MUNICIPAL YEAR 2017/18

Meeting Title: **HEALTH AND WELLBEING BOARD** Date: 10th October 2017	**Agenda Item:** **Subject: Progress Update on Joint Health & Wellbeing Strategy**
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1. EXECUTIVE SUMMARY

The Health and Wellbeing Board (HWB) has previously selected 12 areas to monitor including 3 priority areas where it wishes to focus for the remaining term of the strategy (until 2019). Progress on these areas including the three priority areas are highlighted. Challenges within the 3 priority areas are outlined below for discussion and potential action by the HWB.

2. RECOMMENDATIONS

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

  <Best Start in Life>

  - Maintain a focus on this area and ensure that all partners are delivering appropriately.
  - Support the BSIL task & finish group providing members and oversight of the group's work
  - Attend a focussed session on Best Start in Life 6th January 2018

  <Mental Health Resilience>

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

  <Healthy Weight>

  - Support the Local Government Declaration on the reduction of sugar and healthier food

3. BACKGROUND

3.1 At Health and Wellbeing Board meeting held on the 19th April 2017,the 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
- Obesity
- 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
- 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.

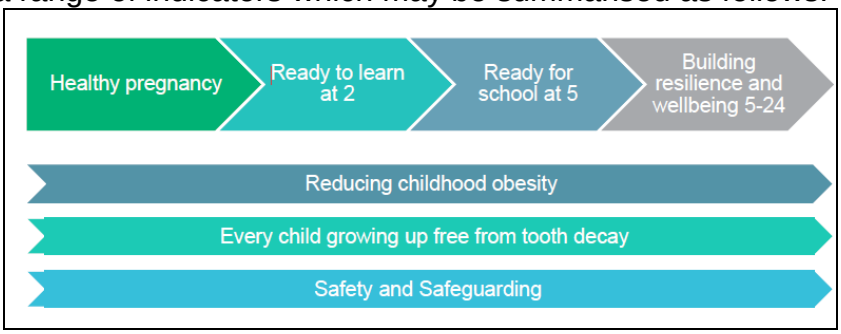
4.4 For the latest statistics of the full set of selected indicators, please see https://new.enfield.gov.uk/healthandwellbeing/jhws/measuring-our-progress/

Priority Focus Areas

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 which may be summarised as follows.



Listed below are 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 (91.6% of mothers breastfeed their baby within 48 hours of delivery) [2016/17 Q3 data]. This is better than England (72.9%) but there is currently no data for the how many 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 (24.3%) of 4/5 year olds; and in Year 6 two fifths (41.5%) of 10/11 year olds are overweight or obese.

- **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).

