Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 27 September 2018 at 6.30 pm
Community House, 311 Fore Street,
Edmonton, N9 0PZ
Room 3

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Please note meeting time and venue

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)
Enfield Voluntary Action – Jo Ikhelef

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. PROGRESS UPDATE ON JOINT HEALTH AND WELLBEING STRATEGY (JHWS) (6:30 - 7:00PM) (Pages 1 - 12)

To receive the discussion paper and presentation by Harriet Potemkin (Strategy and Policy Hub Manager).

4. CYCLE ENFIELD - PRESENTATION AND PROGRESS (7:00 - 7:15PM)

To receive a presentation from Glenn Stewart (Assistant Director, Public Health, LB Enfield) and Richard Eason (Cycle Enfield Programme Director).

5. HEALTH IMPROVEMENT PARTNERSHIP (HIP) UPDATE (7:15 - 7:25PM)

To receive an update on development, issues and challenges from Glenn Stewart (Assistant Director, Public Health, LB Enfield).

6. NORTH CENTRAL LONDON (NCL) STRATEGY FOR GENERAL PRACTICE (7:25 - 7:35PM) (Pages 13 - 50)

To receive a presentation by Dr Chitra Sankaran (GP) regarding consultation on the draft strategy. Please find a covering letter and slides attached.

REPORTS FOR INFORMATION

The following reports are for information only.

7. ANNUAL PUBLIC HEALTH REPORT (7:35 - 7:40PM) (Pages 51 - 58)

To receive this year's annual public health report of the Director of Public Health for 2017/18.

The full report is available online:

https://new.enfield.gov.uk/healthandwellbeing/jsna/annual-public-health-reports/annual-public-health-report-201718/

8. VOLUNTARY SECTOR REPRESENTATIVE APPOINTMENT / SELECTION PROCESS (7:40 - 7:45PM)

To receive an update from Niki Nicolaou (Voluntary Sector Manager, LB Enfield).

9. MINUTES OF THE MEETING HELD ON 26 JULY 2018 (Pages 59 - 66)

To receive and agree the minutes of the meeting held on 26 July 2018.

10. INFORMATION BULLETIN (Pages 67 - 68)

11. NORTH CENTRAL LONDON (NCL) SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) NEWSLETTER (Pages 69 - 78)

The latest newsletter is attached for information.

12. HEALTH AND WELLBEING BOARD FORWARD PLAN (Pages 79 - 104)

The current version of the Forward Plan is attached.

13. DATES OF FUTURE MEETINGS

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

14. 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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Proposal for a new Enfield Joint Health and Wellbeing Strategy 2019 onwards

Discussion paper for Health and Wellbeing Board September 2019

Report of: Stuart Lines, Director of Public Health, LB Enfield

Report author: Harriet Potemkin, Strategy and Policy Hub manager, LB Enfield

Introduction

This paper sets out a proposal for a new Joint Health and Wellbeing Strategy which will tackle health inequality through a preventative approach which is clear, simple and evidence-based. The proposed new strategy will be centred on behaviour change, with a focus on tackling inequality in the opportunities people in Enfield have to make choices which have a positive impact on their health.

The Board is asked to provide feedback on the proposal and agree for the Council's coordinating officers to develop and launch a public consultation on the approach set out in the paper.

Context

Local authorities and clinical commissioning groups (CCGs) have equal and joint duties under the Health and Social Care Act 2012 to prepare a Health and Wellbeing Strategy, through their Health and Wellbeing Board. The purpose is to set out how the local system will work together to improve the health and wellbeing of the local community and reduce health inequalities for all ages.

The existing Enfield Joint Health and Wellbeing Strategy expires at the end of 2019 and a new strategy is being produced by the Enfield Health and Wellbeing Board (EHWB) for 2019 onwards.

The strategy will help the council deliver its corporate plan, and the CCG to deliver its commissioning priorities, while facilitating all members of the Board to work collectively to tackle the borough's health and wellbeing challenges. The Board will oversee the development, delivery, monitoring and evaluation of the strategy, which will be delivered by all organisations and departments represented on the Board. The Health Improvement Partnership (HiP), a sub-group of the Board, will be responsible for the operational delivery of the strategy, and will report back to the Board on progress.

Question for the Board: Do we need an end date for the strategy eg 2024? Or should this be a 'live' document which will be implemented through an annual action plan, and reviewed and evaluated annually to determine whether the strategy should continue for the following year?

Summary of Board Member discussion in July 2018

The Enfield Health and Wellbeing Board (EHWB) considered what the new strategy should achieve at their development session on 26th July 2018. The Board was asked to consider

the approach taken during the current strategy, which ran from 2014 to 2019 and the outcomes achieved during that time period. This strategy had four priorities:

- Ensuring the best start in life
- Enabling people to be safe, independent and well and delivering high quality health and care services
- Creating stronger, healthier communities
- Promoting healthy lifestyles and making healthy choices.

In December 2016, the Board re-prioritised activity to focus on:

- Best Start in Life
- Obesity
- Emotional/ mental resilience

To evaluate the impact of our previous approach, we have considered key outcome measures set out below. The table below shows the outcomes which have either worsened since 2014, or where we are performing worse than the national average.

Priority	**Outcome measures where we are below national, and/or have worsened since 2014**
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

The Board was asked what we could do collectively that would make the biggest impact over the next five years. Board members made the following observations:

- We should be ambitious and outcome-driven.
- We need to focus on prevention and on tackling inequality.

- We need to adopt a Health in All Polices (HiAP) approach.
- We could consider place-based approaches - by focusing on areas within Enfield with specific identified need.
- Making Every Contact Count and Social Prescribing are approaches all partners could commit to and could make a real impact.
- We need to work with the community and actively engage with them.
- We need to have a positive narrative. “Do something good” is better than saying “stop something bad.” The strategy needs to be driven by the need to achieve large-scale behaviour change.
- We need to promote healthy habits by making the healthy choice the easy choice.
- Health road shows have been well-received by communities and are an inclusive platform for disseminating health related messages.
- Taking a life course approach works well, with a continuing focus on the best start in life (BSIL) – e.g. a focus on maternal smoking.
- We need to ‘sweat our assets’ better. Assets include:
    - our power as commissioners – with contracts being an opportunity to make policy changes
    - ourselves as leaders of the health system
    - our staff and office spaces – staff as potential examples of and drivers for positive change and our ability as employers to facilitate healthy behaviours e.g. smoke-free work places, healthy food choices in staff canteen
    - community spaces such as schools, libraries, cycle ways, communal areas in housing blocks where we can facilitate healthy environments
    - people in our community, including parents and carers at the school gate, parents and carers who are members of consultation forums e.g. Parents Engagement Panels (PEP); Health Champions; Over 50s Forum; Faith groups; and voluntary organisations
    - other parts of the Council, such as housing, transport or licensing teams, and other organisations, which have the potential to help us promote and facilitate healthy behaviour, including housing providers, the Fire Service, Police Service, and local businesses such as supermarkets and eateries.

A new strategy centred on behaviour change: 3-4-50

A simple, understandable and memorable message can help the Board make a tangible impact. A strategy centred on behaviour change, which focuses on a small number of behaviours which we know have the biggest impact on health outcomes, helps us to develop a simple narrative. A strategy focused on behaviour change allows us to tackle inequality in the opportunities people in Enfield have to make choices which have a positive impact on their health.

What is 3-4-50?

The 3-4-50 concept was originally developed by the Oxford Health Alliance, a partnership between Oxford University and Novo Nordisk A/S, under the original banner of 3FOUR50 in response to global concerns Long Term Conditions (LTC). In 2016, The Vermont Department of Health unveiled the results of data-based research showing that three behavioural factors of tobacco use, poor diet and a sedentary lifestyle can lead to four chronic conditions of cancer, diabetes, heart disease and lung disease, and that these diseases are responsible for 50 percent of deaths in Vermont. The research also found that being part of a certain population group, such as having a low income, a disability or

depression, is linked to unhealthy behaviours and therefore the increased likelihood of developing chronic diseases. This data driven campaign was also called the 3-4-50.

The research is not only applicable to Vermont, and similar research has been done with different communities worldwide. The research is applicable to Enfield's population, where cancer, heart disease and lung disease account for 73% of all deaths in Enfield (2016)

The four diseases are long term health conditions, which account for around 70% of the health service budget in the UK, as well as more than 50% of deaths.[1] Diseases such as diabetes, cancer, and respiratory diseases are responsible for over 70% of deaths 66.3% of deaths under 65 years of age in Enfield.[2] In Enfield, 7.7% of people are known to have type 2 diabetes, plus there are an estimated 4,800 people who are undiagnosed. In 2014/15, there were 416 new diagnosis of cancer in this year alone. In 2016/17, there were 684 hospital admissions for heart disease for every 100,000 people in Enfield.

A large proportion of these diseases are preventable. There is also a link between these long-term conditions and mental ill-health. Enduring long-term physical health challenges has an associated adverse impact upon mental health and wellbeing.[3]

The 3-4-50 Framework is a strategic model that aims to align the efforts of health care providers, community organisations, businesses, schools and government to change behaviours and create a healthier community. It is based on the principles of transformational change in community health, which cannot just rely on the health care system. The core of the framework is to build communities and environments where healthy lifestyles are encouraged and supported. People can help reduce the risk of developing these diseases, or even prevent them, with positive lifestyle changes. However, factors such as education, income, environment, cultural norms and inconvenience all play a role in whether people are able to make these changes.

For the approach to be successful, there is a need for full commitment and buy-in from across the community. Different organisations, schools, and businesses as well as local government and health services can contribute to the implementation of 3-4-50. It requires a call to action for involvement – and strong leadership. The framework exists to encourage change, support change already being done, and help to bring disparate efforts together with the goal of creating greater collective impact.

Why is 3-4-50 the right approach for Enfield?

[1] NHS England (2014) Five year forward View
[2] ONS mortality file 2016 via PHE fingertips
[3] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

Using the 3-4-50 framework as a basis for our joint strategy gives us the opportunity to bring about large-scale behaviour change at a population level and improve associated health outcomes and tackle inequality through an ambitious strategy.

A strategy which focuses on changing the negative behaviours of smoking, poor diet and physical inactivity is inherently a strategy focused on **prevention**, which was one of the key themes emerging from the EHWB development session in July. The entire strategy will be geared around preventing the three behaviours which local, national and international research shows are linked to poor health outcomes and earlier death.

Given the evidence that the three behaviours are also linked to certain populations such as those on low incomes, or those already managing another health challenge, the framework will also allow us to focus on tackling health **inequality**, another priority for Enfield. Life expectancy at birth in Enfield is significantly better than England averages, but there is still wide variation within the borough. There is an 8.5 years difference between the female life expectancy in the highest (Highland, 87.2 years) and lowest (Upper Edmonton, 78.7 years) wards. We need to think about how we improve healthy life expectancy through supporting positive health behaviours amongst those who currently have the lowest life expectancy.

By focusing on positive behaviour chance, we can work together to improve healthy life expectancy for everyone in the borough: over 15 years are currently lived in 'poor health' in Enfield. Again, this is worse for those in the most deprived areas, the gap between life expectancy and healthy life expectancy being wider in more deprived areas. In Edmonton Green, the average number of years that a female is expected to live in poor health is 28 years.

We need to use our multi-agency partnership to bring about change for populations who are currently facing worse health outcomes.

We know that a significant cause of death and therefore a significant cause of ill health in Enfield are the diseases which are linked to the three behaviours of smoking, poor diet and inactivity. We also know that these diseases impact more on deprived communities. Our strategy will need to consider what our local data tells us about the three behaviours in Enfield, and to identify strategic goals for bringing about large-scale behaviour change, with a particular focus on disadvantaged communities.

Making the healthy choice the first choice for everyone in Enfield

Centred around the 3-4-50 framework, a proposed vision for a new strategy **is to make the healthy choice the first choice for everyone in Enfield.** To make change happen, we need to make healthy behaviours easier than unhealthy behaviours. To do this, we need to be ambitious about making policy change collectively, as a partnership. Importantly, we need to think about the opportunities to do this with our most deprived communities, including groups who currently experience far worse health outcomes than others. This is where the second part of the proposed vision comes in, to make the healthy choice the easy choice ***for everyone in Enfield***. Currently income, ethnicity, gender, having a disability or where someone lives are hugely significant in determining health outcomes. Our strategy can be ambitious about working together, with our communities, to find ways to shift this.

Questions for Board:

Is this the right vision? Do we talk about the healthy choice being the 'easy choice', or the 'first choice'? Does this capture what we want to achieve?

Priority 1: Being smoke-free

What do we know about this behaviour in Enfield?

Smoking is the leading cause of preventable illness and premature death in England, accounting for 21% of deaths in men and 13% of deaths in women aged over 35 in 2014. It is also the biggest cause of health inequalities accounting for approximately half of the difference in life-expectancy between the richest and poorest groups[4]. In 2014/15 there were approximately 1.7 million hospital admissions by those aged 35+ for smoking related illnesses[5]. It is estimated that smoking cost the NHS £2.6 billion in 2015[6]. HM Treasury estimates that the total cost to the economy in England is £12.9 billion per year[7].

Between 2012 and 2016, smoking prevalence fell in Enfield from 19.3% to 13.1% of the 18+ population, making smoking prevalence in Enfield the 10th lowest rate of the 32 London boroughs. In 2017, it rose slightly to 14.9%. Although smoking prevalence amongst the adult population in Enfield is lower than both the national and England averages, more than 32,000 adults in the borough still smoke. Furthermore, smoking prevalence is much higher amongst some groups, including pregnant women, adults with serious mental illness, and the Turkish community.

Concerted efforts are required across the health and care systems and the Council to reduce smoking prevalence further overall, and to reduce prevalence amongst groups where this behaviour is particularly dominant.

Evidence shows that if 10 in every 100 people quit smoking, an area's healthy life expectancy would rise by 6 years one month in men and 7 years one month in women. However, the greatest gain to be made in stopping smoking prevalence, is in making sure people do not start in the first place. A national survey carried out in 2014/15 provided local level data that 3.5% of 15-year olds in Enfield were smokers – lower than London and national averages. This positive behaviour amongst young people is something we will want to continue to encourage and facilitate. It is also behaviour which we could explore using to positively influence others.

What measurable outcomes do we want to improve over the course of the strategy?

- 14.9% of Enfield adults smoke (2016)
- 3.5% of 15-year olds in Enfield currently smoke (2014/15)[8]
- 7% Enfield mothers smoke during pregnancy (2016/17)
- 40.7% of adults with serious mental illness in Enfield smoke (2014/15)
- 50% of adults in the Turkish community smoke (and 28% of young people) (2014)
- £60.5M estimated costs of smoking in Enfield

[4] Office for National Statistics (2016). Health Survey for England 2015. Trend tables commentary.
[5] Action on Smoking and Health (ASH) (2017) The economics of tobacco.
[6] Public Health England (2017) Cost of smoking to the NHS in England: 2015. https://www.gov.uk/government/publications/cost-of-smoking-to-the-nhs-in-england-2015/cost-of-smoking-to-the-nhs-in-england-2015. Site accessed 28th May 2018.
[7] HM Treasury (2014) Tobacco levy consultation.
[8] This data is from a national survey carried out in 2014/15, and we do not know when it might be repeated.

Strategic priorities to consider

1. Create work environments which discourage smoking during the working day.

2. Increase the number of smoke-free community spaces in Enfield.

3. Tackle inequality: develop community-based interventions to decrease smoking prevalence amongst pregnant mothers; adults with serious mental illness and the Turkish community

Questions for Board

Where does your organisation successfully operate smoke-free spaces? Where are there community areas which are currently not smoke free?

Questions for the consultation

Where do people currently smoke in Enfield? This will help us to consider areas where we may want to introduce new smoke-free policies, where we could have the biggest impact.

Questions for the consultation: Capture equalities monitoring information, so we can analyse the results of the consultation to better understand the higher rates of smoking amongst certain communities.

Priority 2: Having a healthy diet

What do we know about this behaviour in Enfield?

In 2016 poor diet was the second leading risk factor for mortality worldwide[9]. Fruit and vegetable consumption is inversely associated with the risk of Coronary Heart Disease (CHD), reduced by 4% for each additional piece of fruit eaten per day and 7% for each additional piece of vegetable[10]. Consumption of fruit and vegetables is associated with a diminished risk of stroke, hypertension, cancer, dementia, osteoporosis, asthma, rheumatoid arthritis, coronary heart disease, type 2 diabetes mellitus, and chronic obstructive pulmonary disease (COPD)[11].

A large proportion of adults and 15-year olds in Enfield are not meeting the recommended guideline of 5 portions of fruit or vegetables a day. The Active People Survey 2017 and the What About Youth (WAY) 2015 survey collected information on the consumption of fruit and vegetable of a sample of the population. The results indicated that 58.7% of 15- year olds and 58.2% of adults in Enfield regularly ate their recommended 5 portions a day. These figures are respectively higher and lower than the national and London. Enfield data also indicates significant differences in excess weight between ethnicities in the borough.

[9] Global Burden of Disease (GBD) 2016 Risk Factors Collaborators (2017) Global, regional, and national comparative risk assessment of 84 behavioural, environmental and occupational, and metabolic risks or clusters of risks, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016 Lancet 2017; 390:1345-1422.

[10] Dauchet, L. et.al (2006) Fruit and Vegetable Consumption and Risk of Coronary Heart Disease: A Meta-Analysis of Cohort Studies J. Nutr. 136: 2588–2593, 2006.

[11] Boeing, H. et.al (2012) Critical review: vegetables and fruit in the prevention of chronic diseases. European Journal of Nutrition September 2012, Volume 51, Issue 6, pp 637–663

Increasing levels of inequality mean that access to healthy food choices is less available for some parts of the population and they experience food poverty. Additionally, Enfield is considered to have an obesogenic environment where highly calorific food is constantly available and where physical activity is being progressively eliminated from modern life. An obesogenic environment could be one of the factors in poor accessibility to affordable healthy foods and the likelihood of experiencing food poverty. A nutritionally inadequate and unhealthy diet has been associated with an increase in the risk of CHD, cancer and obesity and diabetes. While anybody could experience food poverty at any point in life, people in low income jobs or on benefits are more likely to suffer from food poverty. In 2017/18, 6,746 people accessed the North Enfield Food Bank. This represents a 12.6% increase compared to the previous year.

Poor accessibility to affordable healthy foods also plays a role in the likelihood of experiencing food poverty. The development of out-of-town supermarkets and the closure of many shops in more deprived areas might lead to increased costs and decreased quality of available foods in the remaining shops. Action in this regard, needs to focus on changing the 'food environment' – that is, accessibility and affordability of healthy food – in which people live.[12]

What measurable outcomes do we want to improve over the course of the strategy?

- 41.8% of adults in Enfield are not meeting '5 a day' (2017)
- 41.3% of 15-year olds not meeting '5 a day' (2017)
- 226 fast food outlets in Enfield, making our rate 82.0 per 100,000 population
- 24.8% 4 to 5 -year olds; 41.5% 10 to 11 year olds; and 61.4% of adults are overweight or obese in Enfield (2016)
- 30.5% of children with one or more decayed, missing or filled teeth

Strategic priorities to consider

1. Create working environments that support a healthy, balanced diet[13]

2. Create healthy neighbourhoods and town centres that support a healthy, balanced diet

3. Create environments in early years settings, schools, health and social care that support a healthy, balanced diet

4. Tackle inequality: area-based initiatives to increase take up of '5 a day' in the most deprived wards in Enfield.

Questions for Board

As a first step, we have more power to changes practices in our own organisations than those not represented on the Board. How does your organisation currently facilitate healthy food options for staff as part of their working day? What unhealthy food choices still exist and what measures could be taken to decrease those options? As agreed by the Board in Dec 2017, has your organisation pledged to become Sugar Smart?

[12] JSNA

[13] With reference to Public Health England and Business in the Community Toolkit for Employers

Questions for the consultation

For respondents who work within Enfield – what healthy food choices and unhealthy food choices exist in your place of work?

For all – what healthy food choices exist for you, and what unhealthy food choices exist for you?

Priority 3: Being active

What do we know about this behaviour in Enfield?

Physical inactivity is the second main risk factor (after diet) for being overweight or obese, as keeping active is the most effective way of burning calories. The NHS recommends at least 150 minutes of moderate aerobic activity or 75 minutes of vigorous intensity per week. In 2016/17, 60.1% of Enfield adults performed 150 minutes or more of physical activity a week. This was a lower percentage of what was observed both in London and at a national level. Conversely, in the same year 27.7% of Enfield adults were found to engage in less than 30 minutes of physical activity a week. A percentage higher than both the national and London averages.[14]

Active travel is a convenient way of performing physical activity as it allows people to incorporate it in their daily routine, as walking or cycling to work would be an easy way to reaching the recommended levels of physical activity. According to the Active Lives Survey, in 2014/15 less than 5% of Enfield adults used cycling as a means of transport for utility purposes. This figure is lower than the national, London and North Central London averages. The survey identified Enfield adults as being more likely to use walking as a means of active travel, as 63.4% of respondents reported doing 'any walking' at least once a week, 42.6% reported walking for utility purposes at least three times a week and 33.8% reported walking as a way of travel at least five times a week.

What measurable outcomes do we want to improve over the course of the strategy?

- 60.1% of Enfield adults performing 150 minutes or more of physical activity a week (2016/17)
- 27.7% of Enfield adults engaging in less than 30 minutes of physical activity a week. (2016/17)
- Less than 5% of Enfield adults used cycling as a means of transport for utility purposes. (2014/15)
- 63.4% of respondents doing 'any walking' at least once a week (2014/15)
- 33.8% walking as a way of travel at least five times a week. (2014/15

Strategic priorities to consider

1. As employers, increase active travel to work amongst employees.

[14] JSNA

2. Increase active travel amongst children and young people travelling to early years settings and schools and promote physical activity throughout the school day through initiatives like The Daily Mile.

