MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE Health and Wellbeing Board 11 February 2016	**Agenda - Part: 1** **Item: 5a** **Subject: Health Improvement Partnership Board Update**
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1. EXECUTIVE SUMMARY

This report summarises the work of the Health Improvement Partnership Board.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to note the contents of this report.

The next Health Improvement Partnership (HIP) is scheduled for March 2016. This is an interim report on the activities reporting to the HIP board.

1.0 REDUCING LIFE EXPECTANCY GAP - THE FIVE PRIORITY WARDS

The Public Health Core offer team coordinates the measures aimed at reducing health inequality. There has been a significant improvement in reducing the health inequality gap, but there have remained significant challenges to life expectancy across the borough. It was determined that 5 wards (Upper Edmonton, Chase, Ponders End, Enfield Lock and Jubilee) should receive discrete interventions in order to tackle this.

The team works within communities, with patients and health professionals, to improve prevention, early recognition and effective management of long term conditions which are identified as major causes of gap in life expectancy. Long term conditions are also not only a burden to patients and their families but also significant burden to the local health and social care economy.

A GP registration promotion campaign was undertaken in November 2015 in the form of distribution of leaflets across Enfield. A generic leaflet with information on how to register was distributed across Enfield as part of the housing newsletter mail drop. Leaflets with schematic ward maps were distributed, by door-to-door drop, to all households in the 5 priority wards.

The maps show the location of the GPs in the wards and the immediate vicinity and relevant bus routes. Active travel is also encouraged by putting walking distance times around GPs. Adverts were also be distributed at libraries, hospitals and groceries if those hosts permitted.

Health Intelligence team has been actively supporting this programme by providing analyses and evidence. Recently mortality rates by wards were analysed which highlighted the consistently higher mortality rates amongst those five priority wards, in particular, the wide variation in mortality due to cardiovascular disease within Enfield. This gives all the more importance to promote prevention and effective management of the cardiovascular diseases in Enfield to reduce inequality.

2.0 SUPPORTING PRIMARY CARE IMPROVEMENT

2.1 GP practice visits

Systematic reviews have widely reported that the quality of the structural and functional characteristics of primary care determines population health outcomes.

It is also known that an adequately supplied primary care system reduces mortality and can mitigate some of the adverse effects of income inequality. In Enfield, like other areas in England, there is much variation within the borough for primary care management of long term conditions. The Public Health team is meeting with the GP practices in the five high priority wards as a measure to facilitate primary care improvement within the allocated resources.

Public Health representatives have been attending GP surgeries for practice visits since July 2015. This is part of a formalised process to disseminate good practices and to address the underlying causes of variation in performance and outcomes across the borough as a whole.

When we looked at high performing GPs, many of them have their own challenges related to their local demographics or capacity issues, yet did manage to achieve a great deal. Therefore we are attempting to facilitate similar achievement across a range of general practices in Enfield. We are also soliciting the GP's support in smoking cessation activities and other population health initiatives commissioned by both LBE and the NHS. Freezywater, Riley House and Bowes Park were visited in December 2015 and early January 2016.

Information reviewed / discussed at the meetings included –

- Highlighted health issues of the residents of Ponders End, Upper Edmonton and Jubilee.
- Discussed how Public Health and the surgeries can work together to help improve residents' health.

- Public Health services currently delivered in Enfield were promoted. These include NHS Smoking Cessation, NHS Healthcheck, and lifestyle services.
- The importance of reducing the variation in primary care performance including screening and immunisation was highlighted.
- How a single-handed GP can tackle diabetes and other long-term condition management: teamwork and dedication to holistic health.
- How challenging cases of high blood pressure and cholesterol can be managed with innovative support.
- Exchanged information and ideas on how to improve health of the population and reduce inequality.
- Offer of inclusion in Hilo initiative.

2.2 GP Newsletter

Newsletters for local health professionals focusing on hypertension, cardiovascular risk, and diabetes have been produced and delivered to all GP practices in Enfield. These provide information about local epidemiology, health needs, evidence based practices, and variation in practices across the borough. They aim to celebrate improvement and good local practices in order to motivate and encourage improvement across Enfield. These provide additions to the information base relating to long-terms conditions such as hypertension and diabetes. The latest Enfield Public Health Newsletter for Health Professionals celebrated the achievements of Bowes Medical Centre, which is in the top 10% of practices in England in terms of managing blood pressure in patients with coronary heart disease.

