Proposal for a new Enfield Joint Health and Wellbeing Strategy 2019 - 2022

Update report for Health and Wellbeing Board

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For Board meeting: 6th December 2018

Introduction

This paper sets out a proposal for a new Joint Health and Wellbeing Strategy 2019 - 2022 which will tackle health inequality through a preventative approach which is clear, simple and evidence-based. The proposed new strategy will be centred on behaviour change, with a focus on tackling inequality in the opportunities people in Enfield have to make choices which have a positive impact on their health.

The proposal set out in this report was discussed and agreed at the Health and Wellbeing Board on 27th September 2018.[1] The Board agreed for the Council's coordinating officers to develop a public consultation based on the proposal, for the Board to agree prior to the consultation launch. The draft survey questions are attached as an appendix.

Context

Local authorities and clinical commissioning groups (CCGs) have equal and joint duties under the Health and Social Care Act 2012 to prepare a Health and Wellbeing Strategy, through their Health and Wellbeing Board. The purpose is to set out how the local system will work together to improve the health and wellbeing of the local community and reduce health inequalities for all ages. All organisations represented on the Board are responsible for the development, finalisation and delivery of the strategy. Our Health Improvement Partnership (HiP), a sub-group of the Board, will be responsible for the operational delivery of the strategy, and will report back to the Board on progress.

The new strategy will help the council deliver its corporate plan, and the CCG to deliver its commissioning priorities, while facilitating all members of the Board to work collectively to tackle the borough's health and wellbeing challenges.

Our proposed vision: Make the healthy choice the first choice for everyone in Enfield

To make change happen, we need to make healthy behaviours easier than unhealthy behaviours. To do this, we need to be ambitious about making policy change collectively, as a partnership – making physical and emotional health and wellbeing everyone's business. Importantly, we need to think about the opportunities to do this with our most deprived communities, including groups who currently experience far worse health outcomes than others. Currently income, ethnicity, gender, having a disability or where someone lives are

[1] The report presented to the Health and Wellbeing Board on 27th September is available here and minutes from the meeting are available here

hugely significant in determining health outcomes. Our strategy will be ambitious about working together, with our communities, to find ways to shift this.

We propose to do this with three focused priorities, to help people in the borough to:

 **Be active**  **Eat healthily**  **Be smoke free**

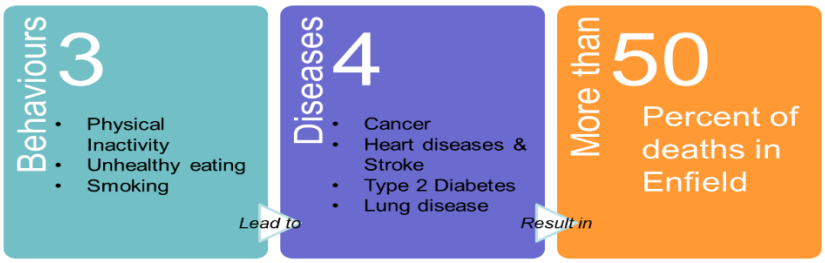
In doing this, we are committing to take a whole-system approach to facilitate healthy behaviours which will:

- reduce the chances of people developing cancer, heart disease, Type 2 Diabetes or lung disease
- improve emotional health and wellbeing
- tackle inequality in health outcomes.

Our Framework: 3, 4, 50

A strategy centred on behaviour change, which focuses on a small number of behaviours which we know have the biggest impact on health outcomes, will help us to tackle inequality in the opportunities people in Enfield have to make choices which have a positive impact on their health.

There is international, national and Enfield-specific data which shows that the three behaviours of **physical inactivity**, **unhealthy eating** and **smoking** can lead to four chronic conditions of **cancer, diabetes, heart disease and lung disease**, and that these diseases are responsible **for 50 percent of deaths**. In Enfield, cancer, heart disease and lung disease account for 73% of all deaths and 66.3% of deaths under 65 years of age.[2] A large proportion of these diseases are preventable.



