MUNICIPAL YEAR 2018/19

Meeting Title: **HEALTH AND WELLBEING BOARD** Date: 26th July 2018	**Agenda Item:** **Subject: Progress on Health and Wellbeing Board Monitoring areas for 2017-19 and Annual Review of key indicators**
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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.

The report also provides the summary of annual review of selected indicators.

2. RECOMMENDATIONS

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

- Continue to support ongoing partnership with Thrive LDN in this area.
- Be aware of relevance of emotional health and wellbeing resilience to other HWB priorities – such as best start in life.
- Be aware of the work towards the future deployment of MECC within the borough.
- HWB member organisations to sign up to Sugar Smart Enfield
- Development of a Healthy Weight Care Pathway

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, following the review of selected indicators.

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 section 5 of this report highlights the key successes and challenges in the last three months in the HWB priority areas.

4.4 Outcomes measures that reflect the progress against the Enfield JHWS are presented in Appendix A. This is the same set of indicators which was reviewed in 2017 when the Board discussed the priorities for 2017-19. This is also available online at:
https://new.enfield.gov.uk/healthandwellbeing/jhws/measuring-our-progress/

4.5 To interpret the information, it is important to look at where Enfield sits compared to the national picture as well as whether we are improving or not. Where appropriate, statistical test was applied to assess the direction of travel more accurately. It is also important to consider the size of population in Enfield who may be affected by this issue and the impact on health inequalities.

4.6 Areas where outcomes show improvement are:

Ensuring the best start in life

- School readiness (reception year)
- 16-18 years not in education, employment or training (NEETs)
- Teenage conception
- Chlamydia detection rate

Enabling people to be safe, independent and well and delivering high quality health and care services

- Successful completion of drug treatment – non-opiate users
- Childhood immunisation (MMR)

Creating stronger, healthier communities

- Adults in employment
- Fuel poverty

4.4 Those areas where either outcomes are worsening or significantly worse than the national position / target which may need particular attention. These are:

Ensuring the best start in life

- School readiness (reception year)
- Breastfeeding initiation
- Smoking at time of delivery
- Hospital admissions caused by unintentional and deliberate injuries in children
- Children's oral health (dental decay)
- Chlamydia detection rate

Enabling people to be safe, independent and well and delivering high quality health and care services

- Diabetes prevalence
- Cancer screening coverage
- Childhood immunisation (MMR) uptake
- Flu vaccination uptake (65+)
- HIV late diagnosis
- Learning Disability Health Check

Creating stronger, healthier communities

- Violent Crime
- First-time offenders
- Statutory homelessness – households in temporary accommodation

Promoting healthy lifestyles and making healthy choices

- Overweight and obesity
- Inactive adults

5. Progress Report

Top 3 priorities

Focus area	Best Start In Life – School Readiness
Partners	Public Health, Enfield CCG, BEHMHT, CAMHS, Children's Services, Education, PVI and Tottenham Hotspur

What's our current performance?

- We have developed a more detailed and comprehensive action plan at the request of the HWB and this has been submitted for HWB perusal and is an agenda item at the next HWB meeting.
- The delivery of a number of Best Start in Life work streams has already been initiated, and details are provided in the action plan noted above.
- We are working very closely with our partners across the council and elsewhere to progress other parts of the action plan
- This is activity clearly is very closely aligned with our other priorities of tacking obesity and enhancing emotional health and wellbeing.

Things that are going well

- Please refer to Action Plan and associated reports. Progress has been quite substantial.

What's next?

- We will continue to progress the Best Start in Life Action Plan.

Challenges that HWB may be able to assist resolving / unblocking

- Continue to support ongoing activity.

Focus area	Mental Health Resilience – Emotional and Mental Health Resilience and Wellbeing
Partners	Public Health, Enfield CCG, BEHMHT, NCL PH Departments. London Health Board, Thrive LDN, Time to Change, Enfield CEPN, Public Health England, Public Health Academy, London South Bank University.

What's our current performance?