3.0 LONDON HIGH BLOOD PRESSURE WORK

If London achieved the same rate of hypertension diagnosis and control as Canada we would have nearly an extra half a million people diagnosed and controlled. It is estimated that over 5000 strokes and 2300 heart attacks would be prevented, over the next five years. If we all achieved what Greenwich is currently achieving nearly 1000 strokes would be prevented.

To kickstart this work at a London level on December 16 a London Hypertension Conference was held. The Public Health team at LBE were involved, from its conception to the delivery of Public Health England's Workshop: "New opportunities to tackle high blood pressure in London" This very useful day explored key evidence and resources in relation to the pathway for high blood pressure, covering prevention, detection and management, through a mix of evidence sessions, practical advice, examples of good work in practice, and group exercises.

As we have often stated high blood pressure is the second biggest risk factor for premature death and disability in this country. Yet it can often be prevented through lifestyle change. Currently of every 10 adults in

England with high blood pressure, only four are both diagnosed and controlled. Addressing this is a huge opportunity both to reduce avoidable mortality and save money in the NHS and social care in a reasonable and useful timeframe.

Links:

- PHE Conference on high blood pressure: https://www.phe-events.org.uk/hpa/frontend/reg/tOtherPage.csp?pageID=210812&ef_sel_menu=1878&eventID=542&eventID=542 ,
- BMJ blog: http://blogs.bmj.com/bmj/2015/12/21/richard-smith-why-are-we-doing-so-badly-with-hypertension/
- Enfield hypertension profile: http://www.yhpho.org.uk/hypertensionla/default.aspx

4.0 COMMISSIONING FOR PREVENTION IN LONDON

We were asked to present our Enfield work on hypertension by Healthy London Partnerships at their Commissioning for Prevention event on January 11.

5.0 Voluntary Care Sector (VCS) Prevention Workshops

Members of the Public health team participated and spoke at two whole day workshops that were being held at Communities House organised by the Department of Health, Housing and Adult Social Care (HHASC).

These workshops invited representatives from Enfield's voluntary sector to attempt to address one central theme: What does good prevention look like?

- The workshops took account of good practice within the VCS, and utilised case studies & scenarios to prompt discussion.
- We highlighted primary prevention but invariably we did also discuss on secondary and tertiary prevention. Public Health was intimately involved with this section of the workshop.
- HHASC will be co-ordinating a report soon after the second workshop.

6.0 EFFICIENCY PROGRAMME (QIPP)

Public health core offer team supports the local CCG with strategic steer, clinical and scientific evidence, and operational support related to engagement and data to improve population health by investing according to need and evidence and allocating the resources in the right place so that patients receive the right care at the right time at the first time, while meeting its £12.5M saving target.

The team also endeavours to ensure population outcomes are improved without compromising vulnerable people or increasing health inequalities. This is undertaken in part by regularly representing Public Health, and giving expert advice in a number of regular meetings and working groups.

These include the Transformation Programme and Financial Recovery Board, the Quality & Safety Group, the Clinical Reference Group, and Working Groups for diabetes, cardiology, respiratory and musculoskeletal conditions. In addition the equalities subgroup, individual funding request panel and better care fund also receive Public Health input.

Public Health Representatives also regularly attend the urgent care transformation board meetings for North Central London. This is especially important as the emergency admissions related to injuries, infections, common paediatric conditions, mental health issues and non-ambulatory care sensitive conditions are increasing year-on-year in Enfield.

On the other hand public health team supports the reduction of rising demand in long-term conditions (e.g. heart disease, stroke, diabetes, and dementia) by designing new models of care and prevention. These include atrial fibrillation recognition and management, pre-diabetes recognition and pathway, complex diabetes care, hypertension recognition and control, and COPD recognition and control.

