Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 8 February 2018 at 6.15 pm
Room 1, Civic Centre, Silver Street, Enfield, EN1 3XA

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Board Secretary
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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 – Parin Bahl
Clinical Commissioning Group (CCG) Chief Officer – John Wardell
NHS England Representative – Dr Helene Brown
Director of Public Health – Tessa Lindfield
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

1. WELCOME AND APOLOGIES

2. DECLARATION OF INTERESTS

Members are asked to declare any pecuniary, other pecuniary or non-pecuniary interests relating to items on the agenda.

3. WHOLE SYSTEM APPROACH TO URGENT CARE RESILIENCE (6:15 - 6:45PM) (Pages 1 - 12)

To receive a report and presentation from John Wardell, Chief Operating Officer, Enfield Clinical Commissioning Group (CCG).

4. HEALTHY HOSPITALS - THE EXPERIENCE OF THE ROYAL FREE HOSPITAL AND CHASE FARM HOSPITAL (6:45 - 7:05PM)

To receive a presentation from Angela Bartley, Consultant in Public Health at the Royal Free on the work she is doing across Royal Free and Chase Farm Hospitals.

5. VIOLENCE AGAINST WOMEN AND GIRLS STRATEGY (7:05 - 7:25PM) (Pages 13 - 16)

To receive the report of Shan Kilby, Domestic Violence Coordinator, LBE Community Safety Unit.

6. CARE CLOSER TO HOME INTEGRATED NETWORKS (7:25 - 7:45PM) (Pages 17 - 30)

To receive the report of John Wardell, Chief Operating Officer, Enfield CCG and Jon Newton, Head of Older People & Physical Disabilities, LB Enfield.

REPORTS FOR INFORMATION

The following reports are for information only.

7. THE INTEGRATION AND BETTER CARE FUND - QUARTER 3 2017/2018 BCF UPDATE (Pages 31 - 38)

To receive the report of Bindi Nagra, Director of Adult Social Care, LB Enfield and Vince McCabe, Director of Strategy & Partnerships, Enfield CCG.

8. PROGRESS UPDATE ON JOINT HEALTH AND WELLBEING STRATEGY (JHWS) (Pages 39 - 58)

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

9. MINUTES OF THE MEETING HELD ON 5 DECEMBER 2017 (Pages 59 - 66)

To receive and agree the minutes of the meeting held on 5 December 2017.

10. INFORMATION BULLETIN (Pages 67 - 72)

11. HEALTH AND WELLBEING BOARD FORWARD PLAN (Pages 73 - 74)

The current version of the Forward Plan is attached.

12. DATES OF FUTURE MEETINGS

Members are asked to note the dates of meetings of the Health and Wellbeing Board:

- Tuesday 17 April 2018

All meetings take place at 6:15pm unless otherwise indicated.

Members are asked to note the dates of meetings of the Health and Wellbeing Board Development Sessions:

- Tuesday 20 March 2018

The development sessions take place at 2:00pm unless otherwise indicated.

13. EXCLUSION OF PRESS AND PUBLIC

If necessary, to consider passing a resolution under Section 100A(4) of the Local Government Act 1972 excluding the press and public from the meeting for any items of business moved to part 2 of the agenda on the grounds that they involve the likely disclosure of exempt information as defined in those paragraphs of Part 1 of Schedule 12A to the Act (as amended by the Local Government (Access to Information) (Variation) Order 2006).

There is no part 2 agenda.

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Agenda Item 3

MUNICIPAL YEAR 2017/2018 - REPORT NO.

Agenda - Part:	**Item:**
Subject: Whole System Approach to Resilience **Wards:** All	
Cabinet Member consulted:	
Approved by:	

Health and Wellbeing Board- 8th February 2018
Whole System Approach to Resilience

John Wardell- Chief Operating Officer
Enfield CCG

Contact officer and telephone number:
Komal Odedra- System Resilience Programme Manager

0203 688 1835

E mail: **komalodedra@nhs.net**

1. EXECUTIVE SUMMARY

This report shares the performance across Royal Free London Hospitals Trust and North Middlesex University Hospital Trust and the contribution of delays from Enfield CCG patients. The report also reviews the impact of supporting schemes across Enfield partners which have contributed to the improvement in delays and continue to support the challenges to demand.

2. RECOMMENDATIONS

The recommendation would be for the Board to note the schemes, next steps and system partnership working within this presentation.

A further recommendation would be for Board Members to suggest the best forum for System Partners to continue to share and involve the members of the committee of the work taking place across the system.

3. BACKGROUND

This Presentation gives a summary on resilience performance including flow into hospital, hospital flow and discharges. The presentation also considers the multi-agency working taking place across the system to support the above areas.

4. ALTERNATIVE OPTIONS CONSIDERED

Not applicable

5. REASONS FOR RECOMMENDATIONS

Recommendations have been made based on request for this information to be presented to the board.

6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

None

6.1 Financial Implications

Not Applicable

6.2 Legal Implications

Not Applicable

7. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

7.1 Ensuring the best start in life- Neutral

7.2 Enabling people to be safe, independent and well and delivering high quality health and care services- Positive, the aim of the schemes outlined in this presentation are for all patients to be cared for an a safe environment whilst ensuring a high quality of care can be given to patients both inside and outside of the Acute environment

7.3 Creating stronger, healthier communities- Positive, the schemes outlined in the paper focus on a 'Home First' initiative which is aimed to have patients living healthier lives for longer

7.4 Reducing health inequalities – narrowing the gap in life expectancy- Neutral

7.5 Promoting healthy lifestyles- Positive, schemes within this presentation are aimed at patients utilising the best place of care for their needs in order to lead a healthy lifestyle and avoid unnecessary attendances to hospital

8. EQUALITIES IMPACT IMPLICATIONS

Not Applicable

Background Papers

Attached is the presentation on "Whole System Resilience" which supports this coversheet.

North Middlesex University Hospital NHS Trust

ENFIELD Council

NHS Enfield Clinical Commissioning Group

Whole System Approach to Urgent Care Resilience

Presented by John Wardell, Enfield CCG

Supported by North Middlesex & London Borough of Enfield

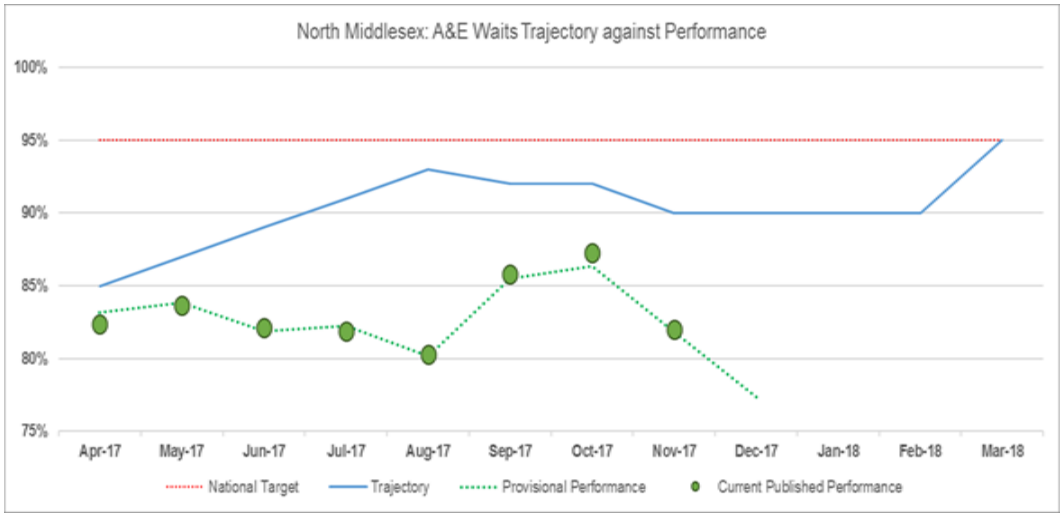
8th February 2018

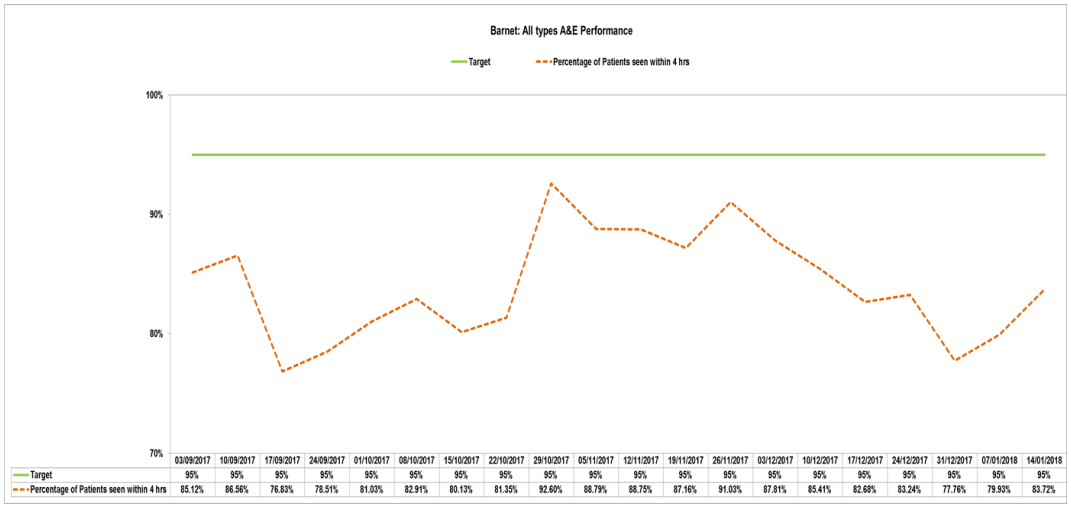



Introduction & Background

- Surge in demand exacerbated the problems in a healthcare system which is already under strain
- Although the National 4 hour A&E target is 95% this is not being met by the majority of Trusts Nationally and Local agreements have taken place to support a recovery trajectory
- The North Middlesex Hospital University Trust (NMUH) recovery trajectory was set to reach 90% in December 2017 and 95% in March 2018
- In hospitals there is a surge in emergency attendances
- Strong upward trend in all contacts (111, OOH, A&E, GP)
- This compounds difficulties in the acute hospital sector often leading to unnecessary attendances and delayed discharges
- The National Delayed Transfer of Care (DToC) target is set at 3.5% with a stretch target of 2.5%, Enfield are consistently under the 2.5% trajectory set
- Resilience planning is done through the important relationship with community and social care services which supports an integrated system to support the Acute

Recent Performance - North Middlesex University Hospital & Barnet & Chase Farm Hospitals





A&E performance across Acute sites locally and nationally dipped across Winter

However, NMUH have managed to recover from December performance to 80% in recent weeks

Focus across A&E Delivery Boards including support from community partners and social care to create system flow to reduce Acute pressures

In Flow- Primary Care & Care Homes

- Throughout October and November 8153 appointments were offered to patients above the usual GP appointments in hours
- 6338 appointments were booked, however 969 patients did not attend (DNA)
- The table below illustrates reduced utilisation particularly Sundays, and a high rate DNA on weekdays.
- On-going work is taking place to review potential reduction of DNA through use of walk in appointments to replace bookable capacity
- Close working with the communications team to produce materials for patients/hospitals/ GP Practices with information on the additional appointments

Hub utilisation	Nov	Oct
# appointments available	4079	4074
# appointments booked	3227	3111
Face to face	3227	3111
Other (e.g. Skype, telephone)	0	0
# DNAs	500	469
Overall hub utilisation (%)	67%	65%

Hub utilisation per day			
Day	# appts available	# appts booked	# DNAs
Monday	168	143	25
Tuesday	168	142	23
Wednesday	216	183	25
Thursday	210	190	40
Friday	156	141	60
Saturday	2064	1713	221
Sunday	1097	715	106
Total this month	4079	3227	500

The Care Home Assessment Team (CHAT) have a strong and collegiate relationship with care homes and are part of the Trusted Assessor implementation locally, creating a relationship where providers feel confident and safe to seek advice.

CHAT has several indicators measured, with the following impact noted up to November 2017:

- Enabled individuals to choose to die in their preferred place (100% in both October and November 2017); individuals outcomes were supported around dignity and choice.
- The CHAT sees new residents within a target of two weeks in their care provision; for Oct they met this in 90% of cases, and 89% of cases in November.
- Work with care homes to reduce A&E attendance for falls continued; CHAT is measured on percentage of people who having falls go into A&E, which stood at 12% in October and 15% in November.

