Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 26 July 2018 at 4.30 pm
Room 1, Civic Centre, Silver Street, Enfield, EN1 3XA

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Please note meeting time

MEMBERSHIP

Cabinet Member for Health and Social Care – Councillor Alev Cazimoglu (Chair)
Leader of the Council – Councillor Nesil Caliskan
Cabinet Member for Public Health – Councillor Yasemin Brett
Cabinet Member for Children's Services – Councillor Achilleas Georgiou
Chair of the Local Clinical Commissioning Group – Dr Mo Abedi (Vice Chair)
Healthwatch Representative – Parin Bahl
Clinical Commissioning Group (CCG) Chief Officer – John Wardell
NHS England Representative – Dr Helene Brown
Director of Public Health – Stuart Lines
Director of Adult Social Care – 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 – 2 x representatives

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. NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST (NMUH) CASE FOR CHANGE (Pages 1 - 14)

A slide presentation to be delivered by Richard Gourlay, Director of Strategic Development, NMUH.

NMUH are currently a clinical partner in the Royal Free London (RFL) Group and have committed to developing the case for change which will determine

whether there is a decision to proceed to closer partnership with RFL and that such a change best serves the needs of NMUH's patients and community. NMUH want to engage all stakeholders about the broad range of challenges they face, and whether RFL group provide the best option for NMUH into the future.

4. INTEGRATION AND BETTER CARE FUND (BCF) (Pages 15 - 26)

To receive the report of Bindi Nagra (Director, Adult Social Care, LB Enfield) and Graham MacDougall (Director of Commissioning, NHS Enfield CCG) setting out the delivery of the BCF for Quarter 4 2017-2018, alongside the noted changes for the 2018-2019 BCF plan.

5. PROGRESS UPDATE ON JOINT HEALTH AND WELLBEING STRATEGY (JHWS) (Pages 27 - 52)

To receive the report of Stuart Lines, Director of Public Health.

6. MENTAL HEALTH - PRIORITY UPDATE REPORT (Pages 53 - 56)

To receive the report of Mark Tickner, Senior Public Health Strategist, providing an update on emotional and mental health resilience activity and progress thus far and proposals for additional activity moving forward.

7. BEST START IN LIFE - PRIORITY UPDATE REPORT (Pages 57 - 68)

To receive the update from Andrew Lawrence, Service Development Manager – Early Years and Early Help, on the area of focus Giving Every Child in Enfield the Best Possible Start in Life through improving school readiness, and action plan.

8. HEALTHY WEIGHT - PRIORITY UPDATE REPORT (Pages 69 - 74)

To receive the report of Dr Glenn Stewart, Assistant Director of Public Health providing an update on the Healthy Weight Partnership and the draft Healthy Weight Strategy and action plan, in addition to highlighting an opportunity to participate in the School Superzones pilot project.

9. KEY MESSAGES FROM THE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

JSNA summary information pack to follow.

TO FOLLOW

REPORTS FOR INFORMATION

The following reports are for information only.

10. HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

To note the updated terms of reference further to submission to Council on 19 July 2018.

TO FOLLOW

11. HEALTH AND WELLBEING BOARD FORWARD PLAN (Pages 75 - 82)

To discuss and update the Forward Plan.

12. INFORMATION BULLETIN (Pages 83 - 86)

13. MINUTES OF THE MEETING HELD ON 17 APRIL 2018 (Pages 87 - 92)

To receive and agree the minutes of the meeting held on 17 April 2018.

14. DATES OF FUTURE MEETINGS

Members are asked to note the dates of meetings for the 2018/19 municipal year:

- Thursday 27 September 2018
  – 4:30pm Development Session & 6:30pm HWB Board

- Wednesday 31 October 2018 – additional Development Session if required

- Thursday 6 December 2018
  – 4:30pm Development Session & 6:30pm HWB Board

- Wednesday 16 January 2019 – additional Development Session if required

- Wednesday 20 March 2019
  – 4:30pm Development Session & 6:30pm HWB Board

15. 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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North Middlesex Hospital
Case for Change

July 2018

Why are we creating a Case for Change?

North Middlesex University Hospital NHS Trust NHS

Our Vision and Objectives

Our vision

Our vision is to provide outstanding care for local people.

Our objectives

Our objectives are:

- Excellent outcomes for patients
- Excellent experience for patients and staff
- Excellent value for money.

We are currently a clinical partner in the Royal Free London group, and are considering closer working partnership with them in the future.

Key priorities for NMUH

Trust Board has identified following as key priorities to address:

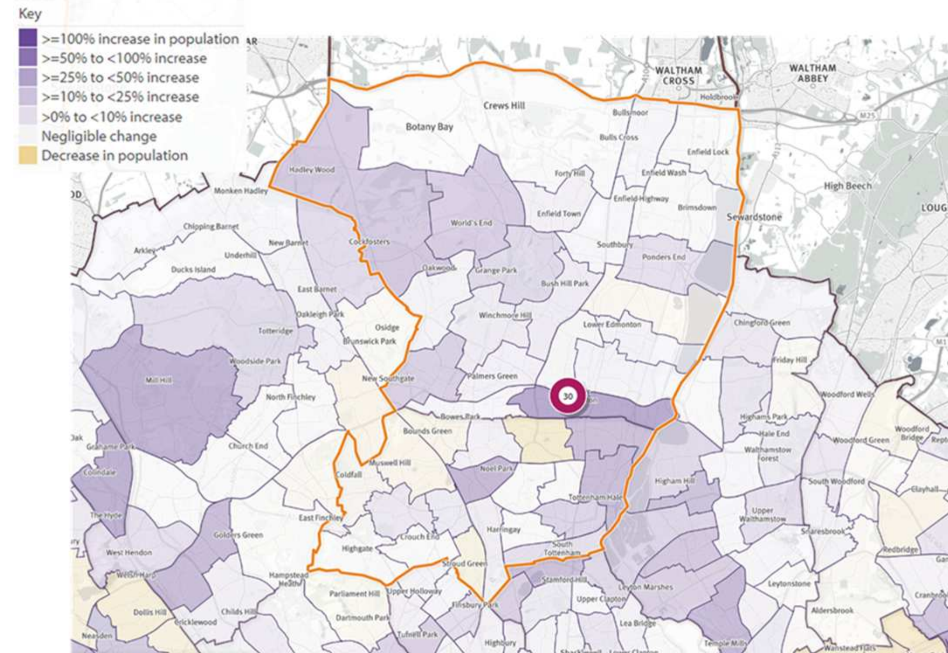
- Culture
- Recruitment & Retention
- Safely deliver standards (access, outcomes etc)
- Value for money
- Clinical & Corporate Governance

'Standing still' is not an option – we must respond to the changing needs of our local population.

NMUH Case for Change

Excellent outcomes for patients

- The population within our catchment area is predicted to rise sharply in the next five years
- We serve a large, diverse population and this can result in pressure on our Accident & Emergency department

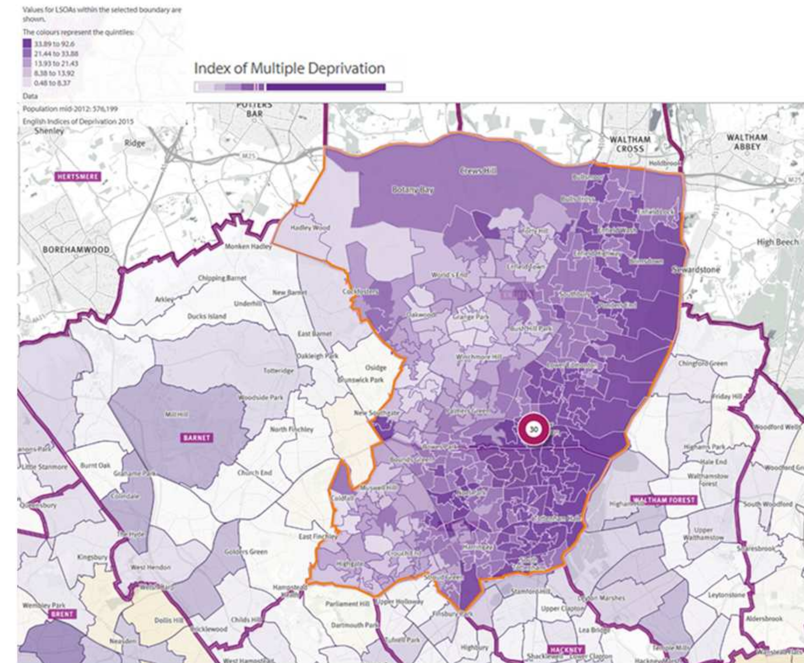


Map showing predicted population increase in Enfield/Haringey

NMUH Case for Change

Excellent outcomes for patients

- The population we serve has a high rate of long-term conditions such as Diabetes
- The population we serve covers some of the most and least deprived wards in the country
- Life expectancy differs by 6.6 years across different parts of Haringey
- Mental health is also an issue, with up to 20,000 people living with an undiagnosed mental health condition in Enfield



Map showing deprivation in Enfield/Haringey

NMUH Case for Change

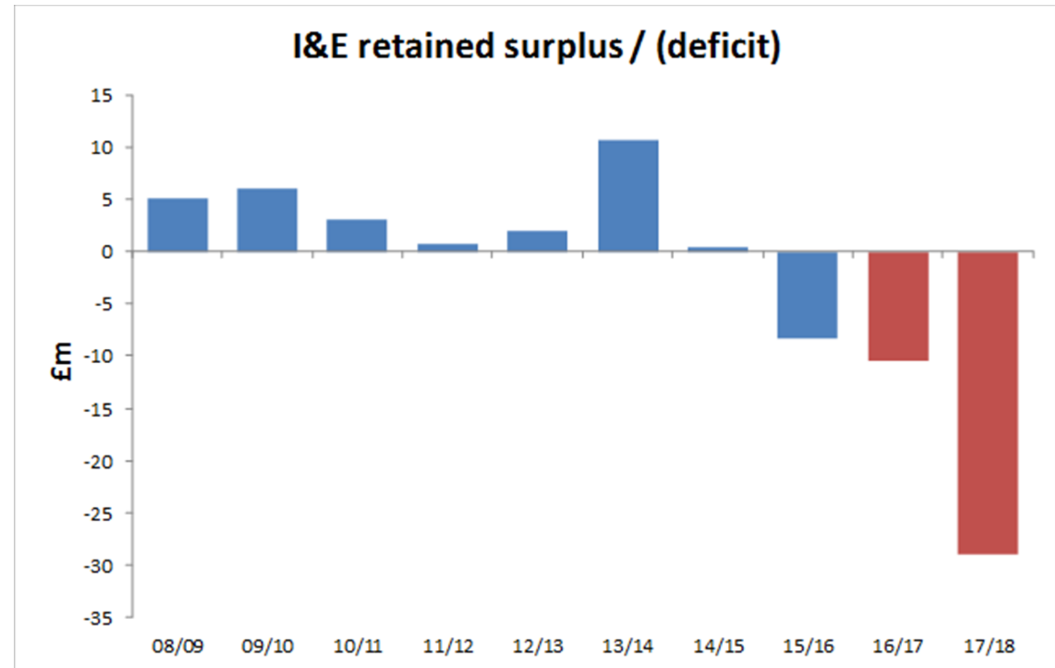
Excellent experience for patients and staff

- Our 2017 Inpatient Survey shows that we need to improve the experiences of patients who we care for, especially in ensuring that patients are listened to
- Annual staff survey results show that we need to do better at providing opportunities for career progression and recognising the value of our staff
- One of the most important issues facing us is recruitment and retention of our staff
- We need to work with our local community to address issues such as nursing recruitment – several successes already e.g. our apprenticeship programme

NMUH Case for Change

Excellent Value for Money

- Like many trusts, NMUH is under significant financial pressure
- In the past three years, costs have grown significantly faster than income
- Our commissioners in Enfield and Haringey are also under significant financial pressure



Why are we speaking to you today?

