Clinical networks, both as a management model and as an organisational concept, are not a new idea. Their origins can be traced back to the Calman–Hine policy recommendations (1995) which first suggested network working as a legitimate means for strengthening collaboration and integration between different organisations and groups with potentially conflicting or competing agendas.

Twenty years on, clinical networks have strengthened as an organisational model but are still seen by some as having a specific interest, whether supporting secondary and tertiary care, and / or a limited relationship with primary care and its outputs and patients. This interpretation, while appreciated, is at odds with Simons Stevens’ vision in the Five year forward view, as he speaks of “networks of services over a geography, integrating different organisations and services around patients, using innovations…to improve the coordination of care for patients.” Primary care networks are referenced, as is the London stroke model as an exemplar of care quality.

The London Cardiovascular Strategic Clinical Network supports a whole systems approach incorporating clinical pathways spanning multiple care settings and localities. It has a strong role to play with those working in primary care including GPs, pharmacists, therapists, nurses and social care workers supporting both the prevention and detection agendas. A number of the clinical network working group priorities start within primary care and the community.

This edition of the CVD newsletter celebrates primary care, those working within it and some of the innovations they are leading on. It also highlights the different national programmes that are supporting both the detection and prevention agendas. I hope that you enjoy the newsletter and its contents. As usual the team and I welcome feedback as to its value and how we can strengthen it.

From Lucy Grothier, Associate Director
Strategic Clinical Networks, NHS England (London region)

This month marks the end of the fiscal year in the NHS, providing us with both a time to reflect and a time to plan for the next year which will begin 1 April.

The national review of Strategic Clinical Networks (SCNs), Senates and Academic Health Science Networks offers us the opportunity to review how we’ve developed these organisations and to identify how best to structure them in future for maximum impact and alignment.

I believe it allows a period of reflection to ensure we fully bring together those involved in improvement work across London, aligned with the Five year forward view and the needs of Londoners, whilst we continue our strong working programmes.

At the outset, the cardiovascular networks established a strong collaborative platform. This alliance will be a powerful force going forward towards improving outcomes and experience in the capital – a key success factor when we consider the pace and scale which we are facing.

Prevention is viewed as an essential element of the future strategy and sustainability of the NHS. The Cardiac and Vascular, Stroke, Renal and Diabetes SCNs are well placed to play a significant part in tackling this challenge. In doing so, we have the power together to radically transform the outcomes of our health and care system and the health and wellbeing of Londoners.
London Cardiovascular Strategic Clinical Network
Network news - March 2015

Events

**CVD data and information master class | 22 April 2015**
*Friends House, 173-177 Euston Road, London, NW1 2BJ*

A free master class on understanding and using CVD data and intelligence to support quality improvement.

*Further details available through Public Health England, [phe-events.org.uk/ncvinlondon](http://phe-events.org.uk/ncvinlondon).*

**London atrial fibrillation network: Uptake of anticoagulation | 6 May 2015**

An educational event will be held on 6 May, 17:30-20:00 for primary care clinicians to ensure their care for atrial fibrillation patients is up to date. This event is aimed primarily at GPs, but also welcomes commissioners and those in other prescribing roles.

*Please contact Jess Brand ([jess.brand@nhs.net](mailto:jess.brand@nhs.net)) for more information.*

**Looking ahead: May / June events**

**London renal network**

The London Renal SCN will be holding three free educational events aimed at improving patient outcomes and service delivery:

» Ensuring chronic kidney disease (CKD) patients 2 and 3 receive optimum, patient-centred care that prevents or delays progression to renal replacement therapy (CKD 4 and 5). CKD 4 and 5 rates are increasing by 5 per cent per year in London, as compared with the rest of England.

» Improving collaboration between clinicians of closely linked specialities to improve patient care and outcomes for patients with co morbidities (renal, diabetes and heart failure).

» Improving patient experience and outcomes through developing good peer support systems to promote shared care and personalisation of care principles and processes. A focused event to develop good peer support systems will be held on 17 May.

*May/June dates TBC. Please contact Katy Gordon ([katy.gordon1@nhs.net](mailto:katy.gordon1@nhs.net)) for more information.*

**Publications**

**Improving diabetes care**

The London Diabetes SCN has published *Understanding diabetes in London – Collaboration for better patient outcomes*, which provides both a snapshot of the scale of the explosive issue of increasing diabetes rates in the capital, plus what the Diabetes SCN is doing – and will do in future – to improve outcomes and experience for Londoners with diabetes.

