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ENFIELD Council

HEALTH AND WELLBEING BOARD

Wednesday, 12 July 2017 at 6.15 pm
Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

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MEMBERSHIP

Leader of the Council – Councillor Doug Taylor (Chair)
Cabinet Member for Health and Social Care – Councillor Alev Cazimoglu
Cabinet Member for Community Safety & Public Health – Councillor Krystle Fonyonga
Cabinet Member for Education, Children's Services and Protection – Councillor Ayfer Orhan
Chair of the Local Clinical Commissioning Group – Dr Mo Abedi (Vice Chair)
Healthwatch Representative – Deborah Fowler
Clinical Commissioning Group (CCG) Chief Officer – Noreen Dowd
NHS England Representative – Dr Helene Brown
Director of Public Health – Tessa Lindfield
Executive Director of Health, Housing and Adult Social Care – Ray James
Executive Director of Children's Services – Tony Theodoulou
Voluntary Sector Representatives: Vivien Giladi, Litsa Worrall (Deputy)

Non-Voting Members

Royal Free London NHS Foundation Trust – Peter Ridley
North Middlesex University Hospital NHS Trust – Libby McManus
Barnet, Enfield and Haringey Mental Health NHS Trust – Andrew Wright
Enfield Youth Parliament – Robyn Gardner, Bobbie Webster

'TO FOLLOW' AGENDA – PART 1

6. PROGRESS UPDATE ON JOINT HEALTH AND WELLBEING STRATEGY (7:15 - 7:30PM) (Pages 1 - 24)

To receive the report of Tessa Lindfield, Director of Public Health.

SENT TO FOLLOW

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Agenda Item 6

MUNICIPAL YEAR 2017/18

Meeting Title:
HEALTH AND WELLBEING BOARD
Date: 12th July 2017

Agenda Item:
Subject: Progress on Health and Wellbeing Board Monitoring areas for 2017-19

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Report by:
Tessa Lindfield
Director of Public Health

1. EXECUTIVE SUMMARY

The Health and Wellbeing Board (HWB) has previously selected 12 areas to monitor including 3 priority areas where it wishes to focus for the remaining term of the strategy (until 2019). Progress on these areas including the three priority areas are highlighted. Challenges within the 3 priority areas are outlined below for discussion and potential action by the HWB.

2. RECOMMENDATIONS

- The Board is asked to note the progress on HWB monitoring areas.
- The Board is asked to discuss how it wishes to support the HWB priority areas, as highlighted below;

  <Best Start in Life>

  - Maintain focus on these important metrics that together provide an indication of the quality of the Best Start in life being achieved in Enfield.
  - Devote focused sessions on Best Start in Life at the Health & Wellbeing Board that brings together key partners that contribute to improving outcomes.
  - Facilitate partnership working in this area between council departments and the CCG.

  <Mental Health Resilience>

  - There is a challenge to the HWB about how best to support the Thrive LDN initiative.

  <Healthy Weight>

  - Members of the Health & wellbeing board are encouraged to champion healthy weight by promoting one healthy behaviour each (e.g.sugar reduction, cake culture, helathy choices, active travel etc)

within their own and partner organisations

- Enfield Council achieved the London Healthy Workplace Excellence Award in 2014. As part of the re-accreditation, we have been asked to record and analyse the data that proves what we are doing is effective. This can be achieved through conducting an annual 'Staff Health & Wellbeing' survey, which the HWB is asked to support.

3. BACKGROUND

3.1 At Health and Wellbeing Board meeting held on the 19th April 2017, HWB agreed on the priority areas it wishes to focus on the final two years of the Joint Health and Wellbeing Strategy 2014-2019.

3.2 The HWB Priority areas were:

<Top 3 priorities>
- Best start in life
- Obesity
- Mental health resilience

<Collaboration>
- Domestic Violence

<Enhanced Monitoring>
- Cancer
- Flu vaccination amongst Health Care Workers
- Housing with a focus on vulnerable adults
- Hospital admissions caused by injuries in children
- Diabetes prevention
- Living well with people with multiple chronic illness
- End of life care
- Tipping point into need for health and care services

4. REPORT

4.1 There are a number of actions the HWB could take in order to improve health and wellbeing in Enfield. These include:
- Strategic oversight
- Deep dive
- Partnership working
- Joint commissioning
- Unblocking system working
- Support across the system
- Constructive challenge
- Referral to scrutiny

4.3 The report below highlights the key successes and challenges in the last three months in the HWB priority areas.

Healthy Enfield

ENFIELD Council

Top 3 priorities

Focus area	Best Start in Life
Partners	Public Health, Children's Services, Enfield CCG

What's our current performance?

- **Breastfeeding**
  - Breastfeeding initiation in Enfield is good (86.7% of mothers breastfeed their baby within 48 hours of delivery) [2014/15 data]. Although this is better than the London and England averages there has been a dip from the highest percentage achieved in 2011/12 of 90.3%.
  - There is currently no data available for the proportion of mothers still breastfeeding at 6-8 weeks.

