

MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE
Health and Wellbeing Board
10 December 2015

Report of: Director of Public Health

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Agenda - Part: 1	Item: 10 a
Subject: Health Improvement Partnership Board Update	
Approved by: Dr Shahed Ahmad	

1. EXECUTIVE SUMMARY

This report summarises the work of the Health Improvement Partnership Board.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to note the contents of this report.

The Health Improvement Partnership is due to meet on Thursday, 10th December 2015.

1.0 HEALTH INEQUALITIES IN THE FIVE PRIORITY WARDS

The Public Health Core offer team coordinates the measures aimed at reducing health inequality. There has been a significant improvement in reducing the health inequality gap, but there have remained significant challenges to life expectancy across the borough. It was determined that 5 wards (Upper Edmonton, Chase, Ponders End, Enfield Lock and Jubilee) should receive discrete interventions in order to tackle this.

Health Intelligence team has been actively supporting programme by providing analyses and evidence. Recently mortality rates by wards were analysed which highlighted the consistently higher mortality rates amongst those five priority wards, in particular, the wide variation in mortality due to cardiovascular disease within Enfield. This gives all the more importance to promote prevention and effective management of the cardiovascular diseases in Enfield to reduce inequality.

2.0 SUPPORTING PRIMARY CARE IMPROVEMENT

2.1 GP practice visits

The Public Health team is meeting with the GP practices in the five wards as a measure to facilitate primary care improvement.

Dean House surgery was visited in mid-October and Evergreen surgery in early November. Three more practices either within or directly related to the 5 high-priority wards are to be visited in December.

Information reviewed / discussed at the meetings –

- Highlighted health issues of the residents of Ponders End, Upper Edmonton and Jubilee.
- Discussed how Public Health and the surgeries can work together to help improve the residents' health status.
- Public Health services currently delivered in Enfield were promoted. These include NHS Smoking Cessation, NHS Healthcheck, and lifestyle services.
- The importance of reducing the variation in primary care performance including screening and immunisation was highlighted.
- How a single-handed GP can tackle diabetes and other long-term condition management: teamwork and dedication to holistic health.
- How challenging cases of high blood pressure and cholesterol were managed with innovative support.
- Exchanged information and ideas on how to improve health of the population and reduce inequality.
- Discussed the challenge of "Population Churn" or turnover in Upper Edmonton.
- Noted the challenge of DNA's both in terms of increasing waiting times for appointments and as a misuse of resources.
- Discussed the challenge of lack of awareness of new customers of the NHS of the mechanism of referral for secondary and other health care.
- Spoke at length about the difficulty of recruiting staff of all grades to work in the Edmonton Green and Upper Edmonton area.

2.2 GP Newsletter

A newsletter on diabetes in Enfield will be sent to GPs in December. This will be used to inform the GPs of progress made so far with diabetes, the challenges ahead and the services available to their patients in Enfield to enable them to live well with diabetes. It should be noted that, although recognition of Enfield GPs is better than London average, there is an increasing demand and higher admissions from complications of diabetes such as renal failure and consequent Renal Replacement Therapy such as dialysis.

3.0 DIABETES

Long term conditions represent a significant cause of morbidity across the borough, and can be greatly influenced by a range of lifestyle factors. There are currently 16,291 patients aged 17 years and older diagnosed with Diabetes in Enfield.

3.1 Diabetes Locally Commissioned Service (LCS)

A pilot to deliver integrated care package within primary care for patients with Type 2 Diabetes was commissioned in South East Enfield Locality. 14 out of 16 practices in the South East Enfield Locality participated in this pilot which ran from December 2014 to September 2015. One of the key elements of this pilot was Multi-disciplinary Team support including Consultant diabetologist and the community diabetes specialist nursing team. Various learning points were raised and recommendations made based on these points.

3.2 National diabetes prevention programme – expression of interest bid

Enfield CCG and Enfield Public Health made a joint expression of interest bid on the National diabetes prevention programme in September and we are still awaiting results from the NHS England.

3.3 Diabetes education in primary care

Using HE NCEL fund, Enfield CCG offered diabetes education in primary care to GP practices across Enfield (January – March 2015). Over 50 delegates (GPs/Practice Nurses/Health Care Assistants) attended the courses and the feedback was excellent.

Patient Structured Education using the Conversation Maps approach will continue to work closely with BME patients with diabetes in Enfield.