This is known as the 3-4-50 framework. Using this as a basis for our joint strategy gives us the opportunity to bring about large-scale behaviour change at a population level, tackle health inequality and improve associated health outcomes, including emotional health and wellbeing.

While the framework clearly helps us to prevent physical health problems, it also helps us to improve **mental health and wellbeing**. There are clear links between mental and physical health. Enduring long-term physical health challenges has an associated adverse impact

[2] Data from 2016, JSNA

upon mental health and wellbeing,[3] and around 30 percent of all people with a long-term physical health condition also have a mental health problem.[4] Reducing the prevalence of long-term physical health can therefore be expected to remove some of the risk factors associated with mental ill-health. Correspondingly, mental health problems can seriously exacerbate physical illness, affecting outcomes and the cost of treatment. The exacerbating effect of poor mental health on physical illnesses is estimated to cost the NHS at least £8 billion a year.[5] There is also evidence that physical activity and a healthy diet can also positively impact on good mental health and wellbeing.[6]

The framework also allows us to focus activity on **tackling poverty and inequality**. We know that being part of a certain population group, such as having a low income, a disability or depression, is linked to unhealthy behaviours and therefore the increased likelihood of developing chronic diseases or having mental ill-health.

Why 3-4-50 for Enfield?

416 new diagnosis of cancer (2014/15)

684 hospital admissions for heart disease every 100,000 (2016/17)

7.7% of population have type 2 diabetes, with potentially another 4,800 people undiagnosed (2016/17)

1.6% of population have COPD (chronic obstructive pulmonary disease)

4.6% have asthma (2016/17)

15.6% of population aged 16 to 74 years have a common mental health disorder (2011)

6.1% of population aged 5 to 16 years have a mental health disorder (2014)

[3] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

[4] 1.Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012). Research paper. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study The Lancet online

[5] Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A (2012). Report. Long-term conditions and mental health. The cost of co- morbidities*The King's Fund and Centre for Mental Health*

[6] https://www.mentalhealth.org.uk/a-to-z/d/diet-and-mental-health and https://www.mentalhealth.org.uk/publications/how-to-using-exercise

How will this framework help us to tackle obesity?

One of the reasons why physical inactivity and an unhealthy diet can lead to the chronic diseases discussed above, is because people become overweight or obese. Obesity also has a negative impact on mental health, quality of life, and has significant cost implications for social care as well as for health services.[7] This is a significant issue in Enfield, with almost half of 10 to 11 year olds; and over half of all adults being overweight or obese. By focusing our joint strategy on the behaviours that can help people maintain a healthy weight, we are aiming to take a whole systems approach to tackling obesity in Enfield.

How will this framework help us to improve emotional health and wellbeing?

The Health and Wellbeing Board is committed to ensuring that mental health is everyone's business and to putting in place a whole system response to the problems we face. This is not a simple argument for "parity of esteem" for emotional and mental health challenges, but a robust, confident change in attitude across the partnership to recognise that our physical and emotional health are intimately linked and attempts to address any challenge in isolation will not succeed.

The cost of not doing this, both in human and fiscal terms is self-evident.

- The estimated annual cost of common mental disorders in Enfield £98.1m.
- Depression presents an annual cost of £44.8m; and psychosis £69.4m in Enfield
- It has been estimated that the costs of poor mental health to Enfield employers is £142m per annum.[8]

Relatively simple physical or environmental interventions or changes can engineer significant improvements in emotional health and wellbeing. These interventions will be considered in our priority for being active – interpreting this as both physical and mental activity and thinking about the environmental factors which can facilitate healthy activity. This could include creating 'greenways', maintaining our already impressive parks, and encouraging simple exercise to be part of our activities of daily living. Adults undertaking daily physical activity can experience a 20-30% risk reduction of depression, distress and dementia.[9]

How will this framework help us tackle poverty and inequality?

Average life expectancy at birth in Enfield is significantly better than England averages, but there is still wide variation within the borough. There is an 8.5 years difference between the female life expectancy in the highest (Highland, 87.2 years) and lowest (Upper Edmonton, 78.7 years) wards. There is also variation in the number of years lived in 'good health.' On average, over 15 years are currently lived in 'poor health' in Enfield. In Edmonton Green, the average number of years that a female is expected to live in poor health is 28 years.