- **Hospital admissions due to unintentional and deliberate injuries in children aged 0-4 years**
  - The rate of hospital admissions (per 10,000 resident population) for these reasons is 130.3 [2015/16 data]. This is significantly higher than London (97.6) and comparable to England (129.6).
  - This is a slight reduction from 143.3 in 2014/15.

- **Children's oral health (dental decay)**
  - Around a third of children in Enfield have one or more decayed, missing or filled teeth (DMFT) (33.9%) [2014/15 data]. This is significantly worse than the London (27.3%) and England (24.8%) averages.
  - There were 252 admissions for dental caries in 0-4 year children between 2013/14 and 2015/16. This is a rate of 333.5 per 100,000, which is similar to the London rate (368.1) but significantly higher than England (241.4).

- **Chlamydia screening and detection (15-24 year olds)**
  - Chlamydia screening is recommended for all sexually active 15-24 year olds. The proportion being screened for chlamydia in 2016 was 16.3%. This is significantly worse than London (27.0%) and England (20.7%) and is a downward trend from a high of 19.2% in 2013.
  - Increasing detection rates indicates better targeting of screening activity; it is not a measure of prevalence. Areas should work towards a detection rate of at least 2,300 per 100,000 population. In 2016, the detection rate in Enfield was 1,608 which is lower than the minimum recommended rate and significantly lower than London (2,309) and England (1,882).

- **School readiness**
  - The global measure of school readiness is the percentage of children achieving a good level of development at the end of reception. In Enfield (2015/16) this was 65.8%, which was worse than London (71.2%) and England (69.3%).

Things that are going well
• The appointment of a Consultant in Public Health with a specific focus on children and young people in May 2017. • This is enabling the development of a closer working relationship between Public Health and Children's services and Enfield CCG, which supports greater focus on children and young people's health outcomes. • Health Visiting, School Nursing and Family Nurse Partnership contracts, which contribute to the achievement of these outcomes, are being reviewed in order to improving delivery and performance improvement. Future work will look to integrate services to further improve outcomes.
What's next?
• To continue to develop strong working relations between Public Health, Children's Services and Enfield CCG to focus on improvements in these indicators. • Improve the performance management of key Public Health contracts, i.e. Health Visiting, School Nursing and the Family Nurse Partnership. • Review metrics on these indicators when updated data available.
Challenges that HWB may be able to assist resolving / unblocking
• Maintain focus on these important metrics that together provide an indication of the quality of the Best Start in life being achieved in Enfield. • Devote focused sessions on Best Start in Life at the Health & Wellbeing Board that brings together key partners that contribute to improving outcomes. • Facilitate partnership working in this area between council departments and the CCG.

Healthy Enfield

ENFIELD Council

Focus area	Mental Health Resilience
Partners	Public Health, Enfield CCG, BEHMHT, NCL PH Departments. London Health Board.

What's our current performance?

- One in four people will experience mental health problems at some point in their lives. Improving mental health resilience and wellbeing is associated with a range of better outcomes including improvement in physical health, better educational achievement, reduced risky behaviours such as smoking and alcohol misuse.
- 14.1% of the Enfield adult reported high-anxiety score [2015/16]. This was significantly below the England (19.4%) and London (20.0%).
- The estimated proportion of the adult population aged 16-74 with a common mental health disorder was 15.6%, which was the 12th lowest of all London boroughs, but the same as England. This equates to 36,106 people. The Enfield's rate was lower than expected than its level of deprivation.
- At present, there is little focus in the borough around improving mental health resilience at a population level and HWB could add significant value in improving this area. There is potential to join the Thrive LDN work in this area. [q.v.]

Things that are going well

Suicide Audit

- The Council completed the suicide audit reviewing inquest records going back to 2002. The focus of the analyses was around the narrative and circumstances leading up to the deaths to identify possible future prevention interventions. The Enfield suicide rate is lower than the London and national averages. Absolute numbers of suicide cases are also very low (on average 18 cases per year).
- Ongoing audit process has been established and it is now extended to other members of the NCL.
- Further work is planned at NCL level and across England and Wales to review variations in the patterns of suicide in each area.

Mental Health and Employment

- Enfield has been working together with Camden, Islington and Barnet to secure funding from the Big Lottery Fund by way of a Social Impact Bond.
- Enfield has been awarded match funding by the Big Lottery Fund to develop an Individual Placement and Support (IPS) Service. The IPS employment model is internationally recognised as the most effective way to support people with mental health problems and/or additions to gain and keep paid employment

Workplace health

- The Council is working in partnership with NCL Public Health partners and Healthy London Programme team to facilitate the award of the GLA Healthy Workplace Charter to local employers. This scheme will include a significant emphasis on mental health and wellbeing in the workplace.

What's next?

- We would refer the Board to the Agenda Item relating to "Thrive LDN" which details the London Health Board programme of work on mental health and wellbeing. This

has potential opportunity to add value for Enfield.