4.0 ENHANCING CARDIOLOGY IN PRIMARY CARE LOCALLY COMMISSIONED SERVICE (LCS)

Long term conditions represent a significant cause of morbidity across the borough, and can be greatly influenced by a range of lifestyle factors. The Enfield Joint Health and Wellbeing Strategy 2014-2019 highlight that the largest cause of death in the borough is Cardiovascular Disease (CVD).

4.1 Cardiovascular Disease (CVD) retrospective case review

CVD retrospective case review is in process to better understand the current status in secondary prevention of Cardiovascular Diseases (CVD) following a CVD event such as heart attack or stroke.

450 cases are to be reviewed by the end of this year and report will be prepared for shared learning early next year. Enfield Public Health team will be supporting the analyses.

4.2 Atrial Fibrillation Pilot

AF pilot project in the South East locality is aimed to decrease stroke rates and reduce costs associated with stroke care in the South East Enfield locality. This project intended to improve detection and management of AF in line with the 2012 European Society of Cardiology (ESC) guidelines.

The participating practices identified 61 additional patients with AF thorough the project and saw an overall increase in the percentage of patients who are receiving anticoagulant therapy.

5.0 MAYOR'S CHARITY EVENT ON DEMENTIA

Public Health will be participating in a Dementia Event on the 28th November. The event is intended to focus on the immediate needs of those who are suffering from dementia and their carers, but Public Health will be publicising the entirely practical means of reducing the risks of developing dementia, particularly vascular dementia, through both lifestyle changes and medical interventions.

6.0 EFFICIENCY PROGRAMME (QIPP)

This programme is designed to deliver better quality healthcare at reduced cost. Enfield CCG has a target to save £12.5M through 19 QIPP schemes.

A Public Health consultant and the core offer team support the CCG in the areas of long-term conditions and also works to address clinical pathway issues through the Transformation Programme Board, Clinical reference Group, Long-term Condition Steering Groups and the Quality and Safety Group.

7.0 PUBLIC HEALTH CAMPAIGN

7.1 GP registration promotion campaign

Following a Healthwatch report on GP registration, a GP registration promotion campaign is being undertaken in November in the form of distribution of leaflets across Enfield. A generic leaflet with information on how to register will be distributed across Enfield using a housing newsletter mail drop. Leaflets with schematic ward maps will be distributed, by door-to-door drop, to all households in the 5 priority wards. The maps show the location of the GPs in the wards and the immediate vicinity and relevant bus routes. Active travel is also encouraged by putting walking distance times around GPs. Adverts will also be distributed at libraries and groceries.

8.0 JOINT STRATEGIC NEEDS ASSESSMENT UPDATE

Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (JHWSs), through the health and

wellbeing board. The purpose of the JSNA is to inform the way in which decisions about health, wellbeing and social care services are planned and arranged.

The Enfield JSNA is available on the Enfield Health and Wellbeing website at <http://www.enfield.gov.uk/healthandwellbeing/jsna>.

The contents are being reviewed and updated to ensure it remains relevant and a useful tool and resource for commissioners, policy makers, local people and other key stakeholders.

The maintenance of Enfield JSNA is led by the Public Health Intelligence team, and the maintenance process is overseen by the JSNA steering group which membership includes Local Authority, CCG and Community and Voluntary sector colleagues. The JSNA steering group meets quarterly and the last meeting was in October 2015.

Data and contents update is progressing well with the support from various stakeholders at LBE and Enfield CCG. We will continue to update the data and contents as appropriate. Since September 2015, following sections are either being updated on the web or being reviewed by lead consultant.

- Child Poverty
- HIV and Sexual Health
- Learning Disability and Autism
- Circulatory Disease
- All Respiratory Disease
- Cancer
- Health Inequalities
- Prevention - Immunisations, Screening, and Health Checks

9.0 QUALITY AND OUTCOMES FRAMEWORK (QOF) 2014/15 HEADLINE REPORT

QOF is the annual reward and incentive programme detailing the GP practice achievement results. The data for 2014/15 was published at the end of October 2015. Health Intelligence team produced a Headline Report summarising Enfield's achievements and analysing trends. The report highlighted increasing demand for major Long Term Conditions (increasing prevalence) and further opportunities for improvements in managing these conditions such as effective control of blood pressure.