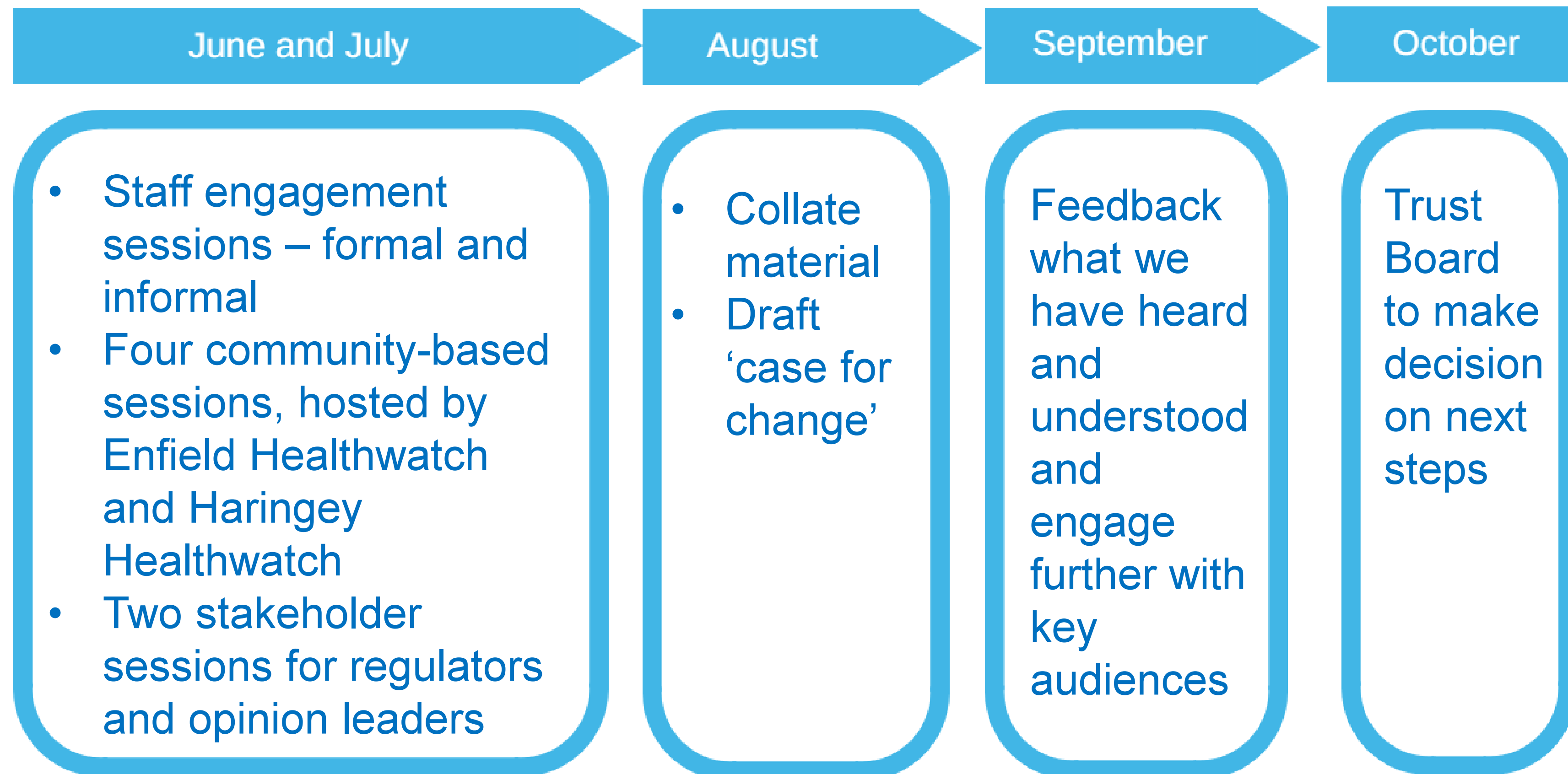
North Middlesex University Hospital NHS Trust NHS

What do we mean by engagement?

- ***Informing*** stakeholders so that they are aware of current issues
- ***Collaborating*** with stakeholders when making decisions
- ***Involving*** stakeholders at all points so that we can understand their concerns and aspirations
- ***Empowering*** stakeholders by giving them a say in the final decision

We cannot base the care we provide around local communities if we do not listen to them.

Timetable for 'case for change'



North Middlesex University Hospital NHS Trust NHS

What does this mean for NMUH?

Current Status

- There is an absolute need for a strong, efficient hospital on our site which delivers high-quality services to the local community
- We are currently a Clinical Partner in the Royal Free Group, which includes initiatives such as Clinical Practice Groups (CPGs) and the GDE Programme
- The case for change seeks to establish the benefits of working even closer with Royal Free London

What does this mean for NMUH?

Future Options

- We have a range of options open to the Trust ranging from maintaining a close alliance as a preferred partner with RFL, to becoming a full member such as Barnet or Chase Farm Hospitals
- The benefits may include greater opportunities for our staff to develop skills & knowledge in different clinical areas. This could improve recruitment & retention of staff
- Closer working with Royal Free London however may remove some of the potential for local leadership and local decision making
- Full membership for instance would likely mean that Trust Board decisions are no longer made at North Middlesex Hospital
- Ultimately the decision is in the hands of NMUH, and the Trust Board will meet to make a decision on the 4th of October

Questions for consideration

We have outlined 5 key challenges for the organisation. Do they capture for you the key issues for NMUH into the future? If not, what else should we consider?

Are there any particular aspects you think any future partnership needs to include, in order to address the challenges we face?

Are there any particular conditions or requirements you want us to bear in mind?

North Middlesex University Hospital NHS Trust NHS

MUNICIPAL YEAR 2018/19		
MEETING TITLE AND DATE **Health and Wellbeing Board**	**Agenda – Part: 1**	**Item:**
	Subject: Integration and Better Care Fund	
	Wards: All	
REPORT OF: Bindi Nagra, Director, Adult Social Care, LB Enfield, and Graham MacDougall, Director of Strategy and Partnerships, Enfield CCG	**Cabinet Member consulted:**	
Contact officer: Keezia Obi / Georgina Diba **Email:** Keezia.Obi@enfield.gov.uk / Georgina.diba@enfield.gov.uk **Tel:** 020 3879 5010 / 020 8379 4432		

1. EXECUTIVE SUMMARY

This report provides an update on:

- Year-end financial position for the BCF
- The delivery of the 17/18 BCF plan against the key performance indicators
- The service / scheme outcomes for 17/18 and the difference they are making to integrated care
- Audit of the BCF undertaken by the LBE Internal Audit Team
- The review of schemes to inform the 2018/19 plan and the outcome of this review

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- **Note** the year-end financial position
- **Note** and **receive** the current BCF performance and outcomes
- **Note** the 2018/19 plan with the noted changes

1. OUTCOME OF THE 2017-2018 BCF PLAN

1.1 Year-end financial position

For information: the expenditure plan for 2017/18 was £512K over the total pooled budget, because of commitment to schemes. Our submitted plan to NHS England for 2017-2019 provided a balanced budget though an equitable reduction off individual schemes across the fund. The over-commitment has been identified during 2017/18 by slippage in schemes, contract monitoring and savings from those schemes commencing mid-year.

Financial monitoring has been ongoing throughout 2017/18 and it is confirmed that both the CCG and Council have achieved the required savings to provide a balance position at end of year.

1.2 Performance against metrics

1.2.1 The following section is a summary of BCF performance as at the end of Q4 and as reported to NHS England. It is important to note that whilst we must continue to seek ways to improve performance where required, this needs to be considered within the wider context of the pressures on A&E's more generally, the population growth, growing demand and the funding position for adult social care.

1.2.2 Delayed Transfers of Care (DToC)

Significant actions were taken by partners throughout the year to manage DToC and as a system we have been able to achieve and meet our target for this metric.

The Enfield Health and Care System, alongside partners in Barnet and Haringey, have prioritised reducing DTOC in mental health services for 2017/18 and 2018/19. This applies equally to working age adult and older people Mental Health services, as part of the Parity of Esteem Agenda. Commissioners from health and care have worked with the Barnet, Enfield and Haringey Mental Health Trust to identify the causes of DTOC in inpatient services and describe a range of interventions that collectively we can implement. The top three causes for delay are described as access to housing, access to accommodation-based services, and people with no recourse to public funding.

DTOC levels have been reducing overall in Enfield and this is due to a range of interventions introduced to work in partnership to manage DTOCs effectively:

- A weekly partnership escalation call that includes CCG Commissioners, Local Authority representatives and BEHMHT operational teams
- BEHMHT hold daily bed management escalation calls internally where DTOC is prioritised
- Tracking of DTOC performance at monthly Contract meetings
- Held a Mental Health DTOC workshop with executive membership in September, followed by another in November 2017 to review position and performance

1.2.3 Non- elective admissions (NEAs)

Further to an improving position reported in quarter 2, the number of NEAs from quarter 3 increased due to systemic winter pressures because of demand and as a result the target for this financial year was not met. We are noting that this is a wider issue across North Central London (NCL) and other areas; as a result, further work is underway to review both remedial actions and the wider lessons learnt through the NCL system resilience groups.

Enfield Paediatric admissions have continued to reduce. Our Integrated Care Programme continues to have a focus on reducing NEAs through co-ordinated support in the community. We will continue to support this model and its expansion with the Care Closer to Home Integrated Networks (CHINs) to reduce NEAs consistently going forward.

1.2.4 Reablement

Reablement refers to the proportion of older people who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. Our target has been met for this year and is an important indicator for us, in terms of indicating the extent to which we are enabling and supporting people to achieve independence.

1.2.5 Admissions to residential care

For residential admissions, as a system in Enfield we are working with individuals so they are both supported to be assessed at home and to take positive risks. Although outside of our target this year, the gap between actual admissions and target has reduced every month since October 2017 through to February 2018. Final figure of 228 admissions to residential care (against a target of 225), which is a reduction from last year which had 263 admissions, despite an increased population during this time.

2. Commissioned schemes and outcome achieved

As at the end of Quarter 4 2017/18, progress against local plans for the integration of health and social care are advancing well, and have been set out below against our five priority areas.

2.1 Integrated Care Models

Our two-year intention was to develop integrated care models to deliver services in the community where possible, including a single point of access to services, and to embed prevention in all planning and commissioning activities to support the self-management of long term conditions. The following outlines the progress made and our current position:

Our **Integrated Care Programme,** consisting of 25 schemes in total, is aimed at those who are 50+ who are frail and pre-fail. This is strongly linked with our Care Closer to Home Integrated Networks (CHINs) as part of the North London Sustainability and Transformation Plans. Schemes work together to improve the experience and pathway for patients and their carers.

The **Enfield Care Home Assessment Team (CHAT)** has consistently supported above 95% of deaths in preferred places; most recent performance for Q4 17/18 was at 100% and is particularly important to us as it shows the importance of supporting individuals and their carers at end of life to maintain this choice and control. The CHAT aims to reduce admission to A&E and have a target of less than 10% of falls going to A&E, which was met at last performance measure in January 2018 at 7%, though increased above this in February and March. Attendances to A&E per registered bed (CHAT coverage) was also positive and within their target of less than 10%. Overall this is a key service for Enfield and is extending its reach to support the trusted assessor model.

Community Navigation delivered through Age UK is a service which helps to connect individuals to their community, for example through linking to services, activities or connecting with people to reduce isolation. For the 17/18 financial year there were 418 individuals who have been supported. A number of these individuals access the service for falls prevention, of which there is a 98% satisfaction rate with the service.

To prevent avoidable admissions and provide a response to individuals in the community in crisis, the **Community Crisis Response Team (CCRT)** is funded by the BCF to deliver several core functions. The service had a target of seeing patients within 2 hours of receipt of referral and achieved this in more than 92% of cases over the quarter, with February seeing the target met 99% of the time.

Supporting Adolescents and Families in Enfield (SAFE) outreach team is a specialist community multidisciplinary team working with Adolescents and Families in crisis with acute mental health problems or concerns. The team also provides an early intervention in psychosis service for young people to support and stabilise them. BCF is used to fund part of the service. Response times are within one working day to a young person in an acute setting and two working days for other urgent referrals. The funding covers 2.5 senior clinicians. Performance is monitored monthly as part of the CCG's Technical and Contract Review governance structures. Strategic direction is provided through the Children and Young People's Mental Health Partnership, which includes CCG and Council representation. In month 11, there were a total of 431 attended appointments to the SAFE Team. Of these appointments, 17 attendances were initial face to face appointments, 323 were follow-up face to face appointments, 91 were telephone contacts.

Also related to children and families is the **Strengthening the Team Around You** (STAY Project). STAY is the positive behaviour support team for young people which aims to keep children and young people in the Transforming Care cohort out of hospital (and residential placements/school). The original business case was developed by a joint working group which has since July 2017 turned into a monthly At Risk Meeting to discuss cases – children and adults – who form part of the Transforming Care cohort. It is at these meetings that packages/actions are agreed and the Council and CCG maintain a single at risk register. With an increasing number of children and young people in this cohort who we are concerned about, the Integrated Learning Disability Service took the project over, and successfully recruited staff in quarter four to support this area.

2.2 System Resilience

We aimed to increase system resilience and seven-day working with additional investment in clinicians to facilitate the safe discharge of patients without unnecessary delay, a market facilitation plan to create sustainable and diverse care and support provision, and a joint integrated workforce strategy to equip staff with the skills and knowledge needed to deliver patient centre care closer to home.