3. Promote active travel and physical activity through all local planning and policy decisions.

4. Tackle inequality: area-based and community-based initiatives to increase active travel and physical activity in the most deprived wards in Enfield.

Cross-cutting strategic priorities to facilitate change for all three behaviours

Health in Policies (HiAP)

A health in all policies approach involves all organisations represented on the HWB considering what influences they can exert on the three behaviours of smoking, eating and physical (in)activity in all actions their organisation takes. This will include what happens in their own organisations, what is included in their commissioning intentions and contracts and what leadership they provide to the general public.

Care Closer to Home Integrated Network (CHINs)
A CHIN is a way of working that aims to bring together primary care, local authorities, community services, voluntary and community sector, mental health services, acute and specialist providers and local people to work in partnership to deliver more integrated and holistic care for individuals. A CHIN can be 'virtual', meaning that it has no designated location, or 'physical', meaning that is has a specific location or locations.

Throughout 2017, Healthwatch Enfield got involved in conversations about delivering a Care Closer to Home Integrated Network model that could work in the borough. The results of this consultation should be used to develop an approach to CHINs in Enfield through the Joint Health and Wellbeing Strategy, which, among other outcomes, will help to bring about behaviour change by bringing health professionals into better contact with residents. CHINs make the healthy choice the easy choice, by making it easier to engage with health professionals at an earlier stage.

Communication and empowerment
We need to use every opportunity to provide residents with the knowledge, skills and opportunities to stop smoking (or not start smoking), to eat healthily, be active and maintain a healthy weight. Making the healthy choice may be difficult if people do not feel control over their environment and their personal circumstances. Health professionals can help people to see a connection between their efforts and health outcomes and can improve and facilitate health literacy.[15]

Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of

[15] *Making healthy choices easy choices: The role of empowerment*, European Journal of Clinical Nutrition · September 2005

individuals, communities and populations. As a partnership, we need to commit to building this approach into all contact we have with residents – be it as a GP, health visitor, school nurse or family support practitioner.

We also need to work with people within the community who influence others and develop strong role models to help influence positive behaviours and change habits, particularly amongst communities currently experiencing the worst outcomes. We can use our public consultation to better understand who within the community have the biggest influence. This may include businesses and corporations, as well as individuals, faith groups and other community groups.

Questions for the consultation
Who and what influences choices and decisions around smoking, activity and food and diet in Enfield?

Social prescribing
Social prescribing is a means of enabling GPs and other frontline healthcare professionals to refer people to 'services' in their community instead of offering largely medicalised solutions. Often the first point of referral is a link worker who can talk to each person about the things that matter to them. Together they can co-produce a social prescription that will help to improve their health and wellbeing. The community activities range from art classes to singing groups, from walking clubs to gardening, and to many other interest groups. It is therefore particularly relevant in regard to helping people start more healthy behaviors. In particular, it can help make people more active.

It is taking off across the country, particularly with people who are lonely or isolated; people with mild mental health issues who may be anxious or depressed; and, those who struggle to engage effectively with services.

It is also relevant to people with wider social issues such as poverty, debt, housing, relationship problems, all of which impact on their health and wellbeing. Very often these people have frequent repeat visits to their doctor or to their local emergency department – effectively trapping them in a 'revolving door' of services.

As a partnership, we need to commit to this approach by working together to build this into our partnership with the community and to how we work with residents to make positive behaviour changes to improve health outcomes.

Structural changes

Frequently it is the environment which is much more influential on health than any other factor. Through the new strategy, organisations will need to consider what health choices they are facilitating or denying in their buildings and the built environment over which they have control. This will include initiatives such as increasing smoke-free areas and reviewing and improving what the food offer is and how people travel. This approach is reflected in the proposed priorities under each of the three behaviours.

Consultation

This paper has considered some of the questions we would like to answer through a public consultation, in order to further develop the proposed strategic priorities. We also need to ask some broader questions regarding the three behaviours to see whether there may be

other priorities we may wish to consider which we have not yet considered, in order to help change behaviours around smoking, diet and physical activity.

We propose to run a survey with the public, to be conducted both online and through face to face interviews in different areas of the borough.

Other relevant strategies to improve health outcomes in Enfield

To help the Board deliver on measurable health outcomes, the proposed new Joint Health and Wellbeing Strategy is focused on three behaviours, where there is national and international evidence of impact on health outcomes. We have used local data to propose specific priorities in regard to changing these three behaviours, which can be further explored through public consultation.

There are many other activities and strategic programmes underway across the partnership to continue to tackle the wider determinants of health. The Board may wish to consider their role in having oversight, and input, into these relevant strategies alongside the further development, finalisation and implementation of a new Joint Health and Wellbeing Strategy. Relevant strategies include:

- Council Corporate Plan 2018
- Housing Strategy and Preventing Homelessness Strategy (New strategies under development)
- Children and Young People Plan (New strategy to be developed 2019)
- Volunteering Strategy – new strategy has links to social prescribing (under development)
- Enfield Children and Young People's Mental Health Transformation Plan 2015/2017 (refreshed October 2017)
- Healthy Weight Strategy 2018
- Food Strategy (new strategy under development)
- Violence against Women and Girls Strategy 2017
- Safeguarding Adolescents from Exploitation and Abuse Strategy (under development)
- Enfield Travel Plan (under development)[16]

[16] This list is not exhaustive, and partners may have other strategies they wish to discuss and develop collectively through the forward plan for the Board and the HIP

NHS Enfield Clinical Commissioning Group

NORTH LONDON PARTNERS in health and care
North Central London's sustainability and transformation partnership

15 August 2018

Dear Councillor Abdullahi

We are writing regarding the refresh of the North Central London strategy for General Practice. We are hoping for the opportunity to discuss the draft strategy at the JHOSC in early October, and wanted to ask if you would like to input to its development outside of the meeting.

As you will know, there is a history of collaboration in primary care in NCL, including previous joint strategies, the latest of which expired in 2016. We know there are many examples of excellent care delivered across the area, and there has been some great progress since the development of the previous strategy, including the availability of primary care appointments from 8am-8pm seven days a week for everyone in NCL. However, there also continues to be too much unacceptable, unwarranted variation, ranging from how people are able to access services, to the quality of the services received, to variation in historical levels of funding. General practice is also facing unprecedented pressure in terms of workforce, demand and funding. The strategy aims to raise standards further.

NCL Clinical Commissioning Groups agreed to refresh a strategy focusing on general practice. Each CCG nominated one clinical or officer lead to sit on a dedicated task and finish group, which also included representation from Healthwatch, nursing and the NCL GP federations. This group met six times between March and June 2018 and produced a draft strategy.

We are now in the process of engaging on this draft, with a view to having a version for approval by late September. As a key partner, we would be very keen for your input, and wanted to ask how you would like to feed your comments into the draft, emerging strategy, including whether a face to face discussion, in addition to the JHOSC, might be helpful?

We are sending the same letter to scrutiny chairs in North Central London and making contact with lead members for health and care.

Please do let Keziah.bowers@nhs.net know how you would like to contribute.

Yours sincerely

John Wardell

John Wardell
Chief Operating Officer, Enfield CCG

Cc: Dr Chitra Sankaran
Tony Hoolaghan
Stuart Lines
Bindi Nagra
Dr Katie Coleman
Sarah Mcilwaine

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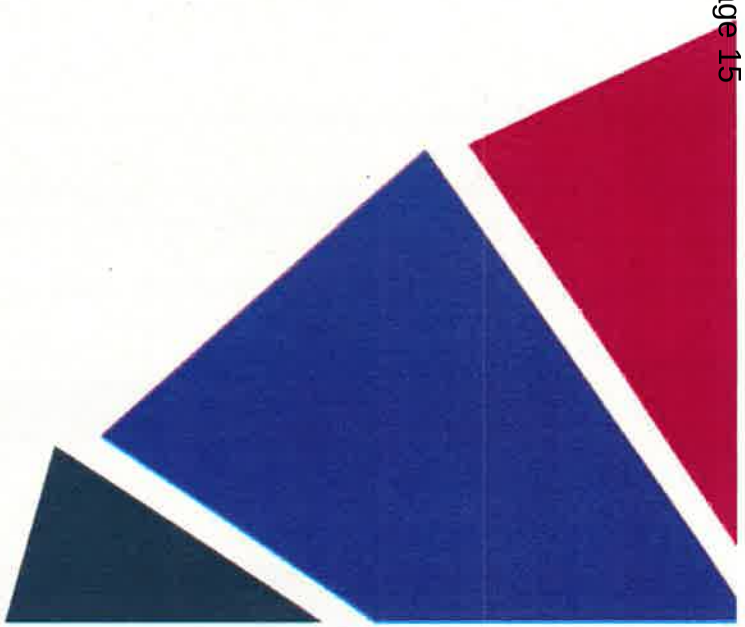
NORTH LONDON PARTNERS in health and care

General practice as the foundation of the NHS

A strategy for North Central London

2018 - 2021



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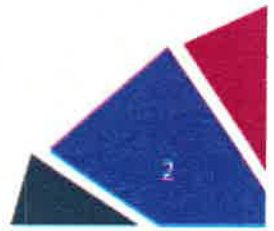
Version control

Version	Date	Author	Changes/ comments
0.1	2/5/18	S. Mcilwaine	-
0.2	11/6/18	S. Mcilwaine	Feedback and comments from Task and Finish Group 2/5/18 and early draft comments from LMC
0.3	5/7/18	S. Mcilwaine	Includes initial feedback and comments from Primary Care Committee in Common, Camden CCG and early comments from Directors of Public Health, and NCL STP Primary Care Commissioning Development Group
0.4 0.4a	16/7/18 19/7/18	S. Mcilwaine	Feedback from Health and Care Closer to Home Programme Board and meeting with NCL GP federations (July 2018) Contract details edited
0.5	31/7/18	S. Mcilwaine	Implementation edits
0.6	7/8/18	S. Mcilwaine	Estates info from draft NLP estates strategy



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Contents

- ***Resilient and thriving general practice***
- ***Person-centred***
- ***At the centre of an integrated health and social care system***
- ***Responsive***
- ***Delivering needs-based high quality,***
- ***equitable and safe care***

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NORTH LONDON PARTNERS in health and care

Overview

The NHS was established 70 years ago, at a time when services were primarily targeted at managing acute disease in hospitals and patients were perceived to be passive recipients of care. The roles of health and care services have changed significantly since this, and society is changing; there are over 15 million people with long term conditions (e.g. diabetes, chronic obstructive pulmonary disease) in England. Care for these people accounts for about 50% of all GP appointments and 70% of all inpatient episodes[3,4]. In total, people with long term conditions account for over 70% of the total NHS and Social Care expenditure, and as the number of people with long term conditions is set to increase then these costs will rise accordingly in future years[5]. Yet, patients with long term conditions spend only a few hours with GPs or other healthcare professionals each year and spend the majority of their time managing their own conditions[6]. General practice can play a greater role in prevention and managing the health of the whole population. It also makes sense for general practice to work with patients and carers, and with strong community networks and the voluntary sector, to encourage people to be informed and engaged, to facilitate them to manage their conditions to the best of their ability.

General practice is the foundation of the NHS and the main point of entry for patients. This strategy focuses primarily on general practice within the wider context of primary care, and the importance of ensuring robust, sustainable general practice as the foundation of the NHS. Traditionally, primary care has been defined as general practice, community pharmacy, dental and optometry services. The scope of primary care however is much wider and could also include appropriate self-care interventions, mental health support and community health care teams, which incorporate nursing and other multidisciplinary care.

The people living in North Central London (NCL) deserve high quality general practice, provided in line with the core values of general practice (page 2). There are many examples of excellent care delivered across the area. However, there also continues to be too much unacceptable, unwarranted variation, ranging from how people are able to access services, to the quality of the services received, to variation in historical levels of funding. This strategy aims to raise standards further.

General practice is also facing unprecedented pressure. Funding for general practice services, as a proportion of the national share of NHS funding has fallen from 9.6% in 2005/6 to 7.9% in 16/17[1], yet evidence suggests that demand has increased by 16% in the 7 years up to 2014, with more frequent and longer consultations[2]. Demand is set to increase further as people live longer with greater complexity and patient expectation grows. These pressures are further compounded by an aging workforce, fewer doctors and nurses choosing general practice as their destination of choice and losing newly qualified general practice staff to other more attractive health services across the globe.

The five Clinical Commissioning Groups (CCGs: Barnet, Camden, Enfield, Haringey and Islington) share the intent of improving health outcomes, reducing inequalities and delivering financially sustainable NHS services to our population; local general practice is critical to the success of this intent, and key to closer working across health and social care. We have previously collaborated on strategy in north central London, we are increasingly working in partnership across services, and this strategy reads across to local plans. With this strategy, we are refreshing our commitment to working together to improve general practice for the people of north central London, making sure registered patients have equitable access to sustainable, high quality services, and that we maintain what works well in general practice.

The strategy aims to consider what is important to and for the people living in north central London, and sets out the vision from a patient and system perspective. It recognises the challenges facing general practice in NCL and acknowledges that we must preserve the strengths of general practice, including continuity of care, a real understanding of the family or personal support network that patients are part of, and the relative ease and accessibility of services. It also provides a direction of travel for general practice across Barnet, Camden, Enfield, Haringey and Islington.

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About this draft strategy

Partners in north central London (NCL) have a history of collaborative working on primary care, including the production of previous strategies for primary care. The previous NCL strategy was produced in 2012 and expired in 2016. In December 2017, leaders of the five clinical commissioning groups (CCG) and GP federations agreed to nominate representatives to co-produce a refreshed strategy for NCL.

A dedicated task and finish group was established, chaired by a lay member of a CCG board, with primary care clinical or officer representatives from each CCG, and representation from nursing, Healthwatch, the NCL GP federations and the North London Partners Health and Care Closer to Home programme. This group met six times between February and May 2018, with the aim of discussing key themes and producing draft output, which would be used for further engagement with partners, in order to produce a strategy for north central London.

This draft document is the result of the task and finish group discussions; we will work with partners, local people and organisations in order to produce a strategy for north central London, which will read across to local CCG plans.

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Key Messages

The challenges facing general practice

Growing demand for services: many people have more complex needs, health inequalities persist and there are high levels of long terms conditions and rising expectations of general practice. The population is growing and people are living longer but in poor health and with greater complexity; older people in north central London are living their last 20 years of life in poor health, which is worse than the England average. The King's Fund has shown how consultations are outstripping population growth (source: King's Fund- Strategic Commissioning Framework). There are poor indicators of health for children – childhood obesity is high while immunisation levels are low. Investment has fallen and the unwarranted variation in outcomes and historical funding need to be addressed. We will not be able to manage the expected growth in demand for healthcare if we do nothing.

A workforce under pressure

NCL faces significant challenges for its future workforce from GPs to general practice nurses and other primary care professionals. 25% of the GP workforce is over 55 and therefore likely to retire within the next 10 years. A recent NCL Local Medical Committee (LMC) survey collected data showing that 45% of responding practices are due to lose one or more GPs to retirement in the next three years. This, along with an ever-growing and more diverse population, demonstrates the need to develop and grow the NCL GP workforce significantly over the next few years.

Fewer GPs are looking for partnerships, and there are recruitment and retention challenges. There are low numbers of GPs per patient in Barnet, Enfield and Haringey, and low numbers of practice nurses in all CCGs in north central London. Low morale is not unusual; GPs, nurses and practice managers report being more stressed than ever before. We need to value the existing workforce and attract and retain new professionals.

An evolving care sector

Sources of information, advice and support regarding patients' health and well-being are more varied; patient expectations change in line with social and technological advances. There is renewed importance on the role of general practice in providing and coordinating trusted accessible, proactive care that is integrated across all parts of an increasingly complex health and care system.

PLACEHOLDER: Financial challenge

The core values of general practice London-wide LMCs

1. The registered list – individuals and practice population
2. Expert generalist care of the whole patient
3. The consultation as the irreducible essence of delivery
4. Take into account socio-economic and psychological determinants of disease and the inverse care law
5. The therapeutic relationship
6. Deliver safe, effective long term and preventative care, balanced with timely episodic care by promoting access to relationship continuity
7. Advocacy and confidentiality

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NORTH LONDON PARTNERS in health and care

North Central London: Case for Change – *What people want now*

Our healthcare services know people want timely access to services and they want their mental health needs to be considered alongside their physical health.

- More health and care will be available **in the community, or out of hospital**, ensuring that people **receive care in the most appropriate setting** at a local level and with local accountability. It is recognised that for some people, health and care being delivered closer to their home is not always the best choice, and therefore high quality hospital-based and care home services will continue to be available when needed.
- At the heart of the care closer to home model is a '**place-based**' population health system of care delivery which draws together **social, community, primary** and **specialist** services underpinned by a systematic focus on **prevention** and **supported self-care**.
- There are many excellent services in north central London; the health and care closer to home model will focus on scaling these services up, **reducing unwarranted variation** and **establishing the Care and Health Integrated Network** model, the default approach to delivering care and to place-based commissioning of services, ensuring services are focused on the care of people within neighbourhoods.
- Social care and the voluntary sector will play a key role in the design, development and delivery of the future model.
- We will work towards addressing the **sustainability** and **quality** of **general practice**, including **workforce** and workload issues.

We want to do more for ourselves

We recognise the NHS is under pressure, but we can help by playing a bigger role in looking after our own health and wellbeing

What would this look like?

I want to be listened to and heard
- I won't have to rely as much on my GP to interpret information for me
- I'll be able to access the information and advice I need to make more decisions for myself
- I'll understand which services to use and when
- I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me[7]

Services will work better for me
- My health records will be up to date and services that help me will be able to access them
- I will tell my story once
- The professionals involved with my care talk to each other; we all work together as a team

I'll have easier access to the support I need to stay well
- I won't have to go to hospital so much
- Investigations such as blood tests and ECGs can be done in alternative places to the hospital

I'll be able to do more online
- I can book and cancel appointments online, when it suits me; I won't have to visit the GP, miss appointments I don't need or wait for the post to get my test results
- I can order repeat prescriptions online; I don't need to make a special trip to my surgery to place the order
- I can see my health and care records and can decide who to share them with. I can correct any mistakes in the information.

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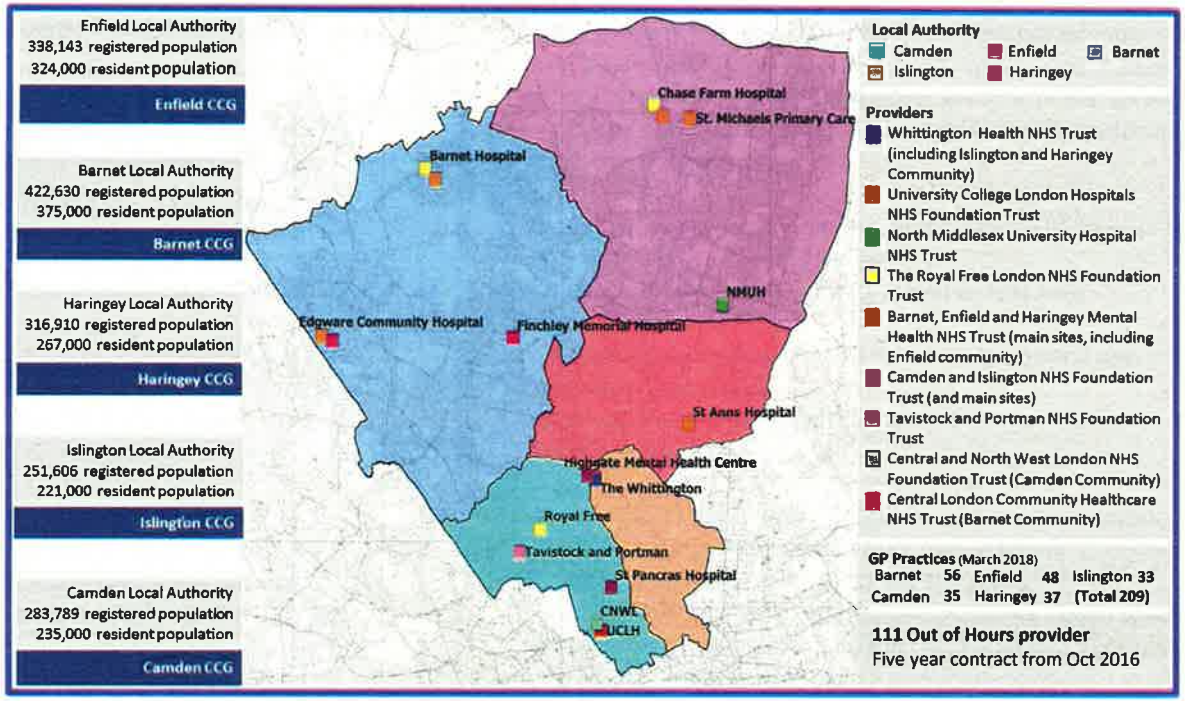
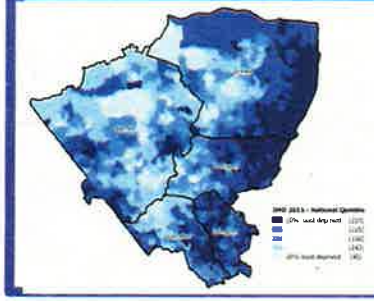
NORTH LONDON PARTNERS in health and care

North Central London: Case for Change – our population

Unwarranted (unnecessary) variation ranging from patient **satisfaction** in how easy it is to get an appointment to availability and use of **technology** for GP services, to unwarranted variation in **clinical outcomes**, e.g. identification and anticoagulation of people with atrial fibrillation. There is also variation in the historical levels of **funding** in primary care, to variation in funding for locally commissioned services.
There is variation in the **condition of primary care estate** e.g. only 23% in Islington is in good condition. There is also variability in **ownership** of the primary care estate across individual GPs, GP partnerships, private sector, NHSPS and CHP.



