Enfield Joint Health and Wellbeing Strategy 2014-2019

Your Health and Wellbeing • Executive Summary

V5.2. DRAFT – January 2014

www.enfield.gov.uk/jhwsconsultation

In partnership with

NHS Enfield Clinical Commissioning Group

healthwatch

ENFIELD Council

Foreword and Executive Summary

Foreword

Work in progress – to be added.

By the Chair of HWB.

Executive Summary

Many factors effect health and wellbeing; issues such as unemployment, poor housing and feeling unsafe can all impact upon mental and physical health. The Health and Wellbeing Board (HWB) will work to mitigate such factors, as well as encouraging people to take a more active role in their own and others health, by promoting healthy weight management through diet and physical activity, controlling excess alcohol intake and supporting people to stop smoking.

The purpose of this strategy is to set out how the Enfield Health and Wellbeing Board (HWB) will work with the population of Enfield to improve health and wellbeing across the borough over the next five years.

The HWB has already engaged the local community through the consultation on the priorities in this strategy. However, this is just the start of an ongoing process. The HWB will engage through a mixture of formal consultations and informal relationships, including with community and voluntary groups, faith groups, schools and children's groups and patient/service user groups throughout the implementation of this strategy.

This strategy will ensure greater integration between health and social care. The HWB are committed to the aim of supporting individuals to plan and control their care and bring together services to achieve the outcomes important to them. The Board will develop integration plans, which will involve the HWB in dialogue with both the population of Enfield and with local stakeholders.

A detailed description of Enfield and the health and wellbeing of its people can be found within the Enfield Joint Strategic Needs Assessment (JSNA), on the Enfield Health and Wellbeing website[1].

The largest cause of death in Enfield is cardio-vascular disease followed by cancer. Much of the burden of early mortality, and its associated morbidity could be avoided by changes in lifestyle. For example:

- Meeting the Chief Medical Officer's guidelines on physical activity reduces the risk of heart disease, stroke and cancer by 30% – in Enfield, 95% of the population is not physically active enough to maximise benefits to their health
- Not smoking reduces the risk of respiratory disease by up to 95% – in Enfield, 18.5% of adults smoke; it is estimated that 4% of 11-15 year olds smoke more than 1 cigarette a week
- In Enfield, 23.2% of the adult population is obese, and 25% of pupils in Year 6 are obese

There is a stark discrepancy between the life expectancy of the residents of the East and the West of Enfield. Those in the East are expected to live significantly shorter lives than those in the West.

1 www.enfield.gov.uk/jsna

The HWB vision is:

Working together to enable you to live longer, healthier, happier lives in Enfield

The vision will be delivered through five key priorities, outlined below. For each of these, a number of key strategic actions have been identified, which have been selected as essential areas of work required under each of the health and wellbeing priorities.

The measures of success tables outline a number of key strategic outcomes the HWB wish to see realised through action in the short, medium and long term. This is not exhaustive, as further measures of success are included in the JHWS detailed action plan, to be monitored by the HWB.

Ensuring the best start in life: we want all children to realise their full potential, helping them to prepare from an early age to be self-sufficient and have a network of support that will enable them to live independent and healthy lives.	
Short term actions	• Understand and plan for the implications of the Children's and Families Bill on the changes for the SEN system up to age 25, including replacing Statements of Need with a local offer and Birth to 25 Education, Health and Care Plan. • Develop a multiagency plan for reducing Infant Mortality, with the HWB having oversight of the plan and supporting its implementation. The plan will have a particular focus on child poverty, early access to ante natal services and integrating services. • Manage the transition of the responsibility for health visitors to public health, ensuring there is an effective transition and stepping in to resolve problems where necessary.
Medium term actions	• Develop a coherent overarching plan for transition to education for all children aged 2 and above which unifies the Healthy Child Programme and the Early Years Foundation Stage. • Redesign treatment pathways to ensure the delivery of high quality, integrated paediatric care, to provide more community-based care options and to improve the experience and outcomes of children who are ill. • Reduce paediatric admissions for asthma and other ambulatory care sensitive conditions by improving early identification and disease management in primary and community services.
Long term actions	• Improve educational attainment by ensuring all agencies involved with children in Enfield work together to provide the best educational experience possible for all children.