For mental health our system resilience plan has been progressing well, and we have set up a system resilience structure for mental health that has parity of esteem with physical health e.g. requires engagement at a senior executive level across partnerships and is part of the current wider system resilience processes. We have developed a new post called the Mental Health System resilience Programme Manager that is funded by the iBCF from contributions in Barnet, Enfield and Haringey areas, and is responsible for:

- Developing enhanced systems to identify and manage DTOC and reduce avoidable admissions
- Developing criteria with clinicians for clinically optimised patients
- Working alongside wider system resilience resources
- Working with key partners and stakeholders to identify key pressures and unblock barriers
- Working as part of the Transformation team to develop a sustainable Mental Health system going forward
- We intend to explore the Red and Green Day system and how this can be used effectively for Mental Health Services. Camden & Islington FT and BEHMHT are working closely on this

We have maintained investment in our seven-day services through the BCF and a continued commitment to work with partners to provide this. We have for example

introduced a pilot for Discharge to Assess over seven days and are working with our care providers to build relationships of trust that enable safe discharges on weekends.

The BCF continues to fund **adult social care capacity** at weekend, supporting the ability to respond to adults needing to be discharged back into the community swiftly and safely. This allows staff to be on cover at hospital sites, attendance at MDT meetings, facilitating the discharge and undertaking assessment and care planning.

Our integrated workforce planning is set for development over the next year as part of our plans for the implementation of the Integrated Locality Teams.

2.3 Prevention

We aimed to provide information and advice in a range of formats and at different locations, to promote prevention, limit the escalation of health conditions and help people manage their own care and health. Our aim remains for service users and carers to be fully involved in decisions about health and social care support and we will provide independent advocates to support their involvement when necessary.

Our advocacy services commissioned jointly across Barnet, Enfield and Haringey areas continues to progress well. In total over Q4 there were 78 active cases, with 32 new and a total of 397 hours of advocacy provided. Advocacy is important to us as a system, as it supports people to contribute to their care and support and have their voice heard at times when they are often most vulnerable. The advocacy service also receives feedback from those who use services, and in this quarter found:

- 94% felt they got better at being more involved in decisions about their life since they had advocacy support
- 28% felt they understand their rights and entitlements more, though for 72% there was no change
- 94% felt they got better at being more involved in decisions about their life since they had advocacy support

Our safeguarding services while partly in response to concerns of abuse, are very much focused on prevention and building resilience to help contribute to the safety of individuals and communities. Our **Safeguarding Nurse Assessor** works with nursing homes to identify issues proactively and support the providers to address these. During this quarter 13 homes were supported with quality assurance activities to help prevent abuse and neglect, with support provided around issues such as nutrition, dehydration and pressure care. There is also support provided during the Provider Concerns Process, which is instigated when there are significant concerns about the ability of a provider to deliver safe care, and the local authority alongside partners work with providers to improve care and support. Eleven providers were supported during this quarter.

Our **Quality Checkers** are volunteer service user and carers, who provide additional eyes and ears to review services. During Q4 the Quality Checkers conducted 25 mystery shopping telephone calls to the Council's Access Team. This was to follow up and check progress of the recommendations made during our initial project in 2017. Quality Checkers made recommendations regarding extra staff training to be given in areas of Mental Health and Safeguarding – this was due to the differing responses received by staff to Quality Checkers during the project. During the 2nd part of our project, the advice given by staff was correct and consistent, and we concluded that our original recommendations were implemented and successful.

There were also 36 Quality Checker visits made to care providers across the borough. Some of the outcomes achieved by Quality Checker visits are detailed below.

- Residents communal area was re-decorated and residents helped to decide on colours. This followed feedback collected from residents by Quality Checkers.
- Garden area of residential home has been improved for residents. Grass cut/ new plants planted and general tidy up. Quality Checkers supported the provider by providing them with details of volunteer schemes specialising in assisting care providers with such projects – which provider was previously unaware of.
- Mobile library service now visiting a residential home, who were previously unaware of the service. This was following feedback given to Quality Checkers by residents requesting a service.

Finally, in relation to safeguarding, the funding towards **Safeguarding Adults Reviews** has contributed to six reviews in 2017/18, which aims to share learning and where possible prevent abuse and harm of a similar nature in the future. There has been considerable work done because of this around fire safety, and a partnership approach between the London Fire Brigade and Enfield Safeguarding Adults Board towards fire prevention and safety.

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 and access to statutory services. 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
- Supporting their families and friends with mental health needs while maintaining their own health and wellbeing
- Culturally specific services, for example with Asian women
- Home from hospital service to enable people to be safely managed at home and prevent re-admission to hospital
- Counselling, including intercultural psychotherapy

The Mind in Enfield contract as part of the above, has now become IAPT compliant and will be moving forward to form part of the IAPT offer commissioned by the CCG. This is a positive step forward in building up the offer locally in Enfield.

For 17/18, Enfield's Improved Access to Psychological Therapies Service (IAPT) Access and Recovery Standard was delivered by our Provider: Barnet, Enfield & Haringey Mental Health Trust (BEH MHT). The Access and Recovery Standards form part of the CCG Operating Plan. Where delivery does not match the plan, escalation procedures are enacted to look at the reasons for non-delivery and implement recovery plans accordingly.

In addition to this, the IAPT service delivery is overseen on a monthly basis at the following groups:

- IAPT Network Meeting;
- BEH MHT Contract Review Group;
- Submission of Minimum dataset to NHS Digital to record delivery against protected characteristics and vulnerable populations;
- Monthly performance reporting to NHSE through CCG.

The recovery rate achieved across Quarter 4 was 50.9%; while the access rate 1487 which fell below the 4.2% access target by 10 patients.

2.4 Place Based Commissioning

We aimed to deliver collaborative models of care that meet outcomes while also being financially sustainable. Services are effectively commissioned through an understanding of the needs of local people, future demand and cost of services.

The BCF has provided a platform where the Local Authority and Clinical Commissioning Group work collaboratively to arrange service which are outcome focused and deliver for the community. The Joint Health and Social Care Commissioning Board continues to meet monthly and provide a steer and commitment towards partnership working and collaboration around our commissioning intentions.

Additional pooled funds were added to the BCF for 2017-2018, marking an ongoing commitment from both the Local Authority and Clinical Commissioning Group to partnership collaboration on commissioned services. This pooled funds also includes a joint commissioning team, with the ability to develop services that are financially sustainable through greater integration of care and a focus on improving population health and wellbeing. Over the last quarter a number of contracts were awarded and work is moving forward with the new VCS providers to commence service delivery.

2.5 Infrastructure and Estates

We aimed to integrated information sharing and technology, so that services can work together in the most effective and efficient way, including ensuring that our physical assets (such as land or buildings) are put to the best use for patients and service users

The programme for a shared care record has been restarted across North Central London STP. It is now a collaboration between 5 CCGs, 5 LA's, 12 providers, 220 GPs and around 500 active social care sites. They are at the point of appointing a preferred supplier as a solution and setting up the necessary governance to commence delivery.

3.0 BCF Audit by the LBE Audit Team

A review was undertaken as part of the 2017/18 Internal Audit programme that was agreed by the Council's Audit & Risk Management Committee, to provide assurance on the key controls in place to deliver a successful Better Care Fund (BCF). To avoid duplication and to enhance partnership working, the CCG and Council together agreed to the scope of the audit with the Council's Audit & Risk Team.

Five schemes were selected for review and these included District Nursing, Improving Access to Therapies (IAPT), STAY Scheme enhanced behaviour support, Disabled Facilities Grant and preventative services under the Voluntary and Community Sector Provision.

The review identified:

- one high risk finding related to performance monitoring at a scheme level, particularly for CCG commissioned services and schemes under the Improving Access to Psychological Therapies (IAPT) fund. As a result, there is insufficient assurance that these schemes are delivering planned outcomes to an acceptable level or providing value for money; and

- one medium risk finding, relating to the absence of an approved business case for all project schemes included in the plan.
- The LBE Audit Team concluded that there is 'Reasonable' assurance' for the areas covered by the review. LBE and CCG partners have agreed the actions need to increase assurance and meet the areas identified in the audit report by 1 October 2018. The Audit Team will follow up progress made in implementing the agreed actions, to ensure that they are implemented in accordance with the target dates set out in the action plan.

4. BCF Plan 2018-2019

4.1 Funding

4.1.1 The current BCF funds have continued with an inflationary increase. The Enfield funding for 2018/2019 can be summarised as follows:

Year	2018/2019
Revenue funding from CCG	£19,899,913
Local Authority contribution (Disabled Facilities Grant)	£3,051,322
Improved Better Care Fund (iBCF)	£8,243,487
BCF total	**£31,194,722**
Additional pooled funds from the Enfield Council and Enfield CCG 75 Agreement for managing jointly commissioned services	£10,464,157
Pooled fund total	**£41,658,879**

4.1.2 The Better Care Fund allocation towards schemes was agreed as part of a two-year plan 2017-2019. This was ratified by the Health and Wellbeing Board in August 2017 and submitted to NHS England, with the plan agreed formally in October 2017.

4.1.3 The Improved Better Care Funding (iBCF) allocation for 2018-2019 has been allocated to meet the following grant conditions:
- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

4.1.3 As noted in the funding summary, there is additional pooling of the **Section 75 Agreement** into the Better Care Fund. Enfield Council and Enfield Clinical Commissioning Group have continued in their commitment towards a joined-up approach to support the transformation and integration of health, adult social care and children's services.

4.2 Monitor and Returns

4.2.1 Both the Better Care Funds and additional monies through the iBCF require regular monitoring and returns to NHS England. Following requests from local areas to combine quarterly reporting templates for the Better Care Fund (BCF) and Improved Better Care Fund, the Ministry of Housing, Communities and Local Government and the BCF's national partners are working together to merge them into one template, with one set of deadlines per quarter. Provisional deadlines for submitting combined templates in 2018-19 have been set.

4.2.2 We are awaiting the formal publication of the BCF Operating Guidance for 2018-2019. Provisional ambitions for Delayed Transfers of Care have been shared and Enfield HWB area is being asked to maintain the level set in Q3 17/18 of 15.3 per delayed transfer of care per day, which was the lowest within the North Central London area.

4.3 Scheme Plan Changes 2018-2019

4.3.1 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; this means we will be able to identify and respond to any changes that take place, both locally and nationally, and if required, change our commitment of resources to new activities.

4.3.2 A review of schemes was undertaken in March 2018 as an opportunity to provide assurance that schemes were delivering as agreed, continued to contribute to the required areas and where providing value for the funding allocated. As a result of this review, the following points should be noted as proposed in the 2018-2019 plan:

1) Integrated Care Programme to continue as is from 2017/18 based on outcomes achieved. This programme is a key delivery mechanism for the Care Closer to Home Integrated Networks (CHINS), which are part of the North Central London Sustainability and Transformation Plans. In addition, schemes will be flexible to respond and adapt to activities needed to implement the High Impact Change Model.

2) Mind in Enfield achieved successful accreditation in Improving Access to Psychological Therapies (IAPT). The funding for Mind is agreed as being moved within the BCF from Third Sector Schemes to sit within Mental Health Schemes.

3) A contract with IG Spectrum that contributed to data analysis has been decommissioned and is being delivered through an alternative route in an existing scheme. This has contributed to savings within the BCF Plan.

4.3.3 Appendix A sets out a summary of the Better Care Fund Scheme Plan for 2018-2019, alongside funding changes. The Health and wellbeing Board are asked to note the changes to the scheme plan which sits within 2017-19 plan previously agreed.

5. Assessment of Risk and Risk Management

5.1 Risks related to the BCF as a programme has been reviewed and considered at the BCF Executive and Delivery Group over 2017-2018. These are separate from individual risk registers for schemes or projects, which rest with the lead commissioner, but will be escalated to the BCF Delivery Group as required.

5.2 Three overall programme level risks have been identified, with plans for risk mitigation and are set out in brief below:

1. Strategic risk identified that BCF may be unable to meet metrics because of the system not being flexible enough to refocus activity when necessary to meet targets. A plan is in place to measure monthly targets and identify any emerging areas where additional activity is required.
2. Strategic risk identified that with increasing demand the system will be unable to sustain services. In response, changes have been agreed more widely to focus on prevention, with the outcomes in individual projects to be reviewed so that we can identify the ability to manage demand more effectively.

3. Strategic risk identified around managing transfers of care, with the risk of blockages in the system which prevent patients being discharged to the community. Joint work has been undertaken to assess the implementation of the High Impact Change Model and these changes are being prioritized for implementation.