Future documents will soon be published, which aim to link us together to improve outcomes and experience of care for all Londoners with diabetes, from prevention, to detection, to management:

» **Detection of diabetes guidance** – Provides advice for detecting diabetes consistently, using HbA1c for diagnosis and recommendations for lifestyle intervention

» **Patient education toolkit** – Produced in conjunction with the Health Innovation Network (HIN), the toolkit overviews available patient education courses and methods for how we can together improve uptake for those with type 2 diabetes.

» **Insulin pump recommendations** – Provides advice to create consistent access to medical technologies within type 1 services.

» **Management of care toolkit** – Case studies, techniques and practical ways for primary care to improve the management of diabetes.
Cardiac and vascular news

From Prof Huon Gray, Clinical Director

The Cardiac and Vascular Strategic Clinical Network is positioned to deliver on many key service improvement initiatives in 2015. These initiatives will see care for cardiac and vascular patients improved across the capital.

With a governance structure now firmly in place, the chairs and members of the various advisory and working groups are progressing with their work plans.

Dr Michael Cooklin and the Arrhythmia Advisory Group are continuing with work on establishing a unified pathway for patients with arrhythmias due to inherited cardiac conditions across London. The group is also focusing on improving detection and care for patients with syncope.

The Vascular Advisory Group, chaired by Mr Obi Agu, in conjunction with the London Ambulance Service, is looking to improve the emergency care for people with abdominal aortic aneurysms. The group’s work will also look at how to reduce lower limb amputation rates in the capital, and is developing strong links with the Diabetic Foot Steering Group, part of the London Diabetes Strategic Clinical Network.

The Cardiac Surgery Advisory Group has undertaken a survey of cardiac surgical centres in London to understand better how to cope with future demands and the capacity needed for cardiac surgery in London. The chairs of the group, Professor Olaf Wendler and Mr Andy Chukwuemeka have also undertaken to look at the provision and training for mitral valve surgery in London.

(cont'd)

The Acute Coronary Syndrome (ACS) group continues to monitor the ST-elevation myocardial infarction (STEMI) pathway and heart attack centre work. The group has now been extended to include representatives from centres that take non-ST elevation ACS (NSTEMI) patients and will concentrate on data collection and service improvement ideas.

The London Heart Failure Advisory Group have set their priorities. This includes using data to improve the quality of care provided in acute provider settings. The group will also be looking at developing guidance on care pathways for heart failure that will include a focus on prevention and primary care.

Members of the Strategic Clinical Leadership Group have also formed a small task and finish group looking at how to improve detection and care of patients with Familial Hypercholesterolemia in primary care and the community, reflecting the high priority placed on this work nationally.

Prevention will continue to be a focus of the work of the Cardiac and Vascular Strategic Clinical Network. NHS England’s Five year forward view contains a strong message on the need for more investment in health prevention activities. We will seek to collaborate with others, such as Public Health England and London CCGs in how best to advance this forward view.

I believe 2015 will be an exciting year for London’s Cardiac and Vascular Strategic Clinical Network and the work underway will help NHS England and London’s CCGs to improve cardiovascular care across London.
London Cardiovascular Strategic Clinical Network

Network news - March 2015

Improving CVD in Wandsworth

Dr Nicola Jones MBE
MBChB DRCOG MRCGP MBA
Clinical Lead for Cardiovascular Disease and Chair,
Wandsworth Clinical Commissioning Group

The Cardiovascular Disease Clinical Reference Group (CVD CRG) meets every two months to support Wandsworth CCG in commissioning high quality services and improving outcomes for people with, or at risk of developing cardiovascular disease in Wandsworth.

Over the past few years, the CRG has implemented a number of initiatives including:

» Case-finding individuals at risk of atrial fibrillation through a pulse-check targeted at over 65 year olds attending for flu immunisation;
» Encouraging GPs to refer patients to the Stop Smoking service as a means of preventing a premature death from cardiovascular disease;
» Integrating the acute and community cardiac rehabilitation service as well as providing additional investment to enable more eligible patients to access the service;
» Becoming the first CCG to commission a specialist exercise programme for patients with peripheral arterial disease.