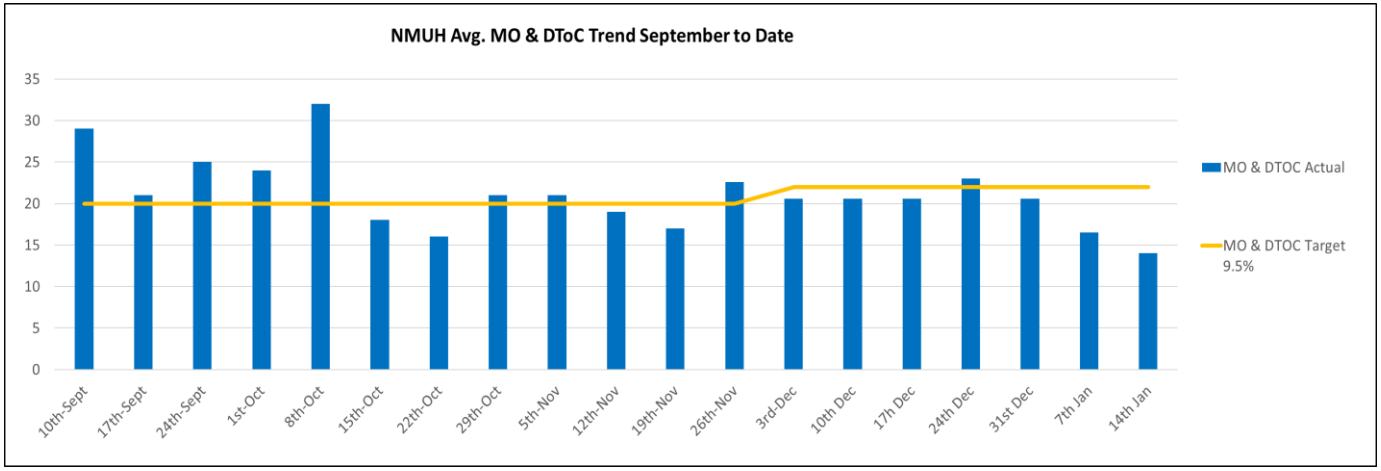
Hospital Flow

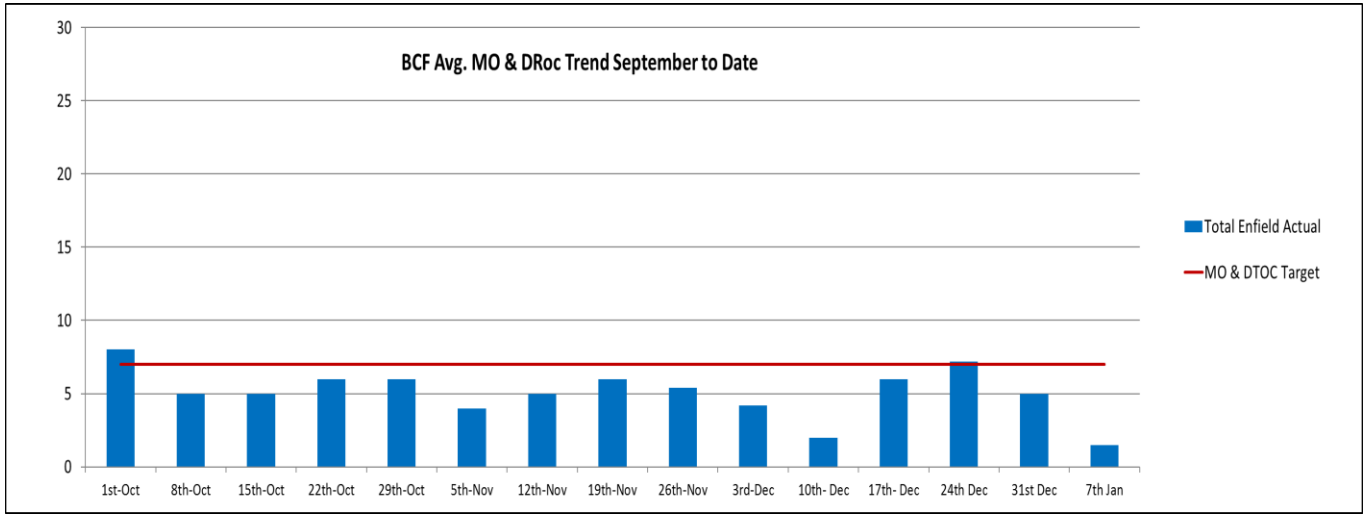
Safer, Faster, Better Dashboard

Workstream	Metric	Target	Week Ending 22-Oct	29-Oct	05-Nov	12-Nov	19-Nov	26-Nov	03-Dec	10-Dec	17-Dec	24-Dec	31-Dec	07-Jan
Emergency Department	Average time from arrival to DTA	210	198	191	192	188	215	238	199	229	251	250	262	294
	Average time from DTA to admission		157	167	141	139	164	218	174	184	273	221	251	285
	Proportion of patients streamed to UCC	50%	45%	47%	46%	45%	44%	44%	43%	45%	45%	42%	45%	43%
	Average number of patients going to OBU per day	20	18	18	18	17	17	15	14	15	11	12	12	8
	Total proportion of patients streamed away from ED	55%	51.6%	53.1%	52.7%	51.3%	50.5%	50.5%	48.6%	50.3%	49.5%	47.2%	48.9%	47.4%
	Average ambulance handover time (mins) * based on unvalidated LAS data	15	20.3	19.5	17.8	17.8	18.4	19.9	17.4	19.4	23.0	24.0	24.4	31.9
Wards	Average admissions per day	63	71	69	71	70	71	63	64	63	60	67	60	58
	Average discharges per day	>= adms.	65	73	70	70	68	60	62	63	56	76	52	54
	Proportion of patients discharged between 07:30 and 12:30	33%	25.0%	19.2%	19.4%	19.4%	16.4%	15.0%	22.0%	16.8%	19.4%	24.9%	22.0%	21.2%
	Proportion of patients discharged at weekends	20%	19.0%	11.2%	15.9%	16.0%	17.1%	14.5%	17.3%	13.2%	13.4%	23.5%	21.2%	11.0%

- Streaming through the Urgent Care Centre (UCC) has stayed consistent despite pressures
- Average admissions per day have improved since November
- Admissions and discharges overall have remained balanced throughout Winter
- There is an increase in time for initial assessment and average time to see a clinician which has a knock on effect on the time for decision to admit
- Average discharges from the Acute Assessment Unit (AAU) have decreased

Outflow- Discharge

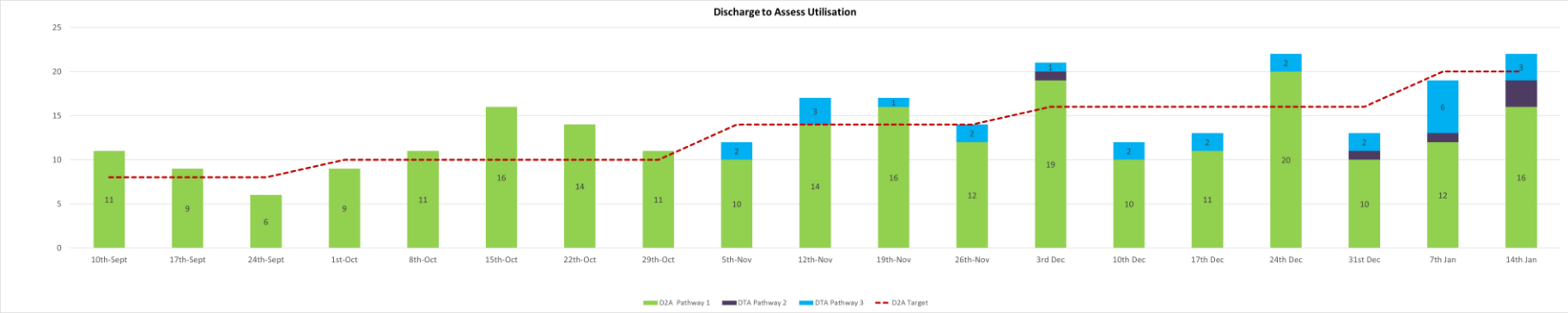




Enfield CCG along with Haringey CCG, Local Authority partners and Community partners have put in place local initiatives to support discharge from hospital

The graphs on the left show the reduction in Enfield delays across both NMUH and BCF since September upon implementation of these projects

Outflow- Discharge



- All pathways have consistently been meeting, if not exceeding, trajectories and supporting the reduction in Enfield delays
- Pathway 1 - 441 patients since Feb 2017
- Pathway 2 -6 Patients since December 2017
- Pathway 3 -26 Patients since November 2017
- Trusted Assessor launched in January 2018- the scheme aims to reducing delays awaiting assessments for care homes and readmissions by providing support and intervention for frequent attenders

System Wide Approach to Resilience Planning

- Working closely with Haringey & Barnet A&E Delivery Boards to implement support for Enfield patients across local Acute sites
- Weekly System Resilience calls including Local Authority
- Local escalation process implemented for North Middlesex University Hospital at Chief Operating Officer/ Director of Commissioning level
- Daily calls to identify early escalation of issues
- Implementation of Discharge to Assess Pathways to support reduction of LOS and delays within the Acute to support flow
- Enfield Social Worker on site across all main Acute sites 7 days a week

Additional Funding Support from NHS England

In December 2018 NHS England offered each system the chance to put forward bids which would further support resilience across the local urgent care systems, particularly the January pressure surge which follows the festive period

Enfield CCG along with NMUH and Haringey CCG submitted a bid and were successful in securing additional funding to support the following initiatives:

- Enfield Crisis and Mental Health Support and Redirection Team to further support rapid mental health discharges and prevent breaches, working in close alignment with the admissions avoidance team at NMUH- recruitment for this scheme is in progress
- Clinical Support in ED - further clinical support to maximise redirection and streaming of patients in A&E; - this post will be working closely with the DTA Pathway 3 team to support patients to be cared for in their home environment and avoiding an unnecessary admission when appropriate

Next Steps

- Enfield will be working with partner organisations over the next few months to review successful schemes from 2017/18 and planning for resilience for 2018/19

- Any schemes identified to be put in place will be communicated early to partners across the system to ensure schemes are in place in advance of the winter months

- DTA has been confirmed to continue for 2018/19 with plans to increase capacity across all pathways due to the success from Winter 2017/18

- Healthwatch Enfield commissioned to identify any further outcomes which will support improvements

How can the system continue to involve elected members on this work outside of the Health and Wellbeing Board?

Agenda Item 5

MUNICIPAL YEAR 2017/2018 - REPORT NO.

MEETING TITLE AND DATE **Health and Wellbeing Board**	**Agenda - Part:** **Item:** **Subject: Violence Against Women and Girls Strategy** **Wards:**
Executive Director of	**Cabinet Member consulted:**
Contact officer and telephone number: E mail:	**Approved by:**

1. EXECUTIVE SUMMARY

The Violence Against Women and Girls (VAWG) Strategy was agreed on 3rd July 2017. This is accompanied by an annual action plan which partners have been asked to contribute to in our partnership response to tackle VAWG including domestic abuse.

There are 4 key objectives in the strategy which are as follows:

1) Prevent violence from happening
2) Provide support and protection where it does occur
3) Provide a coordinated community response
4) Hold perpetrators accountable

There have been numerous developments and progress in relation to our response and further to publication of the new VAWG Strategy which are detailed in this report.

2. RECOMMENDATIONS

A request for contributions from partners to the VAWG Action Plan

Progress the agreed recommendations detailed from the recent HWB development session

3. BACKGROUND

The VAWG strategy sets out how we will address and prevent violence against women and girls in Enfield. It outlines how all of us can contribute to obtaining the best possible outcomes for victims and survivors, whether we are working in statutory or voluntary agencies or are a member of the community.

This aligns with the cross government VAWG strategy and the Mayor's Office of Policing and Crime priorities.

The term violence against women and girls can often cause concern about the exclusion of men and boys from services and a lack of recognition that men and boys can also experience these forms of violence and abuse. The UN Declaration is based on the concept of disproportionate impact of violence and abuse on women and girls. We understand the gendered nature of these types of abuse and crimes, and that men and boys are sometimes victims too.

Men and boys are included in all aspects of our work on all forms of violence against women and girls, particularly work on prevention and awareness-raising. We are committed to ensuring that any victim will receive a sensitive and appropriate response, according to their needs.

The VAWG Strategy objectives inform the annual VAWG action plan. We have requested contributions from partners who are already carrying out work or projects that support victims however the action plan requires the detail of these programmes and any planned work.