5.3 The Health and Wellbeing Board are being asked to note the above risks and the plans set out to mitigate these.

Appendix A: BCF Scheme Plan 2018-2019

Scheme / project		Total Budget 2018/19	Investment/ Disinvestment from 2017/18 to 2018/19
1	Integrated Care Schemes	9,359,428	No change
2	Mental Health Schemes	1,323,308	+ 128,000
3	Safeguarding Schemes	449,000	No change
4	Long Term Condition Schemes	756,000	No change
5	Childrens Schemes	385,000	No change
6	Carers Schemes	489,000	No change
7	Third Sector Schemes	282,000	- 128,000
8	Infrastructure Schemes	100,000	-16,000
9	Care Act Schemes	734,000	No change
10	Protection of Social Care	6,280,000	+ 117,000
	Total scheme spend	20,157,000	Noted that the 257k savings required will be found from existing scheme savings
	Revenue funding received	19,899,913	
	Potential overspend	257,823	
12	iBCF	8,243,487	+ 2,106,594
13	Capital total	3,051,322	+254,545
14	Additional S75 Commissioned Services	10,464,157	+290,147

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Agenda Item 5

MUNICIPAL YEAR 2018/19

Meeting Title: **HEALTH AND WELLBEING BOARD** Date: 26th July 2018	**Agenda Item:**
	Subject: Progress on Health and Wellbeing Board Monitoring areas for 2017-19 and Annual Review of key indicators
Contact officer: Glen Stewart Telephone number: 0208 379 5328 Email address: **@Glen.Stewart@enfield.gov.uk**	**Report from Partners**

1. EXECUTIVE SUMMARY

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

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

2. RECOMMENDATIONS

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

- 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.
- Be aware of the work towards the future deployment of MECC within the borough.
- HWB member organisations to sign up to Sugar Smart Enfield
- Development of a Healthy Weight Care Pathway

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3. BACKGROUND

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

3.2 The HWB Priority areas were:

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

<Collaboration>
- Domestic Violence

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

4. REPORT

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

4.3 The section 5 of this report highlights the key successes and challenges in the last three months in the HWB priority areas.

4.4 Outcomes measures that reflect the progress against the Enfield JHWS are presented in Appendix A. This is the same set of indicators which was reviewed in 2017 when the Board discussed the priorities for 2017-19. This is also available online at: https://new.enfield.gov.uk/healthandwellbeing/jhws/measuring-our-progress/

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

4.6 Areas where outcomes show improvement are:

Ensuring the best start in life

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

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

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

Creating stronger, healthier communities

- Adults in employment
- Fuel poverty

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

Ensuring the best start in life

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

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

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

Creating stronger, healthier communities

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

Promoting healthy lifestyles and making healthy choices

- Overweight and obesity
- Inactive adults

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5. Progress Report

Top 3 priorities

Focus area	Best Start In Life – School Readiness
Partners	Public Health, Enfield CCG, BEHMHT, CAMHS, Children's Services, Education, PVI and Tottenham Hotspur

What's our current performance?

- We have developed a more detailed and comprehensive action plan at the request of the HWB and this has been submitted for HWB perusal and is an agenda item at the next HWB meeting.
- The delivery of a number of Best Start in Life work streams has already been initiated, and details are provided in the action plan noted above.
- We are working very closely with our partners across the council and elsewhere to progress other parts of the action plan
- This is activity clearly is very closely aligned with our other priorities of tacking obesity and enhancing emotional health and wellbeing.

Things that are going well

- Please refer to Action Plan and associated reports. Progress has been quite substantial.

What's next?

- We will continue to progress the Best Start in Life Action Plan.

Challenges that HWB may be able to assist resolving / unblocking

- Continue to support ongoing activity.

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Focus area	Mental Health Resilience – Emotional and Mental Health Resilience and Wellbeing
Partners	Public Health, Enfield CCG, BEHMHT, NCL PH Departments. London Health Board, Thrive LDN, Time to Change, Enfield CEPN, Public Health England, Public Health Academy, London South Bank University.

What's our current performance?

- We continue to work with Thrive LDN as a vehicle for adding value to ongoing mental health resilience work in Enfield.
- Thrive LDN have undergone some internal changes, and have appointed new contact officers recently.
- LBE, Thrive LDN and "Time for Change" continue to work towards the establishment of a de stigmatisation "Hub" in Enfield
- LBE's Public Health officers are working with our NCL neighbours and more formally with Public Health England, The Public Health Academy and London South Bank University on preparatory work towards deploying Making Every Contact Count [MECC] and Mental Health First Aid within the borough.
- Any MECC activity will be within the context of our Health in All Polices [HiAP] activity and strategy.
- We are continuing to develop a Suicide Prevention Strategy for the borough.

Things that are going well

- LBE Public Health continue to work with Thrive LDN, "Time to Change" and other partners to plan and deliver a "Destigmatisation Hub" within the borough.
- This aligns with the extensive activities, agenda and priorities of the "Best Start in Life programme, as discussed in previous HWB meetings and today.
- There are a number of emotional health and wellbeing work streams active within the "Best Start in Life" programme [which may be discussed elsewhere]
- In addition LBE Public Health Officers have been working with Public Health England, The Public Health Academy and The London South Bank University to develop commissioning and evaluation tools around future MECC activities.

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- As has been noted to the HWB previously Enfield has the lowest suicide rate in the country - http://healthierlives.phe.org.uk/topic/suicide-prevention

What's next?

- Thrive LDN are now working with "Time to Change" in a formal partnership
- Enfield local user group representatives [led by EMU] have started to develop programme for next 18 months activities. LBE role as "host" becoming correctly and clearly defined as secondary but supportive.
- LBE Public Health officers continue to work with our NCL neighbours about the potential for adopting an on-line MECC presence level prior to commissioning additional live MECC or MHFA activities.
- As noted LBE Public Health Officers have been working with Public Health England, The Public Health Academy and The London South Bank University to develop commissioning and evaluation tools to ensure that prior to commissioning and/or development of additional MECC or MHFA activities a robust outcome and performance measurement frame work is in place.
- Potential future MECC activity within LBE is being examined as an integral part of our Health in All Polices approach. MECC may be considered as the expression of the HiAP approach at the point of interaction between LBE staff and the citizens they serve.

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 and work going on within those areas – such as best start in life.
- Be aware of our work towards the future deployment of MECC within the borough and as supportive as possible.

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Focus area	Healthy Weight
Partners	Enfield Voluntary Action, CCG, NHS 0-19 + Dietetics LBE- Planning, Sustainable Transport, Road Safety, Enfield Catering Services, School PE, Healthy Schools, Corporate Communications, Environmental Health, VCS, Active Enfield,
What's our current performance?	
The 3 year data shows that the average prevalence of excess weight in year 6 pupils is 41.5%. This is significantly higher than London (37.9%) and England (33.87%) averages. 251 Year 6 pupils were identified as severely obese in 2016/17, equating to 6.1% of all the children measured.	
47.4% of children in the top 10% most deprived parts of the Borough are overweight or obese, compared to 26.2% of children in the 10% least deprived parts of the Borough. Upper Edmonton (47.1%), Ponders End (46.9%), Enfield Highway (46.4%), Lower Edmonton (46.0%) and Edmonton Green (45.8%) had a significantly higher prevalence of excess weight in pupils compared to the Enfield average (41.5%).	
The prevalence of excess weight by ethnicity is significantly higher in Turkish/Kurdish (51.1%) and African (45.5%) pupils compared to the Enfield average (41.5%).	
Things that are going well	
• Healthy Weight – tackling obesity and its pathway was presented at HWB development session on the 20th March 2018 • A draft Healthy Weight strategy and action plan has been developed and cascaded to members of the Healthy Weight Partnership for the first stage of consultation. • The Declaration on Sugar Reduction and Healthier Food has been signed by the new Leader of the Council and the Cabinet Member for Public Health. • 36 settings have registered to become Sugar Smart, including schools, nurseries, leisure centres and community groups to become Sugar Smart. More events are planned over the coming months to engage others. • Currently 48 businesses are signed up to the Healthier Catering Commitment • The Health Trainer service, Next Steps and Challenge You programmes are running over the summer to support children identified as overweight via NCMP. • Numerous initiatives to support healthy eating and a healthy weight in the early years are progressing including training for early years staff, Baby Friendly Initiative- Commitment Level, and Healthy Start	

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What's next?
• Further consultation on the Healthy Weight Strategy and action plan • **School Super Zones:** We've applied to be part of a pilot project with PHE London, which seeks to address public health concerns within 400m of schools e.g. Advertising, Food and drink sales, Gambling, Tobacco, Alcohol, Living streets, Air quality
Challenges that HWB may be able to assist resolving / unblocking
• Development of a Healthy Weight Care Pathway • HWB member organisations to sign up to Sugar Smart Enfield

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Collaboration

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Focus area	Domestic Violence
Partners involved	Community Safety

What's our current performance?

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

Update:

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

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

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

Things that are going well

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

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public sector communications excellence awards – bronze winner • Continuing awareness-raising and targeted digital marketing with the 'Boyfriend Material?' campaign
What's next?
1. Progressing and monitoring the VAWG Strategy Action plan and outcomes of single and multi-agency partnership work 2. Progressing the recommendations from the HWB development session which includes an audit of how Enfield is meeting NICE guidelines on domestic abuse 3. Work with partners and commissioners to ensure continued provision of (a) DV resource (IDVA or advocate educator) at North Middlesex Hospital (b) Perpetrator programme
Challenges that HWB may be able to assist resolving / unblocking
Continue to support embedding work to tackle domestic abuse across the partnership.

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Enhanced Monitoring

Focus area	Cancer
Partners	Public Health, Enfield CCG

What's our current performance?

- Enfield is the highest performing CCG in NCL for all screening rates
- Performance in the 62-day treatment from urgent GP referral nation standard has improved locally and across NCL in the last few months but is susceptible to fluctuations
- Cancer Patient Experience needs improvement (NCPES 2017)
- Enfield's performance in the CCG Improvement & Assessment Framework (IAF) Cancer section has notably improved in two indicators – Cancers diagnosed at an early stage and the one-year survival rate of all Cancers. Both indicators have been on an upward performance trend over the last two years. Enfield is ranked as 60th out of the 207 CCGs nationally for Cancers diagnosed at an early stage and 45th out of 207 for one-year survival rate of all Cancers (within the best performing quartile in England).

Things that are going well

- Monthly Enfield CCG Cancer Action Group attended by commissioners, providers, public health, and other Cancer stakeholders
- Primary care visits underway (18 and 24th June, 2018) with Macmillan GP Cancer Lead and Cancer Research UK Primary Care engagement facilitator. Visits will focus on quality of 2 week wait referrals, improving screening rates and cancer care reviews.
- Five cancer awareness events are planned for the rest of 2018 – targeting lower uptake areas for cancer screening and to raise awareness of early symptoms.
- There is a national pilot project to invite patients at high risk of cancer to offer them blood test and lung check to determine their future cancer risk. Enfield Cancer Action Group has submitted application so that local GPs can participate in this pilot.

What's next?

- A review of the extended access to cervical screening (local GP hub that started Jan 2018) enhanced the update of screening soon in collaboration with GP federation. The evaluation will help us understand improvement required to have an ongoing cervical cancer screening at these locality hubs.
- Joint CCG/Trust action plan to improve Cancer Patient experience – ongoing
- Implementation of key priority actions(identified by Enfield's Cancer Deep Dive in June 2017). These priorities are aimed at Improving:
- The local NHS acute trust performance across all performance indicators
- Screening uptake,
- Direct access to diagnosis of two weeks referrals,
- Long term management of prostate patients discharged into GP,
- Patients experience in receiving care.
- Quality of life for those living with and beyond cancer
- Access for GP and practice nurses

• Multidisciplinary team working between GP, community service and acute specialist
Challenges that HWB may be able to assist resolving / unblocking
• Support future cancer awareness campaigns • To facilitate or encourage earlier launch of bowel scope for Enfield residents

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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?

No new data were received.

Flu vaccination by Health care providers in 2016/17 compared to 2017/18
Table-1 Flu vaccination by providers

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

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

Table-2 Flu vaccination by health care professional groups

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

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

Things that are going well

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

Further update will be provided when the seasonal flu vaccination is published.

What's next?

- Support the flu vaccination campaign for the coming flu season beginning Sept 2018 including flu vaccination for children

Challenges that HWB may be able to assist resolving / unblocking

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- Support future flu vaccination uptake and campaigns

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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

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the planning authority

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

What's next?

- The further development of move on accommodation for adults with mental health support needs who are eligible for ASC services
- The development of the borough's Housing with Care offer, to include the further development of extra care housing options across tenures types
- The consideration of a local 'Care Village, to provide a mixed Housing with Care offer to older residents, that integrates health and wellbeing services
- Incorporation of strategically relevant housing services for adults with support and care needs within key borough development programmes (including Meridian Water)
- Working with estate agents and property developers to seek appropriate step down accommodation that is cost neutral to the Council.

Challenges that HWB may be able to assist resolving / unblocking

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

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

What's our current performance?

- 1,197 Enfield residents who were assessed at high risk of type 2 diabetes were referred to the programme. 435 has completed Initial Assessment appointments.
- Public Health and Enfield CCG commissioners will continue to promote NDPP at GP locality meetings and, GP Protected Learning Time to improve the quality of referral to the programme, to reduce variation across Enfield and to use the programme effectively through pre-diabetes LCS and brief intervention.
- Enfield CCG will fund a coordinator post to work with the provider to ensure equitable referrals and high-quality referrals.
- Enfield will need to expand the service sites to accommodate the number of patients undergoing initial assessment and group sessions.