- We will continue with the GLA Healthy Workplace Charter activity and to progress the IPS plan as set out above.
- We are endeavouring to secure additional funding for a continuance of MECC activity within LBE [for both LBE staff and Primary care and other care staff within the borough]. This will include an element of Mental Health First Aid training as well as a "Dementia Awareness" component.
- We have an aspiration to "embed" Making Every Contact Count (MECC) into LBE as an ongoing training/educational activity in a similar manner to other NCL local authorities. This could be done until the end of 18/19 for £60k

Challenges that HWB may be able to assist resolving / unblocking

There is a challenge to the HWB about how best to support the Thrive LDN initiative.

Healthy Enfield

ENFIELD Council

Focus area	Healthy Weight
Partners	Edmonton Community Partnership, Enfield Voluntary Action, Local businesses LBE- Planning, Sustainable Transport, Road Safety, Enfield Catering Services, School Sports, Healthy Schools, Corporate Communications, Environmental Health

What's our current performance?

- In 2015/16, 4,212 Reception Year pupils (aged 4-5 years) were measured. Enfield's **participation rate** (90.2%) was the **6th worst** amongst the 32 London boroughs.
- **1,008** Reception Year children were overweight or obese. This equates to almost **one in four** Reception Year pupils in Enfield (23.9%). Enfield rate was statistically significantly higher than both London (21.9%) and England (22.1%) averages. Enfield's rate was the 9th highest in London and the second highest in NCL.
- For Year 6 (10-11 years) rate of excess weight is around **two in five** (41.0%) pupils in Enfield, the 6th highest in London and the highest in NCL.
- **1.3%** of all reception year pupils measured in Enfield were underweight (54 pupils). This was similar to both London (1.5%) and England (1.0%) averages.
- Around **two thirds of adults** in Enfield **(63.5%)** are **overweight or obese.** This is **the 8th highest** in London and the highest in NCL**.**

Things that are going well

1. **Local Government Declaration on the reduction of sugar and healthier food**

- An action plan is in development and will be shared with the HWB in September.
- The aim of the Local Government Declaration on Sugar Reduction and Healthier Food is to achieve a public commitment to improve the availability of healthier food and to reduce the availability and promotion of unhealthier alternatives. To sign the declaration the local authority has to commit to take at least six different actions across six key areas.
  - **Area 1** Tackle advertising and sponsorship
  - **Area 2** Improve the food controlled or influenced by the council and support the public and voluntary sectors to improve their food offer
  - **Area 3** Reduce prominence of sugary drinks and actively promote free drinking water
  - **Area 4** Support businesses and organisations to improve their food offer
  - **Area 5** Public events
  - **Area 6** Raise public awareness

2. **The Daily Mile**

10 schools are currently running The Daily Mile, which are:

Oasis Hadley	Latymer All Saints	Brimsdown	Our Lady of Lourdes
Highfield	Brettenham	Eversley	Edmonton County
Chesterfield	Eldon		

Other schools have expressed interest in running this initiative.

3. **School Health & Wellbeing Event**

- A School Health & Wellbeing Event will take place on the 5th October 2017, and aims to
highlight initiatives available to schools to improve the health and wellbeing of

students and staff, including The Daily Mile. The Daily Mile founder, Elaine Wyllie, will present the growing Daily Mile movement, its impact and how local schools can establish the initiative.

4. School Streets

- School Streets is an initiative to make the streets outside schools safer at the start and end of the school day and to discourage driving to school, while encouraging active travel
- The initiative is being piloted at 4 schools- Worcester, Oakthorpe, Carterhatch schools and St Monica's school

5. Healthy Streets

- A new working group has been established consisting of planning, traffic and transport and public health, with the aim to embed the Healthy Streets approach in local policy.
- Further information available at https://healthystreets.com/2017/02/18/healthy-streets-for-london/

6. Healthy Workplace Charter

- The PH team are starting to develop a plan to facilitate the award of the GLA Healthy Workplace Charter to local employers, as well as community organisations and schools. This scheme will include moving more and eating well in the workplace.
- 5 community groups will be supported through the process in August.

7. Eat Well Campaign

- 2017/18 Corporate communications campaign focusing on reducing sugar consumption
- 2016/17 Corporate communications campaign focusing on moving more

8. Healthier Catering Commitment (HCC)

- 21 local businesses were awarded in 2015/16 and a further 4 have been awarded this year.
- HCC recognises those businesses that demonstrate a commitment to reducing the level of saturated fat and salt content in their foods, offering some healthy options (for example, lower sugar drinks and snacks) and making smaller portions available on request.

9. Healthier catering in residential homes

- Funding has been agreed to support Bridgewood House residential home to improve their food provision.

What's next?