Ensuring the best start in life – Measures of success
• Child poverty to reduce to 25% by 2020, decreasing from the 2008 baseline of 36% • Percentage of children receiving the full course of MMR by their 5th birthday to increase from 76.8% to 95% by 2019 • The gap between the most and least deprived wards measured in terms of child poverty to narrow from 42% (based on the 2009 baseline) to 30% by 2020 • Note: measure of success on educational attainment to follow

Enabling people to be safe, independent and well and delivering high quality health and care services: we want people of every age to live as full a life as possible. This means that health issues, both physical and mental, should be recognised as soon as possible, as early intervention is likely to lead to better long term outcomes. It also means that where people do have to live with long term conditions, they should be supported in such a way that the condition has as small an impact on their daily life as is feasible. We want people with any form of disability or impairment are supported in a way that promotes inclusion, independence, choice and control.	
Short term actions	• Develop a register of carers which is co-ordinated across primary care, social care, acute care and mental health. • Increase the early diagnosis of HIV infection. • Develop mechanisms for monitoring and improving audits of health care services.
Medium term actions	• Ensure that there is an increased focus on the early identification of long-term conditions, in particular diabetes, COPD, dementia, hypertension and CVD. • Develop self-management programmes for people with long-term conditions and improve care through integrated models of provision that are preventative in focus. • Ensure that more people are able to access psychological therapies (IAPT) locally by increasing uptake of the service through integrated approaches. • Coordinating services around the needs of the child or young person and family to ensure a positive experience of transition to adult services. • Deliver on the Joint Adult Mental Health Strategy. • Establish an effective model of psychiatric liaison in North Middlesex University Hospital based on the RAID (Rapid Assessment Interface and Discharge) model. • Ensure co-ordinated care provision for people with co-occurring alcohol or substance misuse and mental health problems. • Increase the dementia diagnosis rate in line with the CCG's operating plan, and improve dementia care.
Long term actions	• Develop a mental health and wellbeing service which focuses on recovery and independence for people with mental health and aims to limit the number of people who require secondary mental health care. • Develop integrated models of care for older people. • Develop a whole-life mental health strategy.

Enabling people to be safe, independent and well and delivering high quality health and care services – Measures of success

- Late HIV diagnosis to reduce from 58% to 44% by 2019
- Access to psychological therapies (IAPT) to improve locally by increasing uptake from the current rate of 5% to 15% by the end of 2014/15
- Rate of admissions for people aged over 65 to residential and nursing care to reduce from 513.5 per 100,000 in 2012/13 to 512 per 100,000 by 2013/14
- All unplanned admissions to acute health care to reduce by 5% on the 2012/13 baseline (2012/13 baseline to be added)
- Delayed transfers of care to reduce from 5.74 per 100,000 in 2012/13 to 5.00 per 100,000 by 2013/14
- Rate of admissions of older people to acute health care to reduce by 20% on the 2012/13 baseline (2012/13 baseline to be added)