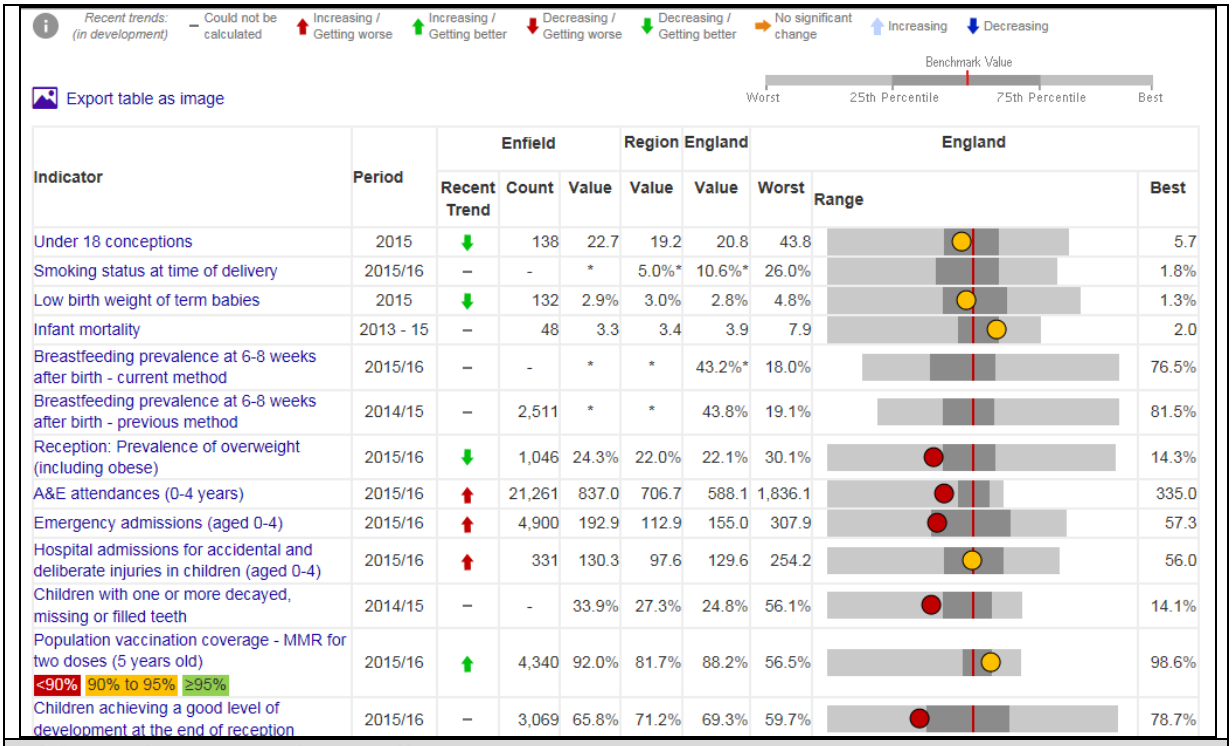
- **School readiness**

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:



Indicator	Period	Enfield			Region	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	2015/16	–	-	*	5.0%*	10.6%*	26.0%		1.8%
Low birth weight of term babies	2015	↓	132	2.9%	3.0%	2.8%	4.8%		1.3%
Infant mortality	2013 - 15	–	48	3.3	3.4	3.9	7.9		2.0
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

- The Teenage Pregnancy Prevention Officer post has successfully been transferred from Children's Services to Public Health and maternity cover recruited to.
- 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).

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 new Best Start in Life (BSIL) task & finish group will consider these trends as part of developing a system-wide response to ensuring a healthy start for children in Enfield.
- The 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 maintains 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, corporate and partnership support.
- Attend a focussed session on Best Start in Life at the 16th January 2018 HWBB development session for key partners that contribute to improving outcomes.

Focus area	Mental Health Resilience
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 the vehicle for mental health resilience work in Enfield.
- Thrive LDN has launched "Are we ok London" campaign to support the Thrive LDN document previously presented to this board. The aim of the campaign was to support Londoners to engage in the conversation what is important for them in terms of mental health resilience.

Things that are going well

- Thrive LDN team has performed a rough-cut analyses of the reach established and interaction generated in the first 6 weeks of the campaign. They have analysed circulation and readership of print and digital media, the TfL poster campaign, twitter, TALK London and engagement event. They estimate over 41,000 interactions potentially reaching over 13 million people. It should be noted that this is an informal analyse and have not been confirmed.

- Various campaigns and events are scheduled to promote the World Mental Health Day (10th October).

- One of the key aims of the Thrive LDN is preventing suicide. Enfield continues to regularly audit suicide information to gather learning, and is working closely with NCL colleagues to align process across NCL footprint.

- Enfield has been working together with Camden, Islington and Barnet to explore funding from the Big Lottery Fund by way of a Social Impact Bond.

- Enfield has been awarded match funding by the Big Lottery Fund to develop an Individual Placement and Support (IPS) Service. The IPS employment model is internationally recognised as the most effective way to support people with mental health problems and/or additions to gain and keep paid employment.
- The assessment of submitted tender applications to supply this IPS service took place on the 19th September, and following selection the service is planned to commence in January 2018.

- The Council continues to work in partnership with NCL Public Health partners and Healthy London Programme team to facilitate the award of the GLA Healthy Workplace Charter to local employers. This scheme will include a significant emphasis on mental health and wellbeing in the workplace. PH staff resource is inhibiting development of this initiative.

- CQC CAMHS Thematic Review took place in September. We are awaiting the final report.

- Formal CQC inspection took place in BEH the week of 25th September.

What's next?

- We are continuing to work with "Thrive LDN" who will be undertaking an engagement event in Enfield on the 8th November 2017.

- We will be taking part in activities related to World Mental Health Day on the 10th October 2017

Challenges that HWB may be able to assist resolving / unblocking

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

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?