Things that are going well

- Enfield Public Health and CCG commissioners are galvanizing the support of the local GPs to the programme.
- Working very closely with national diabetes prevention programme commissioner (NHSE), local provider (ICS) and Enfield CCG to work on many strands of work to improve quality of referral and equity of referrals, and retention of those who are referred to NDDP in the programme until completion.
- There was a case study in NCL where a patient avoids bariatric surgery.

What's next?

- Continue engaging with local GPs to improve quality of referrals and to reduce variation.
- Ensure previously commissioned diabetes prevention locally commissioned programmes are aligned with diabetes prevention programme to improve quality of referral and reduce waiting time.
- Ensure patients referred to the programme are highly motivated and consent to attend the programme before their names were sent to national diabetes prevention programme provider in Enfield (ICS).
- Ensure equity of referral from all GP into diabetes prevention programme specially from areas most affected by diabetes
- Work on public awareness campaign with community leaders in areas of high diabetes prevalence.
- Enfield to actively participate in re-procurement of the service at STP level so that Enfield residents gain benefits as well as other boroughs in the STP

Challenges that HWB may be able to assist resolving / unblocking

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

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

Things that are going well

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

What's next?

- Work continues on the development of the priority areas for CHINs.
- North Central London Partners in Health and Care (NCL STP) are reviewing

long-term conditions management in primary care in all boroughs to ensure high standards across the STP footprint for the residents of NCL. Nonetheless a balance is to be struck between
Challenges that HWB may be able to assist resolving / unblocking
• Support the CHIN development programmes and priorities.

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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

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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

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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

Falls Prevention

- Enfield Public Health has co-designed with existing local services and commissioner to a falls prevention training aiming at health and social care frontline staff such as domiciliary carers (target for the pilot – 100). In the three sessions (in April, May, June) 78 participants have completed the training programme. Of the 78 participants:
    - 54 were from domiciliary, nursing, and care homes
    - 5 from adult social care, and
    - 5 from district nursing.
- 14 Voluntary Sector
- The falls prevention training is highly subscribed and 22 delegates have booked for July and 16 for Sept 2018.

The VCS prevention contracts

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

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

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

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

  Outcome 5 - People recover from illness, safe and appropriate discharge from hospital.

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Lead partner: GGCCE Reducing hospital and residential care admissions through effective early intervention • A meeting was held between representatives from adult social care, public health and Enfield CCG to conduct an analysis on hospital and residential care admissions through hospital admissions, with an aim to find effective early intervention specific to Enfield. A methodology paper on the analysis on hospital and residential care admissions through hospital admissions is being drafted.
What's next?
<VCS prevention contracts> There has been a minor delay in terms of the development of the VCS steering Group. It is expected that this will happen prior to the end of the next reporting round. Performance is being measures against outcomes and KPis monitored against stated achievement. We are progressing a new round of grant funding for small VCS communities of the borough. The fund is specifically aligned to health and well-being outcomes and application to the fund is expected to be invited in August 2018. The fund is aimed at supporting people to be independent and live healthy lives which will include social and leisure activities • We will be looking to develop a VCS Steering Group by the end of May 2018, allowing lead partners a forum to exchange updates, ideas and build strong relationships and networks. The development of processes, pathways and data/performance measures against outcomes will be also be progressed and monitored. It is expected that the result of the first monitoring report will be produced by the end June 2018 Public health are approaching integrated care commissioners to explore opportunity to incorporate falls training into existing work.
Challenges that HWB may be able to assist resolving / unblocking
To support the above activities.

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MUNICIPAL YEAR 2018/19

Meeting Title:
HEALTH & WELLBEING BOARD FORMALSESSION
Date: 16th July 2018

Agenda Item:
Subject: Emotional Health, Wellbeing and Resilience and supporting Public Health activity within Enfield.
Report approved by: Stuart Lines Director of Public Health

Contact officer: Mark Tickner
Telephone number: 020 8379 3060
Email address:
mark.tickner@enfield.gov.uk

1. EXECUTIVE SUMMARY

As previously reported the Enfield Health & Wellbeing Board has identified mental health resilience as a priority.

We continue to work with Thrive LDN as a vehicle for adding value to ongoing mental health resilience work in Enfield.

LBE's Public Health officers are working with our NCL neighbours and more formally with Public Health England, The Public Health Academy and London South Bank University on preparatory work towards deploying Making Every Contact Count [MECC] and Mental Health First Aid within the borough

There are significant emotional and mental health wellbeing work streams within the "Best Start in Life" programme

We are continuing to develop a Suicide Prevention Strategy for the borough.

2. RECOMMENDATIONS

That the Board Considers:

Our emotional and mental health resilience activity and progress thus far and proposals for additional activity moving forward.

3. BACKGROUND

3.1. In April 2017 the Enfield Health & Wellbeing Board selected improving mental health resilience as one of their focus areas for action planning for the final 2 years of the Joint Health and Wellbeing Strategy.

3.2. In July 2017 the LBE Public Health team requested that the HWB authorise their engagement with the Thrive LDN organisation to investigate the potential for joint activity in Enfield to enhance mental health resilience. This was agreed.

3.3. After a pilot Making Every Contact Count scheme in 2017, LBE PH officers are exploring the feasibility and utility of extending a MECC scheme within the council and potentially with other partners.

3.4. In addition LBE Public Health Officers have been working with Public Health England, The Public Health Academy and The London South Bank University to develop commissioning and evaluation tools around future MECC activities.

3.5. We continue to develop a suicide prevention strategy for the borough.

4. REPORT

4.1. LBE Public Health continue to work with Thrive LDN, “Time to Change” and other partners to plan and deliver a “Destigmatisation Hub” within the borough.

4.2. Enfield local user group representatives [led by EMU] have started to develop programme for next 18 months activities. LBE role as “host” becoming correctly and clearly defined as secondary but supportive.

4.3. Thrive LDN are now working with “Time to Change” in a formal partnership and Time for Change are undertaking a number of aligned activities in the NCL area – including with faith groups – we will be progressing this.

4.4. LB Enfield has a statutory responsibility to develop local suicide action plans[i] through the Health and Wellbeing Board. Activity in this area is going on in conjunction with partner organisations at a local, NCL, and National level. This includes suicide audit work at the North London Coroner’s Court in partnership with Dr Rachel Gibbons of the BEHMHT and ongoing contacts with the British Transport Police, Metropolitan Police and London Fire and Rescue

4.5. We are developing our Suicide Prevention Strategy and as has been noted at a previous HWB, Enfield currently has the lowest suicide prevalence in the country. http://healthierlives.phe.org.uk/topic/suicide-prevention

4.6. There is no single over-arching explanation for this figure. Our suicide audit activity with the North London Coroner produced an almost exactly aligned figure for 2017, so there is also a degree of local verification.

4.7. There are a number of Local Authorities, both locally and nationally which have what may appear to be counter-intuitively low suicide prevalence [for example Barking and Trafford], but have some very similar demographic, social and geographic factors.

However, and as noted by the CQC inspectorate when giving feedback after the Thematic Review of our CAMHS team last autumn, there is a great deal of effective cross-team working going on.

4.8. Suicide prevention is also a principle component of Thrive LDN. LBE Public Health staff, including the previous DPH, have met with Thrive LDN representatives including their Suicide Prevention Lead to discuss this issue.

4.9. LBE Public Health officers continue to work with our NCL neighbours about the potential for adopting an on-line MECC presence level prior to commissioning additional live MECC or MHFA activities.

4.10. As noted LBE Public Health Officers have been working with Public Health England, The Public Health Academy and The London South Bank University to develop commissioning and evaluation tools to ensure that prior to commissioning and/or development of additional MECC or MHFA activities a robust outcome and performance measurement frame work is in place.

4.11. Potential future MECC activity within LBE is being examined as an integral part of our Health in All Polices approach. MECC may be considered as the expression of the HiAP approach at the point of interaction between LBE staff and the citizens they serve

Stuart Lines
Director of Public Health

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Giving Every Child in Enfield the Best Possible Start in Life through improving school readiness

July 2018 Update

Background

The JHWBS identified BSIL as a key priority. The working group identified as school readiness as an area of focus, which was agreed by the HWB.

What happens in pregnancy and early childhood impacts on physical and emotional health all the way through to adulthood. Positive early experience is therefore vital to ensure children are ready to learn, ready for school and have good life chances.

It is shaped by several factors such as:

- parenting effectiveness
- deprivation
- the impact of high-quality early education and care

Parents have the biggest influence on their child's early learning. For example, talking and reading to a baby can help stimulate language skills from birth.

Early communication skills help children to develop a range of cognitive skills that are crucial for their development, including working memory and reading skills. This can help prepare children so that they are ready to learn at 2 and ready for school at 5.

Ready for school at five

At the Health and Wellbeing Board Development session it was agreed that ensuring children are ready for school at five should be an area of focus for the remainder of the Joint Health and Wellbeing Strategy, to April 2019.

On leaving the Foundation Stage at the end of Reception, a child is considered to have a 'good level of development' (GLD) if they have achieved at least the expected level in the Early Learning Goals in all aspects of Personal, Social & Emotional (PSE), physical development, Communication and language, Literacy and Mathematics.

Local Context

In Enfield, for a cohort of 4,634 children the data shows an improvement of 1.6% for the GLD from 66% in 2016, to 67.8% in 2017. The unconfirmed national GLD has also risen from 69% to 70.7%.

This means that, whilst Enfield has consistently improved in line with other Authorities, it has not yet narrowed the gap in school readiness measures in terms of national or regional comparators.

This provides a clear challenge and focus for the Best Start in Life work.

The impact of intervention strategies for vulnerable children including boys, Early Years Pupil Premium (an additional payment to settings for some children) and children who attended Two-Year-Old (Terrific Twos) provision in Enfield has led to some schools being able to 'close the gap'.

Some Enfield schools, who have a high percentage of children from families with many complex issues, can ensure that 66+% of children do achieve a GLD while for others it is still only 55%.

Schools are reporting significantly higher mobility within the year group. During the reception year 160 children (4%) left while another 80 transferred internally to another Enfield school, (240 children in total). During the year, 200 children joined the cohort (5%), and from this group only a quarter had attended some form of Early Education in another LA, meaning less children had benefited from proven interventions, leading to lower scores.

Responding to the Challenge

Commissioners and partners across Education and Children's Services, Public Health and Health Providers have worked together to ensure that early intervention services are commissioned and developed to respond to the challenges set by ensuring the Best Start in Life. Early Years education is also at the forefront, with greater support for schools being developed to ensure peer support and learning for teaching staff.

Below are updates on the key examples of work being carried out to respond to the challenge to deliver improved school readiness in for Enfield children:

1. Empowering Parents, Empowering Communities Programme

The importance of good parenting cannot be underestimated when working towards positive outcomes for children and their families. Enfield has developed a consistent approach to its parenting offer over the past three years, starting with the introduction of Webster Stratton: Incredible Years in Children's Centres and then in schools. This programme is delivered by Children's Centre staff with input from Educational Psychologists, trained in the Child and Young People Improving Access to Psychological Therapies programme (CYP-IAPT).

The work around Best Start in Life has identified the need to increase the capacity of parenting support in the early years, especially to reach those families that may not engage with more traditional services.

Commissioners have been successful in bidding to deliver a new service in partnership with parent volunteers, which is able to complement the more traditional work at a neighbourhood level.

Empowering Parents, Empowering Communities (EPEC) developed by the Centre for Parent and Child Support, SLAM and the CAMHS Research Unit, King's College, London is an internationally recognised evidence-based peer-led parenting programme.

It provides a system for training and supervising parent-led parenting groups that help parents to learn practical parenting skills for everyday family life and develop their abilities to bring up confident, happy and co-operative children. Free crèches are provided alongside each group and parents attending the course can choose to gain accreditation for their work through the Open College Network.

EPEC offers parenting support that improves:

- Children's social, emotional and behavioural development.
- Children's readiness for school and learning.
- Parenting, parent confidence and well-being.
- Family communication, interaction, routines and resilience.
- Social support and social capital.
- Parent engagement and service uptake.
- Early identification of risk and effective early intervention.
- Efficiency, cost-effectiveness and integration of local parenting support.

Enfield will deliver an EPEC Hub through its commissioned Children's Centre. The Children's Centre consists of a team of over twenty individuals working across several sites based in schools – mostly located in areas of deprivation – to provide a mix of family support and universal services to families with children under the age of five. The core work of the Children's Centre is to improve outcomes for children and contribute to their school readiness by ensuring effective early help is provided, with a focus on early communication and supporting carers to parent effectively. The Centre works as part of a multi-agency team with health and other partners, using a range of parenting interventions, including Family Star for individual assessment and parenting programmes where needed. The Centre provides individual family support for up to six hundred and fifty families per year and is the focal point of Enfield's early help offer for families with children under five.

The Children's Centre will further develop its relationship with the Enfield Parent Engagement Panel (PEP), which has over 400 affiliated members ready to undertake some form of volunteer work. We would also propose to develop a Local Authority-led steering group, comprising all partner agencies involved in delivering the Enfield parenting offer, to oversee the progress of EPEC. This would include partners already working with the Centre to provide parenting support e.g. CAMHS, Educational Psychology, local Troubled Families team, Public Health.

