MUNICIPAL YEAR 2017/18

Meeting Title: **HEALTH AND WELLBEING BOARD** Date: 5th December 2017	**Agenda Item:** **Subject: Progress on Health and Wellbeing Board Monitoring areas for 2017-19**
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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 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 ensuring attendance and participation in the programme, 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.

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<Healthy Weight>

- To support the following actions:
  - Each organisation implementing the Healthy Catering Commitment within their organisation
  - Each organisation signing up to the Sugar Free Declaration
  - To explore opportunities for more water fountains to be made available across the borough

3. BACKGROUND

3.1 At Health and Wellbeing Board meeting held on the 19th April 2017, 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
- Healthy Weight
- 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 (now addressed as part of the Best Start in Life programme)
- 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.

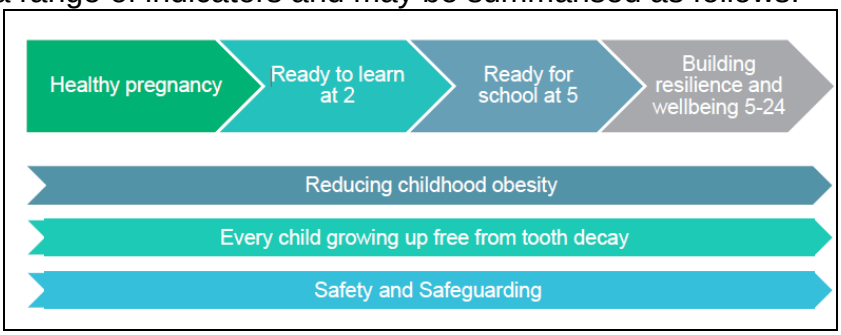
4.4 For the latest statistics of selected indicators, please see https://new.enfield.gov.uk/healthandwellbeing/jhws/measuring-our-progress/

Top 3 priorities

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 and may be summarised as follows.



Below are listed 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 (83.4% of mothers breastfeed their baby within 48 hours of delivery) [2016/17 data]. This is better than England (74.5%) but there is currently no data for the number of 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 (25.1%) of 4/5 year olds; and in Year 6 two fifths (40.7%) of 10/11 year olds are overweight or obese [2016/17 data].

- **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).

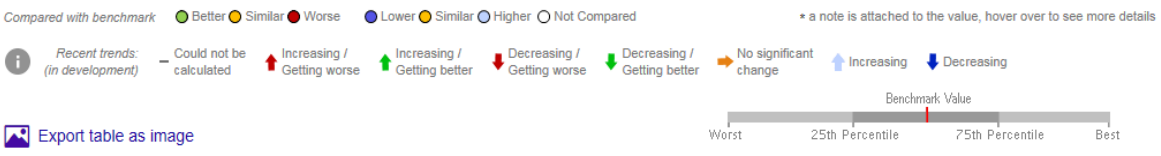
- **School readiness**

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:



Export table as image

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 (current method)	2016/17	↑	291	7.0%*	4.9%	10.7%	28.1%		2.3%
Low birth weight of term babies	2015	↓	132	2.9%	3.0%	2.8%	4.8%		1.3%
Infant mortality	2014 - 16	–	48	3.2	3.2	3.9	7.9		1.6
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

- 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).
- Joint working between the Health Visiting Service and Children's Centres around co-delivery of sessions.
- The Best Start in Life sub group met for the first time on the 1st November. A presentation was given that detailed Enfield's performance across a range of areas and it was agreed that the group would focus on Dental Health, Childhood Obesity and Emotional Well-Being. These areas have been identified as key areas that require development for children and young people in Enfield, and the group felt they would be able to make an impact in improving them.
- The Best Start in Life Group will meet a number of times in December and January in preparation for the Health and Well Being Board Development Session on the 16th January 2018.

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 BSIL 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 could maintain 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 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.

Focus area	Mental Health Resilience – Emotional and Mental Health Resilience and wellbeing
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 a vehicle for adding value to ongoing mental health resilience work in Enfield.

Things that are going well

- Our current partnership activity with Thrive LDN to improve Mental Health Resilience in Enfield was presented and discussed at HWB development session on the 21st November 2017.

What's next?

- The HWB has committed to;
  - Continue to support ongoing partnership with Thrive LDN in this area.
  - Investigate and obtain clarification of Thrive LDN's "Hub Offer" to Enfield and to report on this as appropriate

Challenges that HWB may be able to assist resolving / unblocking

- Continue to support ongoing partnership with Thrive LDN in this area.
- Investigate and obtain clarification of Thrive LDN's "Hub Offer" to Enfield and to report on this as appropriate

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?

- **1087** Reception Year pupils were classed as having excess weight in 2016/17. This means that one in four Reception Year pupils in Enfield were overweight or obese (25.05%). This was significantly higher compared to London (22.3%) and England (22.6%).
- For Year 6 (10-11 years) rate of excess weight increased to **more than two in five** (40.7%) pupils in Enfield. This is the 9th highest in London and the highest in NCL.
- Around **two thirds of adults** in Enfield **(63.5%)** are **overweight or obese.** This is **the 3rd highest** in London and the highest in NCL**.**

Things that are going well

- Enfield's approach to Healthy Weight was discussed at the Health and Wellbeing Board Development Session on the 21st November 2017.