We need to think about how we improve healthy life expectancy through supporting positive health behaviours amongst those who currently have the lowest life expectancy. The three behaviours of being inactive, eating a poor diet and smoking are more likely for those living on low incomes, or those already managing another health challenge. By focusing on

[7] Making obesity everybody's business: A whole systems approach to obesity, LGA November 2017

[8] Enfield Psychiatric Needs Assessment 2016

[9] https://www.mentalhealth.org.uk/sites/default/files/lets-get-physical-report.pdf

changing the three behaviours, we will therefore be working to tackle inequality in outcome and the effects of poverty on people in the borough.

Our strategy will need to consider what our local data tells us about the three behaviours in Enfield, and to identify strategic goals for bringing about large-scale behaviour change, with a particular focus on disadvantaged communities. Making the healthy choice the first choice for everyone in Enfield.

Priority 1: Being active

What do we know about this behaviour in Enfield?

Physical inactivity is the second main risk factor (after diet) for being overweight or obese, as keeping active is the most effective way of burning calories. Physical activity and a healthy diet can also positively impact on good mental health and wellbeing.[10]

The NHS recommends at least 150 minutes of moderate aerobic activity or 75 minutes of vigorous intensity per week. In 2016/17, 27.7% of Enfield adults were found to engage in less than 30 minutes of physical activity a week. A percentage higher than both the national and London averages.[11]

Active travel is a convenient way of performing physical activity as it allows people to incorporate it in their daily routine, as walking or cycling to work would be an easy way to reach the recommended levels of physical activity. According to the Active Lives Survey, in 2014/15 less than 5% of Enfield adults used cycling as a means of transport for utility purposes. This figure is lower than the national, London and North Central London averages. The survey identified Enfield adults as being more likely to use walking as a means of active travel.

What measurable outcomes do we want to improve over the course of the strategy?

- 60.1% of Enfield adults performing 150 minutes or more of physical activity a week (2016/17)
- 27.7% of Enfield adults engaging in less than 30 minutes of physical activity a week. (2016/17)
- Less than 5% of Enfield adults used cycling as a means of transport for utility purposes. (2014/15)
- 63.4% of respondents doing 'any walking' at least once a week (2014/15)
- 33.8% walking as a way of travel at least five times a week. (2014/15)

Strategic priorities to consider

1. As employers, increase active travel to work amongst employees.

2. Increase active travel amongst children and young people travelling to early years settings and schools and promote physical activity throughout the school day through initiatives like The Daily Mile.

[10] https://www.mentalhealth.org.uk/a-to-z/d/diet-and-mental-health and https://www.mentalhealth.org.uk/publications/how-to-using-exercise

[11] JSNA

3. Promote active travel and physical activity through all local planning and policy decisions.

4. Tackle inequality: area-based and community-based initiatives to increase active travel and physical activity in the most deprived wards in Enfield.

Priority 2: Having a healthy diet

What do we know about this behaviour in Enfield?

In 2016 poor diet was the second leading risk factor for mortality worldwide[12]. A nutritionally inadequate and unhealthy diet has been associated with an increase in the risk of CHD, cancer and obesity and diabetes. Fruit and vegetable consumption is inversely associated with the risk of Coronary Heart Disease (CHD), reduced by 4% for each additional piece of fruit eaten per day and 7% for each additional piece of vegetable[13]. Consumption of fruit and vegetables is associated with a diminished risk of stroke, hypertension, cancer, dementia, osteoporosis, asthma, rheumatoid arthritis, coronary heart disease, type 2 diabetes mellitus, and chronic obstructive pulmonary disease (COPD)[14].

A large proportion of adults and 15-year olds in Enfield are not meeting the recommended guideline of 5 portions of fruit or vegetables a day, although for 15 year olds we are performing better than the national and London averages.

Enfield data also indicates significant differences in excess weight between ethnicities in the borough, and between wards. Increasