Enfield Joint Health and Wellbeing Strategy 2014-2019

Your Health and Wellbeing • Executive Summary

FINAL – January 2014

www.enfield.gov.uk/jhws

In partnership with local people and

NHS Enfield Clinical Commissioning Group

healthwatch Enfield

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 Enfield 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.

This strategy is as much about wellbeing as it is about health. The HWB is committed to promoting and supporting wellbeing in our local community, enabling local people to live happy, fulfilling lives.

The purpose of this strategy is to set out how the 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 other activities, 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].

1 www.enfield.gov.uk/jsna

The largest cause of death in Enfield is Cardiovascular disease (CVD) 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 24.2% of pupils in Year 6 are obese

Further strengthening clinical management of existing disease also plays a key role in reducing associated morbidity and mortality.

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.

The Health and Wellbeing Board 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 and performance framework, to be monitored by the HWB. The action plan is a living document, and will be developed and updated throughout the lifetime of the strategy to ensure that actions and measure of success continue to reflect local needs and challenge partners to deliver improved outcomes for local people.

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 multi-agency 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 improved service delivery.
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. • Through more effective use of the School Nursing Service, and closer working with health colleagues, support schools in reducing pupil absence due to illness and medical appointments and thereby improve overall attendance rates.
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 reduce from 42% (based on the 2009 baseline) to 30% by 2020
- 95% of new birth visits to be carried out between 10-14 days after birth
- 95% of pregnant women under the age of 18 who book for maternity care to receive a targeted antenatal intervention from Family Nurse Partnership/ Health Visitor Service
- The percentage of absences from school due to illness to improve on the 2012/13 rate of 2.7%

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, with good health and wellbeing being encouraged from the outset. This means that people are encouraged to have lifestyles which help to prevent the onset of some diseases. When they do occur, 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 to ensure that 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.
Medium term actions	• Ensure that there is an increased focus on the early identification of long term conditions, in particular diabetes, chronic obstructive pulmonary disease (COPD), dementia, hypertension and CVD. • 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, which in part will support early identification and good disease management. – Implementing a 7 day delivery model for integrated care for older people, which will support reductions in the rate of acute admissions. • Ensure that more people are able to access psychological therapies (Improving Access to Psychological Therapies – IAPT) locally by increasing uptake of the service through integrated approaches. • Coordinating services around the needs of the 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
- Delayed transfers of care to reduce from 5.74 per 100,000 in 2012/13 to 5.00 per 100,000 by 2013/14
- Adult (18+) unplanned admissions to acute health care to reduce by 10% on the 2012/13 baseline of 20,371 admissions
- Rate of admissions of older people to acute health care to reduce by 20% on the 2012/13 baseline of 9,215 admissions

Creating stronger, healthier communities: a large part of the lifetime health and wellbeing experience of people relates not to the health and social care that they receive, but the environment in which they live. People who are able to contribute to society through meaningful employment, live in warm, clean, safe accommodation, and live in a community with strong networks, are less likely to suffer from both mental and physical health issues.	
Short term actions	• Develop understanding amongst local people of the role that community cohesion plays in improving health and wellbeing, including reducing loneliness. • 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. • Support the outcome of the Home Office review regarding the links between ending gang and youth violence. In particular agree tasks to be overseen and delivered by the partnership represented on the Health and Wellbeing Board. • Following the publication of the JHWS, HWB to review its structures to ensure effective engagement of local people in work to improve their health and wellbeing.
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. • Partners on the HWB show leadership by modelling healthy behaviours within their organisations (e.g. healthy eating choices, travel for work policies, work life balance). • Promote dementia friendly communities, which aim to improve awareness, inclusion and quality of life for people living with dementia and support for their carers. • Staff from North Middlesex Hospital to visit 50% of Primary and Secondary schools to raise aspirations of Enfield's young people to seek career opportunities and employment at the hospital and in other health related careers.
Long term actions	• Strengthen community networks to enable individuals and families to take responsibility for 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, including children, young people and young parents 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 • The percentage of people who feel safe outside in their local area after dark to increase by 2019

Reducing Health Inequalities – Narrowing the gap in life expectancy: we want to reduce the gap in life expectancy that exists within the borough, of 8 years for men, and 13 years for women.	
Short term actions	• Support implementation of Integrated Care Pathways to improve efficiency and patient experience. • Work with partners in Upper Edmonton to map existing community resources that support health and wellbeing, and identify where gaps exist when compared with evidence-based practice. • Encourage early diagnosis and management (including lifestyle change) of conditions such as CVD, diabetes, cancer and COPD, and work to reduce the risk of death amongst people living with long term conditions.
Medium term actions	• Work with the community to target and deliver specific interventions in Upper Edmonton which address health inequalities. • Reduce smoking rates amongst groups known to be particularly affected by high smoking prevalence. . • 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.

Reducing health inequalities – Narrowing the gap in 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 reduced from 13 years to 10 years by 2019

Promoting healthy lifestyles and making healthy choices: the lifestyle choices that people make about diet, exercise, alcohol consumption, smoking and drug use can affect their health and wellbeing.

We want to ensure that local people understand the impact of 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. • Produce a comprehensive substance misuse strategy, covering both adults and young people. • Health and Education professionals to work jointly to support and promote the Healthy Schools London programme in the borough.
Medium term actions	• Agree on an action plan with schools and young persons' organisations to prevent and reduce smoking uptake. • Identify and develop more opportunities to deliver Identification and Brief Advice (IBA) interventions for harmful drinking, particularly through digital customer pathways. • Reduce the rate of alcohol-related acute representations to ensure that treatment is provided in appropriate, cost-effective settings. • 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
- Acute alcohol-related presentations to reduce by 10% on the 2014/15 baseline by 2015/16, and be maintained thereafter
- 90% of all drug users in treatment to receive HIV and Hepatitis B interventions, and 90% of injecting drug users receive Hepatitis C interventions
- The proportion of drug users successfully completing treatment in 2014/15 to increase to 4% above the 2013/14 target rate
- 30% of local authority schools to achieve the Healthy Schools London Bronze Award, and 10% of local authority schools to achieve Silver Award by December 2014

Next steps

There are some clear health and wellbeing challenges in Enfield and this strategy for Enfield recognises that the needs of local people vary across the Borough and the importance of working closely with communities and local organisations to meet those needs.

This Health and Wellbeing Strategy 2014-2019 sets out the priorities the HWB will focus on with the aim to making a real difference to the lives of Enfield people. There will be a more detailed action plan which will identify leads and outputs to deliver the program of work as set out in the strategy. The HWB will review the progress of the action plan on a regular basis and will update the plan as required in response to changes in the evidence base (JSNA) and to reflect progress.

The HWB is committed to increasing community engagement in the delivery of the strategy. Successful implementation of the strategy relies on community and stakeholder organisations all of whom have an important part to play in the delivery.

The strategy will be implemented at a time when there are significant public sector financial cuts, so innovative use of existing resources will become even more important.

The full Health and Wellbeing Strategy will be reviewed in 2018/19.

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Contact Enfield Council
Civic Centre
Silver Street
Enfield
EN1 3XY

www.enfield.gov.uk

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