- We continue to work with Thrive LDN as a vehicle for adding value to ongoing mental health resilience work in Enfield.
- Thrive LDN have undergone some internal changes, and have appointed new contact officers recently.
- LBE, Thrive LDN and "Time for Change" continue to work towards the establishment of a de stigmatisation "Hub" in Enfield
- LBE's Public Health officers are working with our NCL neighbours and more formally with Public Health England, The Public Health Academy and London South Bank University on preparatory work towards deploying Making Every Contact Count [MECC] and Mental Health First Aid within the borough.
- Any MECC activity will be within the context of our Health in All Polices [HiAP] activity and strategy.
- We are continuing to develop a Suicide Prevention Strategy for the borough.

Things that are going well

- LBE Public Health continue to work with Thrive LDN, "Time to Change" and other partners to plan and deliver a "Destigmatisation Hub" within the borough.
- This aligns with the extensive activities, agenda and priorities of the "Best Start in Life programme, as discussed in previous HWB meetings and today.
- There are a number of emotional health and wellbeing work streams active within the "Best Start in Life" programme [which may be discussed elsewhere]
- In addition LBE Public Health Officers have been working with Public Health England, The Public Health Academy and The London South Bank University to develop commissioning and evaluation tools around future MECC activities.

- As has been noted to the HWB previously Enfield has the lowest suicide rate in the country - http://healthierlives.phe.org.uk/topic/suicide-prevention

What's next?

- Thrive LDN are now working with "Time to Change" in a formal partnership
- Enfield local user group representatives [led by EMU] have started to develop programme for next 18 months activities. LBE role as "host" becoming correctly and clearly defined as secondary but supportive.
- LBE Public Health officers continue to work with our NCL neighbours about the potential for adopting an on-line MECC presence level prior to commissioning additional live MECC or MHFA activities.
- As noted LBE Public Health Officers have been working with Public Health England, The Public Health Academy and The London South Bank University to develop commissioning and evaluation tools to ensure that prior to commissioning and/or development of additional MECC or MHFA activities a robust outcome and performance measurement frame work is in place.
- Potential future MECC activity within LBE is being examined as an integral part of our Health in All Polices approach. MECC may be considered as the expression of the HiAP approach at the point of interaction between LBE staff and the citizens they serve.

Challenges that HWB may be able to assist resolving / unblocking

- Continue to support ongoing partnership with Thrive LDN in this area.
- Be aware of relevance of emotional health and wellbeing resilience to other HWB priorities and work going on within those areas – such as best start in life.
- Be aware of our work towards the future deployment of MECC within the borough and as supportive as possible.

Focus area	Healthy Weight
Partners	Enfield Voluntary Action, CCG, NHS 0-19 + Dietetics LBE- Planning, Sustainable Transport, Road Safety, Enfield Catering Services, School PE, Healthy Schools, Corporate Communications, Environmental Health, VCS, Active Enfield,
What's our current performance?	
The 3 year data shows that the average prevalence of excess weight in year 6 pupils is 41.5%. This is significantly higher than London (37.9%) and England (33.87%) averages. 251 Year 6 pupils were identified as severely obese in 2016/17, equating to 6.1% of all the children measured.	
47.4% of children in the top 10% most deprived parts of the Borough are overweight or obese, compared to 26.2% of children in the 10% least deprived parts of the Borough. Upper Edmonton (47.1%), Ponders End (46.9%), Enfield Highway (46.4%), Lower Edmonton (46.0%) and Edmonton Green (45.8%) had a significantly higher prevalence of excess weight in pupils compared to the Enfield average (41.5%).	
The prevalence of excess weight by ethnicity is significantly higher in Turkish/Kurdish (51.1%) and African (45.5%) pupils compared to the Enfield average (41.5%).	
Things that are going well	
• Healthy Weight – tackling obesity and its pathway was presented at HWB development session on the 20th March 2018 • A draft Healthy Weight strategy and action plan has been developed and cascaded to members of the Healthy Weight Partnership for the first stage of consultation. • The Declaration on Sugar Reduction and Healthier Food has been signed by the new Leader of the Council and the Cabinet Member for Public Health. • 36 settings have registered to become Sugar Smart, including schools, nurseries, leisure centres and community groups to become Sugar Smart. More events are planned over the coming months to engage others. • Currently 48 businesses are signed up to the Healthier Catering Commitment • The Health Trainer service, Next Steps and Challenge You programmes are running over the summer to support children identified as overweight via NCMP. • Numerous initiatives to support healthy eating and a healthy weight in the early years are progressing including training for early years staff, Baby Friendly Initiative- Commitment Level, and Healthy Start	