- Get sign off for the Local Government Declaration on the reduction of sugar and healthier food
- Increase the number of schools who are participating in The Daily Mile or the equivalent
- Evaluate the School Streets intervention
- Engage schools and community groups in the Healthy Workplace Charter
- Increase the number of businesses that are awarded the HCC

Challenges that HWB may be able to assist resolving / unblocking
• Members of the Health & wellbeing board are encouraged to champion healthy weight by promoting one healthy behaviour each (e.g.sugar reduction, cake culture, helathy choices, active travel etc) within their own and partner organisations • Enfield Council achieved the London Healthy Workplace Excellence Award in 2014. As part of the re-accreditation, we have been asked to record and analyse the data that proves what we are doing is effective. This can be achieved through conducting an annual 'Staff Health & Wellbeing' survey, which the HWB is asked to support.

Healthy Enfield

ENFIELD Council

Collaboration

Focus area	Domestic Violence
Partners involved	Community Safety

What's our current performance?

- The rate of Domestic abuse-related incidents in Enfield was 17.89 per 1000 in 2016/17, similar to London average. Sexual Violence in Enfield was 1.68 per 1000 in 2016/17. Sexual Violence in Enfield has increased by 13.04% comparing quarter 1 of 2017/18 to 2016/17.
- Referrals to the Multi-Agency Risk Assessment Conference (MARAC) continue to be slightly higher than the national average (35 referrals for every 10,000 of the population) with 38 referrals for every 10,000 of the population in Enfield.
- Repeat victimisation for MARAC referrals is at 23%, below the average suggested by SafeLives of between 28 – 40%.
- 123 referrals were made in Q1 2017/18 which represents nearly a quarter of the recommended number of cases for the size and population of Enfield.

Things that are going well

- Violence Against Women and Girls strategy has now been finalised by the SSCB
- We have been part of a successful joint bid with Southwark which will provide us extra resource for survivors who are referred to the MARAC but who are difficult to engage- £377k (3 years)
- Tendering process for Independent Domestic Violence Advocate (IDVA) services is underway but interim arrangements are in place to ensure no gap in service and this has actually been increased from 2-4 IDVAs
- Communications campaigns are running and new campaign will start shortly

What's next?

- Operation Athena days will be run by the police to ensure offenders are brought to justice
- Health and Wellbeing Board development session in September will focus on the issue of VAWG.
- MOPAC have successfully bid to the Home Office Transformation fund for a £1m to enhance the provision of Independent Sexual Violence Advocates- possibly within the 4 quadrants of existing commission in London, although the detail is not yet confirmed.

Challenges that HWB may be able to assist resolving / unblocking

- Getting the longer-term commitment to the IRIS project from partners is a challenge.
- There is an increased demand for Mental Health Services.

Healthy Enfield

ENFIELD Council

Enhanced Monitoring

Focus area	Cancer
Partners	Public Health, Enfield CCG, NHS England

What's our current performance?

- One-year survival in Enfield was 70.1, similar to the England average of 69.6. One-year survival is indicative of early detection and treatment (2013).
- 48.5 % of cancer diagnosed in Enfield was early stages (stages 1 or 2). This was below London (51.6%) and England (52.4%) averages (2015)
- In 2016, Bowel screening coverage in Enfield is 57.2%, this is below the London (59.0%) and England (57.9%) averages. Breast screening in Enfield (76.9%) is above England average (75.5%) and Enfield's cervical screening coverage (73.9%) is also above the England average (72.7%).

Things that are going well

- A cancer action group was set up in Enfield to develop set of action plans that will help improve patient journey through screening, referral, treatment and care post-discharge from hospital.
- Working across NCL on cancer screening assurance group to improve screening across the sector.
- Enfield two weeks' referral and 31 days' treatment standards have improved at the end of Q4 of 2016-17
- Screening coverage for breast cancer and cervical cancer in Enfield is above the national average.
- Bowel scope (improved way of bowel screening) roll-out has been planned and this new method will be available for Enfield in 2019.

What's next?

- Work with partners across London and NCL to improve living with and beyond cancer
- Work on improvement of two weeks' referral target and meeting the standard for treatment targets
- As part of the Enfield Single Offer, the CCG will be commissioning a service from GP Practices for patients with stable Prostate Cancer

Challenges that HWB may be able to assist resolving / unblocking

- Evidence finds that positive endorsement of screening from health and care professionals can increase screening uptake.
- Develop cancer awareness programme tailored specifically to areas related to GP practices where there is poor uptake for cancer screening

Healthy Enfield

ENFIELD Council

Focus area	Flu vaccination amongst Health Care Workers (HCWs)
Partners	Royal Free NHS Trust, North Middlesex University Hospital, BEH – community service, Enfield CCG/General Practices

What's our current performance?

Royal Free NHS Trust

- Royal Free achieved 61% in the 2016 winter; this was a 30% increase from the previous year's performance.

North Middlesex University Hospital

- Vaccinated 48.3% of eligible staff in the 2016 winter, there was a very small increase of 0.2% from the previous year's performance.

BEH – Community Services

- Vaccinated 43% of eligible staff in 2016 winter_ an increase from 26% in 2015 winter.

General Practices

- 48.1% of HCWs with direct patient care in general practices were vaccinated.