The recently published multi-inspectorate report: Multi-Agency Response to Children Living with Domestic Abuse https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/645642/JTAI_domestic_abuse_18_Sept_2017.pdf provides information from the 6 Joint Targeted Area Inspections undertaken by the CQC, Ofsted and others and notes the following key points:

- Domestic abuse is a widespread public health issue that needs a long-term strategy to reduce its prevalence
- A long-term approach towards the prevention and reduction of domestic abuse over time, which is more than a task for agencies individually but requires societal change
- A public service message needs to be on those perpetrators who have offended or may offend
- Local authorities can use reviews or audits to improve their services
- Change must start with a more systemic focus on perpetrators' behaviour and preventing their abuse of their victims

Enfield prioritises domestic abuse and VAWG and has a strong multi-agency partnership. We have had numerous successes which continue to develop and enhance our local response. Examples of these are noted below:

- Continuation of the Identification and Referral to Improve Safety (IRIS) scheme with agreement between the CCG and London Borough of Enfield to fund the project until end of March 2019

- The Community Safety Unit continues to provide DV training to multi-agency professionals and agencies / groups. A Domestic Abuse Training Competency Framework has been produced to ensure professionals receive training at the appropriate level

- Re-accreditation awarded to London Borough of Enfield by White Ribbon Campaign UK in recognition of our multi-agency response to domestic abuse

- Development of an LBE Domestic Violence and Workplace Response Policy for employees and planned roll out of training and resources to support this

- Enfield Council – He doesn't love you if…domestic abuse campaign – This has been recognised in the national public-sector communications excellence awards becoming bronze winner

- Continuing awareness-raising and targeted digital marketing with the 'Boyfriend Material?' campaign which re-launches on 1st February 2018

- Funding for sessions at Edmonton Eagles boxing club for victims of domestic abuse and young people who have been affected by gangs / abuse. The sessions provide a safe, secure environment for women and girls to improve health and well-being, work with personal trainers and build confidence and social networks. This is proving successful and well received by attendees.

- Most recently Enfield and Haringey have been successful in a funding bid made to the Department for Culture, Media and Sport to become a Pathfinder site and will be supported over a three-year period to establish comprehensive health practice in relation to domestic abuse in North Middlesex Hospital NHS Trust.

Support for the project will include:

- Pathfinder sites will receive three years ongoing support and access to expertise from Consortium partners including training, consultancy and strategic development to enhance and develop a sustainable health response to a diverse range of domestic abuse survivors
- A total of £110,000 to provide an Independent Domestic Violence Advisor / Advocate Educator in A&E over the 3-year period
- Sites will participate in action research undertaken by the University of Bristol to develop evidence-based best practice
- Sites will also be promoted nationally as a model to be adopted across the health sector

This project will contribute to current resources in Enfield and meet objectives set out in the new VAWG Strategy.

Along with the above noted funding Enfield has been successful in a number of bids to the Department of Communities and Local Government, Home Office and other areas. In the last 18 months we have secured funding of £1,206,500 for single and multi-borough projects.

4. ALTERNATIVE OPTIONS CONSIDERED

5. REASONS FOR RECOMMENDATIONS

To contribute to the multi-agency response to domestic abuse in Enfield. To strengthen collaborative working with the Safer and Stronger Communities Board

6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

6.1 Financial Implications

N/A

6.2 Legal Implications

N/A

7. KEY RISKS

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

8.1 Ensuring the best start in life
8.2 Enabling people to be safe, independent and well and delivering high quality health and care services
8.3 Creating stronger, healthier communities
8.4 Reducing health inequalities – narrowing the gap in life expectancy
8.5 Promoting healthy lifestyles

9. EQUALITIES IMPACT IMPLICATIONS

Background Papers

London Borough of Enfield: Violence Against Women and Girls Strategy - https://new.enfield.gov.uk/enfieldlscb/wp-content/uploads/2017/10/VAWG-Strategy-July-2017.pdf

Agenda Item 6

MUNICIPAL YEAR 2017/18		
MEETING TITLE AND DATE **Health and Wellbeing Board** **9th February 2018**	**Agenda – Part:**	**Item:**
	Subject: Care Closer to Home Integrated Networks	
	Wards: All	
REPORT OF: John Wardell, Chief Operating Officer, Enfield CCG Jon Newton, Head Of Older People & Physical Disabilities, London Borough of Enfield	**Cabinet Member consulted:**	
Contact officer: Sandra Arinze, Commissioning and Transformation Manager **Email:** s.arinze@nhs.net **Tel:** 020 3688 2884		

1. EXECUTIVE SUMMARY

This report provides details of the progress made to date on the development and implementation of the Care Closer to Home Integrated Network Agenda and its impact on the wider health & social care system in Enfield.

This presentation notes:

- The North Central London Sustainability and Transformation Plan;
- Partnership working between London Borough of Enfield, NHS Enfield CCG and Enfield Health to progress phase 2 of the Integrated Locality Teams;
- Development and progress of the Care Closer to Home Network Agenda;

2. RECOMMENDATIONS

- The Health & Wellbeing Board note the content of this presentation;
- The Board is asked to discuss how it wishes to support the development of the Care Closer to Home Network Agenda;

3. BACKGROUND

The North Central London Sustainability and Transformation Plan (STP) sets out plans to build health and social care around the needs of the local population by transforming the way services are provided. One of the key priorities of the STP is to develop a Care Closer to Home Network across NCL which involves

- Improving access to Primary Care
- Care Closer to Home Integrated Networks (CHINs)
- Quality Improvement Supported Teams (QISTs)

This model builds on much of the work already underway across Enfield to develop integrated working and person centred care. Enfield CCG, Enfield Health and London Borough of Enfield Adult Social Care continue to build on Enfield's model for integrated locality-based community services.

4. ALTERNATIVE OPTIONS CONSIDERED

Not applicable

5. REASONS FOR RECOMMENDATIONS

Recommendations have been made based on request for this information to be presented to the board.

6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

None

6.1 Financial Implications

Not Applicable

6.2 Legal Implications

Not Applicable

7 IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

7.1 Enabling a stronger approach to delivering care and support of older people with frailty that is more patient-centred, multi-disciplinary and makes most effective use of existing and new resources to deliver care in the most appropriate clinical setting.
7.2 Reducing health inequalities
7.3 Improve the health and wellbeing of our population
7.4 Improve access and reduce unwarranted variation in quality and use of healthcare

8 EQUALITIES IMPACT IMPLICATIONS

Not Applicable

Background Papers

Attached is the presentation on “Care Closer to Home Integrated Care Network” which supports this coversheet.

NHS
Enfield
Clinical Commissioning Group

Care Closer to Home Integrated Networks

Leading Whole System Transformation

John Wardell
Chief Operating Officer, Enfield CCG
Jon Newton
Head Of Older People & Physical Disabilities





Sustainability and Transformation Plan (STP)

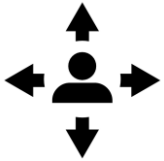
NHS Enfield Clinical Commissioning Group

- NHS 5 year plan - Sustainability & Transformation Plans across 44 area (footprints) in England 2016-2021
- NCL has developed North Central London Plan – Enfield, Haringey, Camden, Islington & Barnet
- Key to plan - Localised Health, Quality of Care , Leadership and Efficiency

Ambition for the STP is built on existing CCG/LA values and strategy

Improve the health of the local population

Reduce health inequalities



Maximise care out of hospital

Sustainability and Transformation Plan (STP)

NHS Enfield Clinical Commissioning Group

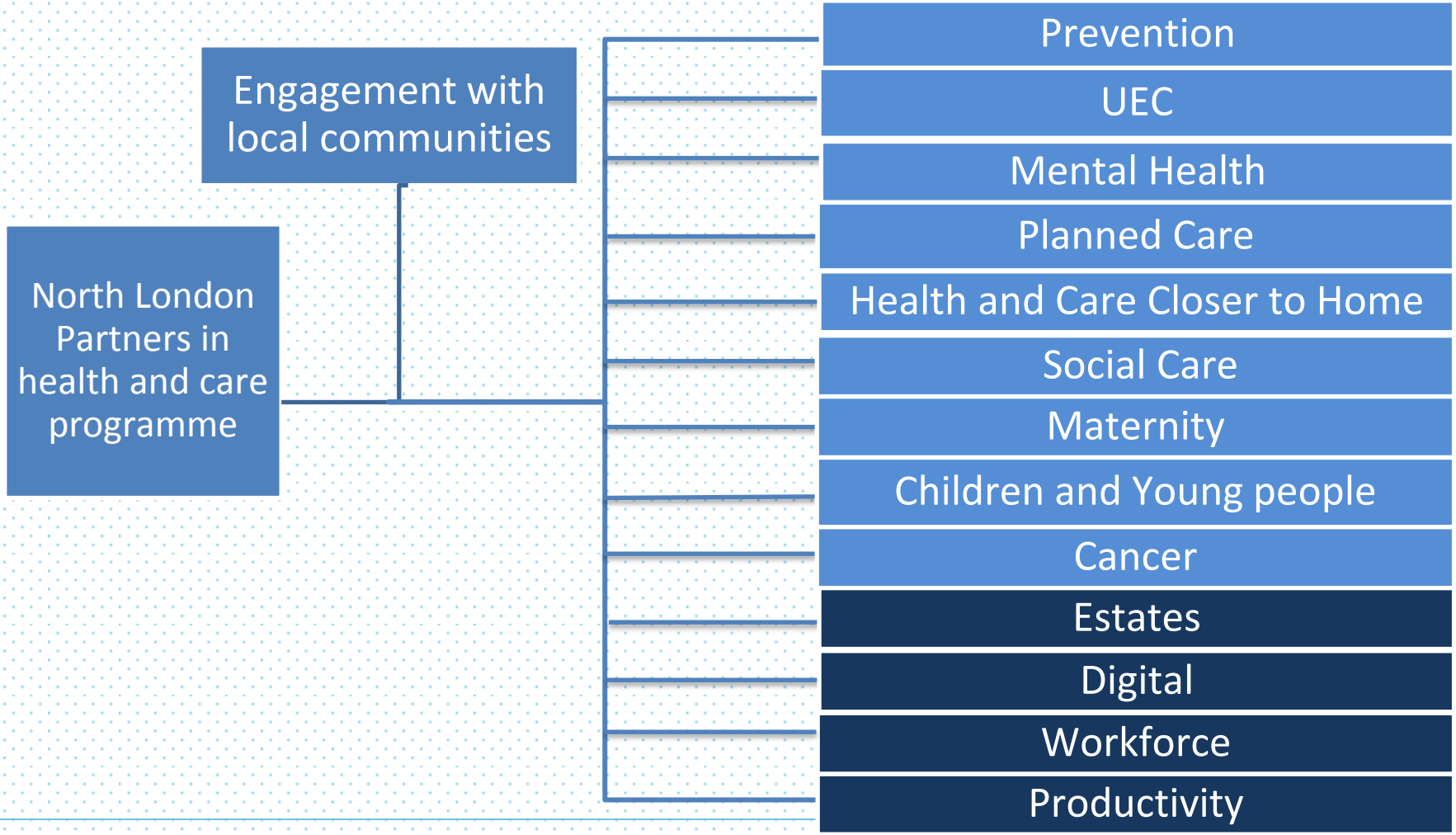
High Level Objectives

- Enhance collaboration and integration between NHS providers, the Voluntary and Community Sector and social care through commissioning place based networks of care
- To improve the quality of primary care and reduce unwarranted variation without stifling innovation;
- Improve access and reduce unwarranted variation in quality and use of healthcare
- Improve management & prevention of chronic disease;
- Support & promote self-care
- Encourage local provider/ commissioner/ social care partnerships which can lead population based health and care planning and strategy

Sustainability and Transformation Plan (STP)