What's next?

- HWB has committed to;
  - Each organisation implementing the Healthy Catering Commitment within their organisation
  - Each organisation signing up to the Sugar Free Declaration
  - To explore opportunities for more water fountains to be made available across the borough

Challenges that HWB may be able to assist resolving / unblocking

To support and action below;

- Each organisation implementing the Healthy Catering Commitment within their organisation
- Each organisation signing up to the Sugar Free Declaration
- To explore opportunities for more water fountains to be made available across the borough

Healthy Enfield
move more eat well drink less stop smoking

ENFIELD Council

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.

Update:

- Recorded Domestic Abuse Incidents have increased by 15 incidents in the 12 months to 30th September 2017 (+0.3%, London: -4.3%).
- In the same period, Violence with Injury offences which were DV related have decreased by 114 offences (-11.9%, London: -1.4%)
- However, Sexual Offences have increased by 29 (+5.2%, London: +8.4%) and Rape Offences by 15 (+7.1%, London: +16.6%)

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)
- The VAWG Strategy will be accompanied by an annual action plan which is being finalised with multi-agency contributions to partnership work
- Re-accreditation awarded to London Borough of Enfield by White Ribbon Campaign UK
- Development of an LBE Domestic Violence and Workplace Response Policy for employees
- Enfield Council – He doesn't love you if…domestic abuse campaign – national public sector communications excellence awards – bronze winner
- Continuing awareness-raising and targeted digital marketing with the 'Boyfriend Material?' campaign

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 from the HWB development session which includes an audit of how Enfield is meeting NICE guidelines on domestic abuse
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

Challenges that HWB may be able to assist resolving / unblocking
Continue to support embedding work to tackle domestic abuse across the partnership.

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%).

Things that are going well

- The local cancer action group meets regularly to help improve patient journey through screening, referral, treatment and care post-discharge from hospital.
- The group recently discussed the North Middlesex Hospital response to improve the outcomes of the National Patient Experience survey through the development of local Trust Action plan.
- Partners in Enfield work with NCL cancer screening assurance group to improve screening across the STP footprint.
- Screening coverage for breast cancer and cervical cancer in Enfield is above the national average.

What's next?

- Although Cervical screening uptake in Enfield is above national average, it is still not reaching the national target of 80%. Enfield Cancer working group is preparing resources for cervical cancer awareness campaign to take place in January 2018.
- The primary care team is working with local provider to ensure that there is sufficient capacity within local GP provider clinics to ensure increase in demand for screening is met.
- Clinical pathways were reviewed to ensure timely cancer referrals from GPs because evidence suggests that GPs' gut feeling about cancer is highly accurate (Hjertholm et al 2014).
- The North Middlesex NHS Trust will report to cancer action group the progress on implementing the action plan at the later date.

Challenges that HWB may be able to assist resolving / unblocking

- Support the local cancer awareness campaign in January 2018.

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.

Staffs at Care and residential homes
In addition to the residents of care and residential homes, NHS England London team has commissioned community pharmacies to provide free flu vaccination for all staffs at residential and care home. 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 within their organisations, especially amongst health and care workers and vulnerable people.

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 (over (£700,000 DoH funding secured to enable individual purchase of homes via shared ownership)
- Supply capacity building in respect of Learning Disability Services, to include new build developments for adults with complex and challenging behaviours and low level move on needs
- Consideration of current housing pathways, including panels and quotas in respect of adults with support and care needs
- Further work to develop wheelchair accessible supported housing accommodation and respite services for adults with learning disabilities – considering incorporation within new build development recently approved by the planning authority
- Research and local consideration of Care Village models including visits to Bowthorpe Care Village and Whitley Village to better understand model and potential benefits.

What's next?

- The further development of move on accommodation for adults with mental health support needs who are eligible for ASC services
- 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?

The NHS DPP was announced in the Five Year Forward View, published in October 2014, which set out the ambition to become the first country to implement at scale a nation evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new NHS Health Check.

The NHS DPP is a joint initiative led by NHS England, Public Health England and Diabetes UK. The programme aims to deliver services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them behavioural intervention that is designed to lower their risk of onset of Type 2 diabetes.

As part of the national rollout programme, Enfield CCG and Enfield's Public Health Team, in partnship with Barnet CCG & PH received approval to mobilise this service as part of wave 2 phased release. The programme is set to deliver 6800 places over a 24-months period (2700 in 2017/18 & 4100 during 2018/19). Within Enfield, 3 site locations have been identified and acquired:

- Evergreen Primary Care Center (N9 0TW)
- Ordnance Road Unity Centre (EN3 6ND)
- Carlton House Surgery (EN1 3LL)

Between May and September 2017/18, 1442 patients have been referred to the service, of those, 386 patients have been seen for an initial assessment and 8 Groups have been established. Patients are expected to engage with the programme over a 9-month period so the first groups will conclude during May 2018.