Things that are going well

Royal Free NHS Trust

- Ordered 7,000 flu vaccines for the 2017 flu campaign and the process for the Patient Group Directions (PGD) is underway to be signed off by July 2017.
- Holding monthly flu meetings with key stakeholders in the Trust to look at ways to improve this year's campaign and we have been in touch with some of the Trust's in London who achieved the 75% target for 2016 to learn lessons from them, part of which is to start early and have our Peer Vaccinators training much earlier in the year.

North Middlesex University Hospital

- Ordered 1,500 flu vaccines for the 2017 flu campaign and the process for the PGD is underway to be signed off by August 2017.
- Holding monthly flu meetings with key stakeholders in the Trust to look at ways to improve this year's campaign and learning from some of the NHS Trusts in London who achieved a higher target than NMUH for 2016.
- The Occupational Health team have attended the NHS England "focus session on improving uptake" evaluation session in May 2017.
- Working with the Matrons and Clinical leads to ensure that we have Peer Vaccinators (Nurses and Doctors) available early in the campaign, to also help cover the weekend and night shift staff.

BEH – Community Services

- Improved from 26% in 2015/16 to 43% in 2016/17
- Putting plan in place to build on the improvement in multiple settings of BEH services

What's next?

Royal Free NHS Trust

- To hold Staff Health and Wellbeing month in September 2017 to coincide with the beginning of Flu vaccination as this benefits to the patients, staff and their families.
- The training of our Flu Peer vaccinators will be starting early this year i.e. July on all 3 main acute sites including Chase Farm site.
- The Directors of Nursing for each site would be the clinical leads for each site in order to have vital executive level buy-in and presence
- To hold monthly meetings on each site to ensure the needs of each site is met
- Work with the communications lead to get the messaging right and reach out all staff.

North Middlesex University Hospital

- Hold a Staff Health & Wellbeing, Benefits & Discounts event on Thursday 29th June and in September 2017 to coincide with the beginning of Flu vaccination in order to promote staff uptake of the vaccination, its benefits to the patients, staff and their families.
- The Directors of Nursing, Human Resources and the Medical Director will be the leads for the Trust in order to have vital executive level buy-in and presence.
- The Director of Human Resources will continue to inform our Trust board of our weekly overall up take of the vaccine.
- Will have screen-savers, posters and the communications lead on board to get the messaging right, e.g. Myth Busting factors.

BEH – Community Services

- The trust is already planning for the 2017/18 flu vaccine campaign, and is aiming to vaccinate at least 75% of eligible staff

Challenges that HWB may be able to assist resolving / unblocking

- Flu-campaign across local health and care economy to make it business as usual
- To encourage GP practices data returns through GP champions

Healthy Enfield

ENFIELD Council

Focus area	Hospital admissions caused by unintentional and deliberate injuries in children (0-4 years)
Partners	Public Health, Health Visiting Team, Enfield CCG

What's our current performance?

- There were 331 hospital admissions to 0-4 year olds due to injuries. The rate of hospital admissions (per 10,000 resident population) for these reasons is 130.3 [2015/16 data]. This is significantly higher than London (97.6) and comparable to England (129.6).
- Enfield rate saw a slight reduction from 143.3 in 2014/15.

Things that are going well

- The appointment of a Consultant in Public Health with a specific focus on children and young people in May 2017.
- This is enabling the development of a closer working relationship between Public Health and Children's services and Enfield CCG, which supports greater focus on children and young people's health outcomes.
- Health Visiting, School Nursing and Family Nurse Partnership contracts, which contribute to the achievement of these outcomes, are being reviewed in order to improving delivery and performance improvement. Future work will look to integrate services to further improve outcomes.
- Information on minor ailments and accident prevention is provided by Health Visitors (HVs) as part of the 6 parental sessions for first time parents at Children Centres.
- HVs also discuss minor ailments and accident prevention with parents during the 1 year and 2 year review.
- HVs and Early Years Practitioners are all trained and skilled to address minor injuries and accident prevention with parents at every contact.

What's next?

- To continue to develop strong working relations between Public Health, Children's Services and Enfield CCG to focus on improvements in these indicators.

Challenges that HWB may be able to assist resolving / unblocking

- Facilitate partnership working in this area between council departments and the CCG.

Healthy Enfield

ENFIELD Council

Focus area	Housing for vulnerable adults
Partners involved	HASC, Housing

What's our current performance?

General Needs Housing Offer

Information on the current housing requirements of adults with learning disabilities and mental health support needs who are eligible for ASC services, shows us that the demand for accessible, affordable general needs housing exceeds supply available through our current allocation systems. The requirements of adults with mental health support needs (who are able to live independently within general needs accommodation) is an area of particular pressure at present.

A review of the Council's Allocation Policy is currently underway and joint work between housing and adult social care is ongoing to identify additional non specialist market capacity, across tenures going forward.

Specialist Housing Offer

ASC work with the market and housing services to directly commission specialist housing services, including supported housing services for adults with disabilities retirement and extra care housing. Analysis of current supply shows that we need to develop key areas including:

- extra care housing across tenure
- supported housing for adults with physical disabilities
- retirement housing

Further detail in respect of Adult Social Care Strategic Commissioning Priorities for Housing across service areas can be identified in our recent Market Potion Statement.

