



Action Notes

Title of meeting: NHS Health Check Expert Scientific and Clinical Advisory Panel
Date: Wednesday 28 November 2018
Time: 14:00 – 16:00
Venue: Room 510/511S, Wellington House, 133-155 Waterloo Road, London

Attendees:

John Newton,	Director of Health Improvement, PHE (Chair)
Gillian Fiumicelli,	Head of Vascular Disease Prevention, London Borough of Bromley
Jamie Waterall,	National Lead CVD Prevention and Deputy Chief Nurse, PHE
John Deanfield,	Professor of Cardiology at University College Hospital, London
Julia Hippisley-cox,	Professor of Clinical Epidemiology and General Practice in the Division of Primary Care, University of Nottingham
Zafar Iqbal,	Associate Medical Director Public Health; Midlands Partnership NHS Foundation Trust
Matt Kearney,	National Clinical Director for CVD prevention NHS England
Jonathan Valabhji,	National Clinical Director for Obesity and Diabetes, NHS England
Huon Gray,	National Clinical Director for Heart Disease, NHS England

Secretariat

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

Apologies

Ruth Chambers	Clinical chair and STP clinical lead clinical lead for technology enabled care services, digital workstream, Staffordshire CCG
Annmarie Connolly,	Director of Health Equity and Place, PHE
Peter Kelly,	Centre Director North East, 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
Nick Wareham,	Director of the MRC Epidemiology Unit and co-Director of the Institute of Metabolic Science, Cambridge
Alistair Burns,	National Clinical Director for Dementia, NHS England
Richard Fluck,	Chair of the Internal Medicine Programme of Care board
Anne Mackie,	Director of Programmes UK National Screening Committee, PHE
Anthony Rudd,	National Clinical Director for Stroke, NHS England
Charles Alessi,	Senior Advisor and Lead for Preventable Dementia, PHE

Timings	Item Description	Paper	Lead
14:00 – 14:05	1. Welcome and apologies As shown on page 1 and 2.		JN
14:05 – 14:15	2. Actions from the last meeting Updates on the actions have been circulated with the papers, with the ambition that we can work through these more swiftly. Actions from previous meetings Actions: 1 addressed under item 6 of the agenda Actions: 2, 13, 15, 21, 22, 23, closed Actions: 3, 4, 6, 9, 12, 24, 25, 27 will be items on a future meeting agenda. Actions: 7&8, 16 will be addressed under item 5 Actions: 11 will be addressed under item 3 Actions: 17 will be addressed under item 4 Action 28: John Deanfield to circulate a short note to ESCAP members providing an update on the NHS Health Check data extraction work. Katherine Thompson gave an update on the NHS HC Digital exemplar project. Members discussed the role of digital in the NHS HC. It was recognised that if we are considering whether a digitally enabled NHS HC is more beneficial, we need to make sure we do research and build evaluation into any programmes. The digital exemplar work is progressing through the discovery phase. PHE's behavioural insights team have commissioned a literature review and supported the analysis of stakeholder interviews to ensure that the concepts developed in the discovery stage are underpinned by the best available evidence. Regular "postcard" updates are being published. Members suggested that it would be useful to explore the development of a digital solution for people who have had a check and were low risk and are being recalled for their next check. Action 29: Katherine Thompson to circulate a short note sharing the digital concepts for the exemplar with ESCAP	Paper 1 – ESCAP action notes	KT

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	<p>members.</p> <p>Members agreed that the programme does tackle a range of non-communicable diseases by addressing the top seven risk factors driving this burden of disease. It was recognized that there could be benefit to framing communications to commissioners and providers in this way, as long as it was clear that the content of the check was not changing.</p> <p>There was some discussion on whether responsibility for delivering the programme was best placed in Local government. It was recognized that the programme needed both local government and the NHS for it to work effectively and that the forthcoming, Green Paper, NHS Long Term Plan, Review of the Public Health Functions Regulations and the Comprehensive Spending Review all provide opportunities to consider how the system can maximize the impact of the programme.</p>		
14:15 – 14:25	<p>3. NHS Health Check evidence update</p> <p>Members were asked how essential it is to keep receiving the evidence update. Katherine Thompson confirmed that Local authority colleagues do use it and that the Evidence Review conducted last year was conducted using them, which allowed for it to be undertaken much more swiftly than otherwise possible.</p> <p>Action 30: Katherine to look at web analytics on number of downloads for the bibliographies from NHS HC website and to feed back to library service.</p> <p>Action 31: Katherine to feed back to the library service that the searches are extremely useful as they enabled the rapid completion of the evidence review, are regularly used by the national team and commissioners working on the programme.</p> <p>Katherine highlighted that the Q1 data continues to show a downward trend in the number of people being offered and having a check.</p> <p>Members discussed the data and the demographics of those attending NHS HC. There was some discussion of the potential for insight work on how people receive and respond to a second invite, and also to what extent those who have had a check encourage others to have one.</p> <p>The point was also raised on whether it is possible to record that it is a recall rather than first HC, so that this</p>	<p>Papers 2 and 3– annotated bibliography</p> <p>Paper 4 – NHS HC 2018-19 Q1 data</p>	KT