What's next?
• Further consultation on the Healthy Weight Strategy and action plan • **School Super Zones:** We've applied to be part of a pilot project with PHE London, which seeks to address public health concerns within 400m of schools e.g. Advertising, Food and drink sales, Gambling, Tobacco, Alcohol, Living streets, Air quality
Challenges that HWB may be able to assist resolving / unblocking
• Development of a Healthy Weight Care Pathway • HWB member organisations to sign up to Sugar Smart Enfield

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 12 incidents in the 12 months to 30th September 2017 (+0.2%, London: -4.3%).
- In the same period, Violence with Injury offences which were DV related have decreased by 111 offences (-11.6%, London: -1.4%)
- However, Sexual Offences have increased by 41 (+7.3%, London: +9.3%) and Rape Offences by 25 (+11.7%, London: +18.1%)

Enfield	Oct 15 to Sept 16	Oct 16 to Sept 17	% Change
Domestic Abuse Incidents	5945	5957	0.2%
Domestic Abuse VWI Offences	957	846	-11.6%
Sexual Offences	558	599	7.3%
Rape	213	238	11.7%

London	Oct 15 to Sept 16	Oct 16 to Sept 17	% Change
Domestic Abuse Incidents	151038	144542	-4.3%
Domestic Abuse VWI Offences	24123	23774	-1.4%
Sexual Offences	17340	18944	9.3%
Rape	6106	7210	18.1%

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

What's our current performance?

- Enfield is the highest performing CCG in NCL for all screening rates
- Performance in the 62-day treatment from urgent GP referral nation standard has improved locally and across NCL in the last few months but is susceptible to fluctuations
- Cancer Patient Experience needs improvement (NCPES 2017)
- Enfield's performance in the CCG Improvement & Assessment Framework (IAF) Cancer section has notably improved in two indicators – Cancers diagnosed at an early stage and the one-year survival rate of all Cancers. Both indicators have been on an upward performance trend over the last two years. Enfield is ranked as 60th out of the 207 CCGs nationally for Cancers diagnosed at an early stage and 45th out of 207 for one-year survival rate of all Cancers (within the best performing quartile in England).

Things that are going well

- Monthly Enfield CCG Cancer Action Group attended by commissioners, providers, public health, and other Cancer stakeholders
- Primary care visits underway (18 and 24th June, 2018) with Macmillan GP Cancer Lead and Cancer Research UK Primary Care engagement facilitator. Visits will focus on quality of 2 week wait referrals, improving screening rates and cancer care reviews.
- Five cancer awareness events are planned for the rest of 2018 – targeting lower uptake areas for cancer screening and to raise awareness of early symptoms.
- There is a national pilot project to invite patients at high risk of cancer to offer them blood test and lung check to determine their future cancer risk. Enfield Cancer Action Group has submitted application so that local GPs can participate in this pilot.

What's next?

- A review of the extended access to cervical screening (local GP hub that started Jan 2018) enhanced the update of screening soon in collaboration with GP federation. The evaluation will help us understand improvement required to have an ongoing cervical cancer screening at these locality hubs.
- Joint CCG/Trust action plan to improve Cancer Patient experience – ongoing
- Implementation of key priority actions(identified by Enfield's Cancer Deep Dive in June 2017). These priorities are aimed at Improving:
- The local NHS acute trust performance across all performance indicators
- Screening uptake,
- Direct access to diagnosis of two weeks referrals,
- Long term management of prostate patients discharged into GP,
- Patients experience in receiving care.
- Quality of life for those living with and beyond cancer
- Access for GP and practice nurses

• Multidisciplinary team working between GP, community service and acute specialist
Challenges that HWB may be able to assist resolving / unblocking
• Support future cancer awareness campaigns • To facilitate or encourage earlier launch of bowel scope for Enfield residents

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?

