MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board** **21 April 2016**	**Agenda - Part: 1** **Item: 10a** **Subject: Health Improvement Partnership Board Update** **Approved by: Dr Shahed Ahmad**

Contact Officer:
Miho Yoshizaki
Tel: 0208 379 5351
Email:

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.

1.0 REDUCING LIFE EXPECTANCY GAP FOR THE PRIORITY WARDS

The core offer team leads on work intended to reduce health inequalities in 5 priority wards, in addition to the support to the CCG. This is undertaken by working within the communities, with patients and professionals, to improve the prevention, early recognition and effective management of long-term conditions which are a burden to patients and the local health and social care economy as a whole.

A GP registration promotion campaign was continued working with urgent care centres, walk-in centres and A&E departments. Maps with GPs and dentists were distributed with an information leaflet to patients. The map also includes walking distance to local GPs and bus routes to prevent unnecessary use of cars and to promote physical activity.

Cardiovascular disease is a major cause of life expectancy gap and there are a number of risk factors that can be modified to reduce significantly the risk of coronary events and stroke. Public Health team delivered presentation to the Enfield GPs at two of their training days around the importance to improve detection and management of blood pressure and atrial fibrillation. They were

joined by a GP with special interest in cardiovascular disease and a lecturer from Queen Mary University of London.

The next important cause of life expectancy gap is cancer, which is also a major cause of mortality across Enfield. There are some types of cancers that cannot be detected by screening such as lung cancer. “If in doubt, check it out!” campaign was delivered from March 2016 till early April 2016. A letter was sent out to the GPs to inform the key findings of cancer JSNA.

2.0 SUPPORTING PRIMARY CARE IMPROVEMENT

2.1 GP NEWSLETTER

Newsletters for local health professionals 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.

Smoking is a common cause of many killer diseases such as heart disease, most types of cancer and stroke. One venue of tackling tobacco is through dentists and oral health. A newsletter is being drafted to encourage Enfield’s dentists to give brief intervention to those who smoke and signpost to smoking cessation service.

2.2 BUSINESS CASES FOR LOCALLY COMMISSIONED SERVICES

Public health Core Offer team also 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 and pre-diabetes recognition and pathway. Case for change has been produced with the evidence and return on investment calculations:

- A 5-year stroke prevention scheme by managing atrial fibrillation will save every year 6 lives and 30 strokes (of which 13 disabling stroke) with net NHS recurrent savings around £350,000 per annum and social care recurrent savings around £200,000 per annum;
- A scheme to identify, recruit and provide intensive behaviour interventions to 10% of those with highest risk of diabetes can produce gross savings to the NHS from £50,000 in the first year to £750,000 in the fifth year.

3.0 ENGAGEMENT WITH DEAF COMMUNITY

As part of our efforts to ensure that our efforts in this area were of utility one of Public Health’s Senior Strategists attended the British Sign Language (BSL) drop-in session at Community House on the 18th February at which there was presentation about dementia by a BSL-trained specialist nurse.

Public Health as a team will be attending on the 21st April at the same venue to present on prevention. As part of this event members of LBE's Communications team will also be present in order to address potential issues with LBE's communications vis-à-vis the deaf community

4.0 SCRUTINY ON PHUBLIC HEALTH ENGAGEMENT WITH PRIMARY CARE

The Public Health Core Offer lead reported at scrutiny on their work in engaging local primary care to improve population health outcomes. The summary of the report can be seen below:

i. Despite improvements there remain significant health inequalities within and across the borough, and wide variation in GP outcomes related to proactive management of long-term conditions.
ii. These remain a priority within the Health and Wellbeing Strategy.
iii. These inequalities tend to be more pronounced within the 5 high-priority wards.
iv. Public Health continues to conduct activities, both focused within the 5 high-priority wards, and elsewhere to help with mitigation of these issues.
v. Primary care provides holistic healthcare of the population. High quality primary care is associated with better health outcomes and lower dependency on the acute and social care sector.
vi. Enfield GPs face a huge challenge related to the high level of long-term conditions. A supportive environment facilitated by health and wellbeing members in their own right will help improve the outcomes in health and social care economy.
vii. One of these measures is the engagement and partnership with our local GPs by public health team.