It is also to be noted that NHS England chooses Enfield CCG as one of the CCGs to receive commissioning support by the “Right Care” approach. We are working closely with the CCG in utilising intelligence and evidence provided through “Right Care” programme.

7.0 PUBLIC HEALTH CAMPAIGN

8.1 HIV prevention campaign

A HIV prevention campaign was carried out in November during the national HIV testing week and including World AIDS Day, to promote the importance of HIV tests and address the high late diagnosis rates in the borough.

8.0 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE

Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWSs), through the health and wellbeing board. The purpose of the JSNA is to inform the way in which decisions about health, wellbeing and social care services are planned and arranged.

The Enfield JSNA is available on the Enfield Health and Wellbeing website at http://www.enfield.gov.uk/healthandwellbeing/jsna.

The contents are being reviewed and updated to ensure it remains relevant and a useful tool and resource for commissioners, policy makers, local people and other key stakeholders.

The maintenance of Enfield JSNA is led by the Public Health Intelligence team, and the maintenance process is overseen by the JSNA steering group which membership includes Local Authority, CCG and Community

and Voluntary sector colleagues. The JSNA steering group meets quarterly and the last meeting was in October 2015.

Data and contents update is progressing well with the support from various stakeholders at LBE and Enfield CCG. We will continue to update the data and contents as appropriate. Since December 2015, following sections are updated and are currently being reviewed by leads before the web update.

- Substance Misuse – Drugs and Alcohol (Health and Wellbeing of Adult Chapter)
- Substance Misuse – Drugs and Alcohol (Health and Wellbeing of Children Chapter)
- Oral Health Children
- Childhood Obesity

9.0 QUALITY AND OUTCOMES FRAMEWORK (QOF) 2014/15 DETAILED ANALYSES

QOF is the annual reward and incentive programme detailing the GP practice achievement results. The data for 2014/15 was published at the end of October 2015. Health Intelligence team produced a LTC management report highlighting the variation in achievement of clinical management indicators between Enfield GP practices. These findings were shared with GPs at the Locality Commissioning meetings in January 2016 and will inform locality commissioning for next year.

10.0 MENTAL HEALTH

Borough's comprehensive Mental Health Needs Assessment is currently being undertaken by UK's leading Public Mental Health specialist and psychiatrist, commissioned by Public Health. It covers the mental health needs of all age groups and has had full support from wide range of partners at local authority, CCG, NHS providers and voluntary sector. The final report is due during February, which will inform commissioning and strategy at both local authority and NHS.

Public Health team have also contributed to the Future in Mind Enfield transformation plan which has now been agreed with NHS England. The children's public health team is working with partners in PHE and the CCG to develop artwork for an anti-stigma campaign in the borough.

11.0 PUBLIC HEALTH SERVICES FOR 0-5 YEARS

From 1 October 2015, the responsibility for commissioning Health Visiting and Family Nurse Partnership services transferred from NHS England to local authorities. The rationale behind this move is that local authorities know their communities and have a better understanding of local needs so they are in a more informed position to commission the services.

Funding for the 0-5 budget will sit within the overall public health budget and is ring-fenced to March 2017.

A review at twelve months, involving Public Health England (PHE) will inform future commissioning arrangements.

Child Health Information Systems (CHIS) and the 6-8 week GP check (Child Health surveillance) have not transferred to local authorities, although the CHIS service is expected to transfer in 2020.

Health Visitors and Family Nurses continue to be employed by the provider, which is currently Barnet Enfield and Haringey Mental Health Trust.

11.1 Health Visiting

Health visiting is a universal service that provides a professional public health service based on evidence of what works for individuals, families, groups and communities.

Health visitors are highly trained specialist community health nurses, skilled at spotting early issues that may develop into problems or risks to the family if not addressed.

The service will vary according to the personalised assessment of each particular family and what will work for them. They lead the delivery of the 0-5 elements of the Healthy Child programme in partnership with other social care colleagues, which places them in a strategic position to tackle and reduce infant mortality because they work closely with the parent and family from pre-natal, during pregnancy, post- natal until the child starts school at 5 years.