- **1,008** Reception Year children were overweight or obese. This equates to almost **one in four** Reception Year pupils in Enfield (23.9%). Enfield rate was statistically significantly higher than both London (21.9%) and England (22.1%) averages. Enfield's rate was the 9th highest in London and the second highest in NCL.
- For Year 6 (10-11 years) rate of excess weight is around **two in five** (41.0%) pupils in Enfield, the 6th highest in London and the highest in NCL.
- Around **two thirds of adults** in Enfield **(63.5%)** are **overweight or obese.** This is **the 8th highest** in London and the highest in NCL**.**

Things that are going well

1. **Local Government Declaration on the reduction of sugar and healthier food**

- An action plan is in development and will be shared with the HWB in November.
- The aim of the Local Government Declaration on Sugar Reduction and Healthier Food is to achieve a public commitment to improve the availability of healthier food and to reduce the availability and promotion of unhealthier alternatives.
- As part of the action plan, we will be launching the Sugar Smart Enfield campaign, supported by Sugar Smart UK. Ahead of the launch in November, we are engaging 14 organisations to make pledges to become Sugar Smart.

2. **School Health & Wellbeing Event**

- A School Health & Wellbeing Event will take place on the 5th October 2017, and aims to highlight initiatives available to schools to improve the health and wellbeing of students and staff, including The Daily Mile. The Daily Mile founder, Elaine Wyllie, will present the growing Daily Mile movement, its impact and how local schools can establish the initiative.

3. **Healthier Catering Commitment (HCC)**

- 35 local businesses (including Bridgewood Care Home) have signed up to HCC.
- HCC recognises those businesses that demonstrate a commitment to reducing the level of saturated fat and salt content in their foods, offering some healthy options (for example, lower sugar drinks and snacks) and making smaller portions available on request.

4. Healthy Start Vouchers

- Healthy Start vouchers help low income families on certain benefits who are either pregnant or have children under four, to buy milk, fresh or frozen fruit and vegetables. Approximately £6 million worth of Healthy Start Vouchers go unclaimed every year in London.
- In conjunction with Health Visiting and Children's Centres, we are developing an action plan to ensure that vulnerable families who are entitled to these vouchers are receiving them.

5. Kitchen Social

- The Mayor's Fund for London has expressed an intention to fund 10 'Kitchen Social hubs' in Enfield. 'Kitchen Social works with local grass root community organisations to create an environment where children, young people, their families and carers can feel comfortable to play, explore new ideas, make new friends, learn and get a good balanced free meal during the holidays.'
- A meeting with key stakeholders took place in September and we are currently identifying potential hubs.

What's next?

- Get sign off for the Local Government Declaration on the reduction of sugar and healthier food
- Increase the number of schools who are participating in The Daily Mile or the equivalent
- Increase the number of businesses that are awarded the HCC
- Identify Hubs for the Kitchen Social project

Challenges that HWB may be able to assist resolving / unblocking

- Support the Local Government Declaration on the reduction of sugar and healthier food

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.

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)
- Delivery of a VAWG presentation at the HWB development session in which the following recommendations were agreed:
  - Commitment to audit how far Enfield is meeting the NICE guidelines on DV and audit how far Enfield is meeting these
  - A commitment to rolling out routine enquiry in wider health settings
  - Placement of IDVA's in A&E / co-locating DV specialist workers (similar to IRIS model) – NB have noted we need to explore funding options for this
  - Take a joint commissioning approach
  - Increased data sharing / analysis
  - Identify a HWB DSVA Champion as part of wider partnerships
  - Expanded DV report on JSNA to include wider health determinants and links
- Increase in funding (through applications to government departments and within the local authority)
- New Information Sharing Protocol agreed
- Continuation of the Identification and Referral to Improve Safety (IRIS) scheme
- The Community Safety Unit continues to provide DV training to multi-agency professionals
- Increased reporting and communications
- Reduction in repeat victimisation
- Awareness Raising Campaign and targeted digital marketing

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 noted above from the HWB development session

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

4. Further to the HWB development session there has been a recently published multi-

inspectorate report: 'The multi-agency response to children living with domestic abuse; Prevent, protect and repair.'[1] Some of these areas are already included in the VAWG Strategy and action plan however there may be areas that partners / agencies will want to plan into future work
Challenges that HWB may be able to assist resolving / unblocking
Continue to support embedding work to tackle domestic abuse across the partnership.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/645642/JTAI_domestic_abuse_18_Sept_2017.pdf

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%).

