HEALTH AND WELLBEING BOARD

Tuesday, 17 April 2018 at 6.15 pm
Civic Centre Restaurant, 2nd Floor, Civic Centre, Silver Street, Enfield, EN1 3XA

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Please note meeting venue

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 – Parin Bahl
Clinical Commissioning Group (CCG) Chief Officer – John Wardell
NHS England Representative – Dr Helene Brown
Director of Public Health – Stuart Lines
Executive Director of Health, Housing and Adult Social Care – Ray James/Bindi Nagra
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 – Natalie Forrest
North Middlesex University Hospital NHS Trust – Maria Kane
Barnet, Enfield and Haringey Mental Health NHS Trust – Andrew Wright
Enfield Youth Parliament – Carla Charalambous and Josh Salih

AGENDA – PART 1 – 'TO FOLLOW' REPORTS

4. HEALTHY WEIGHT - TACKLING OBESITY PARTNERSHIP/TERMS OF REFERENCES (TOR) (Pages 1 - 2)

Dr Glenn Stewart (Assistant Director of Public Health) to present report on the Healthy Weight- tackling obesity partnership/terms of reference, building on the obesity pathway work at the Health and Wellbeing Development Session in March.

(TO FOLLOW)

7. PLAN TO RENEW JOINT HEALTH WELLBEING STRATEGY (JHWS) (Pages 3 - 30)

Stuart Lines (Director of Public Health) and Miho Yoshizaki (Health Intelligence Manager) to present the JHWS report.

Enfield Healthy Weight Partnership

Terms of Reference

DRAFT

Vision

To reduce the prevalence of overweight and obese adults and children in Enfield through the recognition of an obesogenic environment and subsequent work to create a healthier environment.

Within the above the obesity partnership will:

- Disseminate information and data relating to obesity in the borough
- Identify and support initiatives to improve the environment in relation to obesity
- Employ the principle of 'universal proportionalism' e.g. target initiatives to areas / populations of high prevalence whilst recognising that obesity is a problem across the borough
- Produce a healthy weight strategy and action plan

Structure and membership

- LB Enfield Public Health (chair)
- LB Enfield Transport
- LB Enfield Finance
- LB Enfield Leisure Services
- LB Enfield Health Champions
- LB Enfield Voluntary and Community Sector
- LB Enfield Planning
- NHS Enfield CCG
- BEH Health Visitors
- North Middlesex University Hospital
- Royal Free Hospital
- Enfield Over 50's forum
- LB Enfield School Support
- Enfield Voluntary Action

Meetings

Meetings will be held quarterly. The agenda and papers for the meeting will be circulated 5 working days in advance of the meeting and draft minutes will be available within 10 working days.

Reporting

The Obesity Partnership will report to the Health and Wellbeing Board.

Support

Administrative support will be provided by the LBE Public Health team.

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Agenda Item 7

MUNICIPAL YEAR 2018/19

Meeting Title:
HEALTH AND WELLBEING BOARD
Date: 17th April 2018

Agenda Item:
Subject: Progress on Health and Wellbeing Board Monitoring areas for 2017-19 and Annual Review of key indicators
Report from Partners

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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.

The report also provides the summary of annual review of selected indicators.

2. RECOMMENDATIONS

The Board is asked to review the annual outcome indicators provided within this report for information.

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

<Mental Health Resilience>

- Continue to support ongoing partnership with Thrive LDN in this area.
- Be aware of relevance of emotional health and wellbeing resilience to other HWB priorities – such as best start in life.

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, following the review of selected indicators.

3.2 The HWB Priority areas were:

<Top 3 priorities>

- Best start in life
- Healthy Weight
- 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 (now addressed as part of the Best Start in Life programme)
- 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 section 5 of this report highlights the key successes and challenges in the last three months in the HWB priority areas.

4.4 Outcomes measures that reflect the progress against the Enfield JHWS are presented in Appendix A. This is the same set of indicators which was

reviewed in 2017 when the Board discussed the priorities for 2017-19. This is also available online at:
https://new.enfield.gov.uk/healthandwellbeing/jhws/measuring-our-progress/

4.5 To interpret the information, it is important to look at where Enfield sits compared to the national picture as well as whether we are improving or not. Where appropriate, statistical test was applied to assess the direction of travel more accurately. It is also important to consider the size of population in Enfield who may be affected by this issue and the impact on health inequalities.