10.0 PUBLIC HEALTH SERVICES FOR 0-5 YEARS

From 1 October 2015, the responsibility for commissioning Health Visiting and Family Nurse Partnership services transferred from NHS England to local authorities. The rationale behind this move is that local authorities know their communities and have a better understanding of local needs so they are in a more informed position to commission the services.

Funding for the 0-5 budget will sit within the overall public health budget and is ring-fenced to March 2017.

A review at twelve months, involving Public Health England (PHE) will inform future commissioning arrangements.

Child Health Information Systems (CHIS) and the 6-8 week GP check (Child Health surveillance) have not transferred to local authorities, although the CHIS service is expected to transfer in 2020.

Health Visitors and Family Nurses continue to be employed by the provider, which is currently Barnet Enfield and Haringey Mental Health Trust.

10.1 Health Visiting

Health visiting is a universal service that provides a professional public health service based on evidence of what works for individuals, families, groups and communities.

Health visitors are highly trained specialist community health nurses, skilled at spotting early issues that may develop into problems or risks to the family if not addressed.

The service will vary according to the personalised assessment of each particular family and what will work for them. They lead the delivery of the 0-5 elements of the Healthy Child programme in partnership with other social care colleagues, which places them in a strategic position to tackle and reduce infant mortality because they work closely with the parent and family from pre-natal, during pregnancy, post-natal until the child starts school at 5 years.

Health visitors are mandated to undertake:

- an antenatal visit,
- visit new born babies at home between 10 and 14 days, and
- undertake a 6-8 week review, followed by
- another review at one year and
- a further review at 2 - 2½ years,

and focus on six early year's high impact areas including;

- (i) maternal mental health,
- (ii) transition to parenthood,
- (iii) breastfeeding,
- (iv) healthy weight,
- (v) managing minor illnesses / accident prevention and health and wellbeing.

This facilitates regular contact with families and their children at the most challenging times of their lives and plays a key role in early detection of potential risk factors of infant mortality and child development.

One of the strengths of health visiting is that by visiting families in their homes, they are able to take a holistic view of the family and their needs. Through regular contact and with appropriate training, health visitors can influence mothers, fathers and family members to develop healthy behaviours (including increasing physical activity and maintaining a healthy weight) associated with improved wellbeing. In addition, health visitors can encourage greater physical activity among children by providing relevant information to families and working with partners to develop greater opportunities to be physically active within

10.2 Family Nurse Partnership (FNP)

The Family Nurse Partnership (FNP) is an evidenced based, preventative programme offered to vulnerable young mothers having their first baby. It is a nurse led intensive home-visiting programme from early pregnancy to the age of two. The aims are to:

- improve pregnancy outcomes;
- improve child health and development;
- improve parents' economic self-sufficiency.

The criteria for eligibility to be offered the programme are:

- All first time mothers aged 19 and under at conception;
- Enfield residents;
- Eligible if previous pregnancy ended in miscarriage, termination, still birth;
- Enrolment should be as early as possible in pregnancy and no later than the 28th week of pregnancy. 60% should be enrolled by the 16th week of pregnancy.
- Women who plan to have their child adopted or have had a previous live birth are excluded from the programme.

The FNP programme is overseen by a FNP Advisory Board (FAB) chaired by the Assistant Director Commissioning and Community Engagement, Schools and Children's Services.

In the last 12 months:

- 37 clients were enrolled, of whom 41% were enrolled by the 16th week of pregnancy (the target is 60%);
- 75% of those who were offered the programme enrolled, which meant that the target of 75% was achieved;
- 44 pregnancies, 19 infancies and 5 toddlerhood graduations were completed.

There are an increasing number of vulnerable, complex and safeguarding issues within the families enrolled onto the programme.

A strategic vision for FNP in Enfield is being developed as part of the borough's wider maternity and children's services. FNP aligns with the Healthy Child Programme and will be included in future commissioning plans for the wider Health Visiting service.

11.0 SCHOOL NURSING

School nursing service provides a service to all the Council-funded schools in the borough. School nurses assist with safeguarding, health promotion, can advise on health matters and help with training on long term medical conditions (e.g. how to use EpiPens) to help every child attend school and reach their potential. School nurses also deliver the school aged national immunisation programme to all schools in the borough.