Due to the popularity of the programme, our NDPP provider will be increasing capacity during this quarter, to manage the increased demand.

Things that are going well

- Referral rates continue to be high.

What's next?

- The NDPP provider will increase the number of groups held on weekends to improve access to these services outside of core working hours.
- The NDPP provider will start deploying Turkish speaking groups from February 2018
- The partnership to identify a suitable site location within the South West Locality (Winchmore Hill, Southgate and Palmers Green wards).

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.
- The diabetes three treatment target (3TT) to improve the quality of clinical care of diabetes patients (through cholesterol, blood pressure and glucose control) has been awarded to Enfield and will be deliver via GP providers in Enfield. To support the safe and effective delivery, training needs were analysed and information sharing agreement was being put in place to enable the CCG to extract the data related to implementation of the award.
- Works to develop Care Closer to Home Integrated Network (CHIN) is progressing. A CHIN Board is formed with local partners to oversee the integrated care for patients with long-term conditions and other complex needs in Enfield. The GP Federation is in place and the 4 Locality leads within the CHIN are identified
- Enfield CCG's approach to CHINs & QISTs consists of three inter-related strands:
  - Developing Primary Care,
  - Transforming Community Services and
  - New Models of Care for Supporting Patients with Long Term Conditions.

What's next?

- The CHINs delivery group held a CHINs workshop on the 18th of October. The aim of the workshop was to develop key priorities and outcomes to be delivered in each CHIN. Feedback from the workshop will inform discussions at the next meeting which is on the 29th of November
- The Care Home Assessment Team (CHAT) was extended to include an Old Age Consultant Psychiatrist and the Mental Health Occupational Therapist as part of the CHAT Multi-disciplinary team. The additional capacity aim to work towards reducing emergency admissions and A&E attendances as well as reducing unnecessary antipsychotic drug use in Dementia patients and optimising treatment for patients with challenging behaviour
- Primary care programme to improve the care of prostate cancer survivors
- Quality Improvement Support Teams (QISTs) and Care Closer to Home Integrated Care developments to continue
- 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 Care Home Assessment Team proactively support residents in care homes to have comfortable and dignified deaths in their preferred place
Established End of Life Primary Care Champions
Utilising 'You Matter' Milestones Clinical Education material by UCL Partners

Increased engagement with GPs and Marie Curie. Better clarity in referral processes from GP to North London Hospice
Increased EOL profile and education across CCG has reflected a significant increase in the use of Coordinate My Care (CMC) across Enfield.

- Collaborative working with Hospice, community care homes and CHAT to promote GSF training and Sage & Thyme educational sessions

What's next?

- 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
- 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.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.
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.

- NCL-wide falls work is progressing. An extensive mapping exercise of current falls pathways was conducted across the NCL.

- 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.

- Public Health and Adult Social Care team are working together closely to find ways to reduce demand on adult social care in short- and medium term.

- Enfield CCG and NHS England jointly commissions Locally Commissioned Service on Atrial Fibrillation (AF) in Enfield to prevent stroke and vascular dementia. This is a scheme designed with local GPs and Public Health. AF is a form of irregular heart rhythm and without treatment 5% of whom develops forms of stroke every year. Encouraging results are emerging:

    - 9292 pulse checks provided by local GPs;
    - 520 new AF cases identified over the duration of the LCS
    - 1953 with known AF were recalled for blood test and reviews to optimise treatment

- 189 face-to-face consultation provided to ensure patients are referred to anti-coagulation

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.
- Four out of the six Preventative Outcome Contracts will be mobilised on 1st December 2017 those contracts include: -
  - Outcome 1- Helping people to continue caring
  - Outcome 2- Supporting vulnerable adults to remain living healthily and independently in the community including avoiding crises
  - Outcome 4 Helping vulnerable adults to have a voice (advocacy)
  - Outcome 5 Making sure people are helped to recover after illness, including safe and appropriate discharge from hospital for people not eligible for social care support
- It is expected that the two other Outcome Contracts associated with Prevention commissioning will be mobilised in early January 2018. Those contracts include:
  - Outcome 3 Supporting people to improve their health & wellbeing/improving self-management of health conditions
  - Outcome 6 Increased and Improved Information Provision
- NCL wide falls prevention training is currently scoped out.
- Stroke prevention by optimal AF management will continue as a part of primary care commissioning.

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.

5.2 The Board is asked to discuss how it wishes to support the HWB priority areas, as highlighted below;

<Best Start in Life>

- 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 ensuring attendance and participation in the programme, 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>

- To support the following actions:
  - Each organisation implementing the Healthy Catering Commitment within their organisation
  - Each organisation signing up to the Sugar Free Declaration
  - To explore opportunities for more water fountains to be made available across the borough