NHS Enfield Clinical Commissioning Group

Overview of Programme



Enfield's Care Closer to Home Integrated Network

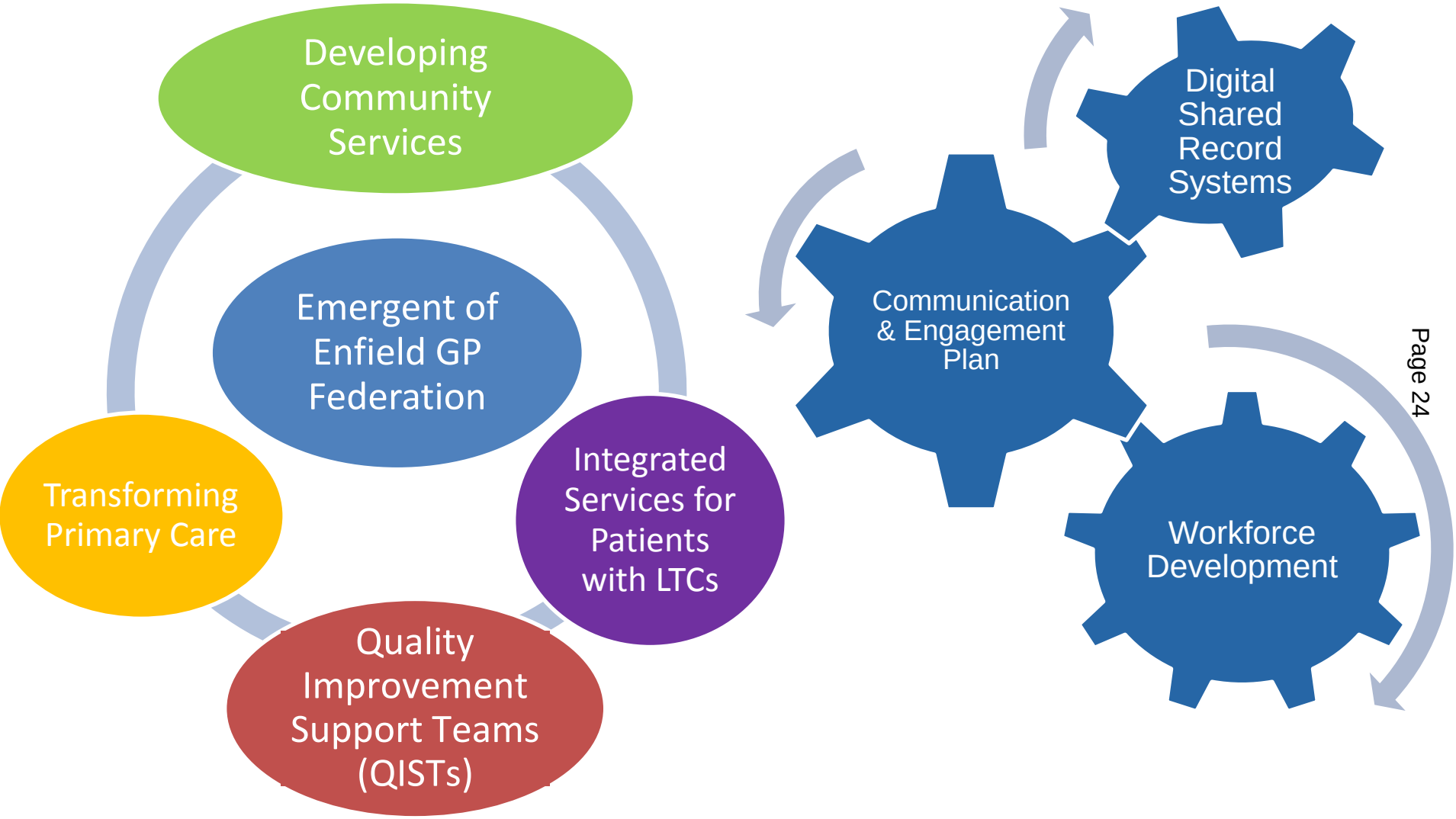
NHS Enfield Clinical Commissioning Group

The STP "Health and Care Closer to Home" work stream proposes we develop Care Closer to Home Integrated Networks (CHINs). This model builds on much of the work already underway across Enfield to develop integrated working and person centred care

This programme of work is being jointly designed and progressed with the London Borough of Enfield, Enfield Health, our GP Federation - Enfield Healthcare Co-operative Limited (EHCL), and all relevant stakeholder in full recognition of the need for a coordinated and integrated approach to promote local health and social care delivery in ways which best meet the needs of the residents and registered population of Enfield

Development of the Enfield Care Closer to Home

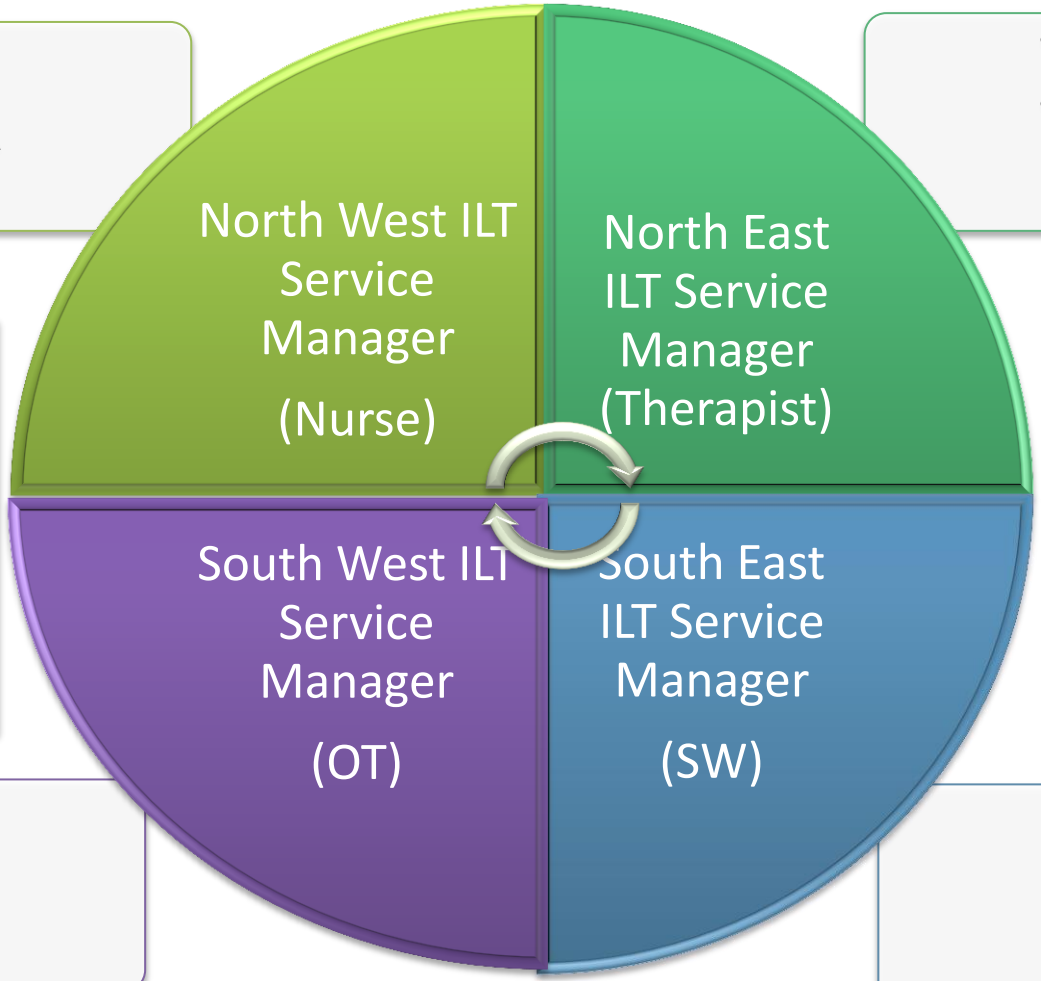
NHS Enfield Clinical Commissioning Group



Enfield Wide System Supporting the CHINs

- Core team co-located and managed by the NW ILT SM
- Additional services aligned to the NW area team: CHAT; SPA / Access; Matrons

- Core team co-located and managed by the NE ILT SM
- Additional services aligned to the NE area team: ICT; Enablement; Magnolia



Services Supporting Core ILTS

- BEH MHTs
- Geriatricians (NMUH)
- HealthWatch
- C&VS

- Core team co-located
- Additional services aligned to the SW area team: Hospital Discharge; MASH

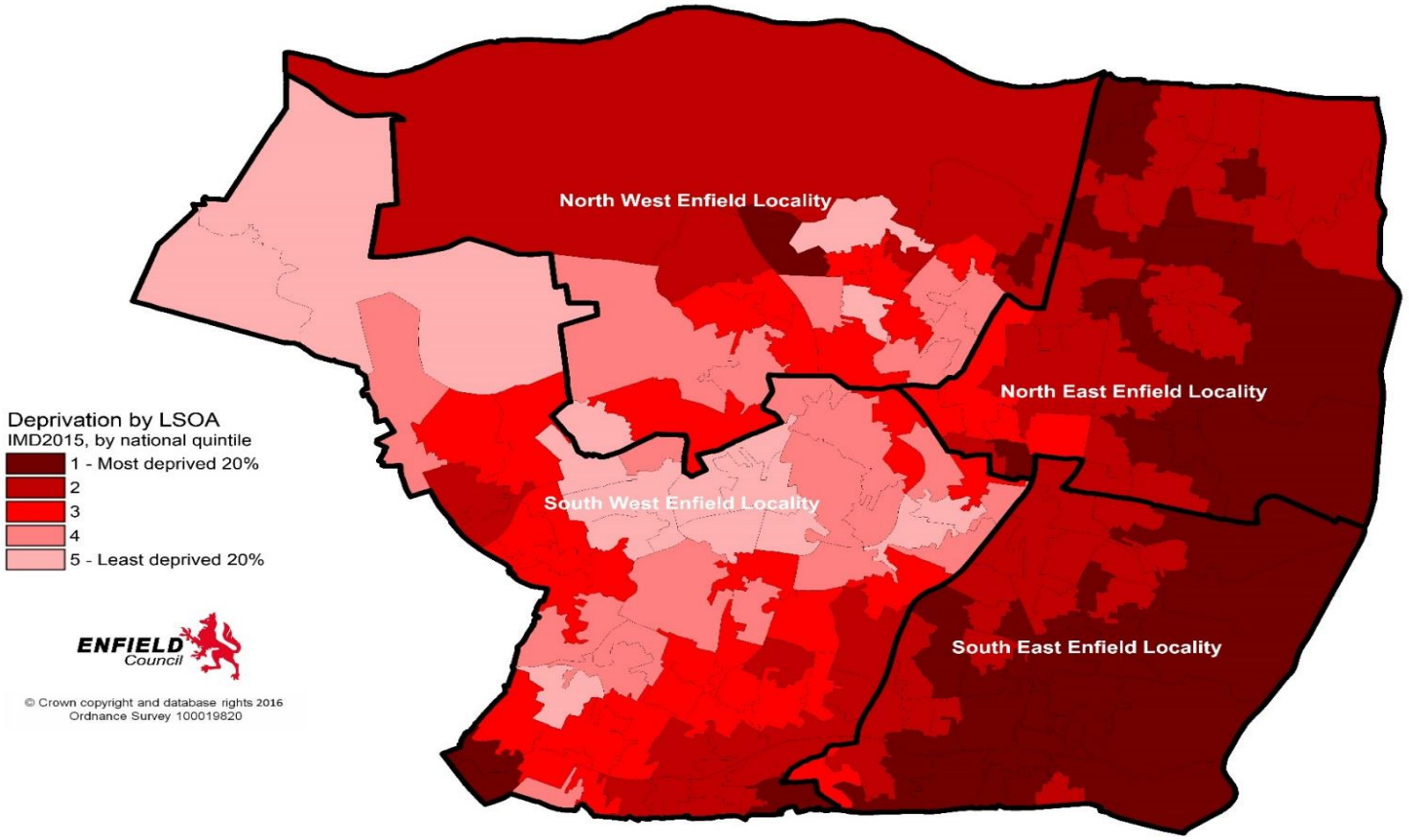
- Core team co-located
- Additional services aligned to the SE area team: Hospital Discharge; Review

ILTs expanded to cover all complex adults
Each SM has responsibility for a borough wide service and local delivery and management of the ILT

Core teams consist of Social Workers, District Nurses and Community Matrons

Over half of Enfield wards within the most deprived 25% in England

The population will increase by nearly 49,000 (15%) between now and 2025 and 20% for age 65+.



Progress to date….

Improved Access to Primary Care

Progress so far:

- NHS Enfield CCG commissioned three locality-based primary care access hubs 8am to 8pm, 7 days per week as set out in the Care Closer to Home Agenda.
- Additional walk in service in the North East of the borough operating from 8am to 8pm on weekends and Bank Holidays.
- Patients can access appointments through a Single Point of Access
- Enfield's newly formed GP Federation, Enfield Healthcare Co-operative Limited, has been commissioned to deliver out of hospital services to the entire patient population of Enfield.

Integrated Networks

Development of the Integrated Locality Team

Improving services for people living with long term conditions and frail older people through our Integrated Locality Team

Progress so far…

Phase 1

- Virtual MDT
- Running for 2 years
- Reviewed

Phase II

- Joint role/ further recruitment
- Develop locality teams/service
- Co-location

Phase III*

- Service re-design
- Embed practices
- Learning & Development

QIST

Aim of the QIST is to reduce variations in health by providing better care, reducing disease and extending life

Progress so far…

- Quality Improvement Support Team provided in the West and the East of the borough

Enfield's Integrated Network - Outcomes Achieved in 2017

The Care Home Assessment Team are vital partners in reducing A&E attendance from care providers; they have a strong and collegiate relationship with care homes and are part of the Trusted Assessor implementation locally, creating a relationship where providers feel confident and safe to seek advice. Enabled individuals to choose to die in their preferred place (100% in both October and November 2017); CHAT is measured on percentage of people who having falls go into A&E, which stood at 12% in October and 15% in November

To prevent avoidable admission and provide a response to individuals in the community in crisis, **the Community Crisis Response Team (CCRT)** is funded by the BCF as part of the integrated care programme to assess and treat patients in their own home. The service had a target of seeing patients within 2 hours of receipt of referral, and achieved this in 100% of cases in October, and 99% of cases in November. Importantly, the feedback from those who use the service is a vital indicator of their experience of care; 100% of patients surveyed reported a positive experience of care.