Children can self-refer to school nursing or can be referred by school staff, social services, the looked after children nurse specialists, child protection nurses or medical colleagues.

There are plans to co-commission an immunisations service with NHSE and to develop a traded service for school nursing to be offered to academies, free schools and independent schools in the borough.

School nursing will be reviewed in the next year to ensure value for money and assure clinical quality and governance.

12.0 SCREENING AND IMMUNISATION

The latest immunisation data suggest an increase in coverage, but these have not been validated and are not available for dissemination yet. Flu vaccination has commenced in schools, but uptake so far has been very low. It is thought that this is due to the use of gelatine in the nasal spray and we have a meeting with NHSE to discuss this and explore what other boroughs have done to address the issue.

The team is working with NHS England to assure the Council of screening programmes in the borough and have invited NHSE to attend the upcoming Scrutiny sessions. The new public health practitioner has also been discussing antenatal and newborn screening with the local maternity units and with NHSE.

13.0 HEALTH PROTECTION

Guinea reported its last case of Ebola virus disease on 29th October and that case has now tested negative. There have not been any cases in November. Sierra Leone was declared Ebola free on 7 November and is now in a 90-day period of enhanced surveillance. Liberia was declared Ebola free, but has unfortunately reported cases in the last few weeks.

There have been cases of Polio in Ukraine, but no instances in European countries. We remain vigilant for the signs of infectious diseases in the borough.

14.0 AIR QUALITY – SEEK TO REDUCE EMISSIONS FROM VEHICLE IDLING

A bid was submitted to the Mayor's Air Quality Fund with the ambition of making Enfield idle-free by 2020. There are several strands to this project which include engagement with schools, the community and local businesses. Specific campaign/target areas include level crossings, outside schools, air quality hot spots, taxi ranks, stations and at key junctions where people are likely to be waiting for over a minute for the lights to change.

Commissioning some "Air Aware" lessons within schools, separate to the bid but will complement it, if it is successful.

15.0 CYCLE ENFIELD

Plans for a pedestrian and cycle-friendly transformation of Palmers Green and Winchmore Hill have received a major boost after they won the backing of local people.

The plans for Palmers Green, which are being funded through the Mayor of London's £30 million Mini Holland fund, will see the town centre improved with wider pavements, more trees, bike lanes, landscaping, and more car parking.

There will be extra parking spaces serving the shopping area and there will also be major improvements to the Winchmore Hill area with a safe, separated cycle track running from Palmers Green to Enfield Town allowing people to make local journeys by bike instead of car.

In all, 60 per cent of the 1,646 people consulted said they supported the plans, while just 40 percent were opposed to them. The Palmers Green proposals will be submitted to Transport for London for approval, and, if obtained, work will start in the Spring of 2016.

16.0 HEALTHY WEIGHT STRATEGY

The Healthy Weight Strategy will be presented to the CCG and Health Improvement Partnership in December.

17.0 HEALTH CHECKS

Backdated health check data indicates that the number of health checks received in Q1 has risen from 1,297 to 2,416. In Q2 data indicates 1604 were received with a cumulative Q2 total of 4020.

18.0 TOBACCO CONTROL

Two surveys appear to indicate that smoking prevalence in Enfield is falling;

- the What about YOUth survey of 298,080 15 year olds showed that Enfield has the second lowest rate of current 15 year old smokers in the country (3.5%)
- the Integrated Household Survey (HIS) (340,000 respondents) has indicated that smoking prevalence in the borough has fallen from 15.8% in 2013 to 13.6% in 2014. This represents approximately 5,000 fewer smokers than we'd expect given the 2013 prevalence.

The most recent national campaign was Stoptober. An event for Stoptober took place on 10th September 2015 at Edmonton Green Shopping Centre (outside Asda) which was covered in the local press and supported by Cllrs Keazor and Brett. This year's themes was humour and 3 comedians (two English and one Turkish), distributed stop smoking materials. 39 client's and seven staff signed up for Stoptober.

The Christmas / New Year campaign is being developed but is likely to focus on finance.

19.0 BUSINESS AND ECONOMIC DEVELOPMENT

Three young people who had all recently experienced severe mental health problems were referred to JOBSnet for structured work placements from the Public Health department. These included working in Business and Economic Development, Legal Services and Serco within the Council. The placements all responded well to individual 1:1s, mentoring and support and employability workshops based around their CV, applications and interview skills.