Health visitors are mandated to undertake:

- an antenatal visit,
- visit new born babies at home between 10 and 14 days, and
- undertake a 6-8 week review, followed by
- another review at one year and
- a further review at 2 - 2½ years,

and focus on six early year's high impact areas including;

(i) maternal mental health,
(ii) transition to parenthood,
(iii) breastfeeding,
(iv) healthy weight,
(v) managing minor illnesses / accident prevention and health and wellbeing.

This facilitates regular contact with families and their children at the most challenging times of their lives and plays a key role in early detection of potential risk factors of infant mortality and child development.

One of the strengths of health visiting is that by visiting families in their homes, they are able to take a holistic view of the family and their needs. Through regular contact and with appropriate training, health visitors can influence mothers, fathers and family members to develop healthy behaviours (including increasing physical activity and maintaining a healthy weight) associated with improved wellbeing. In addition, health visitors can encourage greater physical activity among children by providing relevant information to families and working with partners to develop greater opportunities to be physically active within

The Trust has worked on recruitment and has almost doubled the WTE in the past three years (currently @ 69.7WTE). Staff retention has also been a notable success in the Borough.

It was identified that a trajectory of 79 HVs would be the ideal in order to deliver the whole Healthy Child Programme (HCP). Recruiting is a national issue and it is a continuous struggle to recruit to the full trajectory. The Council is working with the Trust to identify the areas of the HCP that are not being met. As there have not been any safeguarding issues identified, the data provided will enable the Council to review the trajectory and unmet needs.

Public health are currently reviewing the health needs of the 0-5 population in the borough and reviewing the health visiting service. These reviews will inform the commissioning of the services.

11.2 Family Nurse Partnership (FNP)

The Family Nurse Partnership (FNP) is an evidenced based, preventative programme offered to vulnerable young mothers having their first baby. It is a nurse led intensive home-visiting programme from early pregnancy to the age of two. The aims are to:

- improve pregnancy outcomes;
- improve child health and development;
- improve parents' economic self-sufficiency.

The criteria for eligibility to be offered the programme are:

- All first time mothers aged 19 and under at conception;
- Enfield residents;
- Eligible if previous pregnancy ended in miscarriage, termination, still birth;
- Enrolment should be as early as possible in pregnancy and no later than the 28th week of pregnancy. 60% should be enrolled by the 16th week of pregnancy.
- Women who plan to have their child adopted or have had a previous live birth are excluded from the programme.

For 2016/17, Enfield will be localising the service to meet the Borough's needs, for example, whilst the programme is at its full quota, there are 86 active clients. The intention is to empower the FNP Supervisor to

graduate those clients that have not maintained contact in order to allow another vulnerable young mother to be admitted to the programme.

The FNP programme is overseen by a FNP Advisory Board (FAB) chaired by the Assistant Director Commissioning and Community Engagement, Schools and Children's Services.

In the last 12 months:

- 33 clients were enrolled, of whom 45.5% were enrolled by the 16th week of pregnancy (the target is 60%);
- 75% of those who were offered the programme enrolled, which meant that the target of 75% was achieved;
- 41pregnancies, 42 infancies and 4 toddlerhood graduations were completed.

The second annual review took place in November 2015 and the team will have their first graduation from Enfield FNP in March 2016.

A strategic vision for FNP in Enfield is being developed as part of the borough's wider maternity and children's services. FNP aligns with the Healthy Child Programme and will be included in future commissioning plans for the wider Health Visiting service.

12.0 SCHOOL NURSING

School nursing service provides a service to all the Council-funded schools in the borough. School nurses assist with safeguarding, health promotion, can advise on health matters and help with training on long term medical conditions (e.g. how to use EpiPens) to help every child attend school and reach their potential. School nurses also deliver the school aged national immunisation programme to all schools in the borough.

Children can self-refer to school nursing or can be referred by school staff, social services, the Looked After Children nurse specialists, child protection nurses or medical colleagues.

There are plans to co-commission an immunisations service with NHSE and to develop a traded service for school nursing to be offered to academies, free schools and independent schools in the borough.

School nursing will be reviewed in the next year to ensure value for money and assure clinical quality and governance.