All NCL residents have seen an increase in **life expectancy** over the past ten years; current life expectancy for men and women across NCL is higher than England, with the exception of **Haringey** and **Islington**.
Overall residents spend approximately 20 years of their life living in poor health. Trends in healthy life expectancy show that there has been **no significant change** in the number of years people are living healthy lives.
There are **stark differences** in life expectancy between those living in the most affluent areas compared to the most deprived. **Camden** has the highest **life expectancy gap** for men with people living in the most deprived areas living on average 10 years less than those in the least deprived. The gap in life expectancy is smaller for women overall.



Poverty and deprivation are key determinants of poor outcomes in health and wellbeing. NCL is a diverse area containing some of the most deprived (east and south) and more affluent (west and north) areas in the whole country.
Higher levels of deprivation are linked to numerous health and social vulnerability including chronic illness and poor lifestyle choices. 30% of children in NCL are growing up in poverty. **Islington**, **Enfield** and **Haringey** have the highest rates of deprivation relative to the national picture, although pockets of deprivation are dispersed throughout all areas across NCL.
For most aspects of health, there is a **close relationship** between deprivation, the need for health and social care services and higher rates of ill health and premature mortality. Poor health and risk of poor health is unequally distributed in NCL. Actions to improve the wider determinants of health such as good housing and income are needed alongside targeted healthcare provision, working closely with local government and other key services. We have a track record in NCL of working with partners in this way

Sources: Open Exeter, 2017, GP Patient Survey

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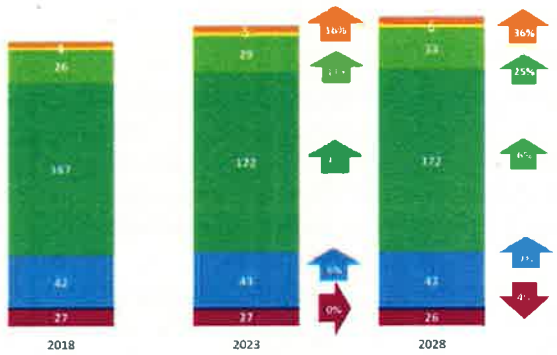
NCL and local population projections

NORTH LONDON PARTNERS in health and care

Overall the population in NCL is expected to **increase by 6%** over the next decade. The majority of this growth (71%) is expected in the first five years. The fastest growth is amongst the **elderly population**, with the proportion of those over 65 expected to grow by 26% (from 181,000 to 227,000) in the next ten years. The population aged 0-4 is expected to decrease by 3% over the same period.

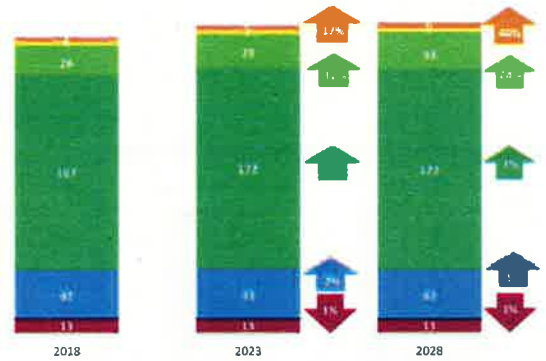
A larger population and an older population is likely to mean increased demand for primary care services.

Barnet



Barnet is expected to have proportionally the largest overall population growth in NCL in the next decade (9%). 62% is expected within the first 5 years.

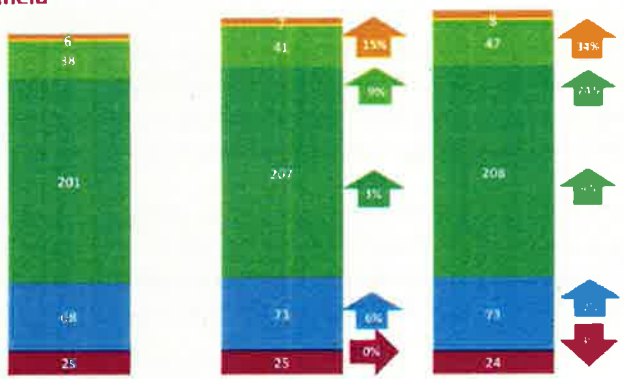
Camden



Camden is expected to have largest growth (40%) in the 85+ age category over the next decade. After initial growth in the under 65s, it is expected that in the second half of the decade this population will decrease by 1%.

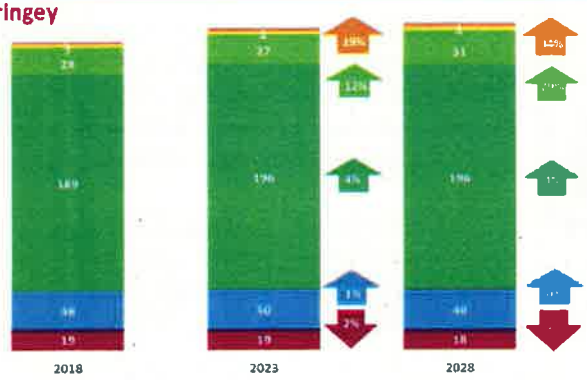
85+
65-84
20-64
5-19
0-4

Enfield



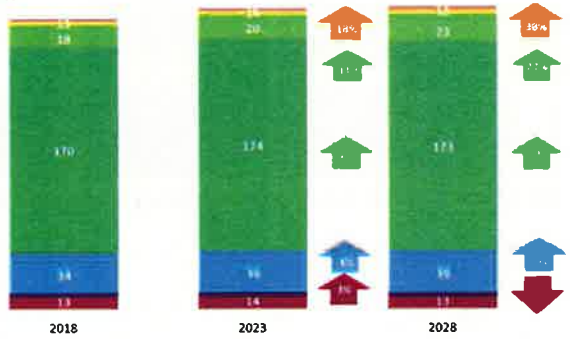
Of Enfield population growth expected over the next decade, it is estimated that 69% will occur in the first five years.

Haringey



Haringey is expected to have the proportionally largest decrease in the 0-4 aged population (5%) over the next decade.

Islington



Of the expected growth in Islington over the next ten years, approximately 80% is expected to occur in the first five years.

Source: GLA, 2016

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NCL and local population projections

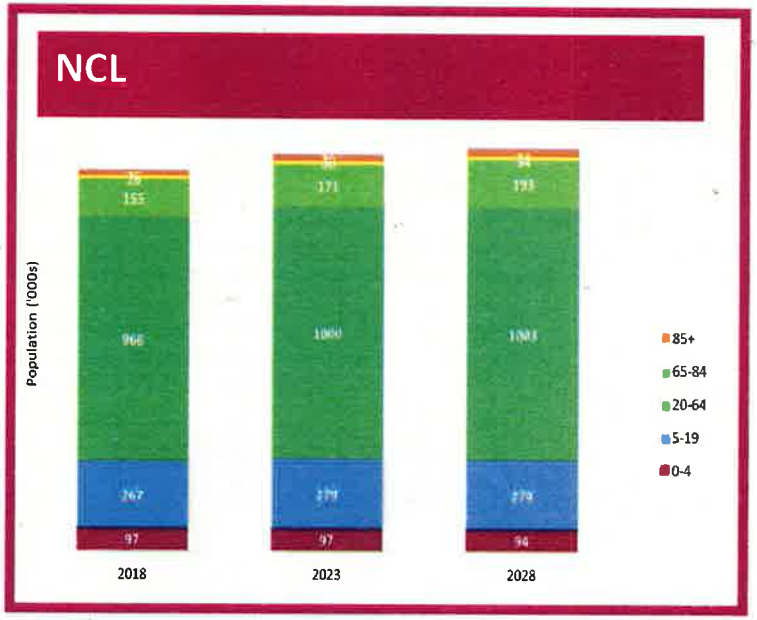
The populations of NCL are **living longer, growing** and **constantly changing**. The fastest growth is expected amongst the **elderly population**; health service use, including both planned and emergency admissions, are much higher in this population group. Conditions such as stroke, dementia, some cancers, falls and fractures, as well as the need for the management of degenerative disease, e.g. major joint replacement, are strongly linked to increasing age.

Overall the age structure of NCL will continue to be dominated by a young working age population. A **younger population** profile presents a significant opportunity for **prevention** of conditions that are significant contributors to death and disability in. Earlier identification of risk, screening, improved early diagnosis of long term conditions and behaviour change, such as stopping smoking, healthy eating and physical activity or reducing alcohol consumption, in this age group will be key in improving premature mortality rates in the short to medium term. **Lifestyle factors**, often linked to deprivation, are important sources of inequalities and poorer health outcomes.

Alcohol related issues are most prevalent in Haringey and Islington so efforts on alcohol prevention need to be focussed on these areas. Cancer screening rates and vaccination coverage are low across all of NCL and action needs to be focussed on increasing these rates.

Primary and community services will need to cope with more people requiring lifestyle risk assessments, behaviour change support, earlier diagnosis of long term conditions and cancer screening.

Good service provision needs to be maintained for the **youngest children** (under fives), including universal and other community health services as well as acute services, and ensure healthy development, including good childhood immunisation uptake rates and breastfeeding. Levels of emotional health and obesity among children and young people will be important, and are correlated with childhood poverty. Children and young people's outcomes, particularly younger children, may be particularly vulnerable to the impact of austerity on households experiencing economic distress, disability or worklessness.



Source: GLA, 2016

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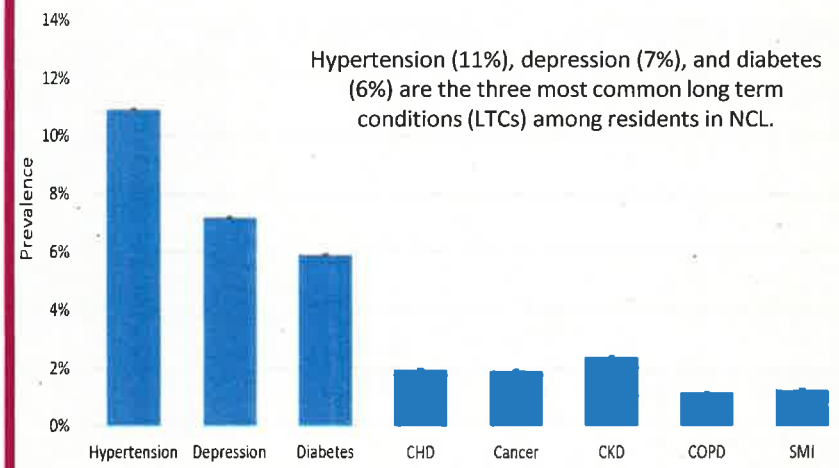
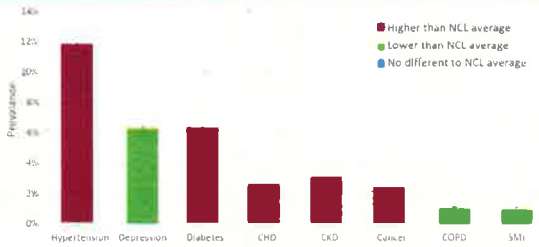
NCL and local prevalence of long term conditions (LTCs)

People with LTCs are the most intensive users of health services, particularly primary care. There will remain a significant number living with one or more LTCs, and a need for support to help people manage their own condition through self-care, take the correct medication or access therapies. Community networks and the voluntary sector also play a key role in supporting people with LTCs, as part of the wider system.
Smoking, obesity and lack of physical activity are significant contributors to the development of LTCs; most of NCL performs poorly or similarly to indicators relating to these areas compared to England. More action is needed to improve outcomes.

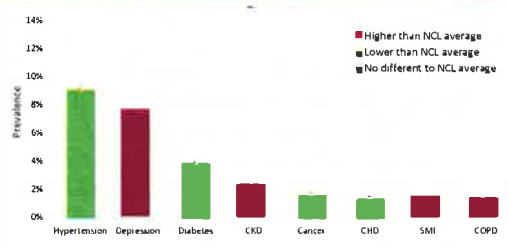
NCL – prevalence of major long term conditions in 2016/17



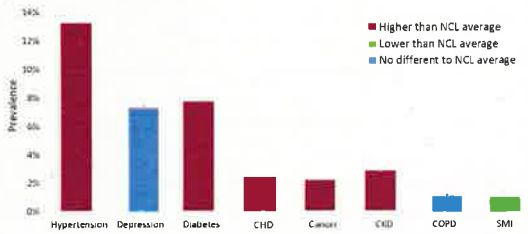
Hypertension (11%), depression (7%), and diabetes (6%) are the three most common long term conditions (LTCs) among residents in NCL.



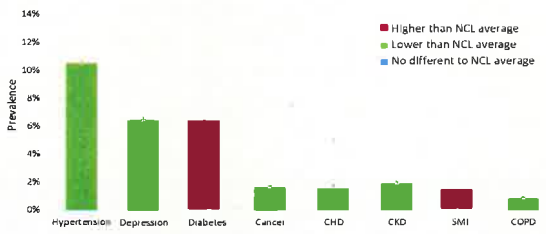
Barnet has a significantly higher prevalence of hypertension, diabetes, CHD, CKD, and cancer than the NCL averages.



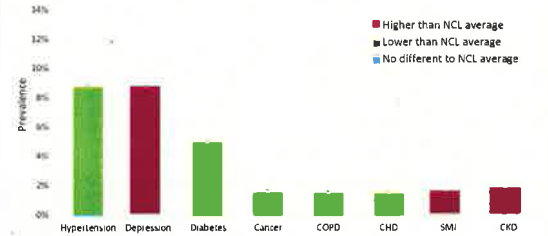
Camden has a significantly higher prevalence of Depression, CKD, serious mental illness, and COPD than the NCL average.



Enfield has a significantly higher prevalence of hypertension, diabetes, CKD, cancer, and CHD compared to the NCL average.



Haringey has a significantly higher prevalence of diabetes and serious mental illness compared to the NCL average.



Islington has a significantly higher prevalence of depression, serious mental illness and CKD compared to the NCL average.

Higher than
Lower than
No different to NCL average

Source: GLA, 2016

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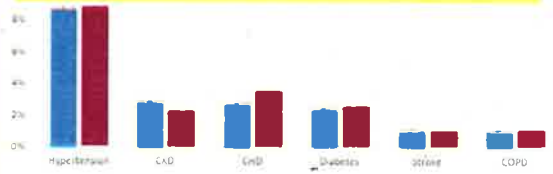
NCL undiagnosed prevalence of long term conditions and progress in performance

	Indicator	Barnet		Camden		Enfield		Haringey		Islington		London		England
		Current value	Progress	Current value	Progress	Current value	Progress	Current value	Progress	Current value	Progress	Current value	Progress	Current value
Reducing death rates from the top 3 killers	Cancer	●		●		●		●		●		●		137
	Cardiovascular diseases	●		●		●		●		●		●		73
	Respiratory diseases	●		●		●		●		●		●		34
Children and young people have the best start in life	Infant mortality	●		●		●		●		●				4
	Child weight management - Reception	●	↓	●	↓	●	↓	●	↓	●	→	●	↓	23
	Child weight management - Year 6	●	→	●	→	●	↑	●	→	●	→	●	↑	34
	School readiness - Reception	●	↑	●	↑	●	↑	●	↑	●	↑	●	↑	71
	School readiness - Year 1	●	↑	●	↑	●	↑	●	↑	●	↑	●	↑	81
	Oral health (dental decay)	●		●		●		●		●		●		1
Residents lead active lives and eat well	Adult weight management	●		●		●		●		●		●		61
	Physical activity	●		●		●		●		●		●		65
Fewer residents are harmed by tobacco	Smoking quits	●		●		●		●		●		●		51
Fewer residents are harmed by alcohol and drug misuse	Premature liver disease mortality	●		●		●		●		●		●		18
	Alcohol related hospital admissions	●		●		●		●		●		●		636
Residents have good sexual life	Teenage pregnancy	●	↓	●	↓	●	↓	●	↓	●	↓	●	↓	21
	Teenage abortion	●	↑	●	↑	●	→	●	↑	●	↑	●	↑	51
Residents have good mental health and wellbeing	Suicide	●		●		●		●		●		●		10
	Excess deaths in serious mental illness													370
People with long conditions are diagnosed earlier	CKD	●	→	●	↓	●	→	●	→	●	→	●	→	4
	Diabetes	●	↑	●	↑	●	↑	●	↑	●	↑	●	↑	7
	COPD	●	→	●	→	●	→	●	→	●	→	●	→	14
	Hypertension	●	→	●	↑	●	→	●	→	●	↓	●	→	14
	CHD	●	↓	●	↓	●	↓	●	→	●	↓	●	→	3
Support residents to age healthily	Healthy life expectancy at birth - men	●		●		●		●		●		●		63
	Healthy life expectancy at birth - women	●		●		●		●		●		●		64

Estimated percentage of undiagnosed LTCs in NCL

PLACEHOLDER –
NARRATIVE WITH THIS SLIDE



Hypertension is estimated to be the most under-diagnosed long term condition across NCL, with 8.7% of the total registered population of NCL estimated to have the condition without a diagnosis.
The undiagnosed prevalence of CKD, COPD and Stroke are significantly higher than the London average.
The undiagnosed prevalence of CHD and Diabetes is significantly lower than the London average.

Current performance
NCL boroughs compared to national average

- ● Significantly better
- ● Not significantly different
- ● Significantly worse

Progress in performance
NCL boroughs compared to performance in previous years

- ↑↓ Increasing/decreasing and getting better
- → No change
- ↑↓ Increasing/ decreasing and getting worse

There is a relatively high number of people in NCL who are unaware they are living with a disease (undiagnosed prevalence). Early deaths amongst people, living with cardiovascular disease, cancer and respiratory disease are the key drivers of the life expectancy gap in NCL. Diagnosing these and other long term conditions (such as diabetes) earlier, better supporting people living with them to adopt healthier behaviours and manage their conditions, and ensuring they receive optimal management and care should help to improve both the length and quality of their lives.

Sources: QOF, 2016/2017, PHOF, 2017 NB blank cells signify where comparisons to historical data cannot be made due to methodological changes to data sources

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NORTH LONDON PARTNERS in health and care

North Central London: Workforce

The NHS spends almost 65% of its operational budget on its most valuable asset; our staff. More than 50% of today's workforce will still be working in the health service in2032.

NCL faces significant challenges for its future GP workforce. 25% of the GP workforce is over 55 and therefore likely to retire within the next 10 years. A recent NCL Local Medical Committee (LMC) survey collected data showing that 45% of responding practices are due to lose one or more GPs to retirement in the next three years. This, along with an ever-growing and more diverse population, demonstrates the need to develop and grow the NCL GP workforce significantly over the next few years.

One in four GPs is aged over 55

Borough / CCG area	% of GPs aged over 55	B/W/S than London average*
Barnet	27%	Worse
Camden	16%	Better
Enfield	32%	Worse
Haringey	32%	Worse
Islington	19%	Better

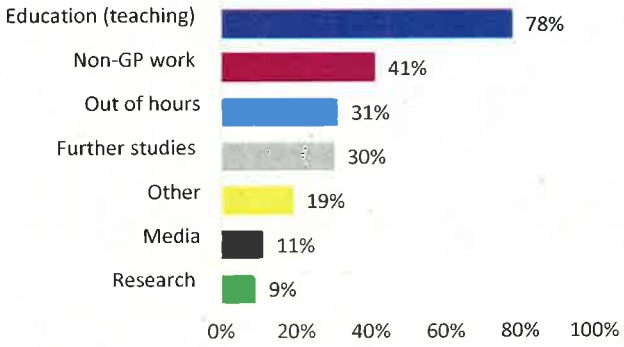
*RCGPs: London average is 22%

Borough/ CCG	GP Headcount	FTE
Barnet	226	163
Camden	181	131
Enfield	199	138
Haringey	175	119
Islington	146	110
NCL total	**927**	**660**

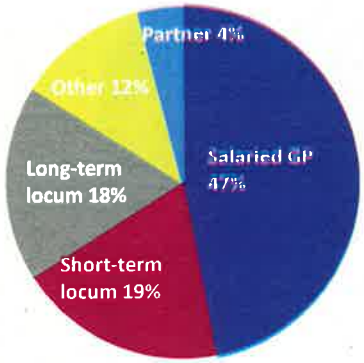
Up to 9,250 in Camden and Haringey

Up to 7,750 in Islington, Barnet and Enfield

The number of patients per practice is variable; Islington, Barnet and Enfield have on average fewer patients per practice than Camden and Haringey, which suggests a greater proportion of smaller practices in Islington, Barnet and Enfield



A recent survey of GP trainees demonstrated the need to consider different employment models and portfolio careers. The majority of GP trainees (93%) want a portfolio career with 78% wanting to be involved in education and teaching. The same survey showed that nearly half of GPs wanted a salaried role



"We know we cannot work any harder, so we have to find ways to work differently"
Dr Arvind Madan, Director of Primary Care, NHS England, 2016

Sources: London GP Trainee (ST3) survey July 2017 (n. 58), HEE, Draft health and care workforce strategy for England, Source: NHS Digital, 2017. NB Workforce data on 5% of GP practices in NCL were unknown and excluded from this chart

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NORTH LONDON PARTNERS in health and care

Workforce: General Practice Nurses

GPN Heat Map analysis

Nurse: Patient ratio

3,665 — 7,295

Tower Hamlets (NEL)	1:3900
Bexley (SEL)	1:4200
Croydon (SWL)	1:4600
Kingston (SWL)	1:4600
Sutton (SWL)	1:4600
Havering (NEL)	1:4700
Southwark (SEL)	1:4800
Central (Westminster) (NWL)	1:4800
Merton (SWL)	1:4900
Harrow (NWL)	1:4900
City and Hackney (NEL)	1:5000
Lewisham (SEL)	1:5000
Wandsworth (SWL)	1:5000
West London (NWL)	1:5100
Ealing (NWL)	1:5100
Islington (NCL)	1:5200
Hammersmith and Fulham (NWL)	1:5300
Lambeth (SEL)	1:5300
Greenwich (SEL)	1:5400
Hillingdon (NWL)	1:5600
Newham (NEL)	1:5700
Barking and Dagenham (NEL)	1:5800
Camden (NCL)	1:5900
Hounslow (NWL)	1:6000
Waltham Forest (NEL)	1:6200
Barnet (NCL)	1:6300
Richmond (SWL)	1:6300
Haringey (NCL)	1:6300
Bromley (SEL)	1:6300
Enfield (NCL)	1:6600
Redbridge (NEL)	1:7000
Brent (NWL)	1:7300
London average	**1:5300**
National average	**1:3600**

General Practice Nursing: the key challenges

NHS England

True assessment of workforce demand is complicated, and there may be under utilisation of nurses and other professionals in general practice.

There is a shortage of general practice nurses (GPNs). All London CCGs are below the national average. To achieve the national average, London needs to recruit 700 additional nurses into primary care. With population growth from 2016-21, this suggests an additional **838** full time equivalent nurses are required to achieve the national ratio.

- 40% of the general practice workforce is aged 50-59
- 33.4% of GPNs are due to retire by 2020 (QNI, Nurses in General Practice Survey 2015)

Considering the high requirement demographic and attrition rates, the focus must be on recruitment of nurses and in developing and implementing retention strategies, e.g. supporting GPNs to work at the top of their license, develop and maintain skills, create development, leadership and career opportunities.

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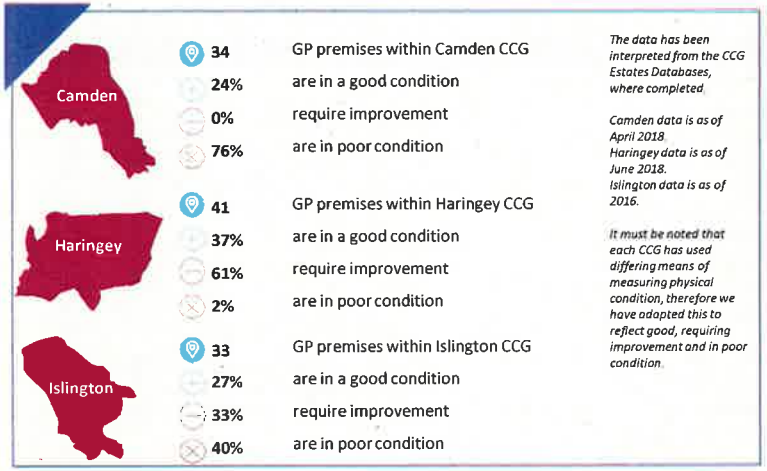
NORTH LONDON PARTNERS in health and care

The state of the estate – primary care

Primary care infrastructure is critical to support the NCL ambition for care closer to home. The current NCL primary care estate is characterised by a large number of small properties, in fragmented ownership which impacts the ability to enact change at pace, given the various interests and complex arrangements which need to be managed. Transformation in the primary care estates is critical as it acts as a key enabler to delivering the overall vision for care described in section 5. Currently only around one third of practices are rated as excellent or good, therefore a 'do nothing' option is not viable if we wish to deliver good quality care in an appropriate environment.

PLACEHOLDER



NCL GP Business Types and Ownership[1]

Business type	3PD/Private	CHP	GP Owned	NHSPS	Total
Corporation	4				4
GP Branch	5		2	1	8
Not Known	1				1
Partnership	90	9	41	15	155
	Single Handed		44	6	19
6	75				
No information				1	1
Total	144	15	62	23	244

1. NCL devolution Business Case, November 2017: Version 5 Master database, NHS England London

Note: data on this slide refers to GP premises. Numbers therefore differ to references to GP practices elsewhere in the strategy. Numbers also vary as a result of differences in timing when data compiled

Primary Care Provision

Across London as a whole, the London Health Commission – Better Health for London 2014 found:

- Whilst 36% of GP premises are rated in excellent or good condition, 51% are rated only average whilst the remaining 13% are rated poor, very poor or terrible.
- Those GP premises rated as average require refurbishment, whilst those GP premises rated poor, very poor or terrible require rebuild.
- Whilst NCL wide data is limited, for the three CCGs with available information, as shown opposite, available data would suggest that approximately one third of primary care premises are operating in good condition with the balance requiring improvement or being in poor condition.

Fragmented estate

Analysis of primary care ownership in NCL in 2016 showed GP services operating out of 244 properties (see table). Of these:

- 75 are occupied by a single handed GP and 155 by a partnership;
- The majority of GP properties are owned by the private sector and leased to GPs;
- The distribution across ownership types is similar for both partnerships and single handed GPs; and
- Only 15% of GP occupied properties are owned by either NHSPS or CHP.

Source: North London Partners – Draft estates strategy

The priorities for development of our estates strategy are:

1. Developing **a place based approach** to allow us to optimise use of our estate in each locality to support service delivery, drawing on One Public Estate principles.
2. To **respond to** care requirements and changes in **demand** by putting in place a fit for purpose estate: Plan for population growth and on-going demographic change with a view to shift the balance across primary, acute and community services to deliver the highest quality care and closer to home, further enabling us to tackle health inequalities in the STP.
3. To increase the **operational efficiency** of the estate (described in section 6): improving utilisation, tackling backlog maintenance and optimising running costs.
4. To enhance **delivery capability** (described in section 5 & 6): supporting wider changes in health care delivery, alongside workforce and digital enablers, including supporting opportunities to create Homes for NHS Staff.
5. To enable the delivery of a portfolio of estates **transformation projects**: that support the implementation of the vision for care (described in section 7) and further development of social and affordable housing.

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The future of the estate – primary care vision

PLACEHOLDER

In line with the NHS FYFV, the STP is developing its estates to support GPs to work collaboratively in 'hubs'[1] and support movement of health and care closer to home and pooling of auxiliary resources.

This will allow primary care to offer a wider variety of services based within the local community and diverted from acute providers.

Improvement of the estates will help allow primary care to match the projected growth in population and associated increase in demand.

The examples opposite demonstrate the relationship between care transformation and estates as an enabler.

Funding

Funding sources include asset disposal, S106, NHS England's Estates and Technology Transformation Fund (ETTF) and, approval pending, further waves of capital funding.

ary Care Hub Network and service exp

- Development of primary care estate to function as a network, pooling resources across community nursing, mental health, clinical pharmacy and diagnostic facilities
- Facilities will be designed to match projected population growth
- Examples include:

1. Finsbury Leisure Centre Redevelopment (page 100) – improvement of the existing leisure and nursery facilities and an additional health centre and 120+ residential units to support the growing population
2. Hampstead Group expansion (page 41) – a potential scheme, pending funding, to support; extra capacity; care closer to home; social care and prevention; and; integration of ambulatory care through collaboration with the Royal Free London, operating as a primary care hub
3. Tottenham Hale and Hawes & Curtis Green Lanes (page 102) – primary care expansion to support housing and population growth

- Implementation of the CHINs, both physical and virtual, to facilitate expansion and development of care to ensure registration for a expanding population and extended hours access (page 37)
- Bringing together virtual multidisciplinary teams will require flexible, high quality estate throughout the community

grated working with primary and social care move care closer to home and provide resources for the wider population

- Redesign of estates to enable some urgent care services to be diverted from acute providers to primary care hubs. Examples include the Archway Primary care hub and the Whittington (page 100)
- Primary care estate redevelopment to include affordable housing . Examples include the Meridian Water development (page 41)

Key milestones

2018-2020

- Primary care hub network and CHINs already underway

2020-2023

- Completion of Meridian Water and Finsbury Leisure Centre redevelopment by 2021
- Completion of Tottenham Hale and Hawes & Curtis Green Lanes developments
- Completion of the Archway Primary Care Hub

2023 and beyond

- Possible review of commissioning models to facilitate applications for alternative funding sources e.g. outcomes based commissioning

1 NHS Next Steps on the Five Year Forward View: Primary Care

Source: North London Partners – Draft estates strategy

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Where have we come from and where do we want to go?

The **previous north central London strategy for primary care** was written in 2012. This strategy referenced the significant variation in general practice size, the number of single-handed GP practices and that much of the primary care estate was not fit for purpose. At that time, there were 258 general practices with 1,413,086 registered patients, excluding the three GP-led health centres and PCT Special Practice. The previous document referred to integrated care networks, in which general practice would see itself at the hub of a wider system of primary care, taking responsibility for coordination and signposting to services beyond health care – in particular, social care, housing and benefits.

	Barnet	Camden	Enfield	Haringey	Islington	London	England
Ease of getting through on the phone	62%	63%	66%	65%	66%	67%	69%
No appointments available	84%	81%	84%	80%	83%	82%	84%
Times didn't suit	19%	20%	16%	17%	18%	18%	15%
Satisfied with opening hours	74%	74%	79%	76%	74%	78%	80%
Know how to access out of hours care	56%	52%	55%	52%	52%	54%	62%

Patient survey 2011

The **context and landscape** have changed significantly since the previous strategy, including an increasing financial challenge, with the 'do nothing' gap for north central London expected to be £811m deficit by 2020/21. The **GPFV** was published in 2016, focusing on priorities including improving patient care and access and investing in new ways of providing primary care. There is now an increased focus in general practice on **quality improvement**, with local investment in dedicated quality improvement support teams aiming to reduce unwarranted variation in each CCG area. There is an increased focus on **collaboration**, both within general practice, and with other partners, and working at scale to deliver the best benefits for the population and for practices. There are new and increased challenges in terms of building, recruiting and retaining sufficient numbers of **healthcare professionals** to work in general practice, and more GPs are opting for salaried positions and portfolio careers, meaning a need to consider new and alternative employment models. There have been significant advances in **technology**, with the introduction and increased use of patient apps, the ability to book appointments online, and products such as Symptom Checker.

Extended Access

Instead of people only being able to access their own GP during core hours, people now have access to appointments with general practice from 8am-8pm seven days a week (since April 2017 in NCL). There may be opportunities to promote these services even more widely, so that everyone is aware of them. We also know that some people still report dissatisfaction getting through to their practice on the phone, and there is more progress to make in these areas.

Working at Scale

There are six GP federations in NCL, four of which are co-terminous with the borough, with two federations in Camden. Most practices now work in an integrated way, to some extent, and many of the GP federations hold contracts ranging from Ear Nose and Throat and community gynaecology services to providing quality improvement support teams, or focusing on GP retention. Also in place are Care and Health Integration Networks (health and care partners working together to deliver care to a cohort of patients)

Digital

PLACEHOLDER: NCL access to NHS 111 online and GP online

PLACEHOLDER: highlight challenging achievements since 2012

However, many of the challenges facing general practice in 2012 remain current; there continues to be too much unacceptable, unwarranted variation, ranging from how people are able to **access** services, to the quality of the services received, to variation in historical levels of funding. In terms of policy, we have seen a continued focus on improving the availability and use of **technology**[8], ranging from GP online services to symptom checkers.

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NORTH LONDON PARTNERS in health and care

Where do we want to go?

Placeholder: vision for digital – health and care information exchange and population health management

IT, data systems and information sharing are critical to delivering integrated
care and can help to co-ordinate care delivered by professionals across different
organisations and even across patients' wider support networks.
Population health management

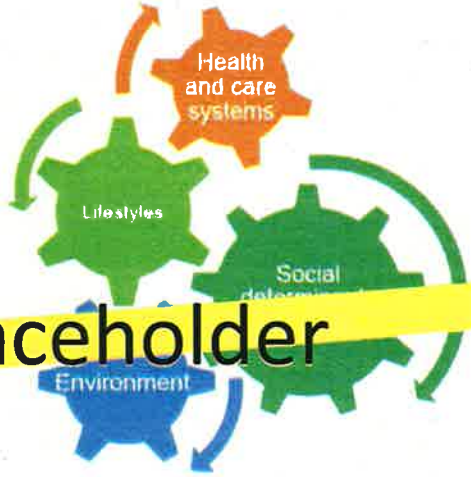
Our STP technology partnership offers ways to use data from separate providers: Health Information Exchange (HIE) andPopulation Health Management (PHM).
HIEis an established technology offering a longitudinal patient and resident record. It works by connecting multiple data into appropriately controlled sectio record.

PHM is the next generation technology offering the proactive facilitation of the preventative health and care measures. It works using sophisticated capabilities with the data to predict, suggest and improve.

The solutions are linked -both have the same data sources for all five health & care economies: primary care, acute care, mental health, community & social care.

Population health management: making the shift from individual-level medicine

Factors that shape our health



- Population health means different things to different people
- Key features
  - **Makes a shift**: from individuals to populations
  - **Widens the focus**: considers all of the factors that shape health, not just health service utilisation
  - **Emphasis on outcomes**: not 'bean counting'
  - **Focuses on inequalities**: looks at the on of outcomes within and population groups
  - **Needs system-wide accountability**: cannot be delivered by a single organisation, need a population health system

Placeholder

PLACEHOLDER: New technology, e.g. more efficient ways of working from record sharing and electronic prescribing to online consultations and appointment booking → better access, better care and a better experience for patients.

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Investment in to primary care

NORTH LONDON PARTNERS in health and care

Adjusted NCL 'Do something' financial gap

Placeholder – investment demonstrating variation and primary care investment in the context of the system

Primary core – core
Primary care – enhanced
Investment into CHIN/ QIST

PLACEHOLDER – TBC

- X% of budget on secondary care
- Y% on primary care
- Recognising differential starting points; increasing % of primary care investment over xxx years?

PLACEHOLDER
In 18/19

- **Recurrent**
- **GMS/PMS/APMS allocation**
- **Enhanced services**
- **QOF**
- **GPIT**
- **Premises**
- **Other**

Placeholder

	£
transformational support from national CCG allocations as a non-recurrent spend of £3 per head of the CCG population	xxx
non-recurrent funding to support the development of general practice at scale	1.6m
extended access (include NHS and CCG contributions)	xxx
development of an NCL solution for online general practice consultations	xxx
GP recruitment	xxx
GP retention	xxx
Resilience	xxx
CCG investment in to Care and Health Integration Networks	Xxx
CCG investment into Quality Improvement Support Teams	xxx

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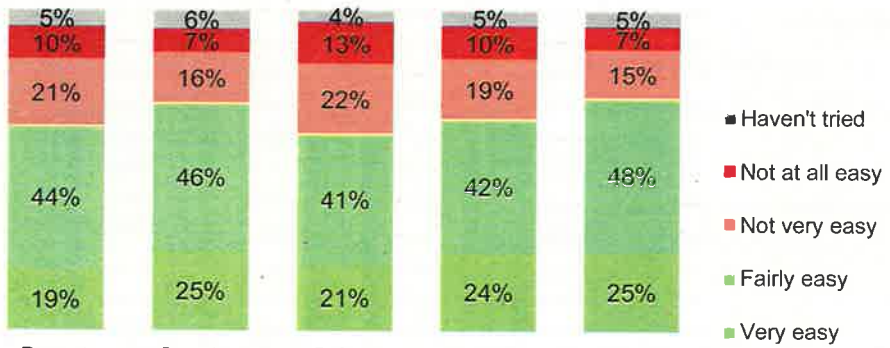
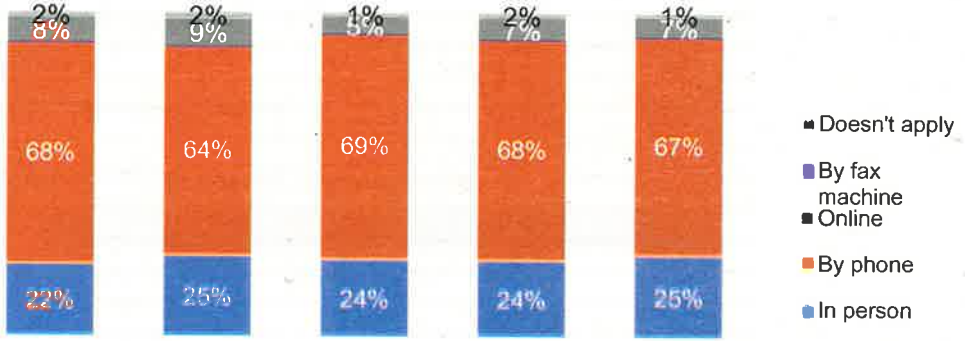
NORTH LONDON PARTNERS in health and care

Access – patient reported measures

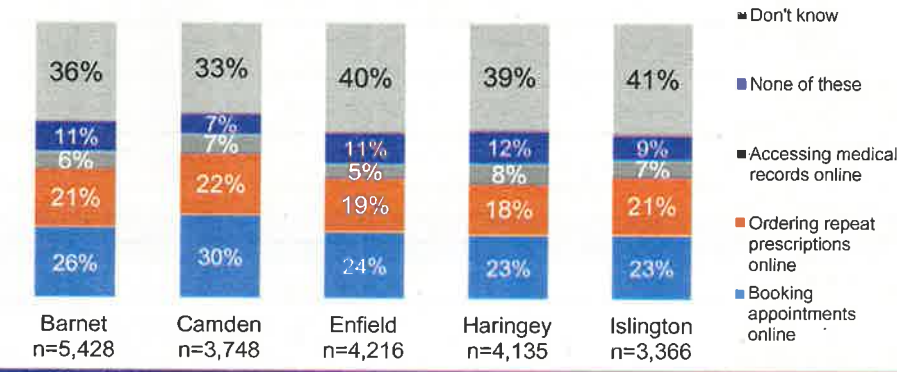
Patient opinion on ease of getting through to someone at GP surgery on the phone



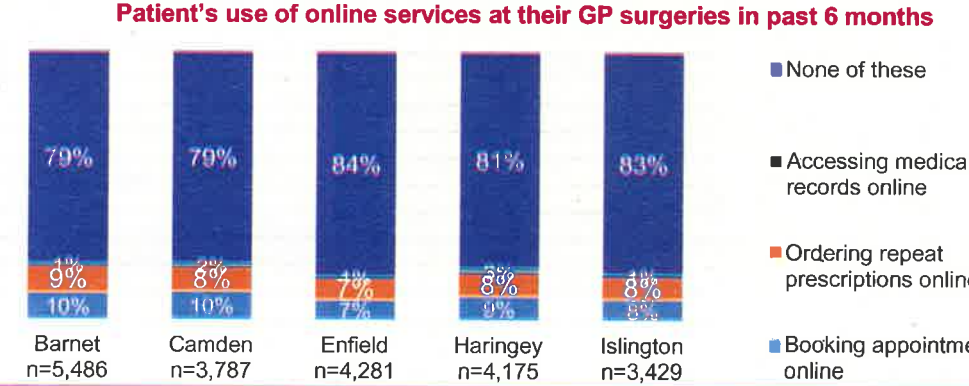
How patients normally book appointments to see a GP or nurse at GP surgery*



Patient's awareness of online services offered by their GP surgery



Patient's use of online services at their GP surgeries in past 6 months



Source: GP patient survey 2017.

*The proportion of respondents communicating via fax was too small to include

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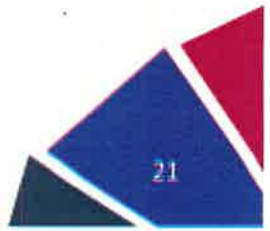
NORTH LONDON PARTNERS in health and care

Where do we want to go?

Given the needs of the local population and the challenges facing general practice, over the next three years we want to achieve:

- **Resilient, sustainable and thriving general practice**
- **High quality, equitable and person-centred safe care**
- **Proactive, accessible and coordinated care**
- **Integrated services that respond to the needs of the patient and the population**



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NORTH LONDON PARTNERS in health and care

Resilient, sustainable and thriving general practice

"There is arguably no more important job than that of the family doctor [...] if general practice fails, the whole NHS fails" Simon Stevens, Chief Executive, NHS England, 2016

We will:

- Make NCL an attractive place to work; value our current workforce and invest in newly qualified healthcare professionals (training, education, quality improvement)
- Build capability within the general practice workforce
- Use a data-driven approach to develop an alert system to mitigate risk ahead of time, providing support to practices, and making sure that practices in need of support know how to access this
- Work with partners to better understand the primary care workforce data
- Work with partners including Health Education England to develop and support new employment models, including portfolio careers and work to demonstrate the impact of any new roles, including supporting pharmacists in general practice
- Explore more alignment of terms and conditions for all general practice staff
- Ensure the patient and carer voice is strengthened in developing of local person-centred service models
- Ensure that services provided within the core and enhanced contracts are available to the population of north central London, whether this is at a patient's own practice, or nearby
- Work towards rebalancing the investment in general practice, recognising the historical variation in funding within NCL
- Maximise opportunities to secure general practice funding, ensure funding follows services when there is a shift from secondary care; work within an affordable system
- Encourage the development of primary care at scale – ensuring the current strengths of primary care, including the ability to balance continuity with access, are not lost
- Where there is limited resource, we will encourage working at scale and sharing across providers

Case study placeholder – demonstrate: general practice looks at patient holistically e.g. Tom's story

What will be different for patients?