In addition to the resource and training being provided as part of the successful bid, Public Health has committed funding for a 0.4 FTE Children's Centre worker to coordinate the programme and the Children's Centre service will provide £5,000 towards ongoing re-imbursement of parent volunteers.

2. Healthy Early Years

Healthy Early Years London (HEYL) is an awards scheme funded by the Mayor of London which supports and recognises achievements in child health, wellbeing and education in early years settings.

Building on the success of Healthy Schools London, HEYL will help to reduce health inequalities by supporting a healthy start to life across themes that include healthy eating, oral and physical health and early cognitive development.

HEYL complements and enhances the statutory Early Years Foundation Stage framework, adding to the focus on children, families and staff health and wellbeing.

The 4 levels of Awards - HEYL First Steps, Bronze, Silver and Gold - can be used to improve and support practice in all Early Years settings:

- private, voluntary and independent nurseries
- early learning and day care in children's centres
- childminders

- Early Years in schools including schools with two-year old provision
- nursery schools
- crèches and playgroups

Enfield's approach to delivering HEYL will be to create a 0.6 FTE post (funded by Public Health) and positioned with the Early Years' Service, as part of its Quality and Outcomes Team, working closely with PVI settings to ensure that provision is of the highest quality.

3. 0-19 recommissioning

There are national specifications for service delivery for Health Visiting, School Nursing and Family Nurse Partnerships. Collectively these specifications offer a comprehensive approach to engaging families and young people to ensure that children are developing well and to work with families who have concerns or additional needs and complexities.

It has been acknowledged as part of the review of current service provision that Health Visiting particularly has a key role to play in promoting and ensuring children's readiness to learn at 2 and readiness for school at 5.

Commissioners have worked closely with the service provider to develop programmes and support mechanisms that extend beyond the work mandated in the national specifications.

This work includes a First Time Parents programme, delivered through the Children's Centre with sessions run by Health Visitors, Speech and Language Therapists and counsellors from the IAPT service.

Sessions focus on key aspects that will promote a positive start in life. These include:

- Emotional wellbeing for the parents
- Information on immunisations, breastfeeding, weaning and child development
- Early communication screening
- Information on whole family support and services available

4. Anna Freud Project

The Anna Freud National Centre for Children and Families (AFNCFF) and Enfield Health Visiting (HV) piloted a model of an integrated baby clinic in three clinics in areas of social disadvantage. The new proposal will roll out the model into more clinics, to reach a greater number of families and incorporate learning from the pilot project. The aim is to create a transfer and cascade of infant-directed intervention skills to establish a culture of baby focussed clinics throughout Enfield.

Under the new arrangements, the Health Visiting Service will work collaboratively with Enfield Children's Centre (CC) to deliver the project at four sites – both health clinics and Children's Centre sites.

The aims of the pilot are to:

- increase staff confidence to support caregiver-baby interactions within the clinics and decrease escalation of referrals to family support;
- increase cooperative working between CC and HV staff in four Enfield baby clinics, where families can be thought about together;
- recruit and supervise mentors from CC and HV in each clinic, who will support for the model and weekly reflection sessions. To develop a service evaluation to assess the success of these aims;

- reduce overall referrals from HV to CC, as it is expected that this model will enable staff to support families during clinic time;
- ensure that any referrals that do need to be made for early help are appropriate and contain full and useful information.

5. Play and Communication and Universal Play & Communication Assessment Toolkit (UPCAT)

In September 2015, Enfield rolled out the Play and Communication Programme, which uses a tool to profile children attending universal Children's Centre sessions, to identify speech, language and communication needs (SLCN) as early as possible. The information captured is fed into the Early Intervention Performance Outcomes Framework to provide a detailed record for each child; this in turn feeds into a summary dataset, demonstrating the outcomes at each review stage (12 weeks, 6 months and 1 year). The programme now forms a key part of the speech and language pathway in the early years and has previously demonstrated a success rate of up to 80% (success being defined as children being supported by the Children's Centre who would otherwise have been referred into the core health speech and language service).

Many children between the ages of 0-4 living in Enfield also attend a private, voluntary and independent (PVI) sector nursery or pre-school, so are unlikely to also attend universal Children's Centre services.

Therefore, a PVI-focussed and delivered variant of the Play and Communication programme has been commissioned. As with the Play and Communication programme, UPCAT utilises a screening tool based on the hierarchy of speech and language development and the EYFS Ages and Stages. A key difference is that the tool and framework can be used by a worker without a parent being present. Commissioned speech and language therapists can train PVI staff to use the tool effectively and provide support to settings on strategies to use to help the child. Children are also able to be referred into the Children's Centre element of the programme if needed and resource is being increased to ensure that supply meets demand. The programme has been piloted successfully with several PVI settings and rollout will be ongoing through 2018/19.

Education and Children's Services have committed an additional £80,000 per annum to commission this service and commissioners expect the following outcomes to be achieved:

- Improvement in the early identification of SLCN in under 5s
- Children's Centre and PVI staff are empowered to accurately identify SLCN and make appropriate referrals
- TalkACTivity – as part of the care pathway – successfully reduces the number of children requiring more specialist intervention
- Children taken onto caseload through accessing access and advice sessions have a reduced waiting time to access clinical SLT services

6. Interschool Moderation

During the start of the spring term 2018 five interschool moderation trialling sessions took place. During these sessions Early Years Team Leaders were asked to bring current observations and assessments as evidence of children's work for the five moderated Early Learning Goals. The evidence includes children who are predicted to achieve the range of outcomes, which are Emerging, Expected and Exceeding by the end of the summer 2019 term. All schools with reception aged children sent a representative to one of these sessions and it is our intention that these meetings will continue to be used to support teaching in the Early Years Foundation Stage.

7. School Peer Cluster Meetings

Over the academic year a programme of local cluster meetings has been arranged for both nursery and reception teachers. Schools have been asked to present five pieces of mark -marking/writing, that represents the range of attainment across the current cohort for either their nursery or reception children, as of the third/fourth week in November.

During the Cluster Meetings team leaders are asked to assess the pieces of children's writing and to align these to the Enfield Writing Progression Template, which provided writing criteria from children working within the 30-50 months range to children who were deemed to be 'exceeding' at the end of the reception year.

Over the previous year, 16 clusters have been formed, with more than 200 delegates attending meetings.

Assessing the Impact

The projects described herein have all been implemented to support the Best Start in Life. Below is a summary of the outcomes we expect the projects to be achieving and by when.

Project	**Outcomes/outputs**	**To be achieved by**
Empowering Parents, Empowering Communities	• 100 parents to benefit from programme • 16 parent volunteers to be delivering • 10 programmes to be delivered • Children's social, emotional and behavioural development. • Children's readiness for school and learning. • Parenting, parent confidence and well-being. • Family communication, interaction, routines and resilience. • Social support and social capital. • Parent engagement and service uptake. • Early identification of risk and effective early intervention. • Efficiency, cost-effectiveness and integration of local parenting support.	June 2019

	•	
Healthy Early Years London	• Accredited private, voluntary and independent sector childcare providers • Creation of dedicated post (to be combined into PVI objectives)	June 2019
0-19 Recommissioning	Embedding First Time Parents programme into the service to achieve: • Emotional wellbeing for the parents • Information on immunisations, breastfeeding, weaning and child development • Early communication screening • Information on whole family support and services available • Health Start Vouchers	April 2019
Play & Communication / UPCAT	• Reduction in number of children requiring core speech and language services	Ongoing – UPCAT fully implemented by December 2018
Interschool Moderation and Peer School Cluster Meetings	• Improvement in Good Level of Development at the end of Foundation Stage • Improved accuracy in assessing children at the end of Foundation Stage	September 2019

Contact: Andrew Lawrence (Service Development Manager – Early Years and Early Help)

July 2018

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Priority and Rationale	Objective	Outcome measure/Indicator and how will be measured	Lead
Data Access and Sharing	Liaise with Registrars and Children's Centre to develop data sharing agreement for new birth data	Revised information sharing protocol	Children's and Registry Services
	Develop a profile of needs including demographic data	A written report	Education and PH
Services	Integration of Parenting Support and Early Years within commissioning of the Health Visitors Contract	First Time Parenting and other partnership ventures reflected in new specification	PH and Children's Services
	Rollout of Anna Freud baby clinic model	model delivered to all families attending clinics at Bowes, Eldon, Galliard, Highlands and St Michaels	Education and BEH-MHT
	Rollout of Universal Play and Communication Assessment Toolkit (UPCAT)	UPCAT embedded in PVI settings Programme accreditation	Education, Children's Centre and BEH-MHT
	Training for Oral Health, Healthy Start, Nutrition and Vitamins with Health Visitors, PVI and change and challenge team to increase access to services for targeted families	A developed training package	PH, HV, PVI and Children's Centre
Healthy Pregnancy and New Birth	Improve and Maintain Maternal Mental Health Resilience in Expectant and New Mothers	i.] Contact Local Midwives re current practices for ante-natal support. Ii] Query utility of "mindfulness" programmes. Iii.] Determine level of current local support iv.] Liase with VAWG team v.] Liase with DAAT team Outcome Measure - reduction in level of referrals to secondary mental health care of expectant mothers.	PH
	Develop Prompt cards for HV's - MLT to provide script for cards .	i. Delivery of Prompt cards to HV's ii Distribution to target clients. Iii Client survey and review	PH
	Smoking cessation services for expectant mothers	As defined in contract KPIs	PH
	Increase number of expectant mothers receiving flu vaccine.	Increase in take-up	PH

	Distribution of Healthy Start Forms as part of HV mandated checks	Increased uptake	PH
	HV sign-up to Baby Friendly Initiative	Reaching defined accredited level	BEH-MHT
	Review current antenatal offer	Improve joint working arrangements between North Middlesex and Barnet & Chase Fam teams, particularly through Children's Centres	Education
Healthy Start Voucher	Complete a Healthy Start Voucher campaign	Deliver through Children's Centre programme	PH, Children's Services and CCG
	Deliver 5 training sessions for health visitors, change and challenge team and PVIs	Attendance Register and Evaluation form	PH, Education and Children's Centre
Language development and ability to learn	Capacity to form and maintain positive relationships with others	Expansion of Play and Communication programme into PVI	Education
Immunisations	Imms information - Send out letters and information GP, Practice Nurse and Practice Manager in the borough	Letters sent	CCG via PLT, PNF, PMF, Locality meetings.
	Placing information on weekly bulletin to all practices	Comms in bulletin	CCG.
	Attend 3 Locality CCG Meetings in relation to imms	Minutes from meeting and attendance records	CCG and PH
Targeted Parenting Programs	Deliver 10 parenting programs within; Edmonton Green Upper Edmonton Turkey Street Lower Edmonton Ponders End	EPEC - track progress using Family Star to measure outcomes. Also, measure attendance and retention	Children's Centre
	% of families receiving Early Help and Support	Use CC contract targets on Early Help delivery, engagement, TAF and outcomes	Children's Services
	Develop guide to what's available in Enfield	i] Delivery of on-line guide to children's and young person's health and care services. Ii] Delivery of PDF/Word version of same. Iii] Potential link with LBE Services directory.	Public Health

Ready for school at 5	Develop a training package for teachers which include mental health obesity, oral health, physical activity and imms	To be developed	To be determined
	Maximise take-up of Free Entitlement	Uptake of eligible 2 year olds increases in line with outer London % averages Children accessing 3-4 year old entitlement % increases in line with other outer London L/As Families accessing the 30 hour uptake is in line with similar L/As 30 hour volunteers impact on uptake within communities currently not accessing the entitlement	Education
	Ensure high quality early years provision	Ensure that childcare places are high quality 95% good 95% of schools with early years provision is judged by Ofsted as being God or better Increase Outstanding outcomes in line with Outer London average	Education
	Raising attainment at all Key Stages through effective commissioning of training and support to schools and in the early years	% of children achieving a Good Level of Development (GLD) accelerates faster than the national increase Enfield performing within the top 20% compared with similar L/As	Education
	Sandwell – develop and deploy.	10 Schools from January 19 initial.	CAMHS/PH
Obesity	Organise nutrition and Weaning Training for PVIs and Change and Challenge Team	3 to 5 training sessions	PH/BEH/Children's Services/Change and Challenge Team
	Sugar Smart - to attain 40 pledges from appropriate settings	40 sessions undertaken in early years settings	PH, Children's Services, Education and PVI's
	Healthy Early Years to be developed within Enfield	To be determined	PVI's
	Healthy Schools to be expanded along Eastern Corridor of borough	To be determined	Education
	Daily Mile to be expanded	To be determined	PH, Education and Tottenham Hotspur

Every Child growing up free from tooth decay	Targeted oral health campaign within early years settings	To be determined	PH, Education, Children
	Oral Health specification and action plan to be reviewed	To be developed	PH
	Increase % of children receiving fluoride varnish within schools program	Increase past 65%.	Oral health promotion team/PH/Education

MUNICIPAL YEAR 2018/2019 REPORT NO.