4.6 Areas where outcomes show improvement are:

Ensuring the best start in life

- School readiness (reception year)
- 16-18 years not in education, employment or training (NEETs)
- Teenage conception
- Chlamydia detection rate

Enabling people to be safe, independent and well and delivering high quality health and care services

- Successful completion of drug treatment – non-opiate users
- Childhood immunisation (MMR)

Creating stronger, healthier communities

- Adults in employment
- Fuel poverty

4.4 Those areas where either outcomes are worsening or significantly worse than the national position / target which may need particular attention. These are:

Ensuring the best start in life

- School readiness (reception year)
- Breastfeeding initiation
- Smoking at time of delivery
- Hospital admissions caused by unintentional and deliberate injuries in children
- Children's oral health (dental decay)
- Chlamydia detection rate

Enabling people to be safe, independent and well and delivering high quality health and care services

- Diabetes prevalence
- Cancer screening coverage
- Childhood immunisation (MMR) uptake
- Flu vaccination uptake (65+)
- HIV late diagnosis
- Learning Disability Health Check

Creating stronger, healthier communities

- Violent Crime
- First-time offenders
- Statutory homelessness – households in temporary accommodation

Promoting healthy lifestyles and making healthy choices

- Overweight and obesity
- Inactive adults

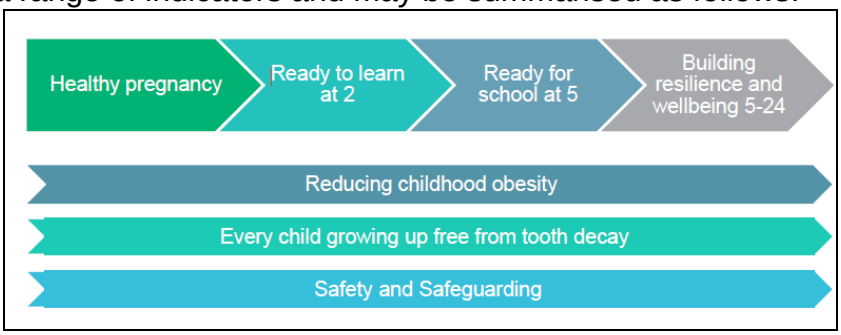
5. Progress Report

Top 3 priorities

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

What's our current performance?

The assessment of whether children in Enfield are getting the *Best Start in Life* is made up of a range of indicators and may be summarised as follows.



Below are listed some of the headline indicators which help measure this. Others will include immunisation uptake rates, smoking in pregnancy and perinatal mental health.

- **Breastfeeding**

Breastfeeding initiation in Enfield is good (83.4% of mothers breastfeed their baby within 48 hours of delivery) [2016/17 data]. This is better than England (74.5%) but there is currently no data for the number of mothers still breastfeed at 6-8 weeks.

- **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 London (27.3%) and England (24.8%).

- **Childhood obesity**

The Enfield trends remain stubbornly above the London and national averages for Reception and Year 6. In Reception Year a quarter (25.1%) of 4/5 year olds; and in Year 6 two fifths (40.7%) of 10/11 year olds are overweight or obese [2016/17 data].

- **Under-18 conceptions**

With a rate of 20.6/1000 in 2016, and despite local reductions over recent years, Enfield rates remain higher than NCL (15.9/1000), London (17.1/1000) and England (18.8/1000).

- **School readiness**

This is a global measure of readiness for school and is measured as the percentage of children achieving a good level of development at the end of Reception year. In Enfield (2016/17) this was 68.0%, which was worse than London (73.0%) and England (70.7%).

- **Hospital admissions due to unintentional and deliberate injuries in children (aged 0-4 years)**

The rate of hospital admissions (per 10,000 resident population) is 134.4 [2016/17 data]. This is significantly higher than London (94.8) and comparable to England (126.3). This is a slight reduction from 143.3 in 2014/15.

These indicators may be summarised in the following table:

Export table as image

Indicator	Period	Enfield			Region	England	England		England
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Under 18 conceptions	2015	↓	138	22.7	19.2	20.8	43.8		5.7
Smoking status at time of delivery (current method)	2016/17	↑	291	7.0%*	4.9%	10.7%	28.1%		2.3%
Low birth weight of term babies	2016	↓	150	3.3%	3.0%	2.8%	5.2%		1.3%
Infant mortality	2014 - 16	–	48	3.2	3.2	3.9	7.9		1.6
Breastfeeding prevalence at 6-8 weeks after birth - current method	2016/17	–	-	*	*	44.4%*	19.3%		75.6%
Reception: Prevalence of overweight (including obese)	2016/17	↓	1,093	24.8%	22.3%	22.6%	28.2%		15.0%
A&E attendances (0-4 years)	2016/17	↑	20,687	824.9	695.0	601.8	1,926.8		333.5
Emergency admissions (aged 0-4)	2015/16	↑	4,900	192.9	112.9	155.0	307.9		57.3
Hospital admissions for accidental and deliberate injuries in children (aged 0-4)	2016/17	↑	337	134.4	94.8	126.3	265.1		47.3
Children with one or more decayed, missing or filled teeth	2014/15	–	-	33.9%	27.3%	24.8%	56.1%		14.1%
Population vaccination coverage - MMR for two doses (5 years old) <90% 90% to 95% ≥95%	2016/17	↑	3,846	84.0%	79.5%	87.6%	57.1%		96.2%
Proportion of children aged 2-2½yrs offered ASQ-3 as part of the Healthy Child Programme or integrated review	2016/17	–	3,160	*	77.2%*	89.4%*	20.1%		100%
Children achieving a good level of development at the end of reception	2016/17	↑	3,175	68.0%	73.0%	70.7%	60.9%		78.9%