Additional skills and capacity in general practice– patients will benefit from increased availability of clinical time and resources

Better, enhanced patient experience through the availability of integrated services supported by shared access to clinical records

Enhanced patient experience with as smooth and uncomplicated as possible a 'journey' through the healthcare system

What will be different for general practice?

Collaborative and integrated working in networks/ across localities will deliver economies of scale and increased sustainability

Development of new employment models; the general practice workforce will change, including a greater role for specialist nurses, pharmacists, physicians' associated, health care assistants, mental health workers and other healthcare professionals

A valued and motivated general practice workforce with training and development for a variety of roles including specialists

Portfolio careers

The destination of choice for healthcare professionals in training

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High quality, equitable and safe, person-centred care

Placeholder: e.g. RCGP Roundhouse example

CASE STUDY – NCL HIWP

We will:

- Focus on delivering high quality primary medical care services and improved outcomes and experiences for the population of north central London, improving the quality of general practice; we will invest in quality improvement support teams
- Reduce unnecessary variation in general practice, so patients know what to expect from their GP, wherever they choose to access services
- Develop services that meet the needs of the population, ensuring that everyone in north central London is able to access quality core primary medical services, either at their practice or nearby
- Take a holistic view of the patient in their community, encouraging local general practice to make community and education links, and take a systematic approach to the way in which person-centred care is delivered
- Ensure a focus on continuity of care for people with complex care needs, people who are especially vulnerable, in a care home or are in need of end of life care
- Regularly review evidence and good practice, supporting initiatives with the potential for the biggest positive impact for patients, e.g. care coordinators for people with long term conditions
- Ensuring that face to face appointments are offered to those who need them; clinicians should assess the requirement for face to face appointments
- Reduce the administrative burden on general practice through collaborative working arrangements, to deliver services in the most efficient way possible, including with community services
- Develop a robust process to monitor quality and measure improvements in line with regulation and national policy
- Ensure patients and carers are supported to be actively involved in their own care, working in partnership with their health care providers.

What will be different for patients?

Improved outcomes and experience
Consistent high-quality care across general practice
There will be safer, less (unwarranted) variability and better quality, consistent care delivered by highly trained GPs, nurses and other professionals
Appropriate continuity of care
Care will be centred around each person so they won't need to have multiple appointments about different long term conditions; they will be arranged around them.
There will be no gaps for patients who are unregistered to fall through.
Patients will have the knowledge, skills and confidence to enable them to work in partnership with their health care professional.

What will be different for general practice?

All practices achieving good or excellent CQC ratings
Shared good practice (policies, procedures, protocols)
Technology used to support long-term conditions management and safe hospital discharge
Staff enabled to work at the top of their licence, so increasing productivity and efficiency and avoiding duplication or waste.
Staff enjoy their work and achieve a good work life balance.

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NORTH LONDON PARTNERS in health and care

Proactive, accessible and coordinated care

We will:

- Continue to develop person-centred, coordinated out of hospital care, working with partners including in general practice, community services and the voluntary sector and aligning channels for general practice e.g. social prescribing, community services
- Develop care registries across networks so people at risk of developing disease are identified systematically, and those with medical conditions are supported to live in good health longer
- Improve information sharing to support 24/7 access to care
- Encourage programmes to develop the ability for GPs to manage demand and supply – a balance between access and continuity of care
- Encourage practices to work together to deliver a full range of services to patients in their local community
- Improve access to general practice including in person, on the telephone and digitally; making sure that everyone can access their GP surgery during the core hours (currently 8am-6.30pm) recognising that different people may prefer different means of access. We will support the uptake of new technology to improve access, and will ensure that services are well-publicised
- Ensure that 20% of all practice patients are registered for GP Online, with 80% of all patients with repeat prescriptions registered for e-prescribing
- Ensure that new premises developments are designed with the future of integrated general practice in mind (e.g. RCGP Roundhouse)
- In line with local priorities, we will support project management, service charge tapers and paying off leases for general practice developments
- Continue to empower people to take a greater role in their care. Through a care and support planning process, people will be supported to set goals, identifying what's important to them. Through active care navigation, people will be able to access local services in their community, increasing their involvement in self care, prevention and health promotion programmes
- Continue to work closely with local authority and public health partners to ensure a more effective prevention and healthy living offer

Proactive care - supporting and improving the health and wellbeing of the population, self-care, health literacy, and keeping people independent and healthy

Accessible care - providing a personalised, responsive, timely and accessible service

Coordinated care - providing a patient-centred seamless experience of care and GP-patient continuity

What will be different for patients?

Better patient experience through more responsive care, which will be delivered in a range of ways, for example online, email and telephone rather than just face-to-face consultations - and improved access to general practice
People will be easily able to book their appointments
Continuity of care for those patients that need it most
Patients will experience better management and care of long-term diseases; when they are frail and elderly; and at the end of life
Improved (and less variable) access to general practice services
Better patient experience through use of more digital technology

What will be different for general practice?

Through the development of closer working relationships with the wider MDT, GPs and the primary care health team will feel supported in delivering care, so will feel more able to manage increasing complexity
Collaboration through partnership working with patients who are informed and engaged, will result in improved utilisation of GP services so ensuring health care professionals experience less demand and an improved work life balance
Reduced duplication of activity through improved sharing of data, will result in improved productivity within general practice
Increased security of service provision as a result of longer contracts, results stable primary care teams

DRAFT

NORTH LONDON PARTNERS in health and care

Integrated services that respond to the needs of the patient and the population

We will:

- Support the development of care and health integrated networks through which teams of professionals and workers can provide innovative, proactive and person-centred care
- Work with our partners in the system, including other health, local authority and voluntary/ third sector/ charity providers to develop more coordinated and integrated models of care, focusing on patient needs and around a shared vision
- Take a proactive, person-centred approach to delivering this care with our partners, through care and health integrated networks
- Provide general practice with the tools to support patients to navigate their way through care, enabler easier access to appropriate care, with access to health, social care, lay and voluntary organisations
- Develop and use and share dashboards across all providers for use at micro, miso and macro levels to support the reduction of duplication and unnecessary variation across the system
- Support the development of at scale provision, including at network, neighbourhood, federation and borough level

Peter is 12 years old and in Year 7 of secondary school. He has had asthma and eczema since early childhood. He lives with his mother, who has mental health problems and a mild learning disability. She does not work. His asthma has previously been well controlled, but he has missed a lot of school during the last year. He has gained weight and is missing sports lessons because of the asthma.

Peter will have access to a nurse specialist in the community. At school he will be seen by an asthma nurse. This is more convenient, improves Peter's ability to self-manage and involves less time in hospital.

Peter and children like him will:

- **require fewer A&E attendances** and admissions
- become involved in care, and **able** to manage
- be **supported** by people who know him and his family
- **miss less school**
- have **improved fitness** and **confidence**

What will be different for patients?

Patients will be able to access more care locally from a range of service providers/ partners
General practice will remain the gate keeper to care, but patients will be able to access a broader range of services through their GP
Patients will have a simpler 'journey' through the health and care system

What will be different for general practice?

Access to a broader range of clinical skills will enable a multi-disciplinary approach to caring for patients, releasing specialist medical resources
Access to patient information broadened through a common clinical IT platform to enable seamless, integrated service provision
Integration ensures duplication is avoided

DRAFT

NORTH LONDON PARTNERS in health and care

Delivering these aims – resources, timescales and implementation

- Resilient, sustainable and thriving general practice
- High quality, equitable and person-centred safe care
- Proactive, accessible and coordinated care
- Integrated services that respond to the needs of the patient and the population

WORKFORCE

Focus on both the **existing and new workforce – retain, recruit and develop a new skill mix**

Retain

Peer support to value and support GPs in the pre-retirement years. The experience and skills of older GPs are much needed by the system, and evidence suggests that helping GPs avoid burnout and providing opportunities for new challenges helps prevent premature departure from general practice.

- Gather examples of opportunities for older GPs through peer networking which may provide new challenges/opportunities
- Consider how to best link in with resources for older GPs which are being developed centrally
- Establish peer support for older GPs including scoping what this might look like (with CEPNs)
- Make sure there is visibility of CEPNs and available training opportunities
- Explore opportunities for accessing secondary care education
- Encourage **good employment practice** e.g. national / SW England good practice approach to terms and conditions for practice nurses
- Improve opportunities for **flexible** working and promote **portfolio career** options (CEPN retention programmes, Innovative GP and First Five programmes)

Recruit

- **Supply**: focus on graduates, returning practitioners and recruitment from elsewhere – creating opportunities to attract people to professions in general practice e.g. work experience, business and administrative / health care apprenticeships, and opportunities for existing health professionals to work in general practice e.g. pre-registration nursing students, medical, pharmacy or paramedic students. Make NCL an attractive place to work, including for new international GP recruits.
- **General practice nursing:** Increase the number of pre-registration placements in general practice. Increase access to clinical academic careers and advanced clinical practice programmes, including nurses working in advanced practice roles in general practice. Develop healthcare support worker (HCSW), apprenticeship and nursing associate career pathways

New skills

- Support the development of **new roles**, e.g. pharmacists, allied health professionals, physician associates in general practices
- Rotations and exposure to primary care
- Local ownership and leadership of at scale providers

PLACEHOLDER:

TO ADD:
Training and education – role of CEPNs, standardising education and training (MaST?)
Strategic workforce action plan – setting out skills, capacity and clinical/ caring roles – to feed into the development of future education and training

Placeholder – define delivery at NCL/ borough/ practice level

Delivery Plan and phasing – commitment to delivery (timescales)

DRAFT

NORTH LONDON PARTNERS in health and care

Delivering these aims – resources, timescales and implementation

- **Targeted investment** and transparency of information on what money CCGs are investing in general practice on an annual basis, enabling providers to plan on a strategic basis
- Clearly tracked and documented investment in general practice to ensure resource delivery adequately matches resource planning

- Investment in **quality improvement** support teams – targeting reducing unwarranted variation in outcomes and providing additional clinical capacity.
- Data driven insights from across health and care – improving identification and assessment of those at risk and connect them to services (health and non-health) and interventions
- Data-driven approach to identifying practices likely to require support
- Continued support of the NCL Quality Improvement Network, established for community, acute, primary and social care; aligned to care and health integrated networks and QISTs
- Take a peer-reviewed, outcome-driven approach to the review and provision of enhanced services. Not all practices opt in to deliver these services, the numbers are small, but are indicative of inequity of access to enhanced primary care services.
- Access – extended hours, increase communications and our monitoring of the take-up of the pre-bookable appointments

- Prioritise the work of enablers including **digital**, with a focus on delivering the north central London **Health Information Exchange,** online consultations and the use of patient apps. Health and care professionals will need to access and share information, and alert, task and notify other relevant professionals across care settings. Data sharing agreements will be put in place for any new instances of information sharing, which are not a part of direct care.
- Improved electronic advice, guidance and other clinical messaging systems between primary and secondary care clinicians e.g. access to EMIS primary care record for intermediate care teams
- Digital approaches will continue to support new models of care and improvements in access, e.g. risk stratification tools to identify patients at risk of hospital admission.
- Patients activated and engaged with care record

- **Targeted estates** support in line with need; agree and prepare a capital priority list to be ready to respond to the availability of capital, and ensuring there is sufficient estate to meet the needs of the population

- Support practices to respond **flexibly** to patient demand, e.g working flexibly across hubs/ neighbouring practices
- Work with at scale providers to ensure they have the resources in place to rapidly support practices in need, to maintain patient care
- Enable **collaborative working** across local healthcare systems, removing organisational barriers, focusing on a common vision
- Share learning from effective new models of care, ensuring scaling of services to become business as usual
- Coordinate and improve signposting to **social prescribing** schemes

- **Resilient, sustainable and thriving general practice**
- **High quality, equitable and person-centred safe care**
- **Proactive, accessible and coordinated care**
- **Integrated services that respond to the needs of the patient**

PLACEHOLDER:
Development of a dashboard?
100% coverage of enhanced services?
Delegated commissioning role – core hours

define delivery at NCL/ borough/ practice level

Delivery Plan and phasing – commitment to delivery (timescales)

DRAFT

NORTH LONDON PARTNERS in health and care

Delivering these aims – resources, timescales and implementation

Estates

- Delivery of our strategy relies our partners – including Local Authorities, CCGs, Trusts, and property companies. At the STP level, our focus is on collaboration and common prioritisation through our Estates Board, whilst not superseding individual organisational autonomy.
- Currently, planned and underway, there are multiple CCG schemes designed to **match population growth, deliver primary care at scale and bring care closer to home** (including eight live estates ETTF schemes) alongside large scale estates **transformation and refurbishment** in the acute provider estate (e.g. St Pancras, St Ann's, Chase Farm, RNOH Stanmore Site). This is being achieved through various funding routes including ETTF, charity and capital funding and surplus land disposal receipts.
- We are optimising operational efficiency through **better utilisation** of the estate, by reconfiguration of services in underutilised space (e.g. Edgware Community Hospital and Finchley Memorial Hospital), and appropriate **disposal of void space** (e.g. Marie Foster Centre).
- By working more effectively **across local public sector partnerships** (e.g. Barnet One Public Estate) we are taking a system-wide strategic approach to asset management.

- **Resilient, sustainable and thriving general practice**
- **High quality, equitable and person-centred safe care**
- **Proactive, accessible and coordinated care**
- **Integrated services that respond to the needs of the patient and the population**

Placeholder – define delivery at NCL/ borough/ practice level

Delivery Plan and phasing – commitment to delivery (timescales)

DRAFT

Delivering these aims – resources, timescales and implementation

NORTH LONDON PARTNERS in health and care

Resilient, sustainable and thriving general practice

	18/19		19/20				20/21				21/22	22/23
Actions	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Strategic workforce action plan												

PLACEHOLDER – EXAMPLE DELIVERY PLAN – TBC WITH PRIORITIES

DRAFT

NORTH LONDON PARTNERS in health and care

Delivering these aims – resources, timescales and implementation

High quality, equitable and person-centred safe care

	18/19		19/20				20/21				21/22	22/23
Actions	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Enhanced services review (phase 1)												

PLACEHOLDER – EXAMPLE DELIVERY PLAN – TBC WITH PRIORITIES

DRAFT

Delivering these aims – resources, timescales and implementation

NORTH LONDON PARTNERS in health and care

Proactive, accessible and coordinated care

	18/19		19/20				20/21				21/22	22/23
Actions	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		

PLACEHOLDER – EXAMPLE DELIVERY PLAN – TBC WITH PRIORITIES

DRAFT

NORTH LONDON PARTNERS in health and care

Delivering these aims – resources, timescales and implementation

Integrated services that respond to the needs of the patient and the population

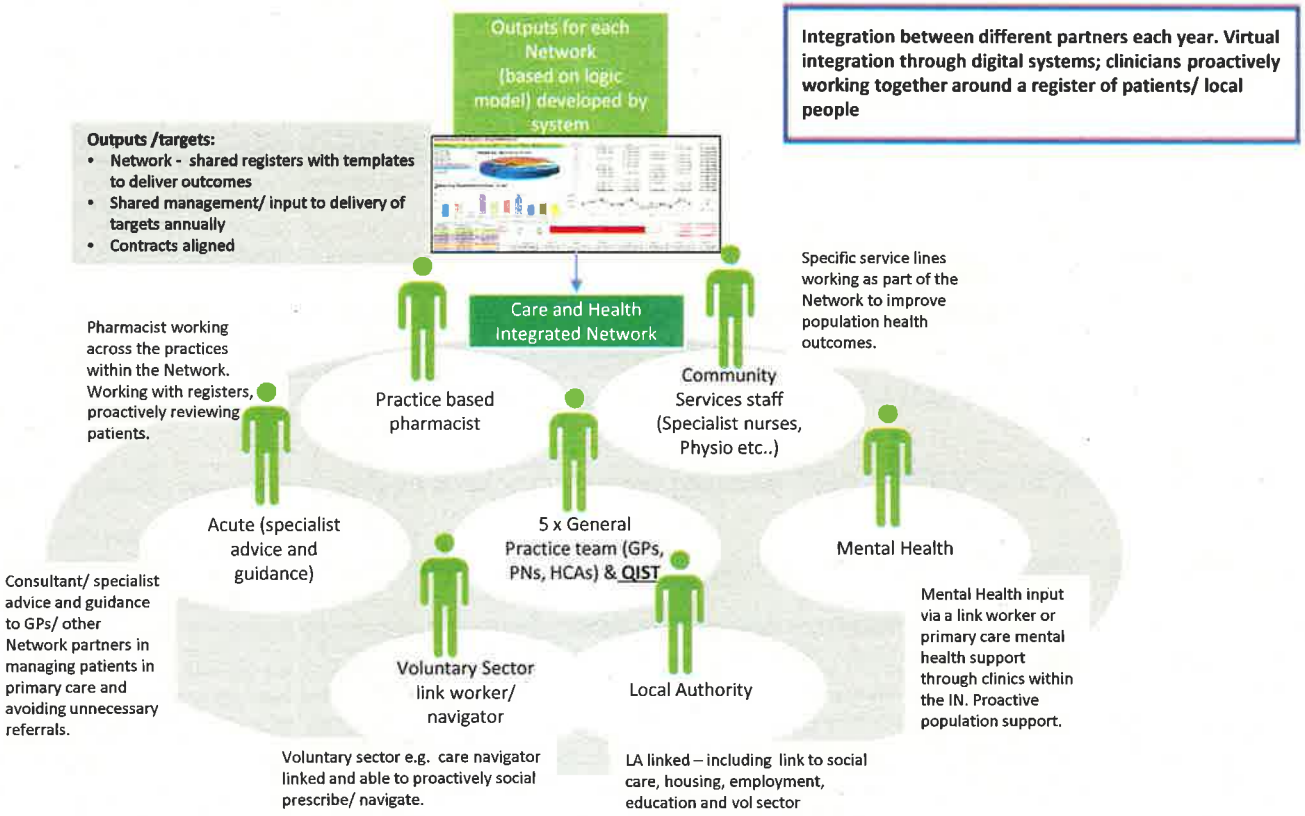
	18/19		19/20				20/21				21/22	22/23
Actions	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Commissioning arrangements												

PLACEHOLDER – EXAMPLE DELIVERY PLAN – TBC WITH PRIORITIES

DRAFT

NORTH LONDON PARTNERS in health and care

The Care and Health Integrated Network Model



A Network IS/ WILL:

- A network of GP practices and system partners sharing registers to manage specific cohorts of patients.
- Partners taking collective responsibility to manage patient outcomes.
- Virtual; cohorts of patients brought together virtually via a register. System partners will proactively work with the patients on the register; it will not involve all patients on the registered list.

A Network IS NOT/ WILL NOT:

- A physical hub for one-stop care for all long term conditions (e.g. a polysystem)
- A new service integrating all services around the whole registered patient list
- A locality where all services work to new geographical boundaries but continue existing ways of working

DRAFT

NORTH LONDON PARTNERS in health and care

References and placeholders

1. https://www.bma.org.uk/collective-voice/influence/key-negotiations/nhs-funding/investment-in-general-practice-in-england

2. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00743-1/fulltext

The Lancet study findings show that the overall workload of GPs in England rose by 16% in the 7 years up to 2014, with more frequent and longer GP consultations. Rates of GP consultations rose by 12·36% per 10 000 person-years, compared with 0·9% for practice nurses. Moderate rises in rates of GP face-to-face consultations (5·2%) were overshadowed by an almost 100% increase in the rate of GP telephone consultations. Additionally, the mean duration of GP face-to-face consultations rose by about half a minute, from 8·65 min (95% CI 8·64–8·65) in 2007–08 to 9·22 min (9·22–9·23) in 2013–14. This rising tide of workload is probably an underestimate, since an additional 40% of GP time is spent on tasks not measured in this study, such as arrangement of referrals or admissions, renewal of prescriptions, administrative and clinical meetings, and teaching.[2]x2Gibson, J, Checkland, K, Coleman, A et al. Eight national GP worklife survey Manchester: University of Manchester. http://www.population-health.manchester.ac.uk/healtheconomics/research/Reports/EighthNationalGPWorklifeSurveyreport/EighthNationalGPWorklifeSurveyreport.pdf; 2015. ((accessed March 7, 2016).)

Google ScholarSee all References Moreover, although the dataset does not provide data about the number of GPs (which could account for the increase in consultations), the investigators point out that other data show there has been a 1% decline in full-time equivalent GPs over this time period.

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5. Mathers N, Roberts S, Hodkinson I, Karet B. Care Planning. Improving the Lives of People with Long Term Conditions. London; 2011 2011.

6. Programme YoC. "Thanks for the petunias". A guide to developing and commissioning non-traditional providers to support the self management of people with long term conditions. Newcastle; 2011 5/2011.

7. Better conversation: Better Health http://www.betterconversation.co.uk/images/Action_Booklet.pdf

8. https://adobeindd.com/view/publications/f1caab26-4963-464e-ba33-6ff71d991a9a/1/publication-web-resources/pdf/VID-169_-_Empowering_the_Person_Timeline_May_2018_v3.pdf

https://www.nottingham.ac.uk/pharmacy/research/divisions/pharmacy-practice-and-policy/research/cpigp.aspx

https://www.nottingham.ac.uk/pharmacy/documents/generalpracticeyearfwdrev/clinical-pharmacists-in-general-practice-pilot-scheme-exec-summary.pdf

https://www.nottingham.ac.uk/pharmacy/documents/generalpracticeyearfwdrev/clinical-pharmacists-in-general-practice-pilot-scheme-full-report.pdf

DRAFT

NORTH LONDON PARTNERS in health and care

Glossary

PLACEHOLDER

Admission - The admission of a patient to a hospital inpatient bed, usually after triage or assessment

Admissions Avoidance - A core workstream within the NCL Urgent and Emergency Care programme – focused on preventing patients from requiring admission overnight to hospital beds.