Creating stronger, healthier communities: a large part of the lifetime health experience of people relates not to the health and social care that they receive, but the environment in which they live. A person who is able to contribute to society through meaningful employment, lives in warm, clean, safe accommodation, and lives in a community with strong networks, is less likely to suffer from both mental and physical health issues.	
Short term actions	• Continuing the dialogue that explores how community cohesion is improving understanding across the ages, thus reducing loneliness and increasing physical and mental wellbeing. • Delivering an annual programme of community engagement with those who come from different backgrounds, and ensuring that Enfield residents can continue to contribute to the development and implementation of the JHWS.
Medium term actions	• To support and work in partnership with faith groups, the voluntary and community sector, schools and children's centres and other local organisations to deliver specific projects aimed at improving community wellbeing. • Improve employment opportunities for Enfield residents by matching local skills with local jobs – particularly in recruitment controlled by the partners on the HWB. • Partners on the HWB show leadership by modelling healthy behaviours within their organisations (e.g. healthy eating choices, travel for work policies). • Establish dementia friendly communities, to improve awareness, inclusion and quality of life for people living with dementia and their carers.
Long term actions	• Strengthen community networks to enable them to take a lead role in improving their own health and wellbeing. • Improve the awareness of people of all ages and communities to make healthy lifestyle choices through positive communication and community interaction. • Building on the agreement with North Middlesex University Hospital, work in partnership with all large public sector providers and partners to promote and expand opportunities for employment, apprenticeships and volunteering for local residents in Enfield.

Creating stronger, healthier communities – Measures of success
• HWB structures to be reviewed by 2015 to ensure on going engagement of local people in improving their health and wellbeing • Faith forums and community leaders to be enabled to take a lead role in improving local health and wellbeing • Communications and Engagement strategy to be developed and implemented to support the on-going implementation of the HWB strategy

Narrowing the gap in healthy life expectancy: we want to reduce the gap in life expectancy within the borough.	
Short term actions	• Support implementation of self-knowledge for service users through Integrated Care Pathways. • Work with community partners to map the resources that we already have in Upper Edmonton, and define the gaps when compared with evidence-based practice. • Work in partnership to reduce the risk of death in people with established condition such as cardiovascular diseases, diabetes, cancer and chronic obstructive pulmonary disease (COPD). • Encourage early diagnosis and management (including lifestyle change) of major killer diseases such as cardiovascular disease and cancer; a focus on men and women over 40 will have the greatest impact on reducing the life expectancy gap. To do this we will support the delivery of NHS Health Checks.
Medium term actions	• Work with the community to target and deliver specific interventions in Upper Edmonton which address health inequalities. • Develop a network model of primary care to ensure better access to consistent, good quality services with the potential to maintain continuity of care by: – Developing a stable system/model for a more integrated delivery of health care focused around networks and general practices. – Implementing a 7 day delivery model for integrated care for older people. • Reducing smoking rates in our most disadvantaged communities. • Further strengthen clinical management of CVD, diabetes and respiratory disease.
Long term actions	• Replicate the successful targeted interventions from the Upper Edmonton inequalities work to other deprived areas of the borough. • Work to address the wider determinants of health such as high levels of deprivation, low educational attainment, low levels of employment and poor housing.

Narrowing the gap in healthy life expectancy – Measures of success
• 75% of Enfield GP practices to achieve 90% in the percentage of patients with coronary heart disease whose blood pressure is controlled by 2019 • The difference in female life expectancy between the best and worst wards to be narrowed from 13 years for women to 10 years by 2019

Promoting healthy lifestyles and making healthy choices: the choices that people make when deciding what to eat, how to exercise, whether and how to use alcohol, tobacco and drugs, affect their health and wellbeing both now and into the future. We want to ensure that our residents understand these choices, and are supported to choose healthier options throughout their lives, making use of the council's regulatory powers to influence local businesses and make local areas healthy places to live.	
Short term actions	• Produce a comprehensive obesity strategy, covering both children and adults.
Medium term actions	• Agree on an action plan with schools and young persons' organisations to reduce smoking uptake. • Develop more locations for Identification and Brief Advice (IBA) interventions on harmful drinking. • Reduce the rate of alcohol-related admissions through integrated community interventions. • Develop healthy workplaces throughout Enfield. • Promote healthy eating throughout Enfield.
Long term actions	• Ensure that transport and building developments prioritise active transport (particularly walking and cycling).

Promoting healthy lifestyles and making healthy choices – Measures of success
• The percentage of year 6 pupils classified as obese to reduce from 24% to 22% by 2019 • Smoking prevalence to reduce from 18.5% in 2012 to 12% by 2030

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