Community Falls prevention prevents is funded through the BCF to reduce fragility fractures and fracture neck of femurs (#NOF) in patients over 65s through improved care pathways and assist navigation from acute to community settings. The service has contributed to an overall reduction in hospital related activity for all fractures (including fractured neck of femurs) in 16/17 by 17% compared to previous year.

The **Older People Assessment Unit** (OPAU) provides unplanned care to patients who need rapid response for assessment and treatment, often to prevent hospital admission. 2017/18 has shown a positive increase in the uptake of this service, which will assist in care outside of an acute in-patient setting. The service is well received by those experiencing care, with 100% of individuals surveyed during October reporting they felt dignity was always respected, and 100% would be extremely likely to use the service again or recommend to family and friends.

Next Steps…

NHS Enfield Clinical Commissioning Group

- Work with all our partners to co-design plans
- Ensure plans are clinically led and evidence based
- Work with UCL Partners on the Placed based Care Network Programme
- Communicate with our stakeholders and communities about the changes ahead
- Align our plans and ensure these contribute to financial sustainability

ANY QUESTIONS?

What other opportunities are there for further developing integrated care closer to home in Enfield ?

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MUNICIPAL YEAR 2017/18

MEETING TITLE AND DATE **Health and Wellbeing Board** **9th February 2018**	**Agenda – Part: 1**	**Item:**
	Subject: The Integration and Better Care Fund - Quarter 3 2017/2018 BCF Update	
	Wards: All	
REPORT OF: Bindi Nagra, Director, Health, Housing and Adult Social Care, LB Enfield, and Vince McCabe, Director of Strategy and Partnerships, Enfield CCG		
Contact officer: Keezia Obi, Head of Transformation (People) / Georgina Diba, Transformation Manager **Email:** Keezia.Obi@enfield.gov.uk / Georgina.diba@enfield.gov.uk **Tel:** 020 8379 5010 / 020 8379 4432		

1. EXECUTIVE SUMMARY

This report provides an update on:

- The assurance process and outcome of the Enfield BCF 2017-2019 Plan
- The metrics for 2017-2018 and our performance against these metrics
- The delivery of the 2017-2018 plan including the current performance against key indicators and service / scheme outcomes
- A summary of the financial position as at the end of Q3 2017-2018

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to note:

- The Enfield BCF 2017-2019 Plan has been approved
- The current BCF performance against metrics and scheme outcomes
- The Q3 financial position, which is projecting a balanced position

3.0 POLICY AND PLAN APPROVAL

3.1 The Integration and Better Care Fund (BCF) is the only mandatory policy to facilitate integration. The policy framework has been set over a two-year period, 2017-2019, to align with NHS planning timetables and to enable greater strategic flexibility.

3.2 The Enfield BCF Plan 2017-2019 was submitted in September 2017 on behalf of the Enfield Health and Wellbeing Board. During the assurance process the plan was approved with conditions, with a requirement for the £528K over-commitment to be identified in advance of plan approval; this activity was completed, with the outcome of the regional assurance process being the reclassification of the Enfield BCF 2017-2019 Plan as approved in December 2017.

4. BCF PLAN 2017-2018 PERFORMANCE OUTCOMES

4.1 The following section is a summary of the BCF performance up to November 2017. Data on the metrics we monitor become available six weeks following the end of the period.

4.2 Metrics

4.2.1 **Diagnosis of dementia –**Currently surpassing the target of 66.70% set for dementia diagnosis at 71.28% for November 2017. Additional consultant capacity commissioned in 2016/17 and improvement in the diagnostic imaging pathway had a positive impact on waiting times. Though not a required metric for the BCF, the BCF Delivery Group continued to monitor this specific indicator as a measure of good practice. Early dementia diagnosis helps to ensure individuals and carers to get the information, advice and treatment that enables and supports them.

4.2.2 **Non-Elective Admissions (NEA) –** At the end of November 2017 the target for non-elective admission was not on target to be met. We had very positive results for NEAs generally from April and particularly in parts of Q2. Our data in October and November have indicated NEAs have increased due to increased systemic pressures. We are noting that this is not just a local issue, with NEAs for over 65s are up noticeably across NCL.

4.2.3 **Delayed Transfer of Care (DToC)-**

This metric is for delayed transfers of care from hospital per 100,000 population. The outcome sought is effective joint working of hospital services and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.

For 2017/2018 the target of 7696 delayed transfers of care days has been set. This is in line with the Health London Partnership (HLP) and NHS England initiative to reduce delayed patients to an average of 20.4 per day by September 2017 and maintain this until March 2018. This target was met in Q2 and in both October and November 2017 are on track to again meet Q3 targets.

4.2.4 **Admissions to residential care –** this metric is measured in order to reduce inappropriate admissions of older people (65+) in to care. As at the end of November 2017 this target was on track to be met.

4.2.5 **Reablement –** This metric relates to the percentage of older people achieving independence through rehabilitation and/ or intermediate care. As at the end of November 2017 this target was on track to be met.

4.3 Outcomes achieved and the difference the BCF has made

4.3.1 The schemes which make up the BCF are reporting on the difference we have made to the health and wellbeing of individuals and our integrated approach. The Social Care Institute for Excellence (SCIE) in December 2017 published a report and model for integrated care which describes what good looks like, providing a visual depiction of how a fully integrated health and care system might be structured and function, and the outcomes and benefits it should deliver for those who use services and their carers. It describes:

- the enablers of integration
- the key components of integrated care
- the outcomes for people who use services, for the integrated services and for the wider health and care system
- the long-term impacts and benefits.

4.3.2 Our reporting on schemes has the difference we have made to individuals as a key focus. The SCIE report includes the 'Logic Model for Integrated Care', which can be found attached as appendix A.

4.3.3 Local providers and stakeholders in Enfield are working together to develop **Care Closer to Home Integrated Networks** (CHINs) and Quality Information Support Teams (QISTs). CHINs will offer an integrated approach to care for those patients with the most health and social care needs. This further embeds the focus on the outcomes for the individual, including their experience and the co-ordination of care around them. The QISTs aim to increase the quality of care and reduce unwarranted variation through identifying and developing best practice, that can enable the CHINs to enhance their integrated care of patients in each of Enfield's four localities. Enfield GPs have come together to form a GP Federation called Enfield Healthcare Co-operative Limited. This Federation is delivering out of hospital services to the entire patient population of Enfield and will be integral to offering patients a greater range of services.

4.3.4 One of our schemes contributing to the CHINs development, the **Integrated Locality Teams**, brought together health and social care services into a virtual team to case manage and support GP Practices. We have ambitious plans to extend the ILTs to cover Enfield over four quadrants, starting with adult social care (such as social worker, occupational therapists) and Enfield Health (such as district nurses and community matrons). These plans are being led by the Local Authority and will feed into the current CHINs Programme. For this financial year through to Q3 the ILTs have supported 729 patients through the existing virtual multi-disciplinary team model in place.

4.3.5 The **Care Home Assessment Team** has several indicators measured, with the following impact noted up to November 2017:

- Enabled individuals to choose to die in their preferred place (100% in both October and November 2017); individuals outcomes were supported around dignity and choice.
- The CHAT sees new residents within a target of two weeks in their care provision; for Oct they met this in 90% of cases, and 89% of cases in November.
- Work with care homes to reduce A&E attendance for falls continued; CHAT is measured on percentage of people who having falls go into A&E, which stood at 12% in October and 15% in November.

4.3.6 The CHAT are vital partners in reducing A&E attendance from care providers; they have a strong and collegiate relationship with care homes and are part of the Trusted Assessor implementation locally, creating a relationship where providers feel confident and safe to seek advice. A local target is set as 10% of A&E attendances per registered bed (CHAT coverage) and the performance was positive in both October and November at 7%; for individuals, this helps to support individuals to receive care where they live and outside of a hospital setting.

4.3.7 To prevent avoidable admission and provide a response to individuals in the community in crisis, the **Community Crisis Response Team** (CCRT) is funded by the BCF to assess and treat patients in their own home. This includes facilitating and providing patient care out of hours, 7 days a week, 5pm - 2am, and reducing the need for unnecessary emergency hospital admissions. In December of 2017/18 the CCRT was funded to respond to in-hours (9am to 5pm) crisis calls on Saturdays. The service had a target of seeing patients within 2 hours of receipt of referral, and achieved this in 100% of cases in October, and 99% of cases in November. Importantly, the feedback from those who use the service is a vital indicator of their experience of care; 100% of patients surveyed reported a positive experience of care.

4.3.8 The **Older People Assessment Unit** (OPAU) provides unplanned care to patients who need rapid response for assessment and treatment, often to prevent hospital admission. We started to see in August through to October (November and December stats are not yet available) a

positive increase in the uptake of this service, which will assist in care outside of an acute in-patient setting. The service is well received by those experiencing care, with 100% of individuals surveyed during October reporting they felt dignity was always respected, and 100% would be extremely likely to use the service again or recommend to family and friends.

4.3.9 Several schemes funded through the BCF are with the Voluntary and Community Services (VCS) with a focus on preventing and delays the onset of needs. **Community Navigation** delivered through Age UK is a service which helps to connect individual to their community, for example through linking to services, activities or connecting with other people to reduce isolation. So far up until November 2017, 295 individuals have been supported. Alongside this within the VCS is falls prevention, with 92% of individuals surveyed reporting they were satisfied with this service.

4.3.10 The VCS, through several providers, are also leading on supporting the community to access:

- Advice and support around issues such as caring roles, benefit maximisation and managing health and wellbeing
- Support to families and friends of individuals with mental health needs, so as to maintain their own health and wellbeing
- A home from hospital service to enable people to be safely managed at home and prevent re-admission to hospital
- Counselling, including intercultural psychotherapy

4.3.11 Some of the outcomes from schemes through our preventative model in Voluntary and Community Sector provision include:

- Home from hospital schemes, which can assist with earlier discharge through immediate implementation of the service; focuses on improving confidence over 5-6 weeks, with a total of 79 clients in Q3 assisted through this scheme.
- One scheme assisted 1250 clients with information, advice and advocacy, so that older people have the information and support to make informed decision and choices.
- Focus on improving the quality of life at end stage of life, by providing 1,560 hours of respite to support carers of terminally ill patients
- Through a scheme offering counselling, 72% of service users reported they felt significant difference after therapy, with a total of 440 clients who have been seen.

4.3.12 **Advocacy** is a key part of our integrated offer, providing the support to individuals to be involved in decisions about their life and improving the care and support around them. In Q3 2017-2018 a total of 348.20 hours of advocacy was provided. Feedback is received from some who use this service, which asks questions on a range of indicators including their involvement in decision, understanding of rights, through to ability to keep themselves safe in the future. For example:

- 14 out of 18 respondents felt their involvement in decisions about their life got better.
- 10 out of the 18 respondents felt their understanding of their rights and entitlements got better.

4.3.13 Our joint **wheelchair service** provides a vital provision to enable people to mobilise and actively participate in daily life. In Quarter 3 the Enfield Wheelchair Service, as part of Independence & Wellbeing Enfield, issued 159 wheelchairs (131 for adults and 28 for children). There were 102 new referrals within the quarter, with an additional 139 re-referrals. The service met 100% of its target of referrals seen within the 13 weeks' timeframe specified, and 98.5% prescribed equipment within the 18 weeks. In addition, the Enfield Wheelchair Service had 99% service user satisfaction reported.

4.3.14 The **Safeguarding Nurse Assessor** quality assures nursing care in local care provision to prevent abuse and neglect. Twelve nursing homes were visited in quarter 3, supporting significant improvements within these care providers. The Safeguarding Nurse Assessor also supports where homes are under the LBE Provider Concerns Process. For example, a nursing home with significant issues affecting safety and quality to residents was supported on issues including hydration, nutrition, hygiene and infection control. Through the support of the Safeguarding Nurse Assessor in Quarter 3, improvements in these areas have been met and a sustainability plans are in place by the provider so that they continue to provide quality care expected. In addition, 64 cases were supported for single reports of alleged abuse in which views from a clinical perspective were required.

4.3.15 The Better Care Fund is used to contribute towards **Safeguarding Adults Reviews** (SAR), with the intention that learning contributes towards the way in which health and social care work together to support individuals, with a focus on quality and safety. In Q3, two new SARs were commissioned. We are awaiting publication and learning events for the four existing SARs. Importantly, the Safeguarding Adults Boards that work across the North Central London area have agreed to do more collaborative work to share learning from these reviews. As they mature, these arrangements will mean that Enfield residents can benefit from improvements in services based on a much wider pool of SAR learning.

4.3.16 The **Quality Checkers** are volunteers who have either been or are service users of care and support, or unpaid carers. They provide additional eyes and ears out in the community and in people's home, providing their views on the services provided and how these can be improved. The manager of the quality assurance service reports that 'Quality Checkers pride themselves on recognizing that small changes made a big difference, and that these things enhance the quality of life and feelings of wellbeing.'