5.0 EFFICIENCY PROGRAMME (QIPP) and RIGHTCARE APPROACH

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 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 9 London CCGs to receive support by the national "RightCare" team. Public health Core Offer and Health Intelligence team is supporting the CCG together with the NHS England team in producing better quality outcomes with increasing efficiency by implementing "Rightcare" approach. The approach identifies the potential areas of quality and efficiency improvement by benchmark the spending and outcomes with similar CCGs.

6.0 JSNA

Maintenance and update of JSNA is progressing well. Work plan for 2016/17 will be agreed at the next steering group meeting scheduled on the 3rd May 2016.

7.0 ANNUAL PUBLIC HEALTH REPORT

Annual Public Health Report is due to be published early May. This year's report focuses on Infant Mortality in Enfield.

8.0 REGIONAL AND NATIONAL WORK

Enfield's DPH continues to lead for ADPH on high blood pressure and London ADPH on cancer and primary care co-leads for London ADPH on healthcare public health. The London Hypertension Leadership Group has been developed, the analytical subgroup has produced pan London analysis, and briefing papers have been produced by the detection subgroup and management subgroup. The Healthcare Public Health Consultants will be discussing cancer and hypertension at its April meeting.

8.1 LONDON HIGH BLOOD PRESSURE LEADERSHIP GROUP

London Hypertension Leadership Group aims to prevent, detect and manage hypertension to prevent further cardiac events such as stroke by supporting CCGs and Local Authorities with evidence base and tools.

As part of the Health Intelligence Work stream of this Group, Enfield Public Health produced a tool summarising opportunities derived from improving Hypertension detection and management for each London CCGs. This information is fed back to the NHS Sustainability and Transformation Plan to

improve health of the Londoners. Enfield Public Health team also contributed evidence to derive a set of measures to maintain and improve blood pressure management across London.

In addition, there is a North Central London (NCL) subgroup to produce an NCL-wide coordinated action to raise awareness, and to facilitate population and community participation in blood pressure detection and control.

8.2 COMMISSIONING FOR PREVENTION IN LONDON

Mayor's office and Healthy London Partnership a piece of work to review the economic case of prevention programmes that can be useful for all CCGs and local authorities (LAs) across London. Enfield Public health representatives contributed to the priority setting and the methodology of the economic review. Ten key areas were short-listed by key stakeholders:

1. Alcohol
2. Obesity
3. Physical activity
4. Smoking
5. Circulatory diseases
6. Diabetes
7. Hypertension
8. Mental Health
9. Musculoskeletal conditions (e.g., falls, back pain)
10. Workplace Health

Enfield public health team continues to take part in the on-going discussion so that the needs of Enfield will be represented and to scrutinise the quality of work. The results will be presented to CCGs and LAs in a way to include both the size and pace of return on investment made to health and social care economy.

9.0 SMOKING

There will be a conference on smoking in the Turkish community on 21st May. A new smoking contract is being negotiated following budget cuts to the PH budget. The new contact will focus on the Turkish community, pregnancy and post-natal women, long-term conditions and schoolchildren. As smoking prevalence has fallen much more than might be expected given the number of quitters we have gained through meeting the four week quitter target it is expected that this will enable us to continue to reduce our smoking prevalence (currently 8th lowest in London). PH is attending GP meetings to explain the new contract and its reasoning.

9.1 TRADING STANDARDS

Trading Standards are working across the sector to plan a series of coordinated raids on establishments potentially selling illegal / illicit tobacco and alcohol. This will be followed up with press releases emphasising that illegal tobacco helps

children to start smoking and that even smokers believe that ‘something should be done’ about the sale of illicit / illegal tobacco.

9.2 SMOKING TARGET

At the end of Q3 Enfield had achieved 1030 four week quitters against a target of 920.

10.0 HEALTH CHECKS

The contract was suspended in February. An end of year figure is still to be finalised. February projections were that we had already achieved the yearly target.

11.0 HEALTH TRAINER SERVICE

The health trainer service has now left the Angel in Edmonton and is operating from the Civic saving accommodation costs of £7.5k per year.

12.0 HEALTHY WEIGHT STRATEGY

A learning meeting was held with other boroughs re childhood obesity at the end of February. Enfield actions included promoting sugar free days, apps for physical activity and developing a physical activity care pathway. Actions will be taken forward this quarter.

13.0 CYCLE ENFIELD CONFERENCE

The cycle Enfield conference was held on the 8th April. It was attended by approximately 60 people including Cllrs Anderson and Pite. Following this a response to the Dept for Transport Walking and Cycling investment strategy has been written for consideration by the relevant Cabinet member.