinical Director for Obesity and Diabetes Nick Wareham, Director of the MRC Epidemiology Unit and co-Director of Metabolic Science Matt Kearney, National Clinical Advisor, PHE Felix Greaves, Deputy Director Science and Strategic Information, PHE Zafar Iqbal, Director of Public Health, Stoke on Trent Charles Alessi, Senior advisor, PHE
Guest	Maria Worbenger, Project manager/research assistant, Imperial College London Kiara Chang, Research Assistant, Imperial College London
Guest	John Robson, GP, Reader, Queen Mary University of London
Secretariat	Bianca Blom, Personal Assistant, NHS Health Check Programme, PHE Craig Lister, NHS Health Check programme manager, PHE
Apologies	Alistair Burns, National Clinical Director for Dementia, NHS England Ash Soni, Vice Chair, English Pharmacy Board Annmarie Connolly, Director of Health Equity and Impact, PHE Huon Gray, National Clinical Director for Heart Disease, NHS England Hilary Chatterton, Public Health Analyst, NICE Anthony Rudd, National Clinical Director for Stroke, NHS England Frances Fuller, Cardiovascular prevention programme manager, London Borough of Lewisham Richard Fluck, National Clinical Director for Renal Disease, NHS England

Theresa Marteau, Director of the Behaviour and Health Research Unit, University of Cambridge
Lesley Hardman, Health Improvement Specialist for Primary Care, Bolton Council
Lynda Seary, Public Health Specialist, Newcastle City Council
David Wood, Professor of Cardiovascular medicine, Imperial College London

Timings	Item Description	Lead
13:30 – 13:35	**1. Welcome and apologies** John Newton welcomed members and guests to the group and noted apologies.	JN
13:35 – 13:45	**2. Actions from the last meeting** **Actions closed:** Action 4 (from Nov 2014), Actions 1, 2, 4, 5, 6, 7, 9, 11, 12, 13, 14 (from Feb 2015) **Actions open / in progress:** *Action 3* – BH to bring together a working group to develop a roadmap of funders. FG to let the group know if any support is needed. *Action 8* – KF met with Celia Ingham-Clark about concerns regarding clinical follow-up and management. KF advised the group that this had moved on since a meeting was held with Una, Simon and Duncan, when it was agreed that NHSE would lead on improving clinical follow-up and management following the NHS Health Check. KF to follow-up with Duncan Selbie regarding next steps. *Action 10* – FG, BH and Julian Flowers to map who is analysing large data sets and identify where this analysis is relevant to the NHS Health Check. This is in progress. There is an options appraisal meeting on 26 May.	JN

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13:45 – 13:50	**3. Programme Update** Paper 2 – NHS Health Check Q3 Data JW provided a brief update on the Q3 data and the likely trajectory for Q4. Guidance is being developed on good data collection to further assist local authorities. **Action 1:** CL to provide data guidance to local authorities. There's been an increase in the number of people invited. 20% aspiration should be achieved for the first time this year in Q4. In terms of offers, uptake is in the region of 48%. Fig. 2 on page 3 shows a vast variation between offers and uptake across the country. 14 submissions were received for the content review process. **Action 2:** All submissions to be presented at the next ESCAP meeting on 6 August for the groups' approval to move to stage 2 of the process. The quality of primary care and percentage of uptake should be reviewed. ZI commented on co-commissioning of PC and that the issue is on quality of PC in general. MK suggested that discussions on NHS Health Check should be included in broader discussions with primary care providers. There is considerable clinical variation and the need for a bigger debate on variation within PC. JN noted that this has an impact on a wider scope than just NHS Health Check. A survey on how to increase uptake was recently sent out in order to better understand the criteria and variables at play. This is due to be published later this month. Paper 3 – Literature review update Paper provided to the group for information.	JW