Things that are going well

- The Best Start in Life sub group delivered a presentation at HWB development session on the 20th March 2018.

What's next?

- Please refer to the separate item "Best Start In Life Action Plan"

Challenges that HWB may be able to assist resolving / unblocking

- Please refer to the separate item "Best Start In Life Action Plan"

Focus area	Mental Health Resilience – Emotional and Mental Health Resilience and wellbeing
Partners	Public Health, Enfield CCG, BEHMHT, NCL PH Departments. London Health Board, Thrive LDN, Time to Change, Enfield CEPN.

What's our current performance?

- We continue to work closely with Thrive LDN as a vehicle for adding value to ongoing mental health resilience work in Enfield.
- Thrive LDN have undergone some internal changes, primarily associated with financial issues. LBE Public Health staff have met with them to confirm ongoing joint activities with PH are assured.
- The "Time for Change" organisation has confirmed after an exhaustive application process that Enfield [with LBE as "Host" organisation is a suitable de-stigmatisation "Hub" location.

Things that are going well

- Our current partnership activity with Thrive LDN to improve Mental Health Resilience in Enfield was presented and discussed at the HWB development session on the 21st November 2017 and formally adopted at the subsequent formal HWB session on 5th December 2017.
- LBE Public Health continue to work with Thrive LDN to plan and deliver a "De-stigmatisation Hub" within the borough.
- The "Time for Change" organisation has confirmed after an exhaustive application process that Enfield [with LBE as "Host" organisation] is a suitable de-stigmatisation "Hub" location.
- This aligns with the activities, agenda and priorities of the "Best Start in Life [BSIL]" task and finish group, as discussed in previous HWB meetings.

What's next?

- Thrive LDN are entering into a formal partnership arrangement with "Time to Change" who have much relevant experience of de-stigmatisation activity in the arena of mental health and wellbeing.
- The "Time for Change" organisation has confirmed after a surprisingly exhaustive application process that Enfield [with LBE as "Host" organisation] is a suitable de-stigmatisation "Hub" location.
- "Kick Off" and Induction Day Meeting with "Time for Change" and "Thrive LDN" representatives took place on 22nd March in Leyton.

- Enfield local user group representatives [led by EMU] have started to develop programme for next 18 months activities. LBE role as “host” becoming correctly and clearly defined as secondary but supportive.
- Thrive LDN community engagement event [to focus on younger people] now taking place later in spring due to i. financial issues at Thrive LDN and ii LBE seeking clarification that event programme/intentions would not conflict with Best Start In Life activities.
- LBE Public Health officers will be consulting at a NCL level prior to commissioning additional MECC or MHFA activities. This is to ensure that robust outcomes and performance monitoring measures are in place.

Challenges that HWB may be able to assist resolving / unblocking

- Continue to support ongoing partnership with Thrive LDN in this area.
- Be aware of relevance of emotional health and wellbeing resilience to other HWB priorities – such as best start in life.

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?

- **1087** Reception Year pupils were classed as having excess weight in 2016/17. This means that one in four Reception Year pupils in Enfield were overweight or obese (25.05%). This was significantly higher compared to London (22.3%) and England (22.6%).
- For Year 6 (10-11 years) rate of excess weight increased to **more than two in five** (40.7%) pupils in Enfield. This is the 9th highest in London and the highest in NCL.
- Around **two thirds of adults** in Enfield **(63.5%)** are **overweight or obese.** This is **the 3rd highest** in London and the highest in NCL**.**

Things that are going well

- Healthy Weight – tackling obesity and its pathway was presented at HWB development session on the 20th March 2018.

What's next?

- Please refer to the separate item on Healthy Weight.

Challenges that HWB may be able to assist resolving / unblocking

Please refer to the separate item on Healthy Weight.