As well as these individual initiatives, the CRG has also worked alongside local clinicians and patients across acute, community and primary care to improve the local heart failure pathway to ensure patients receive care in the right place and at the right time by a specialist team.

This has involved the acute heart failure team working to ensure that all inpatients admitted to St George’s Hospital with heart failure receive the following bundle of care:

» BNP and echocardiogram completed during admission (unless not deemed clinically appropriate)
» Mental health review
» Documented assessment of end of life care needs and plan where appropriate
» Onward referral to the community specialist heart failure service or the heart failure outpatient service

In addition to this, unstable patients with high BNP will be seen within 48 hours and stable patients seen within 2 weeks in an outpatient heart failure clinic.

Additional specialist nurses have been recruited to the community heart failure team. The team is now able to support patients requiring a rapid response to prevent an unplanned hospital admission as well as those patients who may benefit from longer term management.

GPs are reviewing their registered primary care heart failure patient lists to identify and refer individuals where appropriate into the community service who may have received a heart failure diagnosis but have not benefitted from local specialist expertise.

Above: Dr Nicola Jones
Now in its fifth year of commissioning, the NHS Health Check programme in Wandsworth focused initially on engaging GPs in NHS Health Check to create a strong, borough-wide platform for offering and delivering the service.

As a result of this work 42 of 44 GP practices are providing NHS health checks. Wandsworth Council’s public health team has worked to develop and maintain supportive relationships with GPs; this has been essential to ensure commitment from practices in reaching their eligible patients and delivering a good quality service. Strong commitment from the CCG Chair and three locality based cardiovascular disease GP leads has supported this process by advocating for the programme and gaining support from practices across the borough. This work has been rewarded in success stories such as that of Mario’s.

We spoke to Mario Desouza about how an NHS Health Check helped him.

“I was at a low place in my life. My work situation led to my mood and physical wellbeing getting low and I didn’t have enough emotional or social support around me. I was using drink as a cushion to deal with my negative emotions, smoking too much, eating ready meals and unhealthy foods and not getting any exercise.

“I started seeing a counsellor and met my health trainer, Garry. I went for an NHS Health Check at my GP surgery and found out I had high blood pressure, high cholesterol, vitamin D deficiency and I had a really high risk of having a heart attack or stroke in the next five years. That shocked me into changing my life – I want to be around for my kids.

“Within six weeks I got my risk down and lost a stone. It’s been five and a half months since I had a cigarette and I think twice about having alcohol – exercise helped with that. I’ve been running a really tranquil route along the river from near my home in York Road Gardens to Wandsworth Park. Drinking makes me tired so I prefer to go for a run.”

Mario Desouza, NHS Health Check champion

Mario is now an active member in his community encouraging people to change and lead a healthier life.
Camden Clinical Commissioning Group (CCG) is working to improve outcomes from cardiovascular disease (CVD) through a range of projects. These projects aim to improve early identification of people at high risk of vascular complications and to manage diagnosed patients through fully integrated services that deliver a seamless, high quality care experience.

A locally commissioned service (LCS) encourages general practices to commit sufficient resource to undertaking additional work to case find and deliver in-depth management of patients with five conditions: diabetes, chronic kidney disease, hypertension, heart failure and chronic obstructive pulmonary disease (COPD).

Joint working to reduce variation has been encouraged across Camden through the promotion of locality targets for important proxy outcomes, such as prevalence and improved treatment metrics. Since the service launched in October 2013, there have been substantial increases in the numbers of people on practice registers for:

» Diabetes (an additional 641 people or 8 per cent increase on baseline)
» CKD (654 people / 14 per cent)
» Hypertension (1,488 people / 7 per cent)
» Heart failure (214 people / 16 per cent)
» COPD (367 people / 14 per cent)

We are also starting to see improvements in treatment metrics such as a reduction in the proportion of people with poorly controlled glucose.

Table 1 (at right) shows that the percentage of people with HbA1c<75 mmol/mol increased from 78.6 to 85.1 per cent from October 2013 to December 2014. This has been due to better monitoring and more effective care for high risk patients.

For more information, please contact the Camden CCG Long Term Conditions and Cancer team, LTCinfo@camdenccg.nhs.uk.
In London there are 24 specialist TIA services. These are located in hospitals which have an acute stroke unit. Recent reviews of these services have revealed that 10 are not meeting the standards (two in SE London, three in SW London, three in NC London and two in NE London). The Stroke Strategic Clinical Network is engaging with commissioners, providers and vascular surgeons to improve the speed at which patients can access vital treatment.