MEETING TITLE AND DATE:
Health & Wellbeing Board
26/07/2018

REPORT OF:
Assistant Director of Public Health
Glenn Stewart

Agenda – Part:	**Item:**
Subject: Healthy Weight **Wards:** **Key Decision No:**	
Cabinet Member consulted:	

Contact officer and telephone number

Ailbhe Bhreathnach

Email: Ailbhe.bhreathnach@enfield.gov.uk

1. EXECUTIVE SUMMARY

Addressing obesity and promoting healthy weight is one of Public Health's priorities, and has been identified as a priority for the Health & Wellbeing Board for 2017 - 2019. The paper provides an update on the Healthy Weight Partnership and the draft Healthy Weight Strategy and action plan, in addition to highlighting an opportunity to participate in the School Superzones pilot project. It also introduces the Whole Systems Obesity Programme and an opportunity to review a draft guide to implementing this programme at a Local Authority level.

2. RECOMMENDATIONS

It is recommended that the Board:

2.1 encourages their organisations to respond to the Healthy Weight Strategy consultation and consider what actions their organisation can take to support all residents to make healthy food choices, stay physically active and maintain a healthy weight throughout their lives

2.2 supports Enfield Council's efforts to participate in the School Superzones pilot project, as outlined in section 4.5 of this report

2.3 members report on progress on the adoption of the actions from the Declaration on Sugar Reduction and the Obesity management care pathway, as outlined in section 3.6

3. BACKGROUND

3.1	Prevalence of obesity and overweight is high in Enfield and presents formidable health and social care problems. 3 year NCMP data (2014/15 – 2016/17) shows that the average prevalence of excess weight in year 6 pupils is 41.5%. This is significantly higher than London (37.9%) and England (33.87%) averages. 251 Year 6 pupils were identified as severely obese in 2016/17 (e.g. on the 99.6th centile of the 1990 child growth charts), equating to 6.1% of all the children measured.
3.2	47.4% of children in the top 10% most deprived parts of the Borough are overweight or obese, compared to 26.2% of children in the 10% least deprived parts of the Borough. Upper Edmonton (47.1%), Ponders End (46.9%), Enfield Highway (46.4%), Lower Edmonton (46.0%) and Edmonton Green (45.8%) had a significantly higher prevalence of excess weight in pupils compared to the Enfield average (41.5%)
3.3	The prevalence of excess weight by ethnicity is significantly higher in Turkish/Kurdish (51.1%) and African (45.5%) pupils compared to the Enfield average (41.5%)
3.4	If left unchanged, this situation will lead to serious health complications later in life, such as diabetes, heart disease and cancers. Enfield has one of the highest prevalence of Type 2 diabetes in London. Across the country diabetes costs the NHS £25,000 per minute.
3.5	The Foresight report concluded that there is no one solution to obesity and only a multi-pronged approach involving everyone will lead to long term change.
3.6	At the HWB meeting in December 2017, the Board agreed (1) That the Health and Wellbeing Board considered adoption of the actions in the table set out in the report [section 5] 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
3.7	At the HWB meeting in April 2018, the Board "agreed the recommended approach to setting up the Enfield Healthy Weight Partnership."
4.	**REPORT**
4.1	<u>Healthy Weight Partnership</u> The Healthy Weight Partnership met on the 5th July and agreed to the TOR of the group, which had been agreed by the Board.
4.2	<u>Healthy Weight Strategy</u> The Healthy Weight Partnership also agreed to the four main objectives of the Healthy Weight Strategy:

	1. Ensuring all local planning and policy decisions have a focus on creating and preserving health-promoting environments, thereby making the healthy choice the easy choice 2. Ensuring that all health, social care, educational and workplace settings encourage and support healthy eating, active travel and physical activity, particularly early years to enable children to have the best start in life 3. Providing residents with the knowledge, skills and opportunities to eat healthily, be active and maintain a healthy weight 4. Making tackling obesity everybody's business by working in partnership across sectors, and by developing a local workforce that is confident and competent in supporting people to make healthier choices The draft Healthy Weight strategy and action plan has been circulated to members of the Partnership and Public Health for comment. The strategy will be circulated for wider consultation following this feedback.
4.3	Whole Systems Obesity (WSO) Programme Central to the Strategy is considering learnings from the Whole Systems Obesity (WSO) Programme. *A WSO moves away from silo working on isolated short-term interventions to working with stakeholders across the whole system to identify, align and review a range of actions to tackle obesity in the short, medium and long term.*[1] Public Health England partnered with the Local Government Association and Association of Directors of Public Health to develop the WSO programme. Leeds Beckett University was commissioned to work with four pilot areas, with the aim of learning from local practices and creating practical, tried-and-tested guidance that could be used by any local authority in England. Seven other local authorities have since been welcomed into the programme. Three years into the programme, they are now preparing to share some of the learnings from these pilot areas. The final guide and supporting resources will be published in spring 2019, alongside a full evaluation to support the approach. However, they are asking local authorities for expressions of interest to receive the draft guide in September to enable them to review the guidance before it is peer reviewed.

[1] https://local.gov.uk/sites/default/files/documents/15.6%20Obesity-05.pdf

<table>
<tr><td></td><td>Enfield has expressed its interest in receiving this guide to implementing a WSO.</td></tr>
<tr><td>4.4</td><td><u>The Declaration on Sugar Reduction</u>

The Declaration on Sugar Reduction and Healthier Food has been signed by the new Leader of the Council and the Cabinet Member for Public Health. Sustain has accepted our action plan and is due to send us a certificate to display.

Partners will be asked to report on progress in implementing the Sugar Declaration at future HWB meetings.</td></tr>
<tr><td>4.5.</td><td><u>School Superzones Pilot Project</u>

Enfield has expressed an interest in partaking in the School Superzones pilot project with PH England.

One of the London Devolution prevention commitments is to create health super zones around schools. Superzones are a 400m radius area around schools in which actions are taken to protect children’s health and encourage healthy behaviours through interventions that target:
• unhealthy food and drink sales
• advertisements
• alcohol
• smoking
• gambling
• air quality.
• physical inactivity

The aim is to create a healthier and safer environment for our children to live, learn and play. This ambition is also included in the Mayors Health Inequalities Strategy, with a focus on developing superzones in deprived communities.

The school superzones pilot project
This new school superzones initiative will put London at the forefront of innovation, and a leading city in healthy urban design. The pilot project aims to:

• Explore, identify and test policy and fiscal levers and actions that are available on local, regional and national levels
• Use the opportunity of devolution to open negotiations with regional and national partners
• Co-create solutions with communities
• Share learning across pilot sites
• Evaluate the pilot to inform superzone development

The pilot project will run until March 2019, with the intention of developing a transferable superzone approach, and identify ‘once for London’ opportunities to change policy or legislation to improve the environment around schools.</td></tr>
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	Joining the pilot project To participate boroughs are required to: • Designate a superzones lead, who will be available to attend pilot progress meetings and be a point of contact for the project team. • Confirm senior level approval to participate in the pilot project. • Work with local transport team to incorporate superzones into TfL Liveable Neighbourhoods or LIP proposals. • Work with council colleagues (e.g. planning, licencing, transport, healthy schools) to develop a local superzones action plan tailored for your local area.

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MUNICIPAL YEAR 2018/2019 - REPORT NO.

MEETING TITLE AND DATE **Health and Wellbeing Board** Contact officer and telephone number: Stuart Lines Tel: 0208 379 3726 E mail: **Stuart.Lines@enfield.gov.uk**	**Agenda - Part:**	**Item:**
	Subject: Health & Wellbeing Board Forward Plan **Report of:** **Stuart Lines** **Director of Public Health**	

1. EXECUTIVE SUMMARY

Enfield's Health and Wellbeing Board (HWB) recently reviewed and updated its terms of reference to better support the delivery of HWB aims and functions. Developing a Forward Plan that focusses on the HWB's strategic leadership role will be key to delivering those aims and functions.

This report sets out options to consider when discussing and updating the Forward Plan.

2. RECOMMENDATIONS

The Board is asked to discuss and update the Forward Plan.

3. BACKGROUND

3.1 In April 2018 members of the Health and Wellbeing Board started to develop the HWB Forward Plan for 2018/19.

3.2 At the same meeting the Health and Wellbeing Board reviewed and updated its terms of reference. The purpose of the review was to support the effective delivery of the Health and Wellbeing Board's aims and functions by enabling more focussed discussions and ensuring that there are strong links between the HWB meetings and the Development Sessions.

3.3 The new terms of reference state that the primary aims of the Health & Wellbeing Board '*are to provide system leadership to improve health and reduce health inequalities in Enfield and improve local accountability for health improvement. The Board will support the development of strong partnership working and integration, particularly between the Local Authority, the Clinical Commissioning Group (CCG) and other local services and partners for the benefit of residents'*

3.4 The Health & Wellbeing Board's Forward Plan is key to achieving these aims.

4. REPORT

4.1 To provide system leadership and deliver improvement across the health and care system in Enfield the HWB will need take a whole system approach to health and wellbeing, focus on the wider determinants of health and build on its determination to embed health considerations into policy making across the borough (HiAP).

Developing the HWB Forward Plan

4.2 Among the core responsibilities of the Health & Wellbeing Board is the preparation of the Joint Strategic Needs Assessment (JSNA) and the Pharmaceutical Needs Assessment (PNA) and the development and delivery of the Joint Health and Wellbeing Strategy (JHWS). These responsibilities are reflected in the attached Forward Plan (Appendix 1).

4.3 The HWB will continue to receive JHWS progress reports at each meeting and will be able to select one (or more) priorities for a more focussed discussion at a subsequent meeting.

4.4 At the last Health & Wellbeing Board meeting the terms of reference for the refreshed Health Improvement Partnership (HIP) were also agreed. The HIP was set up to support the Health & Wellbeing Board discharge its functions in relation to system leadership.

4.5 The HIP will work to strengthen linkages and support cooperation between the Health and Wellbeing Board and partners across Enfield and North Central London. This will enable it to support the delivery of the Joint Health and Wellbeing Strategy, report on progress and escalate issues to the Board.

4.6 The HWB will receive a regular update from the HIP, outlining the work it has done to take forward HWB actions and suggesting topics for inclusion in the Forward Plan. The HIP will also support the design and delivery of Health & Wellbeing Board development sessions, events.

4.7 Several potential topics for the Forward Plan were discussed at the April meeting. The Health and Wellbeing Board is asked to considerer these and any additional topics, in the context of its strategic leadership, role for inclusion in Forward Plan.

Potential topics for the Forward Plan

- Population Health Management – how can we use this new resource to improve health in Enfield?
- CHINs (Care Closer to Home Integrated Networks)
- North Middlesex Hospital & winter pressures

- Preventing ill health across NCL (STP Prevention plan) including action on:
  - Falls
  - CVD (HT & AF work)
  - Alcohol & Smoking CQUIN in Enfield
- Urgent & Emergency Care (STP)
- Developments in Primary Care including use of Pharmacy to improve Health & General Practice development in Enfield
- Progress in delivery of the Violence Against Women & Girls (VAWG) strategy. September will be 12 months since it last came to HWB
- Improving life for people with Long Term Conditions (LTCs), including work on self-care, diabetes management
- Integration of health and care – perhaps an Extra Dev Session in October?
  - What is our ambition for integration in Enfield?
  - What are new models of care that could work here?
- Healthy Weight Action Plan – building on the obesity pathway work at March Dev Session and sugar smart
- Place design and health – what are the opportunities for Enfield
  - Chase Farm
  - Meridian Water
  - Healthy streets

4.8 Based on discussion and agreement a revised Forward Plan will be shared with the Board.

Background Papers

HWB Draft Forward Plan (Appendix 1)
New Health & Wellbeing Board Terms of Reference
HIP Terms of Reference

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Forward Plan for Health & Wellbeing Board 2018/19

Timetable

- 4.30– 6.15 Development session
- 6.30 – 7.45 HWB
- 4 meetings to take place per year Plus 'extra' Development sessions (between 2 and 4 per year depending on need) to take place between 5.00 – 7.00pm.
- Therefore, a total of 6-8 meetings per year.