13.0 SCREENING AND IMMUNISATION

The latest immunisation data suggest an increase in coverage, but these have not been validated and are not available for dissemination yet. Flu vaccination in schools for children in Years 1 and 2 was completed in December. The final data is yet to be released, but early indications from

NHS England (NHSE) show that Enfield achieved over 50% and fares well compared to other boroughs.

A meeting has been held to discuss immunisation rates in the Looked After Children (LAC) population in the borough and an action plan is being developed with partners, including the LAC health team, NHSE and health visitors.

The new public health practitioner has been attending meetings with the antenatal and new born screening team from the local maternity units and NHSE. The children's public health team is working with NHS England to assure the Council of screening programmes in the borough and have invited NHSE to attend the upcoming Scrutiny sessions. A North Central London Adult Screening Assurance meeting has also been initiated and is due to meet in January 2016.

14.0 HEALTH PROTECTION

The team has been busy preparing for a borough pandemic flu exercise and have consulted with partners in the health protection forum, including Public Health England and the Borough Resilience Forum.

The outbreak of Ebola Virus Disease in West Africa has not been declared as over, as there are still reports of sporadic cases.

There have been cases of Polio in Ukraine, but no instances in European countries.

There is a multi-country outbreak of Zika virus in South America, in countries that have not seen the virus before.

There was a local outbreak of norovirus disease affecting Enfield schools, but this was brought swiftly under control.

We remain in constant contact with colleagues from PHE and remain vigilant for the signs of infectious diseases in the borough.

15.0 AIR QUALITY – SEEK TO REDUCE EMISSIONS FROM VEHICLE IDLING

A bid was submitted to the Mayor's Air Quality Fund with the ambition of making Enfield idle-free by 2020. There are several strands to this project which include engagement with schools, the community and local businesses. Specific campaign/target areas include level crossings, outside schools, air quality hot spots, taxi ranks, stations and at key junctions where people are likely to be waiting for over a minute for the lights to change.

Commissioning some "Air Aware" lessons within schools, separate to the bid but will complement it, if it is successful.

A report from King's College estimates that some 17% of deaths in Enfield are related to air pollution.

16.0 CYCLE ENFIELD

The health benefits of Cycle Enfield have been endorsed by the Health and Wellbeing Board. The project supports the Public Health England work to highlight the importance of physical activity and its effect on both individual and societal health as well as healthcare budgets.

17.0 CHILDHOOD OBESITY

Childhood obesity data for 2014/15 has been released.

In Enfield in Reception year (aged 4-5 years):

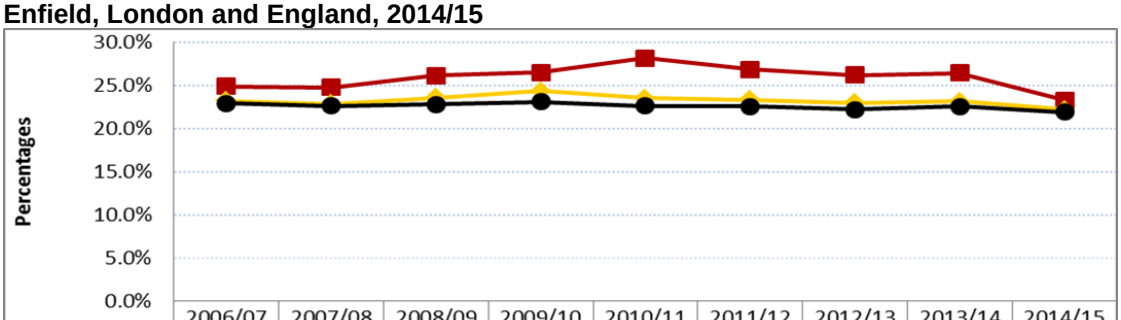
- Almost one in four Reception Year pupils in Enfield were overweight or obese (23.3%), slightly higher than London (22.2%) and England (21.9%) averages.

- Just over one in ten Reception Year pupils in Enfield was obese in 2014/15 (10.5%).This was the 11th highest rate amongst 32 London boroughs. This is similar to London (10.1%) but significantly higher than England (9.1%) averages.