Clinicians in primary care have a critical role to play in the detection and management of risk factors for stroke. Working in partnership with stroke specialists in secondary care approximately 1,680 strokes in London could be prevented each year.

“Working in partnership with stroke specialists in secondary care, approximately 1,680 strokes in London could be prevented each year.”
Stroke prevention in atrial fibrillation:  
*It’s all about primary care!*

**Helen Williams**  
*Consultant pharmacist for cardiovascular disease, South London*

Primary care is key to the delivery of better stroke prevention in atrial fibrillation (AF). Data from the Quality Outcomes Framework (QOF) demonstrates the significant variation in the rates of anticoagulation for stroke prevention in AF across London boroughs, seen below *(Table 2)*.

Further and even more significant variation exists within boroughs at a practice level. In excess of 17,000 people with AF and CHADS\(_2\) score ≥ 2 are currently untreated and, with the implementation of CHA2DS2VASC through QOF next year, even greater numbers of patients will need to be treated in the future.

Primary care is key to the delivery of better stroke prevention in AF. From finding more patients through opportunistic pulse checking – particularly in the elderly and other at risk groups – to ensuring patients are offered anticoagulation that is properly managed, general practice will need to take centre stage.

Several barriers to optimal anticoagulation in primary care exist in London.  
These include:

- Myths regarding the benefits of anticoagulation versus aspirin
- Fears about an overestimated bleeding risk – particularly in the frail, elderly population
- Lack of knowledge of the newer agents such as dabigatran, rivaroxaban and apixaban
- Lack of confidence in both prescribing these newer agents and in monitoring patients

Support for primary care is critical to increasing anticoagulation uptake for AF patients. This support must include a clear pathway of care, consensus guidance, education and training for primary care practitioners (GPs, nurses, pharmacists), availability of specialist advice should problems occur, and resources to support patients and clinicians making informed decisions regarding treatment.

*Table 2:* Reported and actual percentage rates of anticoagulation in high risk AF patients (CHASDS\(_2\) ≥ 2) and number of untreated high risk patients by CCG (QOF 2014)
Renal news
From Dr Neil Ashman, Clinical Director

East London kidney system: Integrating across London

The review of observed prevalence rates against expected rates for chronic kidney disease (CKD) often suggests under recording of patients with CKD on registers.

The burden of disease is significant, first and foremost to patients needing dialysis on reaching end stage kidney failure. Dialysis numbers and costs continue to grow across London. Currently more than 6,000 Londoners are on dialysis, and a single patient year of dialysis can cost £29,000. Additional-ly, patients often find out they have advanced kidney disease too late to ensure effective preventative treatments are started in time.

On the back of innovative work in both inner Birmingham, and Camden, East London is piloting a community-based virtual clinic, and a novel surveillance system to identify and manage CKD in the community. Tower Hamlets, City and Hackney and Newham CCGs, in collaboration with the Clinical Effectiveness Group and Barts Health Renal Unit,

(cont’d)

are rolling out a system seated in the primary care record in EMIS Web, aiming to increase awareness, improve management, identify and identify early those most at risk for progression to end stage kidney disease.

Key patient details will populate a CKD template, which will be visible to a community nephrologist doing e-clinics, using EMIS Web. All referrals, whether for advice alone or potential onward review in the hospital sector, will be discussed, and initial guidance and advice documented as individualised plans. Locally relevant guidelines, care plans and patient information leaflets will be made available to help manage common dilemmas in primary care.

Perhaps as importantly, the system aims to track and identify patients with progressive early CKD on a practice-by-practice basis, ‘pulling’ patients with rapidly declining eGFR to their GP’s notice. By flagging these patients, the project hopes to reduce unplanned starts to dialysis, and eventually stop ever more patients coming to dialysis.

CKD could be a good care model for actually achieving integration between primary and hospital care. The system hopes to ensure that patients understand the health implications of kidney disease early, and that clinicians co-ordinate efforts to prevent progression in a cost-effective manner over time.

Table 3: Renal replacement therapy (dialysis and transplant) by CCG, including the percentage of non-white population (2013)
As an increasing number of providers for care emerge, there is increased potential for fragmentation of healthcare. Hence, it is essential that chronic illnesses do not ‘fall between the cracks’ and clinicians work together to ensure excellence in both prevention of problems and provision of care.