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	<p>can be distinguished in the data.</p> <p>A question was also raised about why the relationship between invitations and take up doesn't seem to be consistent. Katherine confirmed that the cohort of people offered a check and those having a check are not the same which is why the data can show that more people had a check than were offered in a single quarter.</p> <p>There was some discussion of the variation in spending between local authorities in the delivery of the programme and the potential benefits of a nationally commissioned model.</p> <p>Q2 NHS Health Check data was published at 9:30 on the 28 November 2018</p> <p>Action 32: Katherine to circulate the NHS Health Check data for Q2</p> <p>Action 33: Katherine to ask library services to include the conclusion as part of the abstract summary.</p>		
14:25 – 14:55	<p>4. Heart Age Test</p> <p>Jamie Waterall talked to paper 5.</p> <p>The heart age campaign, delivered in September 2018, was hugely successful with over 2 million completions on day 1. However, some high profile media medics felt that this type of test should not be available to 30 – 39 year olds and that advice to go to your GP, if you do not have BP or cholesterol measurements, was inappropriate and would flood primary care.</p> <p>Members agreed that it was important to make younger people aware of the risk factors for CVD given that individuals are exposed to them over their lifetime. It was agreed that the signposting wording in the tool should be softened. However, it was agreed that this should not detract away from importance of people knowing their numbers and the democratisation of health information.</p> <p>It was also agreed that it would be helpful to understand whether there had been any increase in attendances at primary care during the campaign.</p> <p>Jamie Waterall confirmed that the campaign is being evaluated and work to analyse and publish the findings on the data generated by completions of the Heart Age test continues.</p>	Paper 5 – Heart Age	JW

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	<p>Action 34: Heart Age working group to consider adding GP attendances for BP and cholesterol during the campaign to the evaluation.</p> <p>Members agreed it would also be helpful to explore how PHE might mitigate against the impact of the tool on primary care and how this digital platform might mobilise people to lifestyle services. Jamie confirmed that initial feedback from the campaign showed an 8000% increase in the use of the How Are You tool and increased access to other One You lifestyle apps during the campaign.</p> <p>A question was raised by a member on what evidence there is that knowing your risk would reduce your risk? John Deanfield confirmed that there is no evaluation of JBS3, however highlighted a Spanish RCT study on CVD risk conversation. Their findings demonstrated large reduction in CVD incidents for those randomised to have risk conversation, compared to those who didn't.</p> <p>A final note was made for the need to engage more with GP colleagues in the lead up to these sort of campaigns in order to understand any impact on them.</p>		
14:55 – 15:40	<p>5. QRISK3 and the NHS Health Check</p> <p>Katherine Thompson summarised paper 6 highlighting that the transition to QRISK3 is unlikely to increase the number of high risk people nationally but that the improved precision means that some people who were high risk will be reclassified as low and people with one of the seven new conditions captured in the tool are more likely to be classified as high risk.</p> <p>Adopting the tool into practice does present challenges, especially where checks are not being delivered in general practice. Members highlighted that the clinician/patient relationship is a privileged one and therefore it is appropriate for discussions on mental health and sexual function to take place but concerns were raised about the appropriateness of having these conversations where the practitioner is not a clinical professional.</p> <p>It was suggested that where checks are being done by non-clinical staff having software which could extract data from the patient record would help to overcome this issue. In the future digital offers the potential to give people ownership of their data in future, so that they can</p>	Paper 6 – QRISK3	KT

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	<p>pre-populate the tool ahead of an appointment.</p> <p>Confirmed that the CVD Prevention team's preferred approach is a mixed approach. Where the NHS HC is delivered within a General Practice then use Qrisk3, where not then use current core NHS HC data fields.</p> <p>Julia Hippisley-Cox confirmed that QRISK3 is more accurate than QRISK2 and that BP, BMI and cholesterol default to population averages if information is not included. If the new fields are left blank then the risk calculator will still provide a score.</p> <p>The consensus from the discussion was that where checks are delivered in general practice the additional fields in QRISK3 should be completed as the calculator will extract this data automatically. Where checks are not delivered by clinical staff then QRISK3 should still be used and the additional questions can be left blank. However, the practitioner should explain to the individual that their risk might have been under estimated if they have one of the seven new risk factors.</p> <p>Action 35: National team to update the NHS Health Check best practice guidance to reflect ESCAPs advice on using QRISK3.</p> <p>Action 36: CVD Prevention team to consider asking a patient reference group about being asked the additional question fields outside of GP.</p>		
15:40 – 15:55	<p>6. NHS Health Check competence framework update</p> <p>Action 37: Hannah Rees to provide ESCAP members with a written update on the competence framework work.</p>		HR
15:55 – 16:00	<p>7. AOB</p> <p>John Newton invited members to volunteer to be vice-chair of ESCAP.</p> <p>Members agreed that Alf Collins, NHS England's Clinical Director, Personalised Care Group is invited to become a member of ESCAP.</p> <p>Action 38: John Newton to invite Alf Collins to become a member of ESCAP.</p>		All
Dates of 2019	TBC – please inform secretariat if any specific days of the week are not possible, e.g. due to clinical commitments.		

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meetings			