Ambulatory Care - Treating a patient in a hospital setting on a same-day basis, without admitting them to an inpatient hospital bed.

Assessment - The assessment of a patient's condition, in order to establish the best ongoing care and support for them.

At scale a group of general practices working together to deliver services

Attendance - A patient turning up at a health care setting, either independently or conveyed via ambulance.

Business Intelligence - The systems behind or the practice of using data and other information in order to understand more about users of service, activity, trends, and performance.

CCG - Clinical Commissioning Groups

Care and Health Integration Network – xxx

CEPN - Community education provider

Co-design - Patients and service users working directly with health professionals – both clinical and managerial – to develop services or solutions to problems experienced by the health system. In a true sense of co-design, each person's voice and perspective is valued equally in what they bring to understanding the problems and their potential solutions.

CQC – Care Quality Commission

PLACEHOLDER

GP – General pracitioner

GP Federation - A type of healthcare provider - A joint enterprise between local GP practices (usually within a borough), organized usually to provide services that go over and above the normal services provided by local practices individually.

GPFV – General Practice Forward View (national policy document)

Long Term Conditions (LTCs)

Neighbourhoods - xxx

North Central London - The London Boroughs of Barnet, Camden, Enfield, Haringey and Islington.

Population Health Management -

Quality Improvement Support Team – xxx

QOF – Quality and outcomes framework

Record sharing

Ensuring that clinicians can access patient records wherever a patient is seen to reduce risk and duplication.

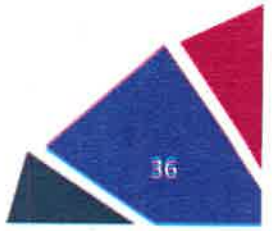
SCF - Strategic Commissioning Framework The strategic document for primary care in London

DRAFT

Workforce Strategy – NCL

NORTH LONDON PARTNERS in health and care

PLACEHOLDER



Agenda Item 7

MUNICIPAL YEAR 2017/2018 - REPORT NO.

MEETING TITLE AND DATE
Health and Wellbeing Board
27 September 2018

Agenda - Part:	**Item:**
Subject: Annual Public Health Report 2018 **Report of:** **Stuart Lines** **Director of Public Health**	

Contact officer and telephone number:
Glenn Stewart
Tel: 0208 379 5328
E mail: glenn.stewart@enfield.gov.uk

1. EXECUTIVE SUMMARY

It is a statutory duty of the Director of Public Health to produce an independent annual report outlining aspects of health that they consider to be of importance that year. The report is available online:

https://new.enfield.gov.uk/healthandwellbeing/jsna/annual-public-health-reports/annual-public-health-report-201718/

2. RECOMMENDATIONS

That the HWB note the Annual Public Health Report (APHR).

3. BACKGROUND

It is a statutory duty of the Director of Public Health to produce an independent annual report outlining aspects of health that they consider to be of importance that year. For 2018 the APHR highlights a 10 year vision of health for the borough and includes 22 fact sheets highlighting areas of action that might be undertaken to improve health in the borough. The report is available online:

https://new.enfield.gov.uk/healthandwellbeing/jsna/annual-public-health-reports/annual-public-health-report-201718/

4. ALTERNATIVE OPTIONS CONSIDERED

N/A

5. REASONS FOR RECOMMENDATIONS

To improve health in the borough. This is an independent report of the Director of Public Health

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

6.1 Financial Implications

N/A

6.2 Legal Implications

N/A

7. KEY RISKS

The key risk is failure to deliver the Strategy by April 2019.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

This will ensure delivery of actions against all Enfield priorities:

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

9. EQUALITIES IMPACT IMPLICATIONS

N/A

A 10-year vision for a Healthy Enfield

Annual Public Health Report 2018

Foreword

I would like to welcome you to this year's annual public health report (APHR) of the Director of Public Health for 2017/18. The report this year focuses on the current challenges we all face in improving residents' health and wellbeing and aims to spark debate about what we can all do together and in partnership to help address these issues.

Our individual level of health and wellbeing will be affected by a wide range of factors – from the climate and environment around us, to the local economy and community we live in. We are influenced by these and other factors everyday in the choices we make to keep us healthy and active. Many of these factors, although they may be beyond individual control, can be improved by the combined efforts of a range partners across all services and sectors.

I am pleased to present this year's APHR which aims to address these wider determinants of health, particularly in this time of austerity, which encourages us all to think about how we can each contribute by embedding health in all that we do.

Finally, I would like to thank the Enfield Public Health team for their hard work and enthusiasm in working towards delivering our vision for a truly ***Healthy Enfield,*** which will enable people to live healthier and happier lives.

Cllr Yasemin Brett

Cabinet Member for Public Health

Introduction

The annual public health report (APHR) of the Director of Public Health provides an opportunity to initiate a wider discussion about our residents' health and wellbeing, to focus attention on current health-related issues and to help galvanise people and organisations to take action.

The intention is not simply to focus on healthcare or specific public health services, but to explore what it is that makes us healthy (or indeed unhealthy) and what further contribution could be made by public services, and other sectors, to help make people healthier.

Enfield has a long and strong history of providing high quality public services for our residents. These include social care, the NHS, the emergency services and education but the question should still be asked, whether we are all doing enough to ensure that Enfield, as a place to live, work and play, is an environment in which we can all achieve our potential and be as healthy as we can be.

This report aims to look forward and to help clarify our collective ambitions for creating a ***Healthy Enfield***. Whilst acknowledging current challenges presented by austerity and economic uncertainty it identifies some of the important local health challenges that we face as a community and sets out approaches that have been used elsewhere and that we might want to develop locally.

It is five years since councils took back the responsibility for improving the health and wellbeing and reducing health inequalities of their residents. The transfer of public health responsibilities from the NHS has provided opportunities over this time for better joint working and a clearer focus on action to tackle the health challenges we face. The Health & Wellbeing Board has set an ambitious five-year strategy that articulates this and brings partners together from across the local system to improve outcomes. The NHS, which celebrates its 70th birthday this year, is an important partner but not the only one we need to work with. It is only through the collective efforts of all partners, including the community and voluntary sector, that real impacts at the societal level may be achieved.

As part of this the Council has set itself the challenge of ensuring that the health and wellbeing of Enfield residents is at the heart of all that it does. This is summarised as:

A 10-year vision for a *Healthy Enfield*

We see a population in Enfield that knows about and wants to lead a healthy life surrounded by organisations and a place that helps them do so. There is a vibrant movement for health locally with residents spontaneously helping each other to live well.

Enfield Council is increasingly seen as a leader in improving health through encouraging healthy choices through policies and design. As the local 'place-shaper' Enfield Council is seen as the champion for improved health and

reduced health inequalities. Enfield Council sees health holistically not just in terms of health and care 'services' but as something that is a result of the place (e.g. not one that encourages us to be overweight or inactive) and the life chances we have as well as the services we use.

Health and care services are designed with and for our residents targeting those that need them most using evidence of what works. We also see a shift in social mobility with people seizing opportunities to help themselves by being helped on the way by local services on a short-term basis in the main.

Inequalities are shrinking because being healthy is not dependent on social background and the local system has tackled issues such as pollution which lie beyond the control of individual. We are in a position where Enfield Council can show where we have made a difference.

Enfield Council continues to work effectively with all partners to achieve these outcomes. Everything Enfield Council does considers health impact, maximising the positive and minimising the negative.

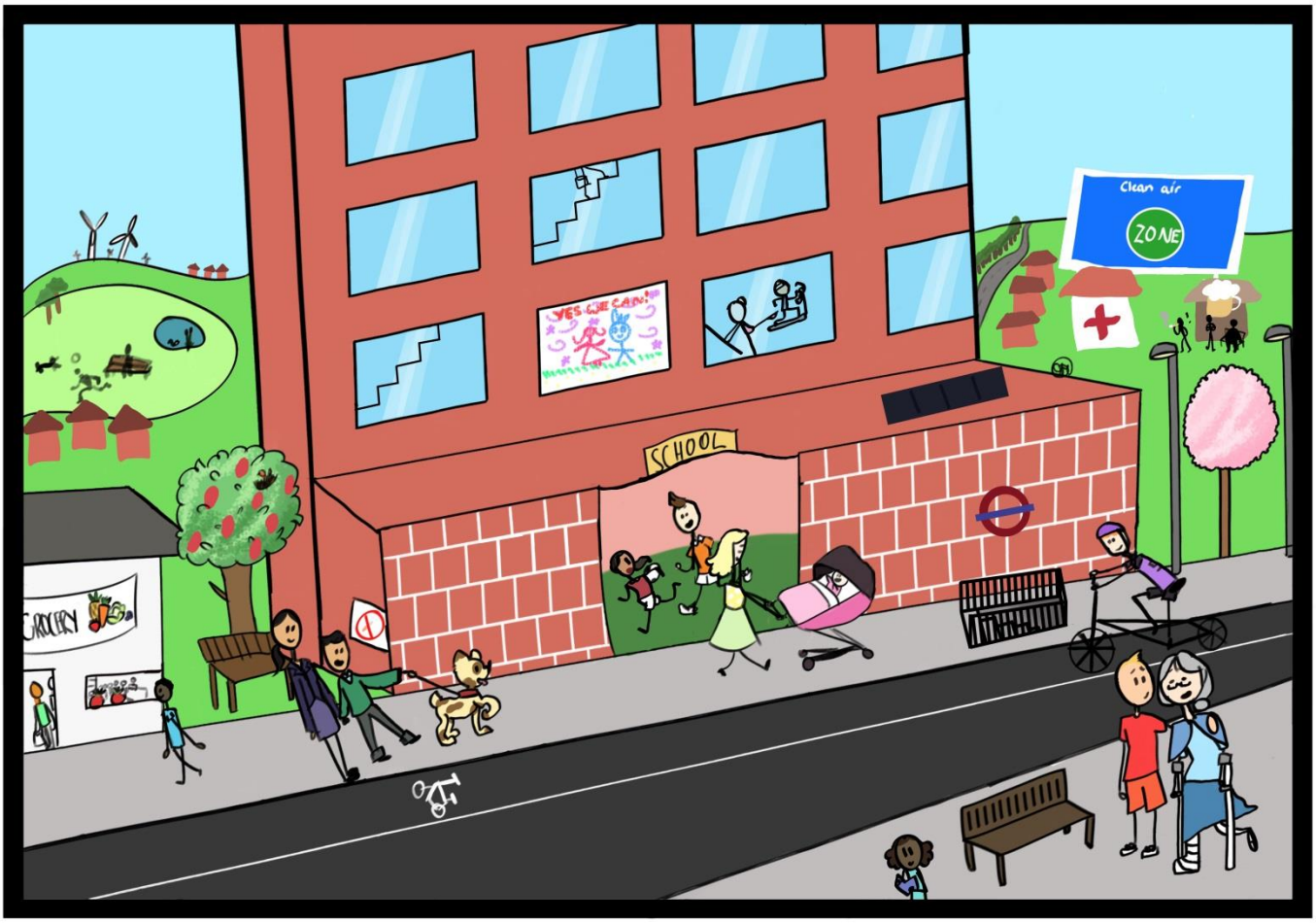
We are using this picture of *a* ***future Enfield***, drawn by Olivia Han[1] (12 years old), to encapsulate our aspirations.

Please hover over and click on each image in the picture to read related factsheets. Next year we hope to report how our Enfield has responded to each of these factsheets.

Stuart Lines

Director for the Public's Health

Click below to enlarge the image. In the enlarged image, you will find 22 factsheets.



Full list of factsheets are also available here.

[1] Olivia is the daughter of our Consultant in Public Health, Dr Tha Han.

APHR 2018 – Factsheets

1. Air pollution is shortening lives

2. Climate change is the greatest threat to global health in the 21st century

3. Planning policy is fundamental to health behaviour and a healthy environment

4. A street that works for people is a street that is good for health

5. Buildings need to encourage healthy lifestyles as far as possible

6. Walking is a simple health behaviour accessible to nearly everyone that could reduce rates of chronic disease

7. Cycling is a cheap, accessible and effective means of making physical activity part of everyday life

8. Independent travel improves health

9. Play is important, but the amount of time children spend playing has declined

10. Obesity is about poverty and cheap food, not laziness

11. There is only one message about smoking – don't!

12. Loneliness isn't just about feeling alone

13. Anxiety can make you physically unwell, but preventing that is a state of mind

14. Emotional wellbeing is something you "do", not something you "are"

15. The health of mothers and their children go together

16. Let's give every child in Enfield the best start in life

17. Good parenting is perhaps the most fundamental determinant of a child's health

18. A healthy school is a school that provides an environment and culture that helps their pupils grow up to be healthy, happy and ready to learn with good aspirations

19. Work is good for you and some workplaces are healthier than others

20. Keeping strong in older age is important for health, quality of life and independence

21. Celebrating 70 years of the NHS and becoming a wellness service rather than a sickness service

22. Preventing what's preventable – immunisation is a simple step to protect people from infectious diseases

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 26 JULY 2018

MEMBERSHIP

PRESENT Cllr Alev Cazimoglu (Cabinet Member for Health & Social Care),Cllr Yasemin Brett (Cabinet Member for Public Health), Mo Abedi (Enfield CCG Chair and Vice Chair of the HWB), Parin Bahl (Chair of Enfield Health Watch), John Wardell CCG Chief Operating Officer), Bindi Nagra (Director of Adult Social Care), Stuart Lines (Director of Public Health), Natalie Forrest (Chief Executive, Chase Farm Hospital, Royal Free Group), Vivien Giladi (Voluntary Sector), Litsa Worrall (Voluntary Sector), Jo Ikhelef (CEO of Enfield Voluntary Action) and Josh Salih (Enfield Youth Parliament)

ABSENT Nesil Caliskan (Leader of the Council), Ian Davis (Chief Executive), Achilleas Georgiou (Cabinet Member for Children's Services), Dr Helene Brown (NHS England Representative), Tony Theodoulou (Executive Director of Children's Services), Maria Kane (Chief Executive North Middlesex University Hospital NHS Trust) and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust)

OFFICERS: Dr Glenn Stewart (Assistant Director, Public Health), Jill Bayley (Principal Lawyer - Safeguarding), Paul Sutton (Assistant Director, People's Services) and Tariq Soomauroo (Secretary)

Also Attending: 9 observers

12
WELCOME AND APOLOGIES

Councillor Cazimoglu (Chair) welcomed everyone to the meeting. Apologies for absence were received from Ian Davis (Chief Executive), Dr Helene Brown, Councillor Georgiou, Tony Theodoulou, Maria Kane and Councillor Caliskan (Leader).

The Chair suggested to the board to hold the next meeting at a different venue (Outside Enfield Town) to aid public awareness of the Board.

The Board **AGREED** this would be a good idea.

13
DECLARATION OF INTERESTS

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

14
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST (NMUH) CASE FOR CHANGE

RECEIVED a presentation by Richard Gourlay, Director of Strategic Development, NMUH.

NOTED
Richard Gourlay introduced the report, highlighting the following:

- North Middlesex University Hospital (NMUH) primarily looking at how to provide a sustainable service
- NMUH trying to digitalise pathways and make decisions in closer collaboration
- Provide essential care for a needy population
- It was highlighted that the current pressure on the A&E department is significant
- Issues raised were Retention and Recruitment regarding staff, improving the culture in the workforce and implementing Governance Arrangements
- It was noted that arrangements will be drafted in August 2018 and engagements with stakeholders to commence in September 2018.

IN RESPONSE comments and questions were received, including:

1. The Chair raised issues regarding Public Transport to and from hospitals, and if anything is being done in connection with this?

   Richard Gourlay advised that he has a specialist team (Estates team) working on this issue and that NMUH representatives sit on that group.

2. Congratulations were passed onto the North Middlesex on how well they did during the Winter crisis. A question was asked regarding the amount of deficit the Royal Free have?

   It was advised that the deficit at the start was 29 Million and is projected to be 18 Million (end of the year), it was also highlighted that integration within the organisations (NMUH & RFL) will improve current deficits.

3. A question was asked for better clarification on the managerial structure with a Royal Free London (RLF) integration.

   Similar management structure as Barnet Royal Free. Royal free to be strategic decision makers.

4. Dr Mo Abedi (Vice-Chair) also made a comment regarding the improved stability the association have brought.

5. Bindi Nagra (Director of Adult Social Care) commented that the Board needed to look at all options not just one, Bindi also advised that Maria Kane's (North Middlesex University Hospital NHS Trust) approach regarding quality improvement has been excellent. It was also highlighted by Bindi that there was a lack of evidence regarding the benefits the Royal Free would bring to guide decision making.

Other questions received:

6. Why can't you go it alone, without any integration with RFL?

   Some services are small and fragile, A&E department demonstrated this with issues around retainment and recruitment in the sector this year.

7. Do you understand why you struggle to recruit/retain staff?

   Inner London waiting is more appealing to potential/current staff and the culture within organisation needs improving.

8. Parin Bahl (Healthwatch Representative) mentioned that she has previously highlighted her disappointment if another crisis happened, residents' value their local hospital and welcome the idea for change.

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9. Stuart Lines (Director of Public health) asked what is the role of the Royal Free in prevention?

Stop smoking services, maintaining care outside hospitals. A bid was recently submitted to CCG looking at other prevention action plans.

15
INTEGRATION AND BETTER CARE FUND (BCF)

RECEIVED the report of Bindi Nagra, Director, Adult Social Care Enfield Council and Graham MacDougall, Director of Strategy and Partnerships Enfield CCG

NOTED
Graham MacDougall introduced the report, highlighting the following:

- The year-end financial position for the BCF's performance was good
- It is confirmed that both the CCG and Council have achieved the required savings to provide a balance position (End of year)
- The Better Care Fund allocation was agreed as part of a two-year plan 2017-2019, this was ratified by the Health and Wellbeing Board in August 17 and submitted to NHS England with the plan formally agreed in October 17
- The improved better care funding for 18-19 has been allocated to meet the following grant conditions; Adult Social Care needs, reducing pressures on NHS and to support the local social care provider market.

16
PROGRESS UPDATE ON JOINT HEALTH AND WELLBEING STRATEGY (JHWS)

RECEIVED the report of Stuart Lines Director of Public Health, on progress on Health and Wellbeing Board Monitoring areas for 2017-19 and the Annual Review of key indicators.

NOTED
Stuart Lines introduction of the report highlighted:

- This is a regular item within the Board Meetings, with the priority areas being Best start in Life, Healthy Weight and Mental Health resilience
- Continue to support ongoing partnership with Thrive LDN in mental health resilience
- Awareness of emotional health and wellbeing resilience to other HWB priorities
- HWB member organisations to sign up to Sugar Smart Enfield and Enfield CCG and LBE to offer more accessible places locally for initial assessments, and group intervention sessions regarding diabetes prevention
- Continue to progress the Best Start in Life Action Plan
- Monitoring the VAWG Strategy Action Plan
- Progressing an audit of how Enfield is meeting NICE guidelines on domestic abuse
- Supporting future cancer awareness campaigns and to facilitate/encourage bowel scope launches for Enfield residents
- Season Flu vaccination performance have improved in 17/18 across all NHS providers and will continue to support flu vaccination uptake and campaigns

17
MENTAL HEALTH - PRIORITY UPDATE REPORT

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

NOTED
Mark Tickner (Senior Public Health Strategist) introduced the report, highlighting the following:

- Proposals will be in place soon for additional activity moving forward
- Mark advised 2 flowcharts will be developed relating to "Making Every Contact Count" [MECC] and "Mental Health First Aid" [MHFA] at the Council
- The first to display how we might introduce MECC and MHFA across LBE, and for whom and to define what additional skills would be delivered. This would include timeframes and optional arrangements including potential partners locally
- The second to show how the referral mechanisms for MECC and MHFA after introduction
- Mental Health resilience is a priority identified by the Health and Wellbeing Board
- Flowcharts are due to be submitted by the 3rd September 2018

18
BEST START IN LIFE - PRIORITY UPDATE REPORT

RECEIVED the background papers on Giving Every Child the Best Possible Start in Life through improving school readiness

NOTED
Andrew Lawrence introduced the report, highlighting the following:

- In Enfield, for a cohort of 4,634 children the data shows an improvement of 1.6% to have a good level of development (GLD) from 66% in 2016, to 67.8% in 2017. The National GLD had also risen from 69% to 70.7%.
- Enfield have consistently improved in line with other authorities, it has not yet however narrowed the gap in school readiness measures in terms if nation/regional comparators.
- Some Enfield Schools, who have a high percentage of children from families with complex issues, can ensure that 66+% of children do achieve a GLD while others it is still only 55+%
- Schools are also reporting higher mobility within the year group. During reception year 160 children (4%) left whilst another 80 transferred to another Enfield school.
- In response programmes such as empowering parents and empowering communities are taking place.

- Healthy early year schemes are also in place in private, voluntary and independent nurseries, early learning/day care in children's centres, schools, nursery schools and childminders.

19
HEALTHY WEIGHT - PRIORITY UPDATE REPORT

RECEIVED the report of Dr Glenn Stewart, Assistant Director of Public Health

NOTED
Dr Glenn Stewart introduced the report, highlighting the following:

- Report encourages their organisations to responds to the Healthy Weight Strategy consultation and consider what actions to take
- Support Enfield Councils efforts to participate in School Superzones pilot project that target unhealthy food and drink sales, advertisements, alcohol, smoking, gambling, air quality and physical inactivity
- Obesity still a priority for the Health and Wellbeing Board for 2017 - 2019

20
KEY MESSAGES FROM THE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

RECIEVED the presentation on the Key Messages from the Joint Strategic Needs Assessment (JSNA) sent to follow.