Early stages of chronic kidney disease (CKD) often present with very subtle and minimal symptoms, if any. However, if allowed to progress to end-stage, CKD can cause devastating effects, both in physical burden and financial cost. Primary care is the most likely place where those with CKD will be detected. To achieve more accurate prevalence statistics not only do we need to ensure that we code appropriately those we are picking up with renal disease, but we also need to ensure we screen those who are more at-risk.

It is imperative that we direct care to prevent progression wherever we can. However, we must also promptly identify those patients where their CKD is progressing. Within a busy general practice, early progression of CKD can easily be overlooked, particularly when solitary results are seen.

Developing a system that alerts a practitioner to changes in estimated glomerular filtration rate (eGFR) will help identify disease progression. Likewise, developing ‘virtual’ patient lists, where preventative actions and appropriate referral to nephrologists can be implemented, are liable to have a positive impact on the number of patients coming to dialysis unprepared, and also hopefully prevent the need for dialysis in some! The integration of primary care with secondary care by means of virtual clinics has proved invaluable for patients with diabetes, and I would hope that more cohesive collaboration with nephrologists would also prove beneficial for CKD outcomes.

In addition, the prevention of the major causes of CKD - namely diabetes and hypertension - has a significant role in reducing the prevalence of CKD, and an important area that needs to be tackled is that of lifestyle changes with improved diet, exercise, and public education, and of looking for the development of co-morbidities when seeing patients with one or more cardiovascular conditions.
The Diabetes pump collaborative is run in collaboration with the Health Innovation Network (HIN, the Academic Health Science Network for south London). The collaborative brings together those from services from across London to attend workshops focused on service improvement and shared learning to increase access to pump technology for people with type 1 diabetes. Workshops 1 and 2 were held in November 2014 and February 2015.

We have developed a toolkit for structured education programmes for patients, written in collaboration with the HIN with patients, clinicians and commissioners involved (available here).

The diabetic eye screening programmes in London are changing; a current procurement process aims to reduce 17 separate programmes to six programmes (at most) offering eye screening across London from autumn 2015.

A London diabetic foot care network event organised by Miss Stella Vig and Mr Richard Leigh was held on 5 March with presentations from Dr Neil Ashman, London renal clinical director amongst others.

There is an audit of acute foot services and community foot teams currently open. Please share with your colleagues as appropriate.

We have established a consensus approach endorsed by the Strategic Clinical Leadership Group to use HbA1c across London for the diagnosis of diabetes. It will enable us to diagnose people more effectively and detect those who are ‘at high risk’ of developing diabetes and offer them suitable intensive lifestyle interventions.
London Cardiovascular Strategic Clinical Network

Network news - March 2015

Transforming diabetes in west London through primary care contracts

Dr Tony Willis
Clinical Lead for Diabetes, CWHHE CCG Collaborative
IT, Diabetes, CKD Lead and CCG Board Member, Hammersmith and Fulham CCG SystmOne National User Group Committee Member

Central London, West London, Hammersmith and Fulham, Hounslow and Ealing (CWHHE) CCGs are about to launch a collection of primary care diabetes contracts with GP federations, designed as part of a strategy to transform diabetes care in west London.

Drawing on elements of best practice from Tower Hamlets, Leicester, Bradford and Portsmouth, the CWHHE Diabetes Strategy Group has created a framework which we believe will both challenge and support practices to deliver better diabetes outcomes. The three contracts are for: high risk of diabetes; diabetes level 1; and diabetes level 2. They are designed both to help prevent or delay the onset of diabetes in those at high risk and to tackle common issues in diabetes care, including injectable initiation.

The contracts will be delivered by GP federations and include:
» Key performance indicators based on average network performance (minimum population size 30,000) for nine key care processes and other diabetes indicators, including care planning
» Mandatory training provided by the CCGs
» Network discussions
» Diabetes dashboard for open reporting at practice, network and CCG levels and performance related payments
» Comprehensive diabetes guidelines accessible from diabetes templates within the clinical system
» Support with mentoring, education and clinical input from reshaped community services
In 2012 Lambeth CCG introduced guidelines for primary care to use HbA1c to diagnose type 2 diabetes. The guidelines were launched at a practice education event which was attended by most clinicians leading on diabetes care in their practices.