Patient survey results

The National Cancer Patient Experience Survey 2016 is the sixth iteration of the survey first undertaken in 2010. It has been designed to monitor national progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients. Patients were asked to rate their care they received on a scale of zero (very poor) to 10 (very good), respondents gave an
average rating of 8.5 for Enfield which is very good.
The respondents said that:

- they were involved as much as they wanted to be in decisions about their care and treatment
- they thought that the GPs and nurses at their general practice would support them through their treatment
- it had been 'quite easy' or 'very easy' to contact their Clinical Nurse Specialist
- overall, they were always treated with dignity and respect while they were in hospital
- hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital definitely did everything they could to support them while they were having cancer treatment.

Things that are going well

- A cancer action group was set up in Enfield to develop set of action plans that will help improve patient journey through screening, referral, treatment and care post-discharge from hospital.
- Working across NCL on cancer screening assurance group to improve screening across the sector.
- Screening coverage for breast cancer and cervical cancer in Enfield is above the national average.

What's next?
• Enfield Cancer working groups is preparing resources for cancer awareness campaign in the borough in line with the national cancer awareness programme. • The cancer awareness resources will also have information to help to know where in the borough they can access cervical cancer screening clinics. • GPs will display cancer screening promotion materials.
Challenges that HWB may be able to assist resolving / unblocking
• Support the local cancer awareness campaign at GPs • Enfield-wide cancer awareness campaign is usually held in January or February.

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.

LBE – social care workers, staff and care and residential homes
NHS England London team has commissioned community pharmacies to provide free flu vaccination for all residential and care home staffs as well as residents of these homes. 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 amongst health and care workers and vulnerable people.

Focus area	Hospital admissions caused by unintentional and deliberate injuries in children (0-4 years)
Partners	Public Health, Children's Services, Enfield CCG
What's our current performance?	
Please refer to the "Best Start in Life" report.	
Things that are going well	
Best start in life working group has been established to develop system-wide response to ensuring a healthy start. This indicator will be monitored and discussed as part of this development.	
What's next?	
Please refer to the Best Start in Life report.	
Challenges that HWB may be able to assist resolving / unblocking	
Please refer to the Best Start in Life report.	

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

Supply capacity building in respect of Learning Disability Services and wheelchair access family accommodation.

What's next?

- Consideration of current housing pathways, including panels and quotas in respect of adults with support and care needs
- The further development of move on accommodation for adults with mental health support needs who are eligible for ASC services
- Further work to develop wheelchair accessible supported housing accommodation and respite services for adults with learning disabilities.
- 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?

Enfield and Barnet were jointly awarded the second wave site for NHS Diabetes Prevention Programme for 2017/18 and 2018/19. Nationally funded places for evidence-based intensive lifestyle intervention will be offered to over 2,000 residents in Enfield with pre-diabetes. With high level of obesity and pre-diabetes in Enfield, if the places are used effectively, the programme will not only benefit the clients of this scheme, but also help reducing future demand related to diabetes and the complications of diabetes.

Service started to accept referrals from May 2017. Service sites confirmed at the following in Enfield:

- Carlton House Surgery (Live from 21st September)
- Evergreen Primary Care Centre (Live from W/C 4th September)
- Ordnance Unity Centre for Health (Live from 8th November 2017)

The number of referrals are satisfactory and we need to keep this momentum to maximise the benefit for Enfield population.

	Total YTD	May-17	Jun-17	Jul-17	Aug-17
NHS Barnet CCG	789	17	152	295	270
NHS Enfield CCG	439	8	88	168	147
CCG Total	1228	25	240	463	417

Things that are going well

- GPs are engaged at local GP meetings. Confirmed sites communicated to GPs through various GP and Practice manager forums.
- Referral rates continue to be high.

What's next?

- The service launch will be publicised in Enfield with LBE support.
- Referral rates will continue to be reviewed as the service become more mature and established.

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.
- Proactive management of long-term conditions in primary care has improved in Enfield. (QOF aggregate rank in London.)
- PH Smoking cessation service is re-commissioned to target people in most need, including those with long term conditions.
- NHS is commissioning a new service to prevent stroke and diabetes by effective management of atrial fibrillation and primary care intervention of pre-diabetes.
- As in most part of London, Enfield diabetes care review shows that there are unwarranted variation in the 3 Treatment Targets (3TTs) for diabetes patients: Blood Pressure, Cholesterol and HbA1c (long term blood sugar level). Reducing these unwarranted variations in the provision of care will improve patients' wellbeing, reduce morbidity of complications and mortality, and NHS and social care costs.
- The 3 TT diabetes improvement project is part of the North Central London – Sustainable Transformation Plan and Diabetes's Transformation Programme to deliver improved care and reduce unwarranted variation across the sector.
- Practices identified within 4 localities as part of the framework of Care Close to Home Initiative(CHINs) to improve integrated care across the borough.