Healthy Enfield
move more eat well drink less stop smoking

ENFIELD Council

Collaboration

Focus area	Domestic Violence
Partners involved	Community Safety

What's our current performance?

Enfield has seen a rise in domestic abuse offences year on year since the establishment of a 2011/12 baseline. However, in the 12 months (to 31st July 2017) there have been 2813 reported domestic abuse offences. This constitutes a 4.4% decline in Domestic Abuse offences in the previous 12 months but a 62.6% rise from the MOPAC 2011/12 baseline.

Update:

- Recorded Domestic Abuse Incidents have increased by 12 incidents in the 12 months to 30th September 2017 (+0.2%, London: -4.3%).
- In the same period, Violence with Injury offences which were DV related have decreased by 111 offences (-11.6%, London: -1.4%)
- However, Sexual Offences have increased by 41 (+7.3%, London: +9.3%) and Rape Offences by 25 (+11.7%, London: +18.1%)

Enfield	Oct 15 to Sept 16	Oct 16 to Sept 17	% Change
Domestic Abuse Incidents	5945	5957	0.2%
Domestic Abuse VWI Offences	957	846	-11.6%
Sexual Offences	558	599	7.3%
Rape	213	238	11.7%

London	Oct 15 to Sept 16	Oct 16 to Sept 17	% Change
Domestic Abuse Incidents	151038	144542	-4.3%
Domestic Abuse VWI Offences	24123	23774	-1.4%
Sexual Offences	17340	18944	9.3%
Rape	6106	7210	18.1%

Things that are going well

- A new Violence Against Women and Girls (VAWG) Strategy has been produced and agreed by the Safer and Stronger Communities Board (SSCB)
- The VAWG Strategy will be accompanied by an annual action plan which is being finalised with multi-agency contributions to partnership work
- Re-accreditation awarded to London Borough of Enfield by White Ribbon Campaign UK
- Development of an LBE Domestic Violence and Workplace Response Policy for employees
- Enfield Council – He doesn't love you if…domestic abuse campaign – national

public sector communications excellence awards – bronze winner

- Continuing awareness-raising and targeted digital marketing with the 'Boyfriend Material?' campaign

What's next?

1. Progressing and monitoring the VAWG Strategy Action plan and outcomes of single and multi-agency partnership work
2. Progressing the recommendations from the HWB development session which includes an audit of how Enfield is meeting NICE guidelines on domestic abuse
3. Work with partners and commissioners to ensure continued provision of (a) DV resource (IDVA or advocate educator) at North Middlesex Hospital (b) Perpetrator programme

Challenges that HWB may be able to assist resolving / unblocking

Continue to support embedding work to tackle domestic abuse across the partnership.

Enhanced Monitoring

Focus area	Cancer
Partners	Public Health, Enfield CCG

What's our current performance?

- Enfield is the highest performing CCG in NCL for all screening rates
- Performance in the 62-day treatment from urgent GP referral nation standard has improved locally and across NCL in the last few months but is susceptible to fluctuations
- Cancer Patient Experience needs improvement (NCPES 2017)

Things that are going well

- Monthly Enfield CCG Cancer Action Group attended by commissioners, providers, public health, and Cancer Research UK
- Appointment of Enfield Macmillan GP and Cancer Clinical Lead
- LBE/ CCG joint communications campaign in conjunction with national cervical screening campaign and breast cancer awareness campaign.
- To improve access to cervical cancer screening for working age women, Cancer Action Group negotiated for Primary Care Access extended access hubs to support cervical cancer screening for those patients that would prefer to be seen for their screening test outside of usual GP hours

What's next?

- Review of effectiveness of cervical screening campaign on screening rates across Enfield
- Clinical review into emergency diagnosis of cancers
- Joint CCG/Trust action plan for improve Cancer Patient experience

Challenges that HWB may be able to assist resolving / unblocking

- Support future cancer awareness campaigns
- To facilitate or encourage earlier launch of bowel scope for Enfield residents

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, LBE

What's our current performance?

Flu vaccination by Health care providers in 2016/17 compared to 2017/18

Table-1 Flu vaccination by providers

Providers list	Vaccine Uptake %	
	2016/17	2017/18 (This year)
London region	55.4%	63.7%
BEH	43.0%	48.7%
North Middlesex	48.3%	72.5%
Royal Free	60.7%	71.8%

As shown in table-1 above, the flu vaccination for health care workers across all the providers has improved substantially from 2016/17.

Table-2 Flu vaccination by health care professional groups

Providers list	Doctors	Qualified nurses (including GP Practice Nurses)
BEH	39.1%	42.8%
North Middlesex	79.4%	53.9%
Royal Free	53.4%	61.0%

It is encouraging to see there a good flu vaccination uptake by frontline health care workers. The differences in the figures between different professional groups could be some health care professionals may work on different sites and may have had vaccine other than their work site in which case the record may not be included.