NOTED

- Population Structures in Enfield;
- 331,395 people in Enfield, 5th largest population in Enfield, Larger proportion of 0-19-year olds compared to London/England average and Enfield population to increase to 354,300 by 2023
- Deprivation;
- Highest deprivation in East of Enfield, 22% of Enfield children (around 19,00) lives in poverty (Tenth highest in Enfield
- Ethnicity is ethnically diverse borough
- Life expectancy in Enfield is 80.1 years (Male) and 84.5 years (Female)
- There are still wide inequalities in health outcomes in the Borough
- Obesity also a serious issue in the Borough.

21
HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

RECEIVED the report of Tony Theodoulou (Executive Director of People's Services) sent to follow.

NOTED

- The amended Terms of Reference were agreed at full Council on the 19th July 2018
- Key amendments include;
- The frequency of Board meetings and Development Sessions
- Revised structure and Governance Arrangements

22
VOLUNTARY REPRESENTATION AT THE HEALTH AND WELLBEING BOARD

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:

- The current Terms of Reference include provision for the election of a representative from the Third Sector for a term of office of 3 years. The current representatives have been on the Board since 2013.
- The revised terms of reference state that there will be one representative from Enfield Voluntary Action (EVA) and another elected representative.
- There is therefore a need to hold a formal, open, transparent and democratic election to secure voluntary sector representation to assist the HWB in fulfilling its health leadership role for the borough.
- Democratic Services have confirmed that the current voluntary sector representatives will remain in place until new voluntary sector representatives have been elected (or re-elected).

PROPOSAL

1. To achieve the above, it is anticipated that engagement with the VCS will start immediately with a view to holding elections in September with the result reported to the HWB on 27th September 2018.

The Board considered that the proposal was satisfactory

IN RESPONSE comments and questions were received, including:

1. An ECS representatives' term of office is three years, with new representatives to be in place by 27th September 2018.
2. It was advised to include as many people as we can to have the best Health and Social Care experience.

23
HEALTH AND WELLBEING BOARD FORWARD PLAN

RECEIVED the report of Stuart Lines, Director of Public Health

NOTED the proposed forward plan.

AGREED

1. That the Health and Wellbeing Board agreed the proposed forward plan.

24
INFORMATION BULLETIN

NOTED the Information Bulletin items.

25
MINUTES OF THE MEETING HELD ON 17 APRIL 2018

AGREED the minutes of the meeting held on 17 April 2018.

26
DATES OF FUTURE MEETINGS

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

Health and Wellbeing Board Information Bulletin

GP extended access service

Extra GP appointments in the evenings and at weekends are now available to Enfield patients. There is now walk-in access at some of the hubs on weekends and 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

Review of adult elective orthopaedic care services

North London Partners in health and care (NLP) is launching a review of adult elective orthopaedic care services (planned surgery of bones and joints) across north central London. For more information, please see:
http://www.northlondonpartners.org.uk/orthopaedicreview

Seasonal influenza vaccination programme

The seasonal flu programme is a long-established vaccination programme that's proven to save lives and deliver a cost-effective prevention programme, along with reducing pressures on NHS services during the winter. Flu vaccinations for the winter 2018/19 are now available in pharmacies and GPs. For more info, visit:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/694779/Annual_national_flu_programme_2018-2019.pdf

Healthy London Partnership Update:

Ask About Asthma Campaign

Healthy London Partnership and NHS England London are launching a campaign #AskAboutAsthma to help improve the lives of those living with asthma in the capital. For more information, please see:
https://www.healthylondon.org/londoners-take-the-asthmarapchallenge-for-a-chance-at-a-studio-recording-session/

Making the case for MECC

Read the case for implementing making every contact count in your organisation. Making the case for MECC has been designed to highlight the benefits of MECC to senior colleagues. Download this presentation at: https://www.healthylondon.org/resource/mecc-making-the-case/

Social Prescribing

Healthy London Partnership's Proactive Care Team attended the NHS Expo conference in Manchester 5-6 September and hosted a 'sofa conversation' about social prescribing along with colleagues from NHS England. Matt Hancock, Secretary of State for Health and Social Care, endorsed the expansion of social prescribing in his keynote address at the conference. More information form is available at: https://www.healthylondon.org/social-prescribing-gains-traction-at-nhs-expo-2018/

Mental Health at London Festival of Culture

London's citywide movement to improve mental health, Thrive LDN, has announced it is organising a festival of cultural activity in London to coincide with World Mental Health Day (WMHD) on Wednesday, 10 October 2018. More information is available at: https://www.healthylondon.org/london-festival-of-culture-announced-to-tackle-mental-health-unfairness/

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

Delivering the NHS Five Year Forward View

An update on the Sustainability and Transformation Partnership in North Central London

September 2018

#AskAboutAsthma - Small steps to improve lives for asthma sufferers

One in ten children and young people in London have asthma but less than half of these have an asthma management plan or know how to use their inhaler correctly.

We are supporting the Healthy London Partnership #AskAboutAsthma campaign which runs from 3rd - 16th September to coincide with the start of the new school year and the highest hospital admission rates for asthma.

We want to encourage children and young people, their parents and carers to ask three simple but important questions that can help them control their asthma:

1. Do I have an **asthma management plan**? The plan helps identify the right colour inhaler and dosage and the time to seek emergency help.
2. Can I use my **inhaler** effectively?
3. Have I had an **annual asthma review**?

If the answer is not always yes, the advice is that it is time to see your GP to get these things in place: it could be life changing!

We're trying to spread the word as far as possible and have joined forces with schools and school nurses to promote the campaign.

You can get involved by sharing the campaign briefing and poster.

We published a blog from our Children and Young People's Programme Director today why this work is important to them and this video of an asthma poem, written by a local child, you can share to get the message out there.

STP news: successes and achievements

We are committed to being open and transparent about the work we are doing across health and social care as a partnership of 21 organisations in North Central London (NCL). We encourage you to forward this newsletter to your teams and more broadly within your organisation.

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NHS

Transforming Diabetes Services across North Central London

By Julie Billett, SRO for Prevention and Director of Public Health for Camden and Islington

Working collaboratively across Barnet, Camden, Enfield, Haringey and Islington, we are taking forward a programme of diabetes transformation work, supported by national funding, in order to improve outcomes for people living with diabetes across north central London (NCL).

The transformation programme is being delivered through work in three main areas:

1. Improving achievement of NICE-recommended treatment targets for diabetes (covering blood pressure, cholesterol and blood sugar);
2. Expanding Diabetes Inpatient Specialist Nurse (DISN) capacity across the system. DISNs are essential for delivering good, patient-centred inpatient service for people with diabetes admitted to hospitals. They provide training and advice to hospital staff to help manage complex needs of these patients.
3. Establishing single point of contact for all people with acute diabetic foot conditions, as part of the Multidisciplinary Foot Team (MDFT). The team brings together podiatrists, psychologists and consultants to assess, treat and triage patients to the correct team.

As the Senior Responsible Officer for the programme, I am delighted to report to you on the milestones we have reached in achieving our ambitions:

- Quality Improvement Support Teams in all five boroughs are working on improving achievement of diabetes treatment targets in primary care. In the last quarter, the targets for improvement set by NHS England were met in all five boroughs.
- As the lead provider for the DISN project, the Royal Free London has successfully recruited eight diabetes inpatient specialist nurses to work across the system. This means specialist nursing support will be available to diabetic patients seven days a week.
- We have established a 'hot clinic' at the Royal Free London, a single point of contact for NCL patients with acute diabetic foot. It is overseen by the MDFT and open seven days a week to referrals and self-referrals.

I look forward to reporting on our progress over the coming months. For more information on the diabetes transformation work, please contact: clare.driscoll1@nhs.net

PoLCE update

The current situation in relation to Procedures of Limited Clinical Effectiveness (PoLCE) in NCL is complex as reviews which could impact on the content of the NCL policy are occurring at national, regional (London) and local level. These reviews are in part happening concurrently and in some cases refer to very similar parts of the NCL policy.

We have put together a briefing that explains what the three programmes are, their timescales, how they will be managed at a local level and how you can respond to them.

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Improving Urology Services for People in North Central London

Urology problems can have a profound effect on both men and women and how they lead their daily lives. They include things like urinary tract infections (UTIs), stones, bladder problems and erectile dysfunction.

Some of these problems can feel embarrassing to talk about and many patients suffer in silence believing that there is nothing that can be done for them, or that these problems are just a normal part of getting older

Patients currently have to wait a long time to see a specialist about these problems, sometimes up to four months, so to try and resolve these issues, a wide group of stakeholders, including GPs, secondary care specialists, community providers, prevention experts and patients have been working together to find solutions that will improve and transform urology services for patients in north central London (NCL). This work has resulted in:

- A range of pathways from the point of presentation to the GP to discharge from specialist care which will ensure that patients will receive the same consistent high quality service irrespective of who their GP is or which hospital they attend
- An event with 75 attendees from care homes across NCL to discuss protocols for the treatment and management of UTIs
- Increased use of advice and guidance where GPs can seek specialist opinion on how to manage a patient

We are confident that when these changes are embedded, patient outcomes will improve, as well as a much better experience of the service.

To find out more, please contact: teresa.callum@nhs.net.

Working to Improve Falls Prevention

The Prevention workstream includes falls prevention as a key priority. Among older people, those aged 65-79, Camden, Haringey and Islington have much higher numbers of people who fall resulting in serious injury.

We aim to reduce hospital admissions by working together to review and improve falls prevention pathways and interventions across north central London (NCL). We have made good progress made over the last year, with workshops being held to gain consensus on best practice and pilot programmes being trialed.

In Islington, we have worked with the London Fire Brigade to carry out Fire, Safe and Well visits, where a falls risk assessment is carried out as part of the safety visit and when required referrals are made into appropriate support services. This pilot is now in implementation stage and a full evaluation will be presented to the STP's Prevention Board next year.

In Enfield, we ran a six-month pilot in conjunction with Enfield Council, Enfield CCG and Age UK Enfield to train 100 frontline health and social care staff working with vulnerable older people on identifying falls risks, making appropriate referrals and provide advice and support on falls prevention. The pilot is due to end in September and has been over-subscribed. We hope to apply the learnings from these pilots across NCL.

For more information, please contact the Prevention Programme Manager, Mubasshir Ajaz, at: mubasshir.ajaz@islington.gov.uk.

Creating the adult social care workforce of the future

By Anne-Marie Gray, Workforce Programme Lead – North London Partners in health and care

My role as part of the STP is to lead work on behalf of the five councils (Barnet, Enfield, Haringey, Islington and Camden) over two areas:

- To develop plans that will support the recruitment and retention of staff in care homes and within the domiciliary care sector (care services that visit people in their own home to support and enable people to live at home) and
- To develop ways to provide training and development opportunities for social care staff.

Since May, I have been out and about meeting staff and management in local care home and home care companies. "Finding and keeping good care-workers is not easy" – that is what the domiciliary and care home providers are saying. People do not know enough about the range of care jobs on offer, how to access a career in care or just how rewarding it can be.

Did you know in North Central London we have 37,000 social care jobs of which:

- just 2,000 are employed by councils
- 29,000 by employers commissioned by local authorities and
- over 5,000 by NHS and people who directly employ their carers
- the sector is estimated to contribute £1bn to the local economy
- and, by 2030, we'll need an estimated 12,000 more jobs!

However, vacancy and turnover rates are high. In 2016/17 23% of the workforce were aged 55 and above, approaching the retirement age within the next 10 years.

To help make sure that we have the right workforce for the future, we need to attract more people to live and work in Care in north central London (NCL). We need to get better at explaining what care work involves and the values and skills we look for - and that is just what we are doing.

In collaboration with home care and care home providers, councils, NHS, CapitalNurse, Health Education England and community education provider networks we are delivering a number of initiatives including:

- **ICare Ambassadors:** providers will be able to start raising the profile of jobs and careers in care through the new ICare Ambassador Employer Partnership. To date, 11 ambassadors (care workers who inspire and motivate people to understand more about working in social care) have been appointed to go out to schools, colleges, universities, job centres and to community events to promote care work.
- A **Proud to Care Portal**: a one-stop shop being built for advertising vacancies in the sector and accessing quality information on roles and progression pathways, training, qualifications, care worker videos and best practice recruitment and retention tools and techniques. Care providers are working now with IT colleagues to shape the site and we are hoping to go live with a pilot site in December.
- **Development schemes:** funded by Health Education England are helping to recruit, retain and develop the workforce across home care services and care home settings. There will be schemes in: -
    - Leadership and management skills for nurses and care managers
    - Clinical skills for care workers

We are adopting a truly integrated approach across Capital Nurse, social care, service providers and community education networks to shape these schemes and recruit to them. It is an opportunity for people in our local communities to get on board and find a great career in health and care.

To find out more, please contact me at: Anne-Marie.Gray@camden.gov.uk

Our strategy for General Practice in NCL

By Dr Katie Coleman, Islington GP and Clinical Lead for Primary Care and Health and Care Closer to Home, North London Partners

As the North London Partners clinical lead for Primary Care and Health and Care Closer to Home, and as an Islington GP, I'm passionate about making sure there is excellent general practice for the people living in north central London.

Locally, we have some great services and examples of excellent care, and since April 2017, appointments with general practice have been available 8am-8pm seven days a week. There is still much to do given the ongoing unnecessary variation ranging from how people are able to access services, to the quality of services received. As a GP, I know that general practice is also facing huge pressure in terms of workforce, demand and funding. In my role as clinical lead, I want to work with partners to make this better for patients and all general practice staff.

We have a history of collaborating on primary care in north central London. We are now refreshing our commissioning strategy for the area, focusing specifically on general practice and its role as the foundation of the NHS. We brought together a group of nominated leads from each CCG in north central London, and the North London Partners' Health and Care Closer to Home programme, to produce a draft strategy.

CCG primary care teams are leading local engagement on the draft strategy, which includes professional and patient groups, local authorities and NHS partners. We are asking partners more widely if they would like to feed into its development. If you would like to be involved, please contact: keziah.bowers@nhs.net.

Adult Elective Orthopaedic Service Review

We have launched a review of adult elective orthopaedic care services (planned surgery of bones and joints) across north central London.

In the first phase of this review, the we are inviting responses to a draft case for change – a document which shares why the review is needed and early thoughts on how this kind of surgery might be organised in the future. This review will run through to Spring 2019 with this initial intensive engagement phase running until 19 October 2018.

At present, elective adult orthopaedic care is currently delivered in 10 different sites in the area. The NHS believes there may be opportunities to improve the quality and the outcomes of that care by creating a smaller number of specialist centres with ring-fenced facilities to carry out adult elective orthopaedic hand, ankle, foot, hip, knee and shoulder surgery. Current thinking is that emergency orthopaedic care will still be delivered at local hospitals, as it is today.

The draft case for change describes the rationale for this thinking, the evidence that supports it and also explores other interdependencies. Anyone with views is invited to read the case for change and let us know their thoughts. You can read the full case for change and respond via our website: www.northlondonpartners.org.uk/orthopaedicreview

We are also working in partnership with Healthwatch groups and NHS CCGs to organise a number of events in September and October. Full details can be found at the website. Comments and queries can be sent to: nclstp.orthopaedics@nhs.net

New Specialist Perinatal Mental Health Service for North Central London

Did you know there is now a specialist perinatal mental health service for women across Barnet, Camden, Enfield, Haringey and Islington?

The service provides specialist treatment and support for pregnant and postnatal women with severe mental illness and offers consultation and training with staff in the wider system, supporting them to work more effectively with women with less complex problems. It is improving equity of access to specialist support for local women.

More information, including eligibility and how to refer, is available here.

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NHS

Setting up our first Maternity Community Hub

We recently brought you the news of the opening of the first maternity community hub in NCL. You can read about the journey behind this achievement in Logan's blog: Setting up our first Maternity Community Hub. Logan Van Lessen is a Consultant Midwife and Workstream Lead for NCL Better Births Community Hubs.

Urgent and Emergency Care in the NCL Sustainability and Transformation Partnership

By Alex Faulkes, Programme Director for Urgent and Emergency Care

Our plan for the Urgent and Emergency Care (UEC) programme was developed with stakeholders across north central London (NCL) with the aim of providing a consistent and reliable UEC service by 2021 that is accessible to the public, easy to navigate, inspires confidence, promotes consistent standards in clinical practice and leads to a reduction in variation of patient outcomes.

The key elements of the programme focus on:

- Avoiding hospital admissions by increasing the uptake of services that will provide "same day emergency care services". This means that patients are assessed, diagnosed, treated and are able to go home the same day, without being admitted into a hospital bed overnight wherever possible.
- Improving discharge processes to reduce delays in patients leaving hospital when they are medically stable (fit to leave).
- Making it easier to access urgent care clinical advice, on the phone and online.
- Bringing specialist advice to staff who are looking after patients in the last phase of their life, ensuring the best possible care and support to patients and reducing inequalities of care provision across NCL.

We continue to work very closely with our partner organisations and stakeholders to progress our plans and deliver tangible gains. I am very pleased to say that the UEC programme has already seen a number of excellent outcomes and real benefits to patients. These include:

- One of the first areas nationally to launch the new integrated urgent care model. This means that more people in NCL ringing 111 now speak directly with a clinician to try to resolve their issue.
- 'Star divert numbers' which enable clinical staff to get through to a clinical expert for urgent advice and support by dialling the appropriate number. In 2017/18, star line activity increased 42% - from 751 calls in May 2017 to 1,068 calls in April 2018 with a total of 11,929 calls recorded across the period.
- Mental health patients can now ring 111, and be directly transfer to crisis team for advice and support. In April, 16 people who rang 111 with mental health issues were successfully transferred to a mental health team.
- A successful bid for enhanced mental health liaison services in A&E at University College Hospital in 2017/18, and North Middlesex University Hospital in 2018/19. This will enable us

to place more mental health staff in hospitals so patients' physical and mental health needs are cared for holistically.

- We have made it faster and safer for patients to get home from hospital by agreeing standard ways of working and working more effectively with social care. Use of the new discharge to assess pathways has increased by 50% over the past six months.

Area of Focus: Improving Discharge

I also wanted to bring to your attention part of the 'improving discharge' work we are undertaking, together with our health and social care colleagues across NCL, to improve the way in which patients are supported to avoid having their discharge from hospital delayed when their ongoing care needs can be met from outside of the acute hospital setting.

To support this, we have developed a *'Supporting Patients' Choices to Avoid a Delayed Discharge'* policy to ensure that patient choice is managed sensitively and consistently throughout the discharge planning process, and that patients, families and carers are provided with effective information and support to make a choice.

This policy also sets out a framework to ensure that NHS inpatient beds across NCL will be used appropriately and efficiently for those people who require inpatient care, and that a clear process is in place for the management of patients who remain in hospital longer than is clinically required.

Why is this policy important?

People's physical and mental ability and independence can decline if they are spending time in a hospital bed unnecessarily, and they are also at risk of acquiring hospital acquired infections. For people aged 80 years and over, 10 days spent in a hospital bed equates to 10 years of muscle wasting. Severely ill patients may be unable to access services, if hospital beds are occupied with patients whose care can be safely cared for in another place.

It is important that we help people to get to the right place as soon as possible after a hospital stay, which in most cases will be their own home. At present, we have too many people who are not able to leave hospital when they are fit to do so. We want to improve this and help patients, their families and carers to make appropriate choices in order to avoid these long stays.

How will the policy be implemented?

The policy has recently been agreed and will be operational from the 1st October across NCL. We will shortly be holding a training session to help organisations implement the policy – further details to follow. The session will be aimed at both health and social care operational leads to enable them to understand the key principles of the policy and how to put these into practice locally.

For further information please contact: Yewande Sangowawa at: y.sangowawa@nhs.net

NORTH LONDON PARTNERS in health and care
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NHS

The Future of Health and Care in North Central London

Last month we asked you to save the date for our Future of Health and Care in North Central London event on Tuesday 16th October. We have had to place this on hold for the time being but rest assured the event will go ahead at a later date. We will be in contact with further details soon.

People news

- A warm welcome to Rhona Hobday, who joined the STP in August as the Programme Manager for the Review of Adult Elective Orthopaedic Services. Rhona joins us from North West London where she has been working on an STP-wide CAMHS programme. Rhona will be based at 5 Pancras Square and will be supporting Anna Stewart in running the programme and will add rigour to the programme management approach for the orthopaedics review.
- Sorayah Anderson has joined the team as Project Manager on the Adult Social Care programme. Sorayah replaces Sam Jacobson who has joined the Civil Service.
- Adam Backhouse has recently joined as the Quality Improvement Programme Lead, which is part of the Health and Care Closer to Home Workstream.
- At the end of August we said goodbye to Julie Juliff, Head of Maternity Commissioning for North Central London CCGs. Julie has made a huge contribution to maternity across NCL and will be missed. Here is just one example of praise for Julie.

Related news

HLP newsletter

The latest versions of the Healthy London Partners bi-monthly newsletters are available. The early August edition contains an update on a range of topics including a health profile from Public Health England for London as at July 2018. It gives a current picture of health of London's adults and children, including deprivation; population and health outcomes; trends in preventable mortality; and an overall health summary for London.

The late August edition shines a spotlight on a whole council approach to gambling. Gambling is often described as a 'hidden addiction' and problem gambling is now recognised as a complex public health issue that has an impact on individuals, families, and communities. A guide is available for public health and other council officers to support the revision of borough statements of policy outlines the areas in which public health can add value and support local gambling policies. Take a look, it's pretty interesting.