It was recommended that HbA1c should be used by practices to screen higher risk people for type 2 diabetes, for example, people with known hypertension or cardiovascular disease.

In addition to identifying more people with diabetes (and thus reducing the local “prevalence gap”), practices identified a group of people with an HbA1c between 6-6.4 per cent who were at high risk of developing diabetes.

It was recognised that we needed to offer something to this group of people to reduce their risk of developing diabetes. The Lambeth Diabetes Intermediate Care Team looked at current recommendations and developed an educational programme called STEPS to prevent diabetes.

STEPS is a group session run by either a dietician or diabetes specialist nurse. Practices are able to refer patients to attend a STEPS course. The session lasts for two hours and the emphasis is on healthy eating and exercise. All attendees are provided with a pedometer and receive a telephone call after the course to see how they are doing. Feedback from patients and practices has been excellent and referral numbers are high.

The CCG has now commissioned the Intermediate Care Team to continue to provide STEPS courses.

Later this year data will be sought for all STEPS graduates to determine how many had subsequent HbA1c checks and, if so, whether the course was effective in reducing HbA1c levels.

Table 4: Data for the STEPS programme (2014)

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NHS Health Check and reducing health inequalities

Health inequalities are systematic, avoidable differences in health between different groups of people. The NHS Health Check programme aims to narrow health inequalities from a range of conditions (heart disease, diabetes, kidney disease and certain types of dementia). It also encourages people to make better lifestyle choices in order to reduce their risk of ill health.

The NHS Health Check programme aims to:
- Increase healthy life expectancy through identification of risk factors which cause disease.
- Reduce differences in healthy life expectancy and life expectancy by encouraging healthy lifestyle intervention.
- Facilitate early identification and management of disease.

Evidence from a number of sources, including the Public Health Outcomes Framework (PHOF) shows that avoidable health inequalities still exist across London and England. Specific population groups, such as people from black, Asian and minority ethnic (BAME) communities and those with disabilities have a higher incidence of cardiovascular disease and diabetes. For example, south Asian people who live in the UK are up to six times more likely to have diabetes than the white population.

A recent Public Health England (PHE) health inequalities briefing states that there are inequities in NHS Health Check uptake by:
- Age (variation depending on local geography)
- Gender (lower uptake by men)
- People with learning disabilities
- People who are homeless
- People who are not registered with a GP practice

In order to make advances in reducing health inequalities across London, the programme needs to have an equitable uptake in high risk populations. NHS Health Check commissioners and providers are all encouraged to facilitate this approach.

Some local authorities in London have developed strategies to target specific populations to increase their uptake of NHS Health Check. The Royal Borough of Greenwich has a programme to deliver health checks in supermarkets, community centres and a local mosque.

Elsewhere in England, Manchester City Council deliver free health checks in deprived neighbourhoods via their First Stop Health Bus, a mobile clinic which provides a range of additional services, such as stop smoking clinics, alongside health checks. This increases the programmes visibility and access.

Taking a targeted approach through primary care has the potential to show a very positive impact in reducing health inequalities. To help support this, PHE’s business plan for 2014/15 makes a shared commitment to offer NHS Health Checks to at least 20 per cent of the eligible population, and aims to reach 66 per cent uptake by 2015.

For further information on the NHS Health Check Programme, please contact Susan Ismaeel (Susan.Ismaeel@phe.gov.uk).

For further information on tackling health inequalities please contact Rosalind Spinks (Rosalind.Spinks@phe.gov.uk).

Contact details

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For general queries about the newsletter or to contribute to a future edition, please contact Jess Brand, jess.brand@nhs.net.

About the London Strategic Clinical Networks

The London Strategic Clinical Networks bring stakeholders -- providers, commissioners and patients -- together to create alignment around programmes of transformational work that will improve care.

The networks play a key role in the new commissioning system by providing clinical advice and leadership to support local decision making. Working across the boundaries of commissioning and provision, they provide a vehicle for improvement where a single organisation, team or solution could not.

Established in 2013, the networks serve in key areas of major healthcare challenge where a whole system, integrated approach is required: Cardiovascular (including cardiac, stroke, renal and diabetes); Maternity and Children’s Services; and Mental Health, Dementia and Neuroscience.

London Strategic Clinical Networks
020 7932 3700 | england.london-scn@nhs.net