Standing agenda items for every HWB meeting

- JHWS progress report – highlights and challenges on progress against the top 10 and DV (in collaboration with SSCB)
- Update from the Health Improvement Partnership (HIP)
- Information Bulletin
- HWB Forward Plan

Date	Meeting	Agenda Items	Sponsor Board Member / Officer
26th July 2018	**Development Session** Health & Wellbeing in Enfield	Joint Health & Wellbeing Strategy development process Workshop - developing the Joint Health & Wellbeing Strategy (JHWBS) – focus on priorities and outcomes	Stuart Lines / Harriet Potemkin
	HWB	North Middlesex University Hospital NHS Trust (NMUH) Case for change Better Care Fund Year End Report Mental Health – priority update Best Start in Life – priority update Healthy Weight – priority update	Richard Gourlay Bindi Nagra Mark Tickner Diane Weston/ Andrew Lawrence Dr Glenn Stewart

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		Key Messages from the JSNA	Dr Glenn Stewart
27th September 2018	**Development Session**	Mental Health in Enfield – to include Healthy Streets, MH Services and Suicide Prevention Strategy – evidence and the development of a strategy	Mark Tickner
	HWB	Draft JHWS prior to consultation	Harriet Potemkin
		Annual Public Health Report	Stuart Lines
		Long Term Conditions Report	CCG
31st October	**Additional Development Session**		
	If required		
6th December 2018	**Development Session**	JHWS – Feedback to date from the consultation	Stuart Lines / Harriet Potemkin
	HWB	Suicide Prevention Strategy	Stuart Lines / Mark Tickner
16th January 2019	**Additional Development Session**		

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20th March 2019	**Development Session**	PNA Annual review	
	HWB	JHWS sign off	Stuart Lines / Harriet Potemkin

Potential topics for the Forward Plan

- Population Health Management – how can we use this new resource to improve health in Enfield?
- CHINs (Care Closer to Home Integrated Networks)
- North Middlesex Hospital & winter pressures
- Preventing ill health across NCL (STP Prevention plan) including action on:
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  - CVD (HT & AF work)
  - Alcohol & Smoking CQUIN in Enfield
- Urgent & Emergency Care (STP)
- Care Closer to Home (STP)
- Developments in Primary Care including use of Pharmacy to improve Health & General Practice development in Enfield
- Progress in delivery of VAWG strategy. September will be 12 months since it last came to HWB
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  - What is our ambition for integration in Enfield?
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- Healthy Weight Action Plan – building on the obesity pathway work at March Dev Session and sugar smart
- Place design and health – what are the opportunities for Enfield
  - Chase Farm
  - Meridian Water
  - Healthy streets

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Health and Wellbeing Board Information Bulletin

Dementia risk now included as part of NHS Health Check

Healthcare professionals in GP surgeries and the community will now give advice to their patients on how they can reduce their dementia risk as part of the NHS Health Check. For further information please see: https://www.gov.uk/government/news/dementia-risk-now-included-as-part-of-nhs-health-check

The Good Thinking Project

The Good Thinking Project helps people find tools and resources that will support them to manage issues such as anxiety, sleep, stress and feeling low and sad.

Further stakeholder information about the project can be found at: https://www.thegoodthinkingproject.london/

The public facing website, which provides information about how to access support can be found here: good-thinking.uk.

GP extended access service

Extra GP and nurse appointments in the evenings, weekends and public holidays are available to Enfield patients. There is now walk-in access at some of the hubs on weekends and also public holidays. The single point of access number is now available 8am-8pm daily. For more information, please see: http://www.enfieldccg.nhs.uk/primary-care-gp-hubs.htm

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Healthy London Partnership Update:

Poor Oral Health & Homelessness

Poor access to dental services has a significant impact on the lives of people experiencing homelessness. Poor oral health commonly causes pain and suffering; dental pain can have a negative impact on mental and physical health and, in some cases, can cause people to use alcohol or drugs to control their pain.

Healthy London Partnership, Public Health England, and Ground have developed a poster that aims to help homeless people access dental services and provide information about how to become an oral health champion. The poster can be downloaded from:
https://www.healthylondon.org/all-londoners-have-the-right-to-a-healthy-mouth/

Social Prescribing

Social prescribing is a way of linking patients in primary care with sources of support in the community that can help them manage or overcome the social factors that can impact on health, such as employment, debt and social isolation. A range of online social prescribing resources can be found here:
https://www.healthylondon.org/our-work/proactive-care/social-prescribing/

Cancer – New Guide for Commissioners

The Transforming Cancer Service team has developed a tool kit which provides a 4-point model to enable STPs, CCGs and front-line staff support patients with a diagnosis of cancer to self-manage. Further Information can be found at:
https://www.healthylondon.org/resource/commissioning-and-delivery-toolkit-for-cancer-as-a-long-term-condition/

Ask About Asthma 3

London's #AskAboutAsthma campaign is back and will run from 3-16 September. The campaign has three simple asks. If you're working or caring for children and young people with asthma make sure they 1) have an asthma plan 2) can use their inhaler properly 3) have an annual review. Further information can be found at:
https://www.healthylondon.org/ask-about-asthma-3-16-september-2018/

Storytelling to get parents and children talking about mental health

Thrive LDN has teamed up with children's story center Discover to promote positive mental health educational events for young children and their parents through a series of free-to-attend storytelling sessions across the capital. For more information, please see:
https://www.healthylondon.org/thrive-ldn-partners-with-discover-storytelling-to-get-parents-and-children-talking-about-mental-health/

London Mental Health Handover Form

The Healthy London Partnership has worked with London's A&E departments, police forces and service users to develop a handover form. This has resulted in 83 per cent fewer people, compared to the previous year, going missing from A&E when having a mental health crisis,. Further information can be found at: https://www.healthylondon.org/resource/case-study-londons-mental-health-handover-form/

The role of cities in improving population health: international insights

The King's Fund has released a report that explores the role cities are playing in improving population health and the conditions needed for success. The report draws on case studies to explore the conditions required for successful health governance in cities and the role that city governments can play in improving population health. The report can be found:

https://www.healthylondon.org/resource/in-focus-the-role-of-cities-in-improving-population-health-international-insights/

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY, 17 APRIL 2018

MEMBERSHIP

PRESENT Doug Taylor (Leader of the Council), Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Parin Bahl (Chair of Enfield Health Watch), John Wardell (Clinical Commissioning Group (CCG) Chief Officer), Tony Theodoulou (Executive Director of Children's Services) and Vivien Giladi (Voluntary Sector)

ABSENT 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), Dr Helene Brown (NHS England Representative), Stuart Lines (Director of Public Health), Natalie Forrest (Chief Executive, Chase Farm Hospital, Royal Free Group), Maria Kane (Chief Executive North Middlesex University Hospital NHS Trust), Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust), Carla Charalambous (Enfield Youth Parliament) and Josh Salih (Enfield Youth Parliament)

OFFICERS: Bindi Nagra (Director of Adult Social Care), Dr Glenn Stewart (Assistant Director, Public Health), Miho Yoshizaki (Health Intelligence Manager), Mark Tickner (Senior Public Health Strategist), Ian Davis (Chief Executive) and Innes Deuchars (Legal Services) Jane Creer (Secretary)

Also Attending: 9 observers

1
WELCOME AND APOLOGIES

Councillor Doug Taylor (Chair) welcomed everyone to the meeting. Apologies for absence were received from Councillors Alev Cazimoglu, Krystle Fonyonga and Ayfer Orhan, Natalie Forrest, Stuart Lines, Maria Kane, Dr Helene Brown, Andrew Wright and Youth Parliament representatives.

2
DECLARATION OF INTERESTS

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

3
PNA REPORT - SIGN OFF & DECISION ON HOW TO REFRESH

RECEIVED the report of Miho Yoshizaki, Health Intelligence Manager, Health, Housing and Adult Social Care.

NOTED
Miho Yoshizaki introduced the report, highlighting the following:
● The process in respect of the Pharmaceutical Needs Assessment (PNA) has been confirmed.
● The Enfield PNA is now complete and available online.
● The Health and Wellbeing Board discussed the maintenance of the PNA; it was recommended to maintain information and to review the PNA at least annually. This would be undertaken by the Enfield PNA steering group.

The Board considered that the proposals were satisfactory.

AGREED
(1) That the Health and Wellbeing Board noted the publication of Enfield PNA 2018-2021.
(2) The Health and Wellbeing Board agreed the recommended approach to maintaining the Enfield PNA.

4
HEALTHY WEIGHT - TACKLING OBESITY PARTNERSHIP/TERMS OF REFERENCES (TOR)

RECEIVED the report of Dr Glenn Stewart, Assistant Director of Public Health, sent to follow.

NOTED
Dr Glenn Stewart introduced the report, highlighting the following:
● At the recent Health and Wellbeing Board development session, it had been requested to put together an Enfield Healthy Weight Partnership to work on the issue, and this report set out the partnership's proposed terms of reference.
● Meetings were proposed to be held quarterly.
● The partnership would report to the Health and Wellbeing Board.

IN RESPONSE comments and questions were received, including:
1. No time limit had been set for the partnership, but the aim was for people to work together to make a strategic plan with ongoing implementation. The first meeting would agree a timeline and actionable objectives.
2. The end to end pathway had been discussed and would be added to the document.

3. Membership of the Healthy Weight Partnership was agreed but noted that other groups including the Youth Parliament should also be consulted. It was noted that the strategy would not focus on young people in particular as everyone was affected by an obesogenic environment.

AGREED that the Health and Wellbeing Board agreed the recommended approach to setting up the Enfield Healthy Weight Partnership.

5
2018-19 HWB ARRANGEMENTS (HWB & HIP TOR)

RECEIVED the report of Stuart Lines, Director of Public Health.

NOTED
Dr Glenn Stewart (Assistant Director, Public Health) introduced the report, highlighting the following:
● The report followed discussions at the recent Health and Wellbeing development session
● The Health and Wellbeing Board had some statutory duties, but development of the Board and its arrangements are ongoing.
● It was recommended that Health and Wellbeing Board development sessions and formal Board meetings should be held on the same day.
● Amendments were suggested to the terms of reference of Enfield Health Improvement Partnership (HIP) for improved support to Enfield Health and Wellbeing Board (HWB).

IN RESPONSE comments and questions were received, including:
1. The representative of the Third Sector was the only non-self-defining member. The selection process was yet to be agreed.
2. It was confirmed in respect of data sharing between agencies that there would be compliance with GDPR.
3. The structure chart should be amended to better reflect the arrangements.

AGREED that the Health and Wellbeing Board
(1) noted and endorsed the updated terms of reference;
(2) noted and approved the proposed frequency of meetings;
(3) noted and approved (subject to amendments discussed) the proposed Structure chart and Governance Arrangements.

6
BEST START IN LIFE (BSIL) ACTION PLAN

RECEIVED the Action Plan – Best Start in Life – Improving School Readiness.

NOTED

Mark Tickner (Senior Public Health Strategist) introduced the plan further to discussions at the recent Health and Wellbeing Board development session, which was for noting at this stage.

IN RESPONSE comments and questions were received, including:
1. It was confirmed that a report would be presented to the next Health and Wellbeing Board meeting. An updated plan would be circulated to all members before then.
2. A list of other stakeholders who could add value to the implementation of the strategy would be drawn up.
3. Output / outcome measures were being developed.

AGREED that the Health and Wellbeing Board noted the BSIL Action Plan.

7
PLAN TO RENEW JOINT HEALTH WELLBEING STRATEGY (JHWS)

RECEIVED the report of Stuart Lines (Director of Public Health) and the additional report circulated which was the routine progress report on HWB monitoring areas for 2017-19 and annual review of key indicators.

NOTED
The introduction by Miho Yoshizaki (Health Intelligence Manager) highlighting in particular the JHWS performance report.

IN RESPONSE comments and questions were received, including:
1. It was advised that the direction of travel trends were important and that some indicators showing poorer outcomes in Enfield were improving.
2. It was also important to look at the size of the population impacted by an indicator which if improved would have a proportionately greater positive effect.
3. Enfield was still doing poorly in terms of obesity, especially child excess weight, for which measuring was done professionally in schools and data was robust and reliable. This also posed concern for future demands for health and care systems.
4. The ability for Health and Wellbeing Board to make a difference quickly in some areas was discussed, particularly the flu vaccination rates.
5. It was also important to look at areas where Enfield was performing well and to showcase our success.
6. Bindi Nagra would provide a verbal update to the next meeting in respect of Learning Disability Health Check performance.
7. Timetables and milestones for action were shown in the report in the agenda pack.
8. The Enfield Joint Health and Wellbeing Strategy (JHWBS) was recommended by Health and Wellbeing Board for submission to other bodies as necessary for approval.

AGREED that the Health and Wellbeing Board

(1) reviewed and noted the annual outcome indicators and support to the HWB priority areas;
(2) noted and endorsed the proposed timeline for the delivery of the 2019 JHWBS.

8
INFORMATION BULLETIN

NOTED the Information Bulletin items.

9
HEALTH AND WELLBEING BOARD FORWARD PLAN

NOTED the proposed forward plan and agenda items to be added at an appropriate date in respect of (1) North Middlesex Hospital and winter pressures; and (2) CHINs.

10
MINUTES OF THE MEETING HELD ON 8TH FEBRUARY 2018

AGREED the minutes of the meeting held on 8 February 2018.

11
DATES OF FUTURE MEETINGS

NOTED that the dates of meetings of the Health and Wellbeing Board for the 2018/19 municipal year would be circulated following formal approval of the Council Calendar of Meetings at the Annual Council meeting on 23 May 2018.

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