- More than one in seven Reception Year pupils was overweight in Enfield (12.7%) in 2014/15. This was significantly higher than London (12.0%) average but similar to England (12.8%) average.

- 1.5% of Reception Year pupils were underweight in Enfield in 2014/15.

Prevalence of Overweight or Obesity in Reception Year pupils (aged 4-5 years), Enfield, London and England, 2014/15



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Enfield	24.9%	24.8%	26.1%	26.5%	28.2%	26.8%	26.2%	26.4%	23.3%
London	23.2%	22.9%	23.6%	24.4%	23.5%	23.3%	23.0%	23.2%	22.2%
England	22.9%	22.6%	22.8%	23.1%	22.6%	22.6%	22.2%	22.5%	21.9%

Source: National Childhood Measurement Programme, HSCIC

In Enfield in Year 6 (aged 10 – 11):

- Almost two in five Year 6 pupils were either obese or overweight in Enfield (41.0%). This was significantly higher than London (37.2%) and England (33.2%) averages.

- Just over one in four Year 6 pupils was obese in 2014/15 (25.4%). This was the 6th highest amongst 32 London boroughs (Figure 2.2), and significantly higher compared to London (22.6%) and England (19.1%) averages.

- Around one in six Year 6 pupils were overweight in Enfield (15.7%), above the London average (14.6%). Enfield rate was significantly higher than England average (14.2%). This was also the 3rd highest amongst 32 London boroughs.

- 1.5% Year 6 pupils were underweight in Enfield in 2014/15.

The Active People Survey indicates that 64.8% of adults in Enfield are either overweight or obese.

Public Health is attending the London Association of Directors of Public Health learning set on childhood obesity on 5th February.

18.0 HEALTH CHECKS

Backdated health check data indicates that the number of health checks received in Q1 has risen from 1,297 to 2,416. In Q2 data indicates 1604 were received with a cumulative Q2 total of 4020. Projected healthchecks for 2015/16 are indicating over performance on the set target (8,000 health checks).

The service will be reviewed for 2016/17.

19.0 TOBACCO CONTROL

Smoking events were held for New Year quitters in Enfield town and Edmonton. A conference on reducing smoking prevalence in the Turkish community is being planned for May 2016.

20.0 SEXUAL HEALTH

The Council has the responsibility for:-

- Integrated Sexual Health Community Services, which is delivered by NMUH; and
- LARC, which is delivered by the borough's GPs

The Integrated Sexual Health Community Services contract delivers GUM treatment for all Enfield residents and Contraception for those not registered with an Enfield GP.

The contract includes specialised Sexual Health Outreach Nurses for young people (4YP) and will be working with voluntary organisations to improve relations with the population identified as 'hard to reach' – sex workers, substance misusers as well as the LGBGTT and certain identified BME population.

The new service model will commence on a phase basis based on the service moving to the new locations, with the Burleigh Way (EN2) location opening on 04 January 2016.

The Council has contractual agreements with 27 of the Borough's GPs to deliver Long Active Reversible Contraception (LARC). Activity is steadily increasing and is expected to continue to grow as the new contractor for Integrated Sexual Health Community Services will be training and supporting the GPs with this service.

21.0 Regional and National Activities

21.1 We support the London Primary Care Transformation group and will be supporting them to develop London-wide standards for primary care. We have also been clear that GP provider networks should ensure that they have access to Public Health expertise.

21.2 We have been working with Public Health England to deliver the London Hypertension Workshop

21.3 We have been providing Public Health advice to the Board of London Cancer and to Cancer Commissioning Board for London.

21.4 We represent local authority public health at the Home Office FGM Stakeholder Group and attend meetings with the London Safeguarding Children Board

21.5 We represent public health at the North Central London Urgent and Emergency Care Network

21.6 We continue to act as Professional Appraisers for Public Health England and benefit from the national Revalidation system for doctors.

21.7 We continue to provide mentoring support for new and aspiring Directors of Public Health and to support Public Health workforce development in London

21.8 We are co-leading the London Healthcare Public Health Group which is committed to making sure that Public Health Consultants working on healthcare public health are making the impact they have the potential to make.