Things that are going well

The seasonal flu vaccination performance has improved in 2017/18 across all NHS providers who have been and will be providing care for Enfield residents.

What's next?

- Follow up future seasonal flu vaccination for health care workers through Enfield Health Protection Forum where all health care providers attend to update infection control and other communicable disease control issues.

Challenges that HWB may be able to assist resolving / unblocking

Support future flu vaccination uptake and campaigns

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.

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

The Council has been active in providing consultation feedback on the impact of proposals to cap rental benefits in the supported housing sector.

Innovative projects are ongoing to meet the housing needs of service users with very specific accommodation requirements. This includes:

- Housing Gateway/ASC Pilot Project
- Home ownership initiatives for adults with long term disabilities (over (£700,000 DoH funding secured to enable individual purchase of homes via shared ownership)
- Supply capacity building in respect of Learning Disability Services, to include new build developments for adults with complex and challenging behaviours and low level move on needs
- Consideration of current housing pathways, including panels and quotas in respect of adults with support and care needs
- Further work to develop wheelchair accessible supported housing accommodation and respite services for adults with learning disabilities – considering incorporation within new build development recently approved by

the planning authority

- Research and local consideration of Care Village models including visits to Bowthorpe Care Village and Whitley Village to better understand model and potential benefits.
- Initial communications with stakeholders in respect of Care Village model – work continues to better understand local need/aspiration including qualitative data collection.

What's next?

- The further development of move on accommodation for adults with mental health support needs who are eligible for ASC services
- 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)
- Working with estate agents and property developers to seek appropriate step down accommodation that is cost neutral to the Council.

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.
- Often competing resources for accommodation; including other authorities looking to place service users within Enfield.

Focus area	Diabetes Prevention
Partners	Enfield CCG, Enfield Council, NHSE, Barnet CCG and Barnet Council

What's our current performance?

- 1122 Enfield residents who were assessed at high risk of type 2 diabetes were referred to the programme.
- The proportion of patients referred who attended initial assessment is improving from previous quarter
- Public Health and Enfield CCG commissioners discussed NDPP at GP locality meeting and, GP Protected Learning Time to improve the quality of referral to the programme, to reduce variation across Enfield and to use the programme effectively through pre-diabetes LCS and brief intervention.

Things that are going well

- Enfield Public Health and CCG commissioners are galvanizing the support of the local GPs to the programme.
- Working very closely with national diabetes prevention programme commissioner (NHSE), local provider (ICS) and Enfield CCG to work on many strands of work to improve quality of referral and equity of referrals, and retention of those who are referred to NDDP in the programme until completion.
- NHS England reported that those who participated in the programme who were obese or overweight have seen an average weight loss of 3.7kg.

What's next?

- We noticed some local resident who are offered to attend the lifestyle intervention offered through diabetes prevention programme may not take up the opportunities. To improve this, we want to develop a dedicated awareness campaign in areas of low uptake but high diabetes prevalence.
- Ensure previously commissioned diabetes prevention locally commissioned programmes are aligned with diabetes prevention programme to improve quality of referral and reduce waiting time.
- Ensure patients referred to the programme receive advice and guidance from local GP and consent to attend the programme before their names were sent to national diabetes prevention programme provider in Enfield (ICS).
- Ensure equity of referral from all GP into diabetes prevention programme specially from areas most affected by diabetes
- Continue engaging with local GPs to improve quality of referrals and to reduce variation.
- Work on public awareness campaign with community leaders in areas of high diabetes prevalence.

Challenges that HWB may be able to assist resolving / unblocking

Enfield CCG, LBE (public health) and voluntary sector work together to encourage and facilitate the provider to offer more accessible places locally for initial assessment and group intervention sessions.

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 CHINs continue to deliver care in their virtual form while plans are being developed for co-location.
- 3 extended access hubs open with blended offer of pre-bookable and walk-in appointments:
- Carlton House:18.30.-20.00 Monday to Friday; 08.00 – 20.00 Saturdays, Sundays and Bank Holidays
- Evergreen: 18.30.-20.00 Monday to Friday; 08.00 – 20.00 Saturdays, Sunday and Bank Holidays
- Woodberry: 18.30.-20.00 Monday to Friday; 08.00 – 20.00 Saturdays and Bank Holidays; with additional walk in services provided from Eagle House Saturday, Sunday and Bank Holidays.
- Services have now seen 61,000 patient's utilisations of the above three hubs that stands at 85% the best in NCL.