In quarter three the quality checkers completed the following activities, to improve the experience and outcomes for individuals in Enfield:

- Quality Checkers have interviewed 38 people with social care needs to find out what activities people consider important for wellbeing. The feedback was collated and submitted to inform the development of other Council led initiatives.

- Ten visits to Enfield Leisure Centres as part of a Dignity in Care Project on social care in leisure centres. Private leisure centres were visited to compare how facilities on offer differ with Council run centres. This project will be completed in January 2018 and recommendations and outcomes will be detailed in our Q4 monitoring.

- There were twenty mystery shopping calls were made to the Access Service to check the effectiveness of the customer pathway into adult services. This work will directly inform the development of the joint single point of entry for health and adult social care being taken forward, as part of the Integrated Locality Teams and wider Care Closer to Home Integrated Networks.

4.3.17 The Quality Checker program also extends to care home providers. In quarter three there were 28 visits to care provider across the borough, all of which have reports submitted to the provider to share the findings and support service improvement in line with feedback from residents and their families/friends. Some of the outcomes achieved by Quality Checker visits include:

- An outdoor open space was created for residents to use at their leisure. The area was previously used to store excess equipment.

- A full-time activities co-ordinator has been employed by a care home. This was a direct result of Quality Checker visits and the feedback given to us by residents which was passed onto the home's management team.

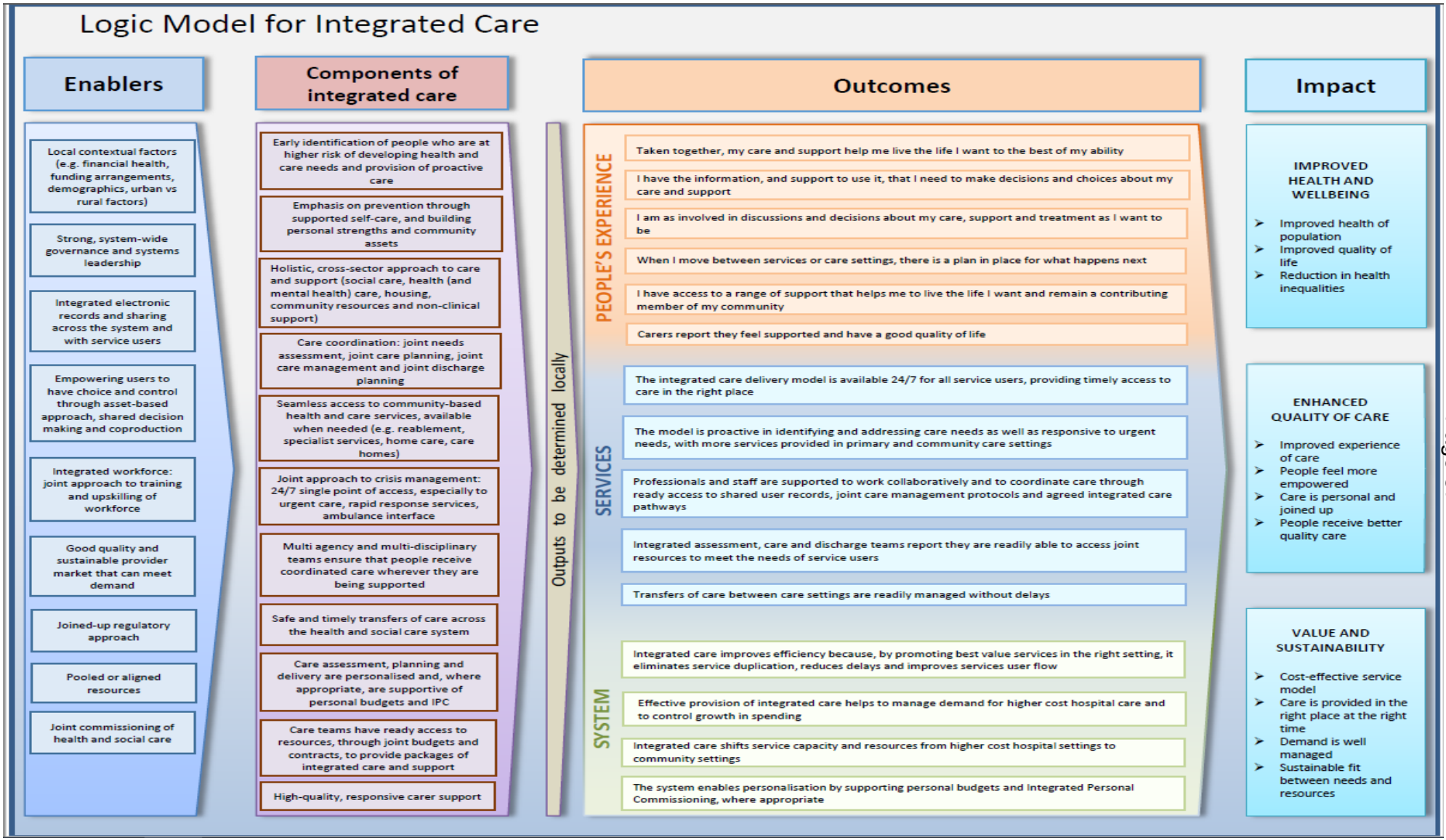
5. A summary of the BCF financial position as at end of Quarter 3

5.1 The Annual CCG BCF commissioning budget is £9.758m (exclusive of Section 75 pooled funds). As at the end of Q3 2017/2018 the CCG has spent £7.121, in line with the YTD plan less the required savings.

5.2 Of the fund, the Annual LBE BCF commissioning budget is £13.095m (£2.796m capital and £10.299m revenue and exclusive of the iBCF and additional Section 75 pooled funds). As at the end of Q3 2017/2018 the Council has spent £9.819m.

5.3 Work is on-going throughout 2017/2018 to achieve the required savings of £0.528m in partnership with the CCG for this financial year through existing governance arrangements.

Appendix A: SCIE Logic Model



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Agenda Item 8

MUNICIPAL YEAR 2017/18

Meeting Title: **HEALTH AND WELLBEING BOARD** Date: 8th February 2018	**Agenda Item:** **Subject: Progress on Health and Wellbeing Board Monitoring areas for 2017-19**
Contact officer: Miho Yoshizaki Telephone number: 0208 379 5351 Email address: **miho.yoshizaki@enfield.gov.uk**	**Report of:** **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

2.1 The Board is asked to note the progress on HWB monitoring areas.

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

<Best Start in Life>

- The HWB is maintaining its focus and support on this area and a proposed action plan for improving school readiness will be presented to the HWB development session in March.
- The Board also acknowledges the strong links between the three priorities of best start in life; healthy weight amongst children and young people and mental wellbeing and resilience in relation to children and young people achieving the best possible start in life.

<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.
- Stand by to receive and respond to any reasonable queries from “Time to Change” if required.

(continue on next page)

<Healthy Weight>

- To support and action below;
  - Each organisation to promote the Sugar Smart survey. The survey is available from here.
  - Each organisation implementing the Healthy Catering Commitment within their organisation
  - Each organisation signing up to the Declaration on Sugar Reduction and Healthier Food

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

4.4 For the latest statistics of selected indicators, please see https://new.enfield.gov.uk/healthandwellbeing/jhws/measuring-our-progress/

Top 3 priorities

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

What's our current performance?

A range of measures help indicate the extent to which children in Enfield are achieving the best start in life. These include:

- **Breastfeeding**

Breastfeeding initiation in Enfield is good; 83.4% of mothers breastfeed their baby within 48 hours of delivery (2016/17), which is better than England (74.5%). There is currently limited data on the number of mothers still breastfeeding at 6-8 weeks but this is being improved with the provider of Enfield's Health Visiting services.

- **Children's oral health (dental decay)**

Around a third (33.9%) of children in Enfield have one or more decayed, missing or filled teeth (DMFT) (2014/15). This is significantly worse than London (27.3%) and England (24.8%). Whilst Enfield remains below the London and England averages we have seen improvements in recent years. In 2011/12 almost 15% of children in Enfield showed evidence of poor oral hygiene, this figure had almost halved by 2014/15 (8.6%).

- **Childhood obesity**

The Enfield trends remain stubbornly above the London and national averages for Reception and Year 6. In Reception Year over a quarter (24.8%) of 4/5-year olds; and two fifths (41.5%) of Year 6 10/11-year olds are overweight or obese (2016/17).

- **Under-18 conceptions**

The downward trend in Enfield is continuing with a rate of 22.7/1000 (2015), but rates remain higher than NCL (18.0/1000), London (19.2/1000) and England (20.8/1000). Work through the Teenage Pregnancy Partnership Board (TPPB) is ongoing.

- **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 (GLD) 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) is 130.3 (2015/16). This is significantly higher than London (97.6) and comparable to England (129.6), but represents a slight reduction from 143.3 in 2014/15.

Things that are going well

School readiness

The HWB has considered the recommendations of the Best Start in Life task & finish group and an action plan on school readiness is currently being prepared.

This is due to be brought back to the HWB development session in March.

Childhood obesity

- The HWB recently made several commitments on tackling obesity (healthy weight), including signing up to actions described in the Local Government Declaration on Sugar Reduction and Healthier Food, in addition to developing an obesity care pathway.
- A range of school-based initiatives to improve physical activity in children are being delivered, including The Daily Mile and Play Streets.

The Sugar Smart Enfield campaign launched on 13th January, and aims to encourage local organisations, including schools, to promote healthier, lower sugar alternatives and help make the borough healthier

Under-18 conceptions

- Public health is funding a post that works with schools in Enfield to improve PSHE (personal, social, health and economic education) and RSE (relationships & sex education).

What's next?

- Services for 0-19s, which includes health visiting, the Family Nurse Partnership and school nursing, continue to deliver interventions that impact on improving the best start in life. These services are being reviewed to ensure that they remain as effective as possible.
- Indicators and trends will be reviewed as data becomes available.

Challenges that HWB may be able to assist resolving / unblocking

- The HWB is maintaining its focus and support on this area and a proposed action plan for improving school readiness will be presented to the Board in March.
- The Board also acknowledges the strong links between the three priorities of best start in life; childhood obesity and mental wellbeing and resilience in relation to children and young people achieving the best possible start in life.

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

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.
- Development of "Destigmatisation Hub Offer" within the borough is progressing.

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 are now working with Thrive LDN to plan and deliver both an "Destigmatisation Hub" within the borough and a second Community Engagement Event, emphasised towards the needs of younger people.
- This also aligns with the activities, agenda and priorities of the "Best Start in Life [BSIL]" task and finish group, which was discussed at the HWB development session on the 16th January 2018.

What's next?

- Thrive "Hub" offer clarification and definition work ongoing during period Jan-Feb 2018.
- Thrive "Hub" local consultations and communications to be initiated during period Feb-March 2018.
- Community Engagement Event planning and communications to be initiated during Feb 2018 period
- Thrive LDN are entering into a formal partnership arrangement with "Time to Change" who have much relevant experience of destigmatisation activity in the arena of mental health and wellbeing.
- "Time for Change" will be requesting some additional information from LBE, via Thrive LDN, relating to their assessment of the borough's suitability to host a "destigmatisation hub". This is not anticipated to present significant challenges.

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. • Stand by to receive and respond to any reasonable queries from “Time to Change” if required.

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?

Childhood obesity

- The Enfield trends remain stubbornly above the London and national averages for Reception and Year 6. In Reception Year over a quarter (24.8%) of 4/5-year olds; and two fifths (41.5%) of Year 6 10/11-year olds are overweight or obese (2016/17).

Adult obesity

- 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

- A paper on the Local Government Declaration on Sugar Reduction and Healthier Food has been prepared for the Council's Executive Management Team.
- Sugar Smart Enfield launched on the 13th January with a Sugar Smart survey for residents. Further information is available here.
- Through Section 106 coaching hours, the Tottenham Hotspurs Foundation has agreed to support 10 primary schools to implement the Daily Mile.

What's next?

- The Town and Country Planning Association will deliver a Healthy Planning workshop in Enfield in March
- London Play will work with parents and volunteers from Eldon Primary school to implement Play Streets on five local streets
- To explore opportunities for more water fountains to be made available across the borough

Challenges that HWB may be able to assist resolving / unblocking

To support and action below;

- Each organisation to promote the Sugar Smart survey. The survey is available from here.
- Each organisation implementing the Healthy Catering Commitment within their

organisation

- Each organisation signing up to the Declaration on Sugar Reduction and Healthier Food

Collaboration

Focus area	Domestic Violence
Partners involved	Community Safety

What's our current performance?

There were 5890 Domestic Abuse Incidents in Enfield in the year ending December 2017, compared to 5888 the previous year, an increase of 0.03%. During the same period, London has experienced a decrease of -3.4%, recording 143997 incidents, compared to 149004 incidents in 2016.