Get involved

NLP Quality Improvement Network Event – Mental Health

The North London Partners (STP) Quality Improvement Network regularly hosts events around different topic areas by providing the opportunity to meet likeminded colleagues, receive useful information, hear about new ideas that ensure the long-term resilience and sustainability of general

practice and support GP staff to put them into practice. The next event will be focused on mental health and all GP practices are welcome to join.

Event will be held on **13th September 2018, 13:00 - 17:00** at Laycock Professional Development Centre, Laycock Street, London N1 1TH. Lunch will be served at 13:00, and the event will start at 13:30. To secure a place please visit: https://bit.ly/2z2hN4m

If you have a story you'd like to share via the newsletter, a blog you'd like us to include on our website or a question please email nclstppmo@nhs.net

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Agenda Item 12

MUNICIPAL YEAR 2018/19- REPORT NO.

Meeting Title AND DATE **HEALTH AND WELLBEING BOARD** **27 September 2018**	**Agenda- Part: Item:** **Subject: Health and Wellbeing Board Forward Plan**
Contact officer: Mark Tickner Telephone number: 0208 379 3060 Email address: **mark.tickner@enfield.gov.uk**	**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 agreed 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 ongoing
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).

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, including reference to our progress against FGM. HWB
- Improving life for people with Long Term Conditions (LTCs), including work on self-care, diabetes management
- Integration of health and care
  - 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.
- Community Pharmacies.
- Poverty.
- Serious Youth Violence
- Progressing MECC

- Immunisation and Screening
- Social Prescription
- Working with VCS
- 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. This is currently being developed.

3. BACKGROUND

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

3.2 The HWB Priority areas were:

<Top 3 priorities>

- Best start in life
- Healthy Weight
- Mental health resilience

<Collaboration>

- Domestic Violence

<Enhanced Monitoring>

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

4. REPORT

4.1 There are a number of actions the HWB could take in order to improve health and wellbeing in Enfield. These include:

- Strategic oversight
- Deep dive
- Partnership working
- Joint commissioning
- Unblocking system working
- Support across the system
- Constructive challenge
- Referral to scrutiny

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

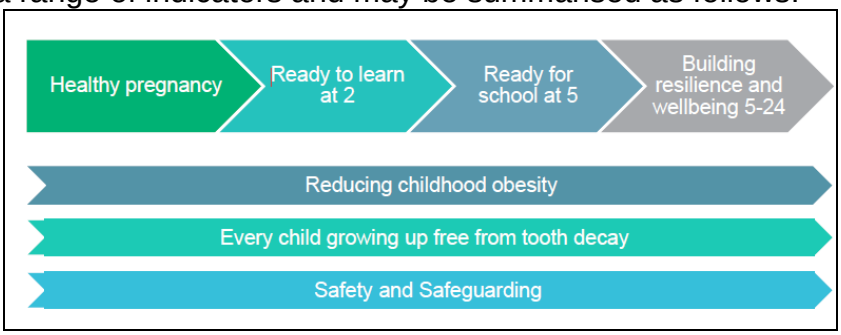
4.4 For the latest statistics of selected indicators, please see https://new.enfield.gov.uk/healthandwellbeing/jhws/measuring-our-progress/

Top 3 priorities

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

What's our current performance?

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



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

- **Breastfeeding**

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

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

Around a third of children in Enfield have one or more decayed, missing or filled teeth (DMFT) (33.9%) [2014/15 data]. This is significantly worse than London (27.3%) and England (24.8%).

- **Childhood obesity**

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

- **Under-18 conceptions**

With a rate of 22.7/1000 in 2015, and despite local reductions over recent years, Enfield rates remain higher than NCL (18.0/1000), London (19.2/1000) and England (20.8/1000).

- **School readiness**

This is a global measure of readiness for school and is measured as the percentage of children achieving a good level of development at the end of Reception year. In Enfield (2015/16) this was 65.8%, which was worse than London (71.2%) and England (69.3%).

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

The rate of hospital admissions (per 10,000 resident population) is 130.3 [2015/16 data]. This is significantly higher than London (97.6) and comparable to England (129.6). This is a slight reduction from 143.3 in 2014/15.

These indicators may be summarised in the following table:

Compared with benchmark: Better / Similar / Worse | Lower / Similar / Higher / Not Compared | * a note is attached to the value, hover over to see more details

Recent trends (in development): – Could not be calculated | Increasing / Getting worse | Increasing / Getting better | Decreasing / Getting worse | Decreasing / Getting better | No significant change | Increasing | Decreasing

Export table as image

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Enfield			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Under 18 conceptions	2015	↓	138	22.7	19.2	20.8	43.8		5.7
Smoking status at time of delivery (current method)	2016/17	↑	291	7.0%*	4.9%	10.7%	28.1%		2.3%
Low birth weight of term babies	2015	↓	132	2.9%	3.0%	2.8%	4.8%		1.3%
Infant mortality	2014 - 16	–	48	3.2	3.2	3.9	7.9		1.6
Breastfeeding prevalence at 6-8 weeks after birth - current method	2015/16	–	-	*	*	43.2%*	18.0%		76.5%
Breastfeeding prevalence at 6-8 weeks after birth - previous method	2014/15	–	2,511	*	*	43.8%	19.1%		81.5%
Reception: Prevalence of overweight (including obese)	2015/16	↓	1,046	24.3%	22.0%	22.1%	30.1%		14.3%
A&E attendances (0-4 years)	2015/16	↑	21,261	837.0	706.7	588.1	1,836.1		335.0
Emergency admissions (aged 0-4)	2015/16	↑	4,900	192.9	112.9	155.0	307.9		57.3
Hospital admissions for accidental and deliberate injuries in children (aged 0-4)	2015/16	↑	331	130.3	97.6	129.6	254.2		56.0
Children with one or more decayed, missing or filled teeth	2014/15	–	-	33.9%	27.3%	24.8%	56.1%		14.1%
Population vaccination coverage - MMR for two doses (5 years old) <90% 90% to 95% ≥95%	2015/16	↑	4,340	92.0%	81.7%	88.2%	56.5%		98.6%
Children achieving a good level of development at the end of reception	2015/16	–	3,069	65.8%	71.2%	69.3%	59.7%		78.7%

Things that are going well

- A range of school-based initiatives to improve physical activity are being developed.
- Public health is funding a post that works with schools in Enfield to improve PSHE (personal, social, health and economic education) and RSE (relationships & sex education).
- Joint working between the Health Visiting Service and Children's Centres around co-delivery of sessions.
- The Best Start in Life sub group met for the first time on the 1st November. A presentation was given that detailed Enfield's performance across a range of areas and it was agreed that the group would focus on Dental Health, Childhood Obesity and Emotional Well-Being. These areas have been identified as key areas that require development for children and young people in Enfield, and the group felt they would be able to make an impact in improving them.
- The Best Start in Life Group will meet a number of times in December and January in preparation for the Health and Well Being Board Development Session on the 16th January 2018.

What's next?

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

indicators.

- The BSIL task & finish group will report to the HWBB development session on 16th January 2018.
- To review the metrics for these indicators to understand the trends when updated data becomes available.

Challenges that HWB may be able to assist resolving / unblocking

- The HWBB could maintain a focus on this area and ensure that all partners are delivering appropriately.
- Supporting the BSIL task & finish group through ensuring attendance and participation in the programme, oversight and helping ensure corporate and partnership support.
- Devote focused session on Best Start in Life at the 16th January 2018 HWBB development session that brings together key partners that contribute to improving outcomes.

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

What's our current performance?

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

Things that are going well

- Our current partnership activity with Thrive LDN to improve Mental Health Resilience in Enfield was presented and discussed at HWB development session on the 21st November 2017.

What's next?

- The HWB has committed to;
  - Continue to support ongoing partnership with Thrive LDN in this area.
  - Investigate and obtain clarification of Thrive LDN's "Hub Offer" to Enfield and to report on this as appropriate

Challenges that HWB may be able to assist resolving / unblocking

- Continue to support ongoing partnership with Thrive LDN in this area.
- Investigate and obtain clarification of Thrive LDN's "Hub Offer" to Enfield and to report on this as appropriate

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

What's our current performance?

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

Things that are going well

- Enfield's approach to Healthy Weight was discussed at the Health and Wellbeing Board Development Session on the 21st November 2017.

What's next?

- HWB has committed to;
  - Each organisation implementing the Healthy Catering Commitment within their organisation
  - Each organisation signing up to the Sugar Free Declaration
  - To explore opportunities for more water fountains to be made available across the borough

Challenges that HWB may be able to assist resolving / unblocking

To support and action below;

- Each organisation implementing the Healthy Catering Commitment within their organisation
- Each organisation signing up to the Sugar Free Declaration
- To explore opportunities for more water fountains to be made available across the borough

Collaboration

Focus area	Domestic Violence
Partners involved	Community Safety

What's our current performance?

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

Update:

- Recorded Domestic Abuse Incidents have increased by 15 incidents in the 12 months to 30th September 2017 (+0.3%, London: -4.3%).
- In the same period, Violence with Injury offences which were DV related have decreased by 114 offences (-11.9%, London: -1.4%)
- However, Sexual Offences have increased by 29 (+5.2%, London: +8.4%) and Rape Offences by 15 (+7.1%, London: +16.6%)

Things that are going well

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

What's next?

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

Challenges that HWB may be able to assist resolving / unblocking
Continue to support embedding work to tackle domestic abuse across the partnership.

Enhanced Monitoring

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

What's our current performance?

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

Things that are going well

- The local cancer action group meets regularly to help improve patient journey through screening, referral, treatment and care post-discharge from hospital.
- The group recently discussed the North Middlesex Hospital response to improve the outcomes of the National Patient Experience survey through the development of local Trust Action plan.
- Partners in Enfield work with NCL cancer screening assurance group to improve screening across the STP footprint.
- Screening coverage for breast cancer and cervical cancer in Enfield is above the national average.

What's next?

- Although Cervical screening uptake in Enfield is above national average, it is still not reaching the national target of 80%. Enfield Cancer working group is preparing resources for cervical cancer awareness campaign to take place in January 2018.
- The primary care team is working with local provider to ensure that there is sufficient capacity within local GP provider clinics to ensure increase in demand for screening is met.
- Clinical pathways were reviewed to ensure timely cancer referrals from GPs because evidence suggests that GPs' gut feeling about cancer is highly accurate (Hjertholm et al 2014).
- The North Middlesex NHS Trust will report to cancer action group the progress on implementing the action plan at the later date.

Challenges that HWB may be able to assist resolving / unblocking

- Support the local cancer awareness campaign in January 2018.

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

What's our current performance?

Flu vaccination campaign for the winter 2017/18 has commenced in September.

Things that are going well

NHS Trusts
Flu vaccination campaign for the winter 2017/18 has commenced in the NHS Trusts in Enfield.

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

What's next?

Ongoing scrutiny of uptake rates.

Challenges that HWB may be able to assist resolving / unblocking

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

Focus area	Housing for vulnerable adults
Partners involved	HASC, Housing

What's our current performance?

General Needs Housing Offer

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

Specialist Housing Offer

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

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

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

Things that are going well

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

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

What's next?

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

Challenges that HWB may be able to assist resolving / unblocking

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

Focus area	Diabetes Prevention
Partners	Enfield CCG, Public Health

What's our current performance?

The NHS DPP was announced in the Five Year Forward View, published in October 2014, which set out the ambition to become the first country to implement at scale a nation evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new NHS Health Check.

The NHS DPP is a joint initiative led by NHS England, Public Health England and Diabetes UK. The programme aims to deliver services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them behavioural intervention that is designed to lower their risk of onset of Type 2 diabetes.

As part of the national rollout programme, Enfield CCG and Enfield's Public Health Team, in partnship with Barnet CCG & PH received approval to mobilise this service as part of wave 2 phased release. The programme is set to deliver 6800 places over a 24-months period (2700 in 2017/18 & 4100 during 2018/19). Within Enfield, 3 site locations have been identified and acquired:

- Evergreen Primary Care Center (N9 0TW)
- Ordnance Road Unity Centre (EN3 6ND)
- Carlton House Surgery (EN1 3LL)

Between May and September 2017/18, 1442 patients have been referred to the service, of those, 386 patients have been seen for an initial assessment and 8 Groups have been established. Patients are expected to engage with the programme over a 9-month period so the first groups will conclude during May 2018.

Due to the popularity of the programme, our NDPP provider will be increasing capacity during this quarter, to manage the increased demand.

Things that are going well

- Referral rates continue to be high.

What's next?

- The NDPP provider will increase the number of groups held on weekends to improve access to these services outside of core working hours.
- The NDPP provider will start deploying Turkish speaking groups from February 2018
- The partnership to identify a suitable site location within the South West Locality (Winchmore Hill, Southgate and Palmers Green wards).

Challenges that HWB may be able to assist resolving / unblocking

Not at this stage.

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

What's our current performance?

- The gap between Life Expectancy and Healthy Life expectancy in Enfield is 11.7 years for males and 18.2 years for females [2013-2015 data]. These years are likely to be lived with multiple conditions and chronic illness.
- The data is currently not available to determine how many people are living with multiple long-term conditions in Enfield, but it is likely that many of them need social care support.
- Social care-related quality of life in Enfield was 18.7% (quality of life score based on Adult Social Care Survey), similar to London average (18.6%) but was statistically below the England average (19.1%). Enfield's score was the joint 9th highest in London, along with Lewisham, Islington and Haringey [2015/16].
- Number of people with diabetes, cancer, dementia and mental health conditions are increasing, and is expected to continue to rise.

Things that are going well

- BEH has initiated planning for implementation of "Personalised Care and support planning" as part of national framework.
- Enfield CCG hosts a long-term condition steering group which PH is a core member.
- The diabetes three treatment target (3TT) to improve the quality of clinical care of diabetes patients (through cholesterol, blood pressure and glucose control) has been awarded to Enfield and will be deliver via GP providers in Enfield. To support the safe and effective delivery, training needs were analysed and information sharing agreement was being put in place to enable the CCG to extract the data related to implementation of the award.
- Works to develop Care Closer to Home Integrated Network (CHIN) is progressing. A CHIN Board is formed with local partners to oversee the integrated care for patients with long-term conditions and other complex needs in Enfield. The GP Federation is in place and the 4 Locality leads within the CHIN are identified
- Enfield CCG's approach to CHINs & QISTs consists of three inter-related strands:
  - Developing Primary Care,
  - Transforming Community Services and
  - New Models of Care for Supporting Patients with Long Term Conditions.

What's next?

- The CHINs delivery group held a CHINs workshop on the 18th of October. The aim of the workshop was to develop key priorities and outcomes to be delivered in each CHIN. Feedback from the workshop will inform discussions at the next meeting which is on the 29th of November
- The Care Home Assessment Team (CHAT) was extended to include an Old Age Consultant Psychiatrist and the Mental Health Occupational Therapist as part of the CHAT Multi-disciplinary team. The additional capacity aim to work towards reducing emergency admissions and A&E attendances as well as reducing unnecessary antipsychotic drug use in Dementia patients and optimising treatment for patients with challenging behaviour
- Primary care programme to improve the care of prostate cancer survivors
- Quality Improvement Support Teams (QISTs) and Care Closer to Home Integrated Care developments to continue
- Dashboard for performance management of delivering the 3(TT)care across all GP's in Enfield developed
- Integrated IT that enables identification of Targets and Outcomes work in progress

Challenges that HWB may be able to assist resolving / unblocking

- Support public engagement in taking up the 3TT in areas of high diabetes prevalence and deprivation in the borough.
- HWB is encouraged to champion smoking cessation in their respective organisations as part of the care and services they provide to their patients / clients, in particular for those patients / clients with long term conditions.

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

What's our current performance?

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

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

Things that are going well

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

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

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

What's next?

- Supporting the emerging Care Closer to Home Integrated Networks (CHINs) which aims to reduce avoidable unplanned admissions which includes last phase of life including for people receiving end of life care
- Work with CMC to co-ordinate roll out of patient accessible CMC app MyCMC for carers and patients. This app will give patients the opportunity to record their decisions and to express wishes about their care so that this information

is available to all professionals who are looking after them, helping to ensure that any care the patient receives is in line with what they've decided.Work with CMC to co-ordinate roll out of patient accessible CMC app **MyCMC** for carers and patients. This app will give patients the opportunity to record their decisions and to express wishes about their care so that this information is available to all professionals who are looking after them, helping to ensure that any care the patient receives is in line with what they've decided.
Challenges that HWB may be able to assist resolving / unblocking
• Supporting the emerging Care Closer to Home Integrated Networks (CHINs) programme

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

What's our current performance?

- There are estimated 13,600 older people who are Low Risk "Pre-Frail" and in addition there are around 7200 older people at high risk of frailty in Enfield
- In 2015/16, 72.9% of elderly people were discharged from acute or community hospitals to their usual place of residence in Enfield. This compared to 85.4% in London and 82.7% in England.
- Emergency readmissions within 30 days of discharge from hospital in Enfield was 10.3%, similar to London (12.1%) and England (12.0%) averages.
- Multiple entry points into existing falls and musculoskeletal services leading to duplication and omission of care. The target across NCL is to reduce falls-related admissions by 10% (390 fewer falls-related admissions per year) among adults aged >65 years through multi-disciplinary interventions, including strength and balance and home modifications. Plans are in place to increase the number of Safe and Well visits and referrals made by London Fire Brigade.

Things that are going well

- The contract for Preventatives Services focused at the VCS community have been tendered out and evaluated. Contract awards are expected in October and mobilisation of new services will happen from the end of October 2017 to contract commencement date 1st December 2017. The first monitoring report on performance and outcomes for service users is expected at the end of Q1 2018.

- NCL-wide falls work is progressing. An extensive mapping exercise of current falls pathways was conducted across the NCL.

- Enfield has a well-developed falls care pathway and currently working to develop a single point of access into the pathway. Enfield has multiple services that contribute to falls prevention and support those who have fallen to reduce their risk of further falls. These services are fully capable of identifying and referring to most appropriate support including improving bone health and increase stability.

- Public Health and Adult Social Care team are working together closely to find ways to reduce demand on adult social care in short- and medium term.

- Enfield CCG and NHS England jointly commissions Locally Commissioned Service on Atrial Fibrillation (AF) in Enfield to prevent stroke and vascular dementia. This is a scheme designed with local GPs and Public Health. AF is a form of irregular heart rhythm and without treatment 5% of whom develops forms of stroke every year. Encouraging results are emerging:

    - 9292 pulse checks provided by local GPs;
    - 520 new AF cases identified over the duration of the LCS
    - 1953 with known AF were recalled for blood test and reviews to optimise treatment

- 189 face-to-face consultation provided to ensure patients are referred to anti-coagulation

What's next?

- Preventatives Services focused at the VCS community mobilisation from the end of October.
- Review current falls provisions in the borough and consider how they are aligned with Public Health England and NICE recommendations.
- Four out of the six Preventative Outcome Contracts will be mobilised on 1st December 2017 those contracts include: -
  - Outcome 1- Helping people to continue caring
  - Outcome 2- Supporting vulnerable adults to remain living healthily and independently in the community including avoiding crises
  - Outcome 4 Helping vulnerable adults to have a voice (advocacy)
  - Outcome 5 Making sure people are helped to recover after illness, including safe and appropriate discharge from hospital for people not eligible for social care support
- It is expected that the two other Outcome Contracts associated with Prevention commissioning will be mobilised in early January 2018. Those contracts include:
  - Outcome 3 Supporting people to improve their health & wellbeing/improving self-management of health conditions
  - Outcome 6 Increased and Improved Information Provision
- NCL wide falls prevention training is currently scoped out.
- Stroke prevention by optimal AF management will continue as a part of primary care commissioning.

Challenges that HWB may be able to assist resolving / unblocking

<Preventative Services focused at the VCS community>
This is a new way of partnership working with the voluntary organisation to enhance the work HHASC do and to ensure that those we commission are following the same pathways as the department. Outcomes will be closely monitored using the council's Care first system and we should be able to quantify the number of people being supported as well as measured improvement to their health and well-being and a reduction in demand for social and health care.
Challenges will be for VCS coming together to work effectively as a consortium to meet the outcomes within the specification and measuring outcomes. This will have to be undertaken using a variety of mechanism and tools. It is also thought that the mobilisation period may also be a challenge especially if we are managing the existence of an incumbent provider.

<NCL Falls programme>
Finding sufficient transformation resources to implement single point of access to falls care pathway in Enfield.

5.0 Recommendations

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

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

<Best Start in Life>

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

<Best Start in Life>

- The HWBB could maintain a focus on this area and ensure that all partners are delivering appropriately.
- Supporting the BSIL task & finish group through ensuring attendance and participation in the programme, oversight and helping ensure corporate and partnership support.
- Devote focused session on Best Start in Life at the 16th January 2018 HWBB development session that brings together key partners that contribute to improving outcomes.

<Mental Health Resilience>

- Partners are encouraged to prioritise the World Mental Health day event and Thrive LDN workshop.

<Healthy Weight>

- To support the following actions:
  - Each organisation implementing the Healthy Catering Commitment within their organisation
  - Each organisation signing up to the Sugar Free Declaration
  - To explore opportunities for more water fountains to be made available across the borough

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Date	Meeting	Agenda Items	Sponsor Board Member/Officer
6th December 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	Suicide Prevention Strategy	Stuart Lines/Mark Tickner
		Flu performance	
		MECC Progression	Mark Tickner
16th January 2019	**Additional Development Session**		
		January Health Scrutiny Children's Oral Health and Child Obesity	
20th March 2019			
	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:
- Falls

- 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
- Improving life for people with Long Term Conditions, 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 street
- FGM
- Community Pharmacies
- LTC's
- Poverty
- Seroius Youth Violence
- FGM/VAWG
- Imms and screening
- LSP intergration
- Social Prescribing
- Working with VCS