Things that are going well

Innovative projects to meet the housing needs of service users with very specific accommodation requirements and for whom other housing acquisition routes have been exhausted. This includes:

- Housing Gateway/ASC Pilot Project
- Home ownership initiatives for adults with long term disabilities

Supply capacity building in respect of Learning Disability Services and wheelchair access family accommodation.

What's next?

- Consideration of current housing pathways, including panels and quotas in respect of adults with support and care needs
- The further development of move on accommodation for adults with mental health support needs who are eligible for ASC services
- Further work to develop wheelchair accessible supported housing accommodation and respite services for adults with learning disabilities.

- The development of the borough's Housing with Care offer, to include the further development of extra care housing options across tenures types
- The consideration of a local 'Care Village, to provide a mixed Housing with Care offer to older residents, that integrates health and wellbeing services
- Incorporation of strategically relevant housing services for adults with support and care needs within key borough development programmes (including Meridian Water)

Challenges that HWB may be able to assist resolving / unblocking

- Limited site availability for the development of affordable specialist housing services – this is a particular challenge when seeking to secure site on the open market.
- The decommissioning of some Housing Related Support services has led to supply loss in some areas, though where possible, sustaining housing supply has been negotiated.
- Limitations to knowledge and influence in respect to new providers of specialist housing services establishing within the borough at high cost with the view to provide for high need out of borough placements, placing increasing pressure on local services.

Healthy Enfield

ENFIELD Council

Focus area	Diabetes Prevention
Partners	Enfield CCG, Public Health

What's our current performance?

Enfield and Barnet were jointly awarded the second wave site for NHS Diabetes Prevention Programme for 2017/18 and 2018/19. A nationally funded places for evidence-based intensive lifestyle intervention will be offered to over 2,000 residents in Enfield with pre-diabetes. With high level of obesity and pre-diabetes in Enfield, if the places are used effectively, the programme will not only benefit the clients of this scheme, but also help reducing future demand of diabetes.

Service started to accept referrals from May 2017. Steady increase in referral rates is seen on a weekly basis – the number of referrals is expected to increase considerably when provider sites go live in Barnet and Enfield. The plan is to eventually create over 200 referrals per month.

NHS Barnet CCG	46
NHS Enfield CCG	12
CCGs Total	58

Things that are going well

- Barnet and Enfield CCG is supporting the NDPP provider identify appropriate venues for local sites. NDPP provider has visited a number of potential provider sites and negotiations are underway. Enfield site will be launched in the East of the borough first, where there are higher needs for diabetes prevention, expanding to the West shortly after. Until Enfield sites are fully set up, Enfield residents will be invited to the service sites in neighbouring areas.
- GPs are engaged at local GP meetings. Once provider sites are established, referral from GPs is expected to increase.

What's next?

- Pending successful negotiations between landlord/ NDPP provider. Communications with GP and stakeholders will be updated and circulated.
- The service launch will be publicised in Enfield with LBE support.
- Referral rates will continue to be reviewed as the service become more mature and established.

Challenges that HWB may be able to assist resolving / unblocking

None at this stage.

Healthy Enfield

ENFIELD Council

Focus area	Living well with multiple conditions and chronic illness
Partners	HHASC, Enfield CCG, PH, BEHMHT – community health service

What's our current performance?

- The gap between Life Expectancy and Healthy Life expectancy in Enfield is 11.7 years for males and 18.2 years for females [2013-2015 data]. These years are likely to be lived with multiple conditions and chronic illness.
- The data is currently not available to determine how many people are living with multiple long-term conditions in Enfield, but it is likely that many of them need social care support.
- Social care-related quality of life in Enfield was 18.7% (quality of life score based on Adult Social Care Survey), similar to London average (18.6%) but was statistically below the England average (19.1%). Enfield's score was the joint 9th highest in London, along with Lewisham, Islington and Haringey.
- Number of people with diabetes, cancer, dementia and mental health conditions are increasing, and is expected to continue to rise.

Things that are going well

- A patient enablement initiative by Enfield Health's District Nursing service has commenced. Its aim is to promote independence and self-care so residents develop the self-management skills their health care needs require.
- Enfield CCG hosts a long-term condition steering group which PH is a core member.
- Proactive management of long-term conditions in primary care has improved in Enfield. (QOF aggregate rank in London.)
- PH Smoking cessation service is re-commissioned to target people in most need, including those with long term conditions.
- NHS is commissioning a new service to prevent stroke and diabetes by effective management of atrial fibrillation and primary care intervention of pre-diabetes.
- Currently out to tender for newly commissioned services with the voluntary and Community Sector for supporting vulnerable people not eligible for statutory Adult Social Care Services. Specification 5 focuses on preventing people from hospital admission by supporting self-management of care in their own home environment and supporting discharging process.

What's next?