No new data were received.

Flu vaccination by Health care providers in 2016/17 compared to 2017/18
Table-1 Flu vaccination by providers

Providers list	Vaccine Uptake %	
	2016/17	2017/18 (This year)
London region	55.4%	63.7%
BEH	43.0%	48.7%
North Middlesex	48.3%	72.5%
Royal Free	60.7%	71.8%

As shown in table-1 above, the flu vaccination for health care workers across all the providers has improved substantially from 2016/17.

Table-2 Flu vaccination by health care professional groups

Providers list	Doctors	Qualified nurses (including GP Practice Nurses)
BEH	39.1%	42.8%
North Middlesex	79.4%	53.9%
Royal Free	53.4%	61.0%

It is encouraging to see there a good flu vaccination uptake by frontline health care workers. The differences in the figures between different professional groups could be some health care professionals may work on different sites and may have had vaccine other than their work site in which case the record may not be included.

Things that are going well

The seasonal flu vaccination performance has improved in 2017/18 across all NHS providers who have been and will be providing care for Enfield residents.

Further update will be provided when the seasonal flu vaccination is published.

What's next?

- Support the flu vaccination campaign for the coming flu season beginning Sept 2018 including flu vaccination for children

Challenges that HWB may be able to assist resolving / unblocking

- Support future flu vaccination uptake and campaigns

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

The Council has been active in providing consultation feedback on the impact of proposals to cap rental benefits in the supported housing sector.

Innovative projects are ongoing to meet the housing needs of service users with very specific accommodation requirements. 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.
- Initial communications with stakeholders in respect of Care Village model – work continues to better understand local need/aspiration including qualitative data collection.

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, Enfield Council, NHSE, Barnet CCG and Barnet Council

What's our current performance?

- 1,197 Enfield residents who were assessed at high risk of type 2 diabetes were referred to the programme. 435 has completed Initial Assessment appointments.
- Public Health and Enfield CCG commissioners will continue to promote NDPP at GP locality meetings and, GP Protected Learning Time to improve the quality of referral to the programme, to reduce variation across Enfield and to use the programme effectively through pre-diabetes LCS and brief intervention.
- Enfield CCG will fund a coordinator post to work with the provider to ensure equitable referrals and high-quality referrals.
- Enfield will need to expand the service sites to accommodate the number of patients undergoing initial assessment and group sessions.

Things that are going well

- Enfield Public Health and CCG commissioners are galvanizing the support of the local GPs to the programme.
- Working very closely with national diabetes prevention programme commissioner (NHSE), local provider (ICS) and Enfield CCG to work on many strands of work to improve quality of referral and equity of referrals, and retention of those who are referred to NDDP in the programme until completion.
- There was a case study in NCL where a patient avoids bariatric surgery.

What's next?

- Continue engaging with local GPs to improve quality of referrals and to reduce variation.
- Ensure previously commissioned diabetes prevention locally commissioned programmes are aligned with diabetes prevention programme to improve quality of referral and reduce waiting time.
- Ensure patients referred to the programme are highly motivated and consent to attend the programme before their names were sent to national diabetes prevention programme provider in Enfield (ICS).
- Ensure equity of referral from all GP into diabetes prevention programme specially from areas most affected by diabetes
- Work on public awareness campaign with community leaders in areas of high diabetes prevalence.
- Enfield to actively participate in re-procurement of the service at STP level so that Enfield residents gain benefits as well as other boroughs in the STP

Challenges that HWB may be able to assist resolving / unblocking

Enfield CCG, LBE (public health) and voluntary sector work together to encourage and facilitate the provider to offer more accessible places locally for initial assessment and group intervention sessions.