Things that are going well

- Work to develop Care Closer to Home Integrated Network (CHIN) continues. The CHIN project board, chaired by Dr Johan Byran continues to meet.
- Each of the 4 local CHINs has agreed overarching priorities (frailty for the two in the West, respiratory for the NE and diabetes for the SE) with the aim of sharing learning across the four.
- Engagement with the GP Federation continues.
- The Enfield system (primary & secondary care, ECCG/LBE/NMUH reps) have participated in 4 Placed-Based Care Network Programme workshops, alongside other NCL and NEL STP systems. This has helped underpin work on the local CHIN development.
- Recruitment to a Locality Development manager was successful. The worker should start in May and will assist LBE and Enfield Health to develop its approach to locality development.

What's next?

- LBE and Enfield Health continue to map staffing requirements with support from Public Health
- Work continues on development of the CHINs' priority areas.

Challenges that HWB may be able to assist resolving / unblocking

- Support the CHIN development programmes and priorities.

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 Care Home Assessment Team proactively support residents in care homes to have comfortable and dignified deaths in their preferred place
Established End of Life Primary Care Champions
Utilising 'You Matter' Milestones Clinical Education material by UCL Partners

Increased engagement with GPs and Marie Curie. Better clarity in referral processes from GP to North London Hospice
Increased EOL profile and education across CCG has reflected a significant increase in the use of Coordinate My Care (CMC) across Enfield.

- Collaborative working with Hospice, community care homes and CHAT to promote GSF training and Sage & Thyme educational sessions

What's next?

- 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
- 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.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.
Challenges that HWB may be able to assist resolving / unblocking
• Supporting the emerging Care Closer to Home Integrated Networks (CHINs) programme

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

What's our current performance?

- There are estimated 13,600 older people who are Low Risk "Pre-Frail" and in addition there are around 7200 older people at high risk of frailty in Enfield
- 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.
- Multiple entry points into existing falls and musculoskeletal services leading to duplication and omission of care. The target across NCL is to reduce falls-related admissions by 10% (390 fewer falls-related admissions per year) among adults aged >65 years through multi-disciplinary interventions, including strength and balance and home modifications. Plans are in place to increase the number of Safe and Well visits and referrals made by London Fire Brigade.

Things that are going well

<u>Falls Prevention</u>

- Enfield Public Health has co-designed with existing local services and commissioner to a falls prevention training aiming at health and social care frontline staff such as domiciliary carers. The procurement is at its completion stage and the training will start very soon for 200 front line workers looking after older people.

<u>The VCS prevention contracts</u>

- The VCS Prevention contracts for the following consortiums commenced on the 12th December 2017

  Outcome 1 - Helping People Continue Caring;
  Lead partner: Enfield Carers Centre

  Outcome 2 - Supporting vulnerable adults to remain living healthily and independently in the community including avoiding crises;
  Lead partner: Age UK Enfield

  Outcome 4 - Helping Vulnerable Adults to have a voice
  Lead partner: Enfield Disability Action (EDA)

  Outcome 5 - People recover from illness, safe and appropriate discharge from hospital.
  Lead partner: GGCCE

<u>Reducing hospital and residential care admissions through effective early intervention</u>

- A meeting was held between representatives from adult social care, public health and Enfield CCG to conduct an analysis on hospital and residential care admissions through hospital admissions, with an aim to find effective early

intervention specific to Enfield. A methodology paper on the analysis on hospital and residential care admissions through hospital admissions is being drafted.
What's next?
<VCS prevention contracts> • We will be looking to develop a VCS Steering Group by the end of May 2018, allowing lead partners a forum to exchange updates, ideas and build strong relationships and networks. The development of processes, pathways and data/performance measures against outcomes will be also be progressed and monitored. It is expected that the result of the first monitoring report will be produced by the end June 2018
Challenges that HWB may be able to assist resolving / unblocking
To support the above activities.

6.0 Recommendations

6.1 The Board is asked to review the annual outcome indicators provided within this report for information.

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

<Mental Health Resilience>

- Continue to support ongoing partnership with Thrive LDN in this area.
- Be aware of relevance of emotional health and wellbeing resilience to other HWB priorities – such as best start in life.

Enfield Joint Health and Wellbeing Strategy - performance report

March 2018

IN 2014 Enfield Health and Wellbeing Board (HWB) developed a 5 year Joint Health and Wellbeing Strategy (JHWS) with the aim of promoting and supporting wellbeing in our local community, enabling local people to live happy and fulfilling lives. The strategy sets out five priorities. This report aims to monitor progress around these priorities.