- Work with existing patients has started and here is a need to discuss it further with Acute Trusts, GP's and Practice Nurses.
- Using evidence based medicine to promote effective management of LTCs and reduce waste.
- Primary care programme to improve the care of prostate cancer survivors
- Quality Improvement Support Teams (QISTs) and Care Closer to Home Integrated Care

Challenges that HWB may be able to assist resolving / unblocking
• The patient enablement initiative is concentrating on Hospitals and GP's and the HWB could help unblock/resolve barriers should they arise. • HWB is encouraged to champion smoking cessation in their respective-organisations as part of the care and services they provide to their patients / clients, in particular for those patients / clients with long term conditions.

Focus area	End of Life Care
Partners	London Borough of Enfield, Marie Curie, CMC, North London Hospice, Barndoc, Primary Care, Enfield Community Services, North Middlesex Hospital, Royal Free Hospital

What's our current performance?

- Death at hospital has been dropping over the past few years (see table below- death for all ages 2010-14))
- The trend in death at home has been on the increase however small and approaching the London and England average figure.

Place of death	CCG	2010		2011		2012		2013		2014	
		Value(%)	Count	Value(%)	Count	Value(%)	Count	Value(%)	Count	Value(%)	Count
Hospital Deaths	**Enfield**	**63.9%**	**1244**	**59.9%**	**1095**	**59.8%**	**1157**	**54.6%**	**1097**	**57.2%**	**1142**
	London	58.7%	28099	56.4%	26125	55.2%	26264	54.6%	25775	53.9%	25520
	England	53.1%	243802	50.8%	229044	48.9%	227308	48.3%	227748	47.4%	221277
Home Deaths	**Enfield**	**17.1%**	**333**	**18.1%**	**332**	**18.2%**	**352**	**21.4%**	**430**	**20.9%**	**417**
	London	19.9%	9542	21.2%	9821	21.0%	9991	22.2%	10494	22.1%	10457
	England	20.9%	95805	21.9%	98618	22.2%	102978	22.4%	105773	23.0%	107383
Care Home Deaths	**Enfield**	**11.8%**	**229**	**13.1%**	**240**	**14.3%**	**277**	**15.1%**	**304**	**15.4%**	**307**
	London	13.0%	6225	13.5%	6270	14.6%	6934	14.8%	6993	14.9%	7033
	England	18.5%	84723	19.5%	87751	21.1%	98202	21.6%	101991	21.7%	101383
Hospice Deaths	**Enfield**	**5.4%**	**106**	**7.0%**	**128**	**5.8%**	**113**	**6.1%**	**123**	**4.9%**	**97**
	London	6.2%	2959	6.5%	3018	6.9%	3258	6.1%	2870	6.8%	3207
	England	5.4%	24854	5.7%	25657	5.7%	26669	5.5%	26090	5.7%	26795
Deaths in Other Places	**Enfield**	**1.8%**	**35**	**2.2%**	**41**	**1.8%**	**35**	**2.7%**	**54**	**1.7%**	**34**
	London	2.2%	1047	2.3%	1071	2.3%	1097	2.4%	1109	2.3%	1097
	England	2.1%	9795	2.2%	9700	2.1%	9637	2.2%	10151	2.2%	10437

Things that are going well

The Joint Enfield End of Life Care Strategy aimed to ensure that we deliver better quality of care and greater choice in End of Life Care. The primary focus for Enfield CCG is on increasing the number of people who are able to exercise a positive choice about their place of death.

The strategy will help to enhance the quality of end of life care across health care (primary and secondary), social care and the voluntary sector, enabling people to live and die well across Enfield. It will facilitate choice and boost confidence to enable people to die where they wish with the support they need. This should avoid unnecessary hospital admissions by reducing emergency admissions and extended hospital stays.

Good progress has been made in the last 12 months:

1. The Care Home Assessment Team have proactively supported residents in care homes to have comfortable and dignified deaths in their preferred place and the service has seen a significant success, achieving its aim to support residents to die at their preferred place of death. In 2016/17 CHAT achieved 99% of deaths in preferred places.

2. As part of its delivery of workforce development to care staff, CHAT in collaboration with the North London Hospice and the Macmillan EoL GP have a structured formal training programme in place for all groups of professionals dependent on role and grade. CHAT run these sessions all through the year to support the skills and

knowledge of developing advanced care plans for residents but also provide practical support to care staff on how to deal with end of life challenges

3. Increased EOL profile and education across CCG has reflected a significant increase in the use of Coordinate My Care (CMC) across Enfield. There have been a consistent number of records created since Nov 2016 till April 2017 following a targeted approach to the use of CMC from hospital visits, GP education sessions and CMC intra-operability with North London Hospice IT system. There are 185 patients in Enfield with a CMC record.

4. Delivery of an EOL practice nurse session in April 2016 with over 25 nurses in attendance across Enfield. Feedback from the session was all positive with a significant change in practice for practice nurses following the session from anecdotal discussion at subsequent meetings.