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 Care Closer-to-Home Integrated Care Networks (CHINs) continue to deliver care in their virtual form while plans are being developed for co-location.
- 3 extended access hubs open with blended offer of pre-bookable and walk-in appointments:
    - Carlton House:18.30.-20.00 Monday to Friday; 08.00 – 20.00 Saturdays, Sundays and Bank Holidays
    - Evergreen: 18.30.-20.00 Monday to Friday; 08.00 – 20.00 Saturdays, Sunday and Bank Holidays
    - Woodberry: 18.30.-20.00 Monday to Friday; 08.00 – 20.00 Saturdays and Bank Holidays; with additional walk in services provided from Eagle House Saturday, Sunday and Bank Holidays.
    - Services have now seen 61,000 patient's utilisations of the above three hubs that stands at 85% the best in NCL.

Things that are going well

- Work to develop Care Closer to Home Integrated Network (CHIN) continues. The CHIN project board, chaired by Dr Johan Byran continues to meet.
- Each of the 4 local CHINs has agreed overarching priorities (frailty for the two in the West, respiratory for the NE and diabetes for the SE) with the aim of sharing learning across the four.
- Engagement with the GP Federation continues.
- The Enfield system (primary & secondary care, ECCG/LBE/NMUH reps) have participated in 4 Placed-Based Care Network Programme workshops, alongside other NCL and NEL STP systems. This has helped underpin work on the local CHIN development.
- Recruitment to a Locality Development manager was successful. The worker should start in May and will assist LBE and Enfield Health to develop its approach to locality development.
- Mapping of staffing requirements and use of Public Health data has concluded

What's next?

- Work continues on the development of the priority areas for CHINs.
- North Central London Partners in Health and Care (NCL STP) are reviewing

long-term conditions management in primary care in all boroughs to ensure high standards across the STP footprint for the residents of NCL. Nonetheless a balance is to be struck between
Challenges that HWB may be able to assist resolving / unblocking
• Support the CHIN development programmes and priorities.

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

<u>Falls Prevention</u>

- Enfield Public Health has co-designed with existing local services and commissioner to a falls prevention training aiming at health and social care frontline staff such as domiciliary carers (target for the pilot – 100). In the three sessions (in April, May, June) 78 participants have completed the training programme. Of the 78 participants:
  - 54 were from domiciliary, nursing, and care homes
  - 5 from adult social care, and
  - 5 from district nursing.
- 14 Voluntary Sector
- The falls prevention training is highly subscribed and 22 delegates have booked for July and 16 for Sept 2018.

<u>The VCS prevention contracts</u>

- The VCS Prevention contracts for the following consortiums commenced on the 12th December 2017

  Outcome 1 - Helping People Continue Caring;
  Lead partner: Enfield Carers Centre

  Outcome 2 - Supporting vulnerable adults to remain living healthily and independently in the community including avoiding crises;
  Lead partner: Age UK Enfield

  Outcome 4 - Helping Vulnerable Adults to have a voice
  Lead partner: Enfield Disability Action (EDA)

  Outcome 5 - People recover from illness, safe and appropriate discharge from hospital.

Lead partner: GGCCE

Reducing hospital and residential care admissions through effective early intervention

- A meeting was held between representatives from adult social care, public health and Enfield CCG to conduct an analysis on hospital and residential care admissions through hospital admissions, with an aim to find effective early intervention specific to Enfield. A methodology paper on the analysis on hospital and residential care admissions through hospital admissions is being drafted.

What's next?

<VCS prevention contracts>

There has been a minor delay in terms of the development of the VCS steering Group. It is expected that this will happen prior to the end of the next reporting round. Performance is being measures against outcomes and KPis monitored against stated achievement.

We are progressing a new round of grant funding for small VCS communities of the borough. The fund is specifically aligned to health and well-being outcomes and application to the fund is expected to be invited in August 2018. The fund is aimed at supporting people to be independent and live healthy lives which will include social and leisure activities

- We will be looking to develop a VCS Steering Group by the end of May 2018, allowing lead partners a forum to exchange updates, ideas and build strong relationships and networks. The development of processes, pathways and data/performance measures against outcomes will be also be progressed and monitored. It is expected that the result of the first monitoring report will be produced by the end June 2018

Public health are approaching integrated care commissioners to explore opportunity to incorporate falls training into existing work.

Challenges that HWB may be able to assist resolving / unblocking

To support the above activities.