Violence with Injury offences which were domestic related have decreased by -3.2% in Enfield, recording 898 offences in the year ending December 2017, compared to 928 offences in the previous year. In London, there was a slight increase in the same period of +1.5%, recording 24102 offences, compared to 23737 offences in the same period.

Domestic related Violence With Injury currently accounts for around 1/3 of all Violence With Injury offences in Enfield.

Things that are going well

- A new Violence Against Women and Girls (VAWG) Strategy is accompanied with a VAWG Action Plan. This requires contributions/additions from multi-agency partners
- Production of a draft LBE Domestic Violence and Workplace Response Policy for employees
- Successful in a funding application to the Department of Culture, Media and Sport to become one of three Pathfinder sites in the UK. This will provide funding for 3 years to co-locate an Independent Domestic Violence Advocate / Advocate Educator in North Middlesex Hospital A&E
- Continuing awareness-raising and targeted digital marketing with the 'Boyfriend Material?' campaign which is being re-launched on 01.02.18

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 DV 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, NHS England

What's our current performance?

- One-year survival in Enfield was 73.3%, similar to the England average of 72.3%. One-year survival is indicative of early detection and treatment (2015).
- 52.4 % of cancer diagnosed in Enfield was early stages (stages 1 or 2). This was below London (50.2%) and England (52.4%) averages (2015)
- In 2016/17, bowel screening coverage in Enfield for people aged 60-74 is 53.7%, this is below the England (59.2%) averages. Breast screening 3-year coverage in Enfield (67.2%) is below the England average (72.3%) and Enfield's cervical screening coverage (72.5%) is also below the England average (73.8%), but above the London (65.8%) average.

Things that are going well

Partners in Enfield worked together to increase uptake of cervical cancer screening in Enfield. Enfield women now has more choices in terms of time and place for cervical cancer screening test, as GP hubs will also offer extended availability for this screening. A poster campaign to raise awareness of the cervical cancer screening has commenced on the week beginning 15th of January in line with the national cervical cancer awareness week 22-28 January, 2018. The poster was developed in partnership with CCG Cancer Action Group, Enfield Public Health and LBE Communication team.

What's next?

- To continue to monitoring performance data.

Challenges that HWB may be able to assist resolving / unblocking

- Support the local cancer awareness campaign.

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?

Table below shows the flu immunisation uptake rate amongst health care workers involved with direct patient care at our major trusts (1st September to 31st December 2017).

Trust	Uptake rate
North Middlesex University Hospital Trust	70.4%
Barnet, Enfield and Haringey Mental Health NHS Trust	38.9%
Royal Free NHS Foundation Trust	64.4%

Source: NHS England

Uptake rates at both North Middlesex University Hospital Trust and the Royal Free NHS Foundation Trust is higher than previous year.

There are currently no official measures for flu immunisation uptake rates amongst care workers.

Things that are going well

NHS Trusts
Flu vaccination campaign for the winter 2017/18 is continuing in the NHS Trusts in Enfield.

Staffs at Care and residential homes
In addition to the residents of care and residential homes, NHS England London team has commissioned community pharmacies to provide free flu vaccination for all staffs at residential and care home. Council is working with these homes as well as community pharmacies to maximise the uptake of flu vaccination amongst this group.

What's next?

Ongoing monitoring of uptake rates.

Challenges that HWB may be able to assist resolving / unblocking

HWB members to actively promote flu campaign within their organisations, especially amongst health and care workers and vulnerable people.

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.

What's next?

- 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, Public Health

What's our current performance?

National Diabetes Prevention Programme (NDPP): As part of the national rollout programme, Enfield CCG and Enfield's Public Health Team, in partnership with Barnet CCG & PH have been implementing this service, working with the provider ICS commissioned by NHS England.
From the three sites on Enfield (Evergreen Primary Care Centre, Ordnance Road Unity Centre, Carlton House Surgery), 129 initial assessments out of 787 referrals were made. DNA rate is 19%.

Things that are going well

- Referral rates continue to be high
- The provider has overcome the language barrier by recruiting Turkish and Farsi speaking Coaches to help accommodate local community needs.

What's next?

- Working with the provider to increase the capacity so that the initial assessment can be offered in a timely manner to ensure meaningful engagement with patients.
- Partners are facilitating to ensure there is a good geographical spread of referral GPs across the borough.

Challenges that HWB may be able to assist resolving / unblocking

Not at this stage.

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 [2015/16].
- 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

- Work to develop Care Closer to Home Integrated Network (CHIN) continues. The CHIN Board has met 3 times since the last report and oversee the integrated care for patients with long-term conditions and other complex needs in Enfield.
- A CHIN event run by Enfield Healthwatch was well attended with over 100 attendees from across primary care, social care and the voluntary sector
- The GP Federation CHIN stocktake meeting is now established and priorities for local CHINs are expected to emanate from these. Work with the 4 Locality leads within the CHIN areas is expected to feed into this

What's next?

- The Enfield system (primary & secondary care, ECCG and LBE reps) will participate in a Placed-Based Care Network Programme for the local STP. An aspect of this will be to work on a specific CHIN project.

Challenges that HWB may be able to assist resolving / unblocking

- Support public engagement in taking up the 3TT in areas of high diabetes prevalence and deprivation in the borough.
- 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 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

Recommissioning of VCS in Adult Social Care

- 5 out of the 6 Contracts have been awarded and 4 are currently in their mobilisation period. Full mobilisation of all six contract is expected in the beginning of 2018/19.
- Outcomes and pathways have been agreed and monitoring arrangements are in place to ensure delivery of outcomes as stipulated in the specifications
- As the contract are in the mobilisation phase it time needs to be given to embed new ways of working and the achievements of outcome.

Preventing hospital and residential care admissions

- Adult social care, public health and Enfield CCG is working in partnership to conduct an analysis on hospital and residential care admissions (via hospital admissions), with an aim to find effective early intervention appropriate for Enfield residents.

Falls Prevention Training

- Enfield partners are working together to co-design a falls prevention training that meets the needs of health and social care frontline staff in Enfield.

What's next?

Recommissioning of VCS in Adult Social Care

- Full mobilisation of six contracts and the measurement of performance against target outcomes by the end of quarter one in the new financial year

Preventing hospital and residential care admissions

- Agree on the scope and data gathering from providers. It is expected 3-6

months for completion after which will be presented to Joint Commissioning Board.
Challenges that HWB may be able to assist resolving / unblocking
Not at this stage.

5.0 Recommendations

5.1 The Board is asked to note the progress on HWB monitoring areas.

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

<Best Start in Life>

- The HWB is maintaining its focus and support on this area and a proposed action plan for improving school readiness will be presented to the HWB development session in March.
- The Board also acknowledges the strong links between the three priorities of best start in life; healthy weight amongst children and young people and mental wellbeing and resilience in relation to children and young people achieving the best possible start in life.

<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.
- Stand by to receive and respond to any reasonable queries from “Time to Change” if required.

<Healthy Weight>

- To support and action below;
  - Each organisation to promote the Sugar Smart survey. The survey is available from here.
  - Each organisation implementing the Healthy Catering Commitment within their organisation
  - Each organisation signing up to the Declaration on Sugar Reduction and Healthier Food

MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY, 5 DECEMBER 2017

MEMBERSHIP

PRESENT Doug Taylor (Leader of the Council), Alev Cazimoglu (Cabinet Member for Health & Social Care), Krystle Fonyonga (Cabinet Member for Community Safety & Public Health), Ayfer Orhan (Cabinet Member for Education, Children's Services & Protection), Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Parin Bahl (Chair of Enfield Health Watch), John Wardell (Clinical Commissioning Group (CCG) Chief Officer), Tessa Lindfield (Director of Public Health), Tony Theodoulou (Executive Director of Children's Services), Vivien Giladi (Voluntary Sector) and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust)

ABSENT Dr Helene Brown (NHS England Representative), Ray James (Executive Director of Health, Housing and Adult Social Care), Natalie Forrest (Chief Executive, Chase Farm Hospital, Royal Free Group) and Litsa Worrall (Voluntary Sector)

OFFICERS: Bindi Nagra (Joint Chief Commissioning Officer), Dr Glenn Stewart (Assistant Director, Public Health), Jill Bayley (Principal Lawyer - Safeguarding), Niki Nicolaou (Voluntary Sector Manager), Jayne Fitzgerald (Finance & Business Partner SCS), Ilhan Basharan, Tha Han (Public Health Consultant), Grant Landon (ESCB Business Manager), Mark Tickner (Senior Public Health Strategist) and Miho Yoshizaki (Health Intelligence Manager) Jane Creer (Secretary)

Also Attending: Geraldine Gavin (Independent Chair of Enfield Safeguarding Children's Board)

1
WELCOME AND APOLOGIES

Councillor Doug Taylor (Chair) welcomed everyone to the meeting. Apologies for absence were received from Dr Helene Brown, Libby McManus, Peter Ridley, Natalie Forrest, Ian Davis, Ray James, and Litsa Worrall. Apologies for lateness were received from Councillor Ayfer Orhan.

2
DECLARATION OF INTERESTS

There were no declarations of interest registered in respect of any items on the agenda.

3
LONDON BOROUGH OF ENFIELD BUDGET CONSULTATION

The Board received a presentation on LB Enfield's 2018/19 budget and consultation process from Jayne Fitzgerald, Head of Strategic Finance.

Budget Presentation

Jayne Fitzgerald highlighted the following:

- The Council spending and income were set out, noting that the authority was not permitted to make savings on all areas.
- Government funding would continue to decline to 2019/20.
- The impact of government funding reductions was described; and that since 2010 LB Enfield had delivered £161M of savings.
- There were demographic pressures, with the borough's population continuing to rise and with large proportions of younger and older people in comparison with the rest of London.
- Enfield was the 12th most deprived borough in London on indices of multiple deprivation. Temporary accommodation was becoming an increasing pressure.
- Other pressures included pay awards and national minimum wage/London living wage; inflation and changes in interest rates; pension fund; and funding changes from central government.
- The Council faced a difficult challenge in setting a balanced budget. Savings were being delivered across all service areas. There was an increasing emphasis on developing income generating proposals and commercial opportunities.
- Consultation on the budget was running for 11 weeks, from 23/10/17 to 08/01/18. There were a number of ways it could be accessed, but the focus was on completing it online. A 'Money Matters' section was included in 'Our Enfield' magazine which was delivered to all households. Two public meetings were scheduled, on 13 and 14 December at Community House, Edmonton and at Enfield Civic Centre.
- The questions in the consultation covered prioritisation of services for protection and services for savings; services which could be made available online; and suggestions for ways to raise income to minimise the effect of funding reductions.
- So far there had been 299 responses to the consultation online and 16 other. All responses would be collated and fed into a report to Overview and Scrutiny Committee's budget meeting on 18 January, and taken into account when the budget was set by full Council in February.

Questions / Comments

1. In comparison to last year, the consultation response rate was doing relatively well. The communications team were also monitoring responses weekly and nudging through social media.
2. It was confirmed that all voluntary and community sector organisations had been written to for consultation, and a special budget consultation document was being prepared for the Youth Parliament. Officers acknowledged points in respect of accessibility of the consultation and they were available to make presentations to meetings if invited.
3. It was confirmed that income raising could include putting up fees and charges, but there was also emphasis on commercial opportunities and new initiatives.
4. The Chair thanked officers for attending and all comments would be fed into the consultation and report to Council's budget setting meeting.

4
HEALTH AND WELLBEING BOARD ACTIONS FOR THE PRIORITY, MENTAL HEALTH RESILIENCE

RECEIVED the report of Tessa Lindfield (Director of Public Health).

NOTED

Tessa Lindfield introduced the report, highlighting the following:
● Improving mental health resilience was one of the three priorities selected by Health and Wellbeing Board (HWB) for action planning for the final two years of the Joint Health and Wellbeing Strategy, with a focus on prevention.
● HWB agreed to explore using Thrive LDN to deliver this. A workshop was held in November with a range of stakeholders, which was discussed at the recent HWB development session.
● Mark Tickner (Senior Public Health Strategist) having met with Thrive LDN yesterday recommended the proposed activities and focus on younger people. Having seen the work on suicide prevention it was considered that engagement would be worthwhile. Tessa Lindfield felt that engagement would give Enfield access to specialist advice and would contribute to a coherent approach across London.

Councillor Orhan arrived at the meeting at this point.

IN RESPONSE comments and questions were received, including:
1. Vivien Giladi highlighted concerns around rising inequalities in living conditions, housing issues, insecure work, and government policies, and that mental health services were under resourced; and that though she would support the recommendations she was concerned not to mask underlying deficits in services.
2. Dr Mo Abedi recommended trying to build resilience, and that the proposals would build into the prevention arm of the existing mental health strategy.