5. Positive engagement with GP practice across Enfield which has led to identification of EOL Clinical Champions for Enfield comprising of 3 GPs and 1 practice nurse with an interest in EOL who will act as informal EOL champions across the 2 localities. They will be actively involved in working with the EOL Macmillan GP in ensuring EOL matters continue to be at the forefront of discussions particularly in older people with dementia, care homes residents, patient's with long term conditions and integrated conditions work-streams.

6. The Palliative Care Support Service is accessible for all patients with a district nurse, enabling the district nurse to have more autonomy and freedom when planning crisis management and end of life care at home. In 2016/17 93% of patients under the care of the Palliative Care Support Service died in their preferred place of death

What's next?

1. Supporting the emerging Care Closer to Home Integrated Networks (CHINs) which aims to reduce avoidable unplanned admissions which includes last phase of life including for people receiving end of life care
2. Contributing to the Enfield Primary Care Single Offer of enhanced services which includes effective coordination of the end of life care needed by people in nursing or their own homes
3. Increasing the CMC interoperability steps with EMIS, Hospice and Hospital IT systems.
4. Work with CMC to co-ordinate roll out of patient accessible CMC app **MyCMC** for carers and patients. This app will give patients the opportunity to record their decisions and to express wishes about their care so that this information is available to all professionals who are looking after them, helping to ensure that any care the patient receives is in line with what they've decided.
5. Work with the NCL Last Phase of Life Work Stream as part of the CHINs to implement the e-SHIFT telehealth model to expand existing capability of the specialist clinicians, via tablet/smartphone with a technician remotely guided by a specialist.

Challenges that HWB may be able to assist resolving / unblocking

Healthy Enfield

ENFIELD Council

Focus area	Tipping point into need for health and care services
Partners	Voluntary and Community Sector, Enfield Council

What's our current performance?

- In 2015/16, 72.9% of elderly people were discharged from acute or community hospitals to their usual place of residence in Enfield. This compared to 85.4% in London and 82.7% in England.
- Emergency readmissions within 30 days of discharge from hospital in Enfield was 10.3%, similar to London (12.1%) and England (12.0%) averages.

Things that are going well

Currently out to tender for newly commissioned services with the voluntary and Community Sector for supporting vulnerable people not eligible for statutory Adult Social Care Services. The focus is on Prevention. Six Specification have been produced focusing on

1. Supporting Carers in the Community
2. Supporting Vulnerable People to Remain Safe and Avoid Crisis
3. Improving Health and Well-being
4. Supporting Vulnerable People to have a Voice
5. Keeping People Out of hospital and Supporting Hospital Discharge
6. Improving and Promoting Good Health and Care Information for the Communities of Enfield

Specification 2 is focus at reducing diabetes, supporting pre-and post diagnosis of dementia, managing and preventing falls of older people in the community and stroke management. These cover the areas of priority within the HWB Tipping Point Heath and Care
Specification 3 and 6 looks to develop a hub to support well-being and the provision of information. A hub in an assessable area within the borough and where its services is promoted by the successful consortium providing the service
Specification 5 is focused on preventing people from hospital admittance with self-management of care in one's own home environment and when someone is admitted to ensure that the discharge process is a smooth and speedy process ensuring that the service users and their home is prepared for the discharge

The VCS have been involved in developing the above six outcome areas and HHASC have turned them into specification for 5-7 years contracted services

What's next?

Shortlisting of organisations will be undertaken late in July and the Invitation to tender from the shortlisted organisations will be evaluated by a panel August. Contracts are due to start early December

Challenges that HWB may be able to assist resolving / unblocking

This is a new way of partnership working with the voluntary organisation to enhance the work HHASC do and to ensure that those we commission are following the same pathways as the department. Outcomes will be closely monitored using the council's Care first system and we should be able to quantify the number of people being supported as well as measured improvement to their health and well-being and a reduction in demand for social and health care.
Challenges will be for VCS coming together to work effectively as a consortium to meet the

outcomes within the specification and measuring outcomes. This will have to be undertaken using a variety of mechanism and tools. It is also thought that the mobilisation period may also be a challenge especially if we are managing the existence of an incumbent provider.

Recommendations

5.1 The Board is asked to discuss how it wishes to support the HWB priority areas, as highlighted below;

<Best Start in Life>

- Maintain focus on these important metrics that together provide an indication of the quality of the Best Start in life being achieved in Enfield.
- Devote focused sessions on Best Start in Life at the Health & Wellbeing Board that brings together key partners that contribute to improving outcomes.
- Facilitate partnership working in this area between council departments and the CCG.

<Mental Health Resilience>

- There is a challenge to the HWB about how best to support the Thrive LDN initiative.

<Healthy Weight>

- Members of the Health & wellbeing board are encouraged to champion healthy weight by promoting one healthy behaviour each (e.g.sugar reduction, cake culture, helathy choices, active travel etc) within their own and partner organisations
- Enfield Council achieved the London Healthy Workplace Excellence Award in 2014. As part of the re-accreditation, we have been asked to record and analyse the data that proves what we are doing is effective. This can be achieved through conducting an annual ‘Staff Health & Wellbeing’ survey, which the HWB is asked to support.

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