What's next?

- Using evidence based medicine to promote effective management of LTCs and reduce waste.
- Primary care programme to improve the care of prostate cancer survivors
- Quality Improvement Support Teams (QISTs) and Care Closer to Home Integrated Care
- Care Closer to Home Board will be formed with local partners to oversee the integrated care for patients with long-term conditions and other complex needs in Enfield.
- 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 Joint Enfield End of Life Care Strategy aimed to ensure that we deliver better quality of care and greater choice in End of Life Care. The primary focus for Enfield CCG is on increasing the number of people who are able to exercise a positive choice about their place of death.

The strategy will help to enhance the quality of end of life care across health care (primary and secondary), social care and the voluntary sector, enabling people to live and die well across Enfield. It will facilitate choice and boost confidence to enable people to die where they wish with the support they need. This should avoid unnecessary hospital admissions by reducing emergency admissions and extended hospital stays.

Good progress has been made in the last 12 months:

1. The Care Home Assessment Team have proactively supported residents in care homes to have comfortable and dignified deaths in their preferred place and the service has seen a significant success, achieving its aim to support residents to die at their preferred place of death. In 2016/17 CHAT achieved 99% of deaths in preferred places.

2. As part of its delivery of workforce development to care staff, CHAT in collaboration with the North London Hospice and the Macmillan EoL GP have a structured formal training programme in place for all groups of professionals dependent on role and grade. CHAT run these sessions all through the year to support the skills and

knowledge of developing advanced care plans for residents but also provide practical support to care staff on how to deal with end of life challenges

3. Increased EOL profile and education across CCG has reflected a significant increase in the use of Coordinate My Care (CMC) across Enfield. There have been a consistent number of records created since Nov 2016 till April 2017 following a targeted approach to the use of CMC from hospital visits, GP education sessions and CMC intra-operability with North London Hospice IT system. There are 185 patients in Enfield with a CMC record.

4. Delivery of an EOL practice nurse session in April 2016 with over 25 nurses in attendance across Enfield. Feedback from the session was all positive with a significant change in practice for practice nurses following the session from anecdotal discussion at subsequent meetings.

5. Positive engagement with GP practice across Enfield which has led to identification of EOL Clinical Champions for Enfield comprising of 3 GPs and 1 practice nurse with an interest in EOL who will act as informal EOL champions across the 2 localities. They will be actively involved in working with the EOL Macmillan GP in ensuring EOL matters continue to be at the forefront of discussions particularly in older people with dementia, care homes residents, patient's with long term conditions and integrated conditions work-streams.

6. The Palliative Care Support Service is accessible for all patients with a district nurse, enabling the district nurse to have more autonomy and freedom when planning crisis management and end of life care at home. In 2016/17 93% of patients under the care of the Palliative Care Support Service died in their preferred place of death

What's next?

1. 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
2. Contributing to the Enfield Primary Care Single Offer of enhanced services which includes effective coordination of the end of life care needed by people in nursing or their own homes
3. Increasing the CMC interoperability steps with EMIS, Hospice and Hospital IT systems.
4. 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.
5. Work with the NCL Last Phase of Life Work Stream as part of the CHINs to implement the e-SHIFT telehealth model to expand existing capability of the specialist clinicians, via tablet/smartphone with a technician remotely guided by a specialist.

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.

Enfield has contributed to NCL-wide falls stocktake and the mapping exercise where Public Health worked in partnership with providers and commissioners. In May, 2017, a workshop was held between the three boroughs (Haringey, Islington and Camden where Enfield and Barnet where also in attendance) and identified key areas of priorities to improve falls in these boroughs as well as shared across NCL. NCL identified six areas of priority to be collaborated across NCL. These are :

- Develop falls care pathway
- Ensure falls provisions in the borough is aligned to NICE guideline
- Ensure the appropriate voluntary sector, housing, and emergency services' contribution to falls prevention
- Ensure standardised multifactorial falls risk assessment tool
- Explore how the e-Frailty Index can contribute to multi-factorial falls risk assessment
- Ensure all older people in contact with services are asked about falling or fear of falling

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.

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.
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.

- 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 providing 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>

  - Support the Local Government Declaration on the reduction of sugar and healthier food