They all had a very enjoyable and beneficial experience and felt that they had received a lot of useful information. Through this intervention one of the placements has now been recruited as an apprentice in the Council's IT department.

The job brokerage team has been trained in giving health advice on smoking, diet and exercise as part of the offer to support people towards the labour market. Staffs are working together on an ESF bid aimed at supporting people with common mental health problems towards employment as part of a 10-borough sub-regional submission led by Hackney Council.

20.0 MENTAL HEALTH

Environment & Regeneration Public Health are producing a draft Mental Health Promotion Action Plan and this should be available by the end of the year, which will identify the top three indicators.

21.0 PUBLIC REALM

- The Council have 17 outdoor gyms that provide free access to exercise equipment for a high proportion of the residents within the borough
- We will soon begin a consultation on the installation of a new outdoor gym within Town Park
- We have two community food growing schemes in the borough, which have started to provide healthy food for the community
- We support a range of running and walking events in the borough, some of which are free of charge, which enables the community to both exercise and socialise.
- This year we have invested over £80,000 in new equipment and pitch enhancements

22.0 DAAT

The latest data for the 12 month rolling period October 2014 to September 2015 is confirming that Enfield has seen 1055 drug users for treatment during the year. This is a marked improvement over the previous excellent performance already achieved. Enfield remains strong in respect of its London ranking for the Numbers of Drug Users in Treatment as it is currently placed 13th; against an investment ranking of 20th. The Number of Successful Treatment Drug Completions has improved even further and now reached 25%; 5.1% above the London average and 9.7% above the National average. The DAAT is currently ranking 8th in London for Successful Treatment Drug Completions.

The number of alcohol users in treatment has remained stable and is consistently good with 354 alcohol users taking up Treatment during the latest 12 month rolling period. It is pleasing to note that the quality in provision has also continued to improve as the Successful Treatment Completion rate is 45.2% which is 3.9% above the London average and 6.1% above the National average. The Enfield ranking for Alcohol Successful Completions is now 7th in London.

The Number of Young People in drug or alcohol treatment for the full year 2014-15 was 175. The Planned Treatment Exit Rate remains very good at 93%; which is 13% above the National Average and 16% above the performance achieved to the same period last year.

The most recent performance for young people has confirmed that 175 young people received substance misuse treatment for the 12 month period up to June 2015. This performance is relatively consistent with the previous year's data and remains good compared to the level of investment afforded to the young people's substance misuse provision.

Enfield DAAT Partnership Board has to also prioritise drug and alcohol related crime reduction initiatives and it receives designated funding from the Mayor's Office for Police and Crime (MOPAC) for this purpose. The performance measures for drug and alcohol crime reduction are as follows:-

- The key target is the Percentage of Drug and Alcohol Offenders with Reduced Offending and Q2 is showing that Enfield has achieved 26.2% against a target of at least 20%;
- The target for Successful Treatment Drug Completions has to be above the London average of 19.6% and Enfield is currently achieving 35.1%;
- The target for the Numbers of Drug and Alcohol Users in Treatment in the crime reduction service was based upon the 2013/14 Baseline of 149 with a 40% minimum growth factored in to equal 208. Enfield is currently achieving 319 for the latest 12 month rolling period.

23.0 SEXUAL HEALTH

The Council has the responsibility for:-

- Integrated Sexual Health Community Services, which is delivered by NMUH; and
- LARC, which is delivered by the borough's GPs

The Integrated Sexual Health Community Services contract delivers GUM treatment for all Enfield residents and Contraception for those not registered with an Enfield GP.

The contract includes specialised Sexual Health Outreach Nurses for young people (4YP) and will be working with voluntary organisations to improve relations with the population identified as 'hard to reach' – sex workers, DAATrs as well as the LGBGTT and BME population.

The opening hours will increase by 25%:-

- Monday – Friday 8am – 7pm;
- Weekends 9am – 2pm

The new service model will commence on a phase basis based on the service moving to the new locations:-

- Burleigh Way: 01 January 2016 commencement;
- Enfield Highway: 01 April 2016 commencement,

The Council has contractual agreements with 27 of the Borough's GPs to deliver Long Active Reversible Contraception (LARC). Activity is steadily increasing and is expected to continue to grow as the new contractor for Integrated Sexual Health Community Services will be training and supporting the GPs with this service.