3. Members had expressed initial scepticism but supported continued engagement.
4. Tony Theodoulou reported positive feedback on what was already being done in the borough, and that engagement could be complimentary to that.
5. Andrew Wright stressed the importance of attitude change and that it was important for people who may have an emerging mental health condition and for the population at large to have a better understanding.
6. It was confirmed that the sum sought from LB Enfield was £30,000, and that further details were awaited, but the emphasis was how to be protective of mental health. The Thrive LDN offer was still being developed locally but would be focussed on Enfield's needs. Tessa Lindfield acknowledged the requests to link in more with the mental health partnership.

AGREED that the Health and Wellbeing Board endorsed:
(1) The Thrive LDN "Hub Offer" is scoped in order for the Board to consider signing up to.
(2) Continued work with Thrive LDN and our local partners to undertake an additional engagement event in Enfield with focus upon the aspirations, needs and ideas of our younger people in the area of emotional health, wellbeing and resilience.
(3) That Public Health continues to engage with Thrive LDN in the area of suicide prevention and resilience.

5
HEALTH AND WELLBEING BOARD ACTIONS FOR THE PRIORITY, HEALTHY WEIGHT

RECEIVED the report of Tessa Lindfield (Director of Public Health).

NOTED
● Addressing obesity and promoting healthy weight was the second priority for action for the Health and Wellbeing Board 2017-19.
● The report included suggestions which the Board could implement.
● There had been discussion at the recent development session, but a clear direction had not been agreed.
● Recommendations were set out in Section 5 of the report and members were asked to go back to their organisations to consider what could be done to support an improved food environment, then come back to the Board

Councillor Taylor left the meeting at this point, and Dr Mo Abedi took the chair for the remainder of the meeting

IN RESPONSE comments and questions were received, including:
1. Parin Bahl suggested that Enfield could learn from good practice of other councils which had implemented the Local Government Action on Sugar Reduction and Healthy Food.

2. Councillor Orhan agreed that boroughs should support each other. It was also hoped that amendments to the London Plan would help councils to be firmer with organisations and outlets. Glenn Stewart confirmed that LB Enfield wanted to work with the London Mayor around this.
3. Potential links with the sustainability and transformation plan, and the healthy hospitals strategy were highlighted.
4. Action on moving forward was discussed and would need further consideration at the next Health and Wellbeing Board development session.

AGREED :

(1) That the Health and Wellbeing Board considered adoption of the actions in the table set out in the report as a means of increasing healthy weight in the borough and to report progress regularly through the Joint Health and Wellbeing Strategy progress report.
(2) The Health and Wellbeing Board encouraged the development of an obesity management care pathway and would receive regular reports on progress.
(3) There would be more detailed consideration of actions at the Health and Wellbeing Board development session on Tuesday 16 January 2018.

6
SAFEGUARDING CHILDREN'S BOARD ANNUAL REPORT 2016-17

RECEIVED the report of Tony Theodoulou (Executive Director of Children's Services).

NOTED

Geraldine Gavin (Independent Chair of Enfield Safeguarding Children's Board (ESCB)) introduced the report, highlighting:

● All the agencies were focussed on keeping children safe, and there were incredible pressures felt by every partner.
● The ESCB wanted early help and assessments made earlier in a child's history to prevent problems.
● The ESCB had closely monitored the Enfield Family Resilience Strategy and all partners had signed up.
● From 2019 there would be no legal requirement for a local authority to have a Safeguarding Children's Board, but some legislation had not yet been enacted.
● Many local authorities were looking at reshaping safeguarding services to include young people up to the age of 24.

IN RESPONSE comments and questions were received, including:

1. In response to queries, it was advised that there was duplication, and therefore scope for more shared working across boroughs, but a pan London approach was felt to be too big and localism should not be lost.

There was also more work with the Adult Board and a need for more joined-up working and multi-disciplinary partnership arrangements.
2. The Chair thanked Geraldine Gavin for her attendance and the really good work of the ESCB.
3. Tony Theodoulou wished to acknowledge the support from Grant Landon and thank him for his work.

AGREED that the Health and Wellbeing Board noted the progress being made to safeguard children and young people and the Enfield Safeguarding Children's Board Annual Report.

7
PROGRESS UPDATE ON JOINT HEALTH AND WELLBEING STRATEGY (JHWS)

RECEIVED the report of Tessa Lindfield (Director of Public Health).

NOTED

Tessa Lindfield's introduction of the report highlighted:
● Miho Yoshizaki was thanked for putting the report together and everyone thanked for their contributions. A full set of indicators was on the Healthy Enfield website.
● The Best Start in Life sub group was preparing submissions for the January development session and the February Health and Wellbeing Board meeting.
● The Violence Against Women and Girls Strategy would be brought back to Health and Wellbeing Board.
● Excellent progress was noted in respect of housing for vulnerable adults.

IN RESPONSE comments and questions were received, including that there was some concern regarding under take-up of flu vaccination, and its importance should be better communicated.

AGREED that Health and Wellbeing Board:
(1) noted the progress on HWB monitoring areas;
(2) considered how it wished to support the HWB priority areas within their own and partner organisations.

8
MINUTES OF THE MEETING HELD ON 10 OCTOBER 2017

AGREED the minutes of the meeting held on 10 October 2017.

9
INFORMATION BULLETIN

NOTED the Information Bulletin items, with apologies for delay, and a copy would be distributed to all members by email.

10
HEALTH AND WELLBEING BOARD FORWARD PLAN

NOTED

1. The 16 January Health and Wellbeing development session would focus on Best Start in Life.
2. Future items were suggested for future meetings of the Health and Wellbeing Board to consider long term conditions and prevention work; suicide prevention plan; engagement and the STP and update on CHINs.
3. John Wardell, the new CCG Chief Operating Officer, was welcomed and would be a regular attender at Health and Wellbeing Board from now on.
4. The incoming Chief Executive of North Middlesex University Hospital NHS Trust would be invited to attend the next Board meeting. There had been concerns recently about performance.

11
DATES OF FUTURE MEETINGS

NOTED the dates of future meetings of the Health and Wellbeing Board and dates of future development sessions.

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Enfield Health and Wellbeing Board

Information Bulletin January 2018

ECHO Clinic Silver Point

ECHO Clinic Silver Point will be launched on the 14th February 2018. Once opened, it will provide improved access to sexual and reproductive health to the Enfield residents.

Further information will be available on ECHO website, Enfield Council Website and Healthy Enfield Website in due course.

For further information, please contact Fulya.Yahioglu@enfiled.gov.uk

Sugar Smart Enfield The Sugar Smart Enfield initiative was launched on Saturday (13 January) with The Great Sugar Debate at Enfield Town FC's home match at the Queen Elizabeth II stadium.

The initiative is part of Enfield Council's Healthy Enfield campaign and aims to encourage local organisations to promote healthier, lower sugar alternatives and help make the borough healthier.

For further information please visit:
https://new.enfield.gov.uk/healthandwellbeing/healthy-community/sugar-smart/
Contact: Ailbhe.Bhreathnach@Enfield.gov.uk

Cervical Cancer Screening Campaign to raise awareness about cervical cancer screening in Enfield was launched on the 22nd January, coinciding with the national Cervical Cancer Prevention Week (22-28 January). The test can potentially save lives and women who have received an invitation for a cervical screening test is urged to book an appointment at their GP surgery or at a primary care access hub.

For further information please visit:
https://new.enfield.gov.uk/healthandwellbeing/cancer-screening/

Healthy London Partnership Update

Blow are an update from Healthy London partnership.

Health and care leaders work together to implement devolution: The signing of the London Health and Care Devolution Memorandum of Understanding by London and national partners and central government marked a significant milestone for the future of health and care. In December, London's health and care leaders met to discuss what it means for London. The event was the first step in on-going engagement to co-design London's future health and care with system leaders across the capital ...Find out more

Thrive LDN reaches 15.5 million people: Early findings are available from Thrive LDN's 'Are we OK London?' campaign. It launched in July last year as an open conversation with Londoners about mental health and wellbeing. The report has an overview of the engagement so far and feedback from Londoners to inform the next stages of community outreach. It sets out the most frequent themes and ideas shared by Londoners; feedback from those who took part in 17 problem solving booths held over the summer; and Talk London online discussions held on London.gov.uk ...Find out more

Good thinking London! Londoners experiencing sleep difficulties, anxiety, low mood and stress can now use 'Good Thinking' the digital wellbeing service in its testing phase. Two million Londoners will experience mental ill health this year but 75% of Londoners with depression and anxiety get no treatment at all. Good Thinking uses social listening and marketing to direct Londoners who self-identify as having issues around sleep, anxiety, low mood and stress to personalised digital support such as clinically endorsed apps ...Find out more

London on fast track to reduce HIV: Last week the Mayor of London, Sadiq Khan, with borough leaders, Public Health England and NHS England signed the 'Paris Declaration on Fast-Track Cities Ending the AIDS Epidemic'. We will be leading partners to deliver London's fast-track city commitments to cut rates of new HIV infection and eliminate associated discrimination and stigma. London has made great strides towards achieving the primary United Nations targets for the initiative but there is plenty more to do ...Find out more.

What do Londoners think of their cancer care? Our Transforming Cancer Services Team has published analysis of the 2016 National Cancer Patient Experience Survey results for each London CCG and STP to support commissioners and clinical leaders in improving cancer care for patients. The team analysed each CCG's results against 26 of the questions in the national survey. These were selected for the effect a poor score has on a patient's short and long-term health and wellbeing. The analysis and results for each CCG and STP are on an interactive dashboard to support commissioners and clinical leaders in understanding the experiences of people with cancer in their local area ...Find out more

Working with Londoners to make London the healthiest global city Our report on the engagement activities we carried out with Londoners last year is now online. Every day our teams are working with people in communities, online and at events. Londoners from all walks of life, of all ages and all cultures, and across all boroughs are involved in improving London's health and care ...Find out more

Healthy Enfield
move more eat well drink less stop smoking

Resources for referring patients with a suspected cancer Updated suspected cancer referral forms for patients with a suspected cancer are now on our website for primary care referrers (including GPs, dentists and optometrists). Following feedback by stakeholders in primary and secondary care the referral forms and tumour guides have had generic and specific clinical changes since they originally launched in April 2016. Forms are available to download for Word, EmisWeb, SystmOne (Integrated, Non-integrated), Vision and DXS. Leaflets in 11 languages are also available to support patients who have been referred to hospital with a suspected cancer. Please contact england.tcstlondon@nhs.net for further information ...Find out more

Spotlight

Accountable Care Organisations

A House of Commons briefing on the introduction of Accountable Care Organisations (ACOs) in the NHS in England, the development of the ACO policy, and comment on its potential impact.

Conditions for which over-the-counter items should not routinely be prescribed in primary care: a consultation on guidance for CCGs

NHS England seeks views on proposals to end routine prescribing of over-the-counter products for minor or short-term conditions that are self-limiting or that could be managed by self-care. Items of low clinical value that are of high cost to the NHS are also being considered. Feedback on this consultation will be accepted until 14 March 2018.

Free virtual learning programme for change activists

NHS staff who want develop knowledge and skills to help them make change happen are invited to join a free five week virtual learning programme run by NHS Horizons. The School for Change Agents provides an opportunity for change agents and leaders in health and care to build their skills, confidence and networks for leading change.

Making obesity everybody's business

A Public Health England and the Association of Directors of Public Health briefing focusing on the Whole-Systems Obesity programme (a different approach to tackling obesity that involves whole local systems). The programme is exploring current evidence and local practice to develop guidance and tools to help councils set up a whole-systems approach to obesity.

NHS efficiency map

The Healthcare Financial Management Association (HFMA) and NHS Improvement have worked in partnership to update and revise the NHS efficiency map. The map is a tool that promotes best practice in identifying, delivering and monitoring cost improvement programmes (CIPs) in the NHS.

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Enfield Health & Wellbeing Board – Forward Plan	
Date time and Venue	**Key Themes to be Considered**
8th February 2018 6.15pm – 8.15pm Room 1 Civic Centre Silver St Enfield EN1 3XL	JHWS Progress System Resilience CHINs Violence Against Women & Girls Strategy Healthy Hospitals
17th April 2018 6.15pm – 8.15pm Conference Room Civic Centre Silver St Enfield EN1 3XL	JHWS Progress Action Plan – Best Start in Life STP Engagement Progress on Healthy Weight MH Resilience – progress report Good Thinking
2018 / 19	Our approach to prevention Healthy Enfield website STP JHWS

Enfield Health & Wellbeing Board Development Sessions Forward Plan	
Date time and Venue	***Key Themes to be Considered***
20th March 2018 2.00pm – 5.00pm Room 1 Civic Centre Silver St Enfield EN1 3XL	*The Best Start in Life in Enfield Developing an obesity pathway*
2018 / 19	

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