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13:50 – 14:15	**4. Community Providers of the NHS Health Check Programme Target Younger, More Deprived Individuals and Those at Higher CVD Risk** Maria Worbenjer (MW) presented the findings of their research into the outreach delivery of the NHS Health Check in targeting people at a higher risk of CVD. Primary care providers find some groups hard to reach and these groups may be at increased risk of CVD. Objectives of the analyses is to assess the effectiveness of community providers of NHS Health Checks in reaching hard to reach populations by using health options, clinical practice research datalink CPRD, office for national statistics census and department for communities and local government. Summary of the results: • Shows community providers using health options software to target some of the heard to reach groups. • Community providers serve a bigger proportion of high CVD risk people than primary care among younger and older age groups. • Primary care delivers checks equitably by deprivation, serves older patients and few ethnic minorities. The group discussed these findings: What is the risk mitigated by treatment? Those with a lower socioeconomic status in general don't visit GPs and therefore they need to be identified in communities explaining they're at high risk. The proportion of health checks offered in community centres is presently unknown. CA said that designing different routes of entry may not be appropriate as primary care could change in the next 6 months/1 year. Adding additional steps to access information or care is a deterrent. The need for further clarification/evidence on point of care testing.	MW/MS
14:15 – 14:40	**5. Evaluation of the NHS Health Check Programme: retrospective database study** Kiara Chang (KC), research assistant from the Department of Primary Care & Public Health at Imperial College presented the research findings. The aim of the study is to determine coverage of the NHS health check programme nationally in the first 4	KC/MS

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	years, to assess predictors of health check attendance, to examine prevalence of CVD risk factors among health check attendees, and to examine levels of statin uptake after health checks. MS confirmed that these findings are being published very soon. **Action 3:** KF mentioned that we need to align terminology before publication i.e. these findings refer to programme coverage, whilst PHE speaks about proportion of public who has been offered a NHS Health Check. This needs to be defined as uptake based on people who've taken up the offer of a health check. **Action 4:** KC to provide JD with the cholesterol levels of those who got statins. JV said he will be interested to see a timeline of NHS Health Check uptakes throughout the year.	
14:40 – 15:05	**6. NHS Health Check: national survey** John Robson (JR) presented a summary of the findings from the national NHS Health Check research, based on QResearch data base of eligible people who attended the NHS Health Check (coverage). This data is unpublished. It highlighted that family history is poorly recorded. It's possible that some checks were missed because of coding. After the first year the code set has become more reliable. It was confirmed that NHS Health Checks are identified purely from the codes. JN asked if the CPRD and QResearch recording of ethnicity is different. This analysis shows more complete ethnicity data than Imperial College's findings. JR used data entry templates to ensure standardisation. QResearch had 90%. JR said that the value of QRisk was that it was disseminated better. This led to better measure uptake of ethnicity. JV was interested to know how many people at high risk of diabetes went on to have interventions. **Action 5:** JR will check if he was given categorical data for this. JR confirmed that there is no data on what happened to those patients with high blood pressure but that protocol would have been followed. KF asked about lessons learned from data. JR stated there were more referrals in lower risk areas for those who were obese which may be worth pursuing if intervention is successful. JN commented that the basic finding is that if people have	JR

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	preventable risk factors and go for a health check, they are more likely to do something to lower risks. **Action 6:** All presentations to be summarised after publication and distributed to the group with a summary paper drawing together the different results.	
15:05 – 15:25	**7. Diabetes prevention programme** JV provided an update on the programme. Type 2 diabetes prevention programme (DPP) links well to NHS Health Check. A prevention board has been formed with PHE, NHS England and Diabetes UK, to move the programme forward. The objective is to gain buy in from the system to be more preventative than reactive. There was concern that the NHS has no capacity to hold an extra 1/2 million face-to- face interventions. JV has established an expert reference group that overlaps with NHS Health Check, which is a separate project with very clear interfacing. The first task is to review the diabetes filter findings. KF reinforced the need for the DPP to work in unison with the NHS Health Check programme and not create a potential for competition reducing overall engagement and duplication.	JV
15:25 – 15:30	**8. AOB** There being no other business the meeting ended at 15:30. The next meeting is on Thursday, 6 August from 2pm to 4pm.	All