24.0 UPDATE ON PUBLIC HEALTH GRANT

Public Health England (PHE) consulted on the formula for the future *target* grant allocation and Enfield Council has submitted a response. Since then the comprehensive spending review announced reductions to the national public health budget. No proposals about how this will be implemented have been produced by government.

25.0 ROYAL FREE UPDATE

Following the acquisition of Barnet and Chase Farm (BCF) by the Royal Free London NHS Foundation Trust (RFL) the Clinical Pathway Redesign Programme seeks to align pathways across the local health economy between the 5 CCGs (Barnet, Camden, Enfield, Herts Valley and E&N Herts) and RFL to ensure that services are financially and clinically sustainable.

There are a total of 45 pathways which were designed across 8 specialities.

25.1 Pathways

The Trust has agreement to roll out all clinical pathways in Enfield CCG. Meetings have begun to look at launching the Dermatology pathways and associated services in the New Year. To date the Trust has also launched pathways in Barnet and East and North Herts CCGs with agreement to launch all pathways in Herts Valley CCG, which will begin the early 2016.

Pathways will be launched in phases working with local CCGs and GPs to identify areas of need that the pathways can help address.

In order to compliment the pathways the trust has started an internal transformation programme ensuring that it has the right services in place to meet the changing demand.

25.2 Cancer

An internal piece of work is underway to map all the cancer pathways across the expanded trust. The aim is to ensure that pathways are integrated and streamlined and that services adapt in order to meet the changing demands. This is reflected in the rebuild of Chase Farm with the expanded Breast, Endoscopy and Chemotherapy services on site.

25.3 Clinical Advice and Navigation (CAN)

A key component to ensuring that GPs have access to fast consultant opinion on patients being managed in primary care, CAN is one of the key enablers to the pathway work. To date the following services have been launched:

- Email advice for Gastroenterology and Cardiology in Enfield, Barnet and East and North Herts CCGs.
- Telephone advice for Respiratory in Enfield, Barnet and East and North Herts CCGs.
- Teledermatology service in East and North Herts CCG.

25.4 MSK tender

The Royal Free has formed a partnership to respond to a tender for an integrated MSK service in Enfield with a number of other local providers. The partnership was successful at Pre-Qualification Questionnaire stage, and is awaiting the issuing of the Invitation To Tender.

25.5 Health Information Exchange (HIE)

HIE's allow for the seamless transfer of data and patient information between existing healthcare systems. i.e. primary care records can be reviewed in secondary care and vice versa.

The benefits of HIE include:

- The system will allow patients to be tracked along pathways ensuring they are receiving the right diagnostics, appointments and treatments at the right time and in the right place.
- Clinicians will be able to see older information about patients (e.g. discharge letters) without having to request copies of letters.
- The system allows for various levels of access ensuring that only certain health professionals can see specific information about patients, protecting confidentiality and sensitive information.

HIEs are a key enabler of the pathway work and the Trust will be rolling out the systems in collaboration with Enfield GP federations in early 2016.

26.0 DEVELOPING ENFIELD COUNCIL'S PUBLIC HEALTH CAPABILITY

26.1 Public Health Delivery Meetings are being held with each Enfield Council team who have received Public Health staff or financial allocations

26.2 Wider Public Health group meetings have been held with Schools and Children's Services and with Environment to discuss how they can be best supported to improve the health of Enfield's population. A council-wide meeting will be held in the new year to strengthen knowledge exchange.

26.3 Community Health Wellbeing Fund has gone live.

26.4 Public Health and Community Resilience Outreach Office has been recruited.

27.0 REGIONAL AND NATIONAL ACTIVITIES

27.1 We continue to act as Professional Appraisers for Public Health England and benefit from the national Revalidation system for doctors.

- 27.2** We continue to provide mentoring support for new and aspiring Directors of Public Health and to support Public Health workforce development in London.
- 27.3** We support the London Primary Care Transformation group and will be supporting them to develop London-wide standards for primary care.
- 27.4** We have been working with Public Health England to deliver the London Hypertension Workshop.
- 27.5** We have been providing Public Health advice to the Board of London Cancer and to Cancer Commissioning Board for London.
- 27.6** We have been invited by Healthy London Partnerships to present Enfield's work on hypertension to their Commissioning for Prevention Event in January.