1. Ensuring the best start in life
2. Enabling people to be safe, independent and well and delivering high quality health and care services
3. Creating stronger, healthier communities
4. Reducing health inequalities – narrowing the gap in life expectancy
5. Promoting healthy lifestyles and making healthy choices

The tables in this report present a selection of indicators from the Public Health Outcomes Framework (PHOF), Adult Social Care Outcomes Framework (ASCOF), Office for National Statistics (ONS) and CCG Outcomes Framework (CCG OF) that illustrate the progress of Enfield Joint Health and Wellbeing Strategy 2014-2019.

The direction of travel column denotes whether outcomes in Enfield have been increasing, decreasing or not changing compared to previous years (where possible, this was tested statistically). The column is colour coded to illustrate whether outcomes are statistically improving or worsening.

Direction of Travel
Enfield's outcome significantly worsening
No significant change
Enfield's outcome significantly improving
Trend data observed or not available

Some indicators do not have sufficient data for statistical trend analyses. Where this occurs, outcomes have not been coloured and the direction of travel is based on observation.

The Impact on population (size) column denotes the size of the population affected by a measure – "high" covers areas with risk/measure affecting the whole population or where the total affected per annum runs into thousands, "medium" covers areas where large sub-sections of the population are at risk, low covers areas where a small sub-group of the population is at risk or where the total affected is less than 100 people per annum.

Compared to England figures: *Better* *Similar* *Worse*

Ensuring the Best Start In Life

	Indicator	Year	Enfield	London	NCL	England	Direction of Travel	Size of the
1.1	Children in low income families (all dependent children under 20)	2015	**22.0%**	23.9%	22.8%	19.9%	Observed decrease - getting better	High
1.2	School Readiness: the percentage of children achieving a good level of development at the end of reception	2016/17	**68.0%**	73.0%	70.8%	70.7%	Increasing - getting better	High
1.4	16-18 year olds not in education employment or training	2016	**8.2%**	5.3%	6.7%	6.0%	Decreasing getting better	Low
1.5	Breastfeeding - breastfeeding initiation	2016/17	**83.4%**	87.2%	92.4%	74.5%	Trend data not available	Medium
1.6	Smoking status at time of delivery	2016/17	**7.0%**	4.9%	5.0%	10.7%	Increasing - getting worse	Low
1.7	Under 18 conceptions rate / 1,000	2016	**20.6**	17.1	15.8	18.8	Decreasing - getting better	Low
1.8	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) (rate per 10,000)	2016/17	**89.1**	78.1	73.5	101.5	No significant change	Low
1.9	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years) (rate per 10,000)	2016/17	**134.4**	94.8	95.1	126.3	Increasing - getting worse	Low
1.10	Proportion of five year old children free from dental decay	2014/15	**66.1%**	72.6%	72.0%	75.2%	Trend data not available	High
1.11	Infant mortality (rate per 1,000)	2014 - 16	**3.2**	3.2	2.6	3.9	Observed decrease - getting better	Low
1.12	*Chlamydia Detection rate 15-24 year olds (Rate per 100,000)	2016	**1608.5**	2308.8	1842.2	1882.3	Increasing - getting better	Medium - High
1.13	Hospital admissions as a result of self-harm (aged 10 - 24) (rate per 100,000)	2016/17	**151.2**	197.2	130.0	404.6	Observed decrease - getting better	Medium High

N.B. Some values are not colour coded due to the indicators having limited national variation to allow for comparisons.

** This indicator uses a different colour coding method* * <1,900 | 1,900 to 2,300 | ≥2,300

Compared to England figures: *Better* *Similar* *Worse*

Enabling people to be safe, independent and delivering high quality health and care services

	Indicator	Year	Enfield	London	NCL Average	England	Direction of Travel	Size of the population affected
2.1	Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2016/17	**66.1%**	67.8%	66.5%	67.4%	Observed increase - getting worse	High
2.2	Successful completion of drug treatment - opiate users	2016	**8.0%**	7.2%	6.7%	6.7%	No significant change	Low
2.3	Successful completion of drug treatment - non-opiate users	2016	**33.0%**	38.7%	37.2%	37.1%	Increasing - getting better	Low
2.4	Recorded diabetes	2016/17	**7.7%**	6.5%	5.9%	6.7%	Increasing - getting worse	High
2.5	Cancer screening coverage - bowel cancer	2017	**53.8%**	49.6%	50.6%	58.8%	Insufficent trend data available	Medium
2.6	*Population vaccination coverage - MMR for two doses (5 years old)	2016/17	**84.0%**	79.5%	80.8%	87.6%	Increasing - getting better	Medium
2.8	Population vaccination coverage - Flu (65+)	2016/17	**68.2%**	65.1%	67.3%	70.5%	Decreasing and getting worse	High
2.9	**HIV late diagnosis	2014-16	**50.4%**	33.7%	31.8%	40.1%	No change observed	Low
2.10	Mortality rate from causes considered preventable	2014-16	**149.3**	167.7	163.1	182.8	Observed decrease - getting better	Medium - High
2.11	Under 75 mortality rate from all cardiovascular diseases	2014-16	**69.6**	74.9	72.1	73.5	Observed decrease - getting better	Medium - High

N.B. Some values are not colour coded due to the indicators having limited national variation to allow for comparisons.

** This indicator uses a different method of colour coding* *<90% 90% to 95% ≥95%

*** This indicator uses a different method of colour coding* **<25% 25% to 50% ≥50%

Compared to England figures: *Better* *Similar* *Worse*

Enabling people to be safe, independent and delivering high quality health and care services (continued)

	Indicator	Year	Enfield	London	NCL Average	England	Direction of Travel	Size of the population affected
2.12	Emergency readmissions within 30 days of discharge from hospital	2011/12	**10.3%**	12.1%	12.0%	11.8%	No change observed	Low - Medium
2.13	IAPT reliabe recovery following completion of treatment	2016/17	**41.9%**	-	37.9%	43.5%	Trend data not available	Medium
2.14	IAPT reliable improvement following completion of treatment	2016/17	**64.4%**	-	60.2%	45.7%	Trend data not available	Medium
2.15	Social care related quality of life	2016/17	**18.5**	18.6	18.76	19.1	Trend data not available	Low
2.16	Health Check Uptake (aged 40-74)	2013-2018	**34.6%**	46.5%	44.3%	41.9%	Trend data not available	Medium - High
2.17	Learning Disability Health Check	2016/17	**35.9%**	48.4%	41.1%	48.9%	Observed decrease - getting worse	Medium - High

N.B. Some values are not colour coded due to the indicators having limited national variation to allow for comparisons.

Compared to England figures: *Better* *Similar* *Worse*

Reducing health inequalities - narrowing the gap in life expectancy

	Indicator	Year	Enfield	London	NCL Average	England	Direction of Travel	Size of the population affected
4.1	Proportion of life lived in "good health" - male	2014-16	**80.2%**	78.9%	79.0%	79.6%	Trend data not available	High
4.2	Proportion of life lived in "good health" - female	2014-16	**75.5%**	76.5%	75.9%	76.8%	Trend data not available	High
4.3	Gap in life expectancy between the most and least deprived parts of Enfield - male	2014-16	**6.7**	-	7.66	-	Trend data not available	High
4.4	Gap in life expectancy between the most and least deprived parts of Enfield - female	2014-16	**4.7**	-	4.94	-	Trend data not available	High
4.5	Gap in life expectancy based on deprivation - male	2009 -13	**14.4**	-	13.6	-	Trend data not available	High
4.6	Gap in life expectancy based on deprivation - female	2009 -13	**15.0**	-	14.2	-	Trend data not available	High

N.B. Some values are not colour coded due to the indicators having limited national variation to allow for comparisons.

Compared to England figures: *Better* *Similar* *Worse*

Promoting healthy lifestyles and making healthy choices

	Indicator	Year	Enfield	London	NCL Average	England	Direction of Travel	Size of the population affected
5.1	Child excess weight in 10-11 year olds	2016/17	**41.5%**	38.5%	37.5%	34.2%	Increasing and getting worse	Medium
5.2	Excess weight in Adults	2015/16	**63.5%**	55.2%	51.9%	61.3%	Trend data not available	High
5.3	Smoking prevalence at age 15 - current smokers (WAY survey)	2014/15	**3.5%**	6.1%	6.2%	8.2%	Trend data not available	High
5.4	Percentage of physically active and inactive adults - inactive adults	2016/17	**27.7%**	22.9%	21.6%	22.2%	Trend data not available	High
5.5	Smoking Prevalence in adults - current smokers (APS)	2016	**13.1%**	15.2%	14.1%	15.5%	Observed decrease - getting better	High
5.6	Proportion of adults meeting the recommended '5-a-day' on a 'usual day'	2015/16	**57.4%**	56.4%	58.0%	56.8%	Trend data not available	Unknown
5.7	Alcohol consumption - increased risk drinking	2008-09	**18.7%**	20.6%	20.7%	22.3%	Trend data not available	Unknown
5.8	Admission episodes for alcohol related conditions (Narrow) (Directly age - standardised rates per 100,000)	2016/17	**575.4**	529.4	607.6	636.4	No change observed	Unknown

N.B. Some values are not colour coded due to the indicators having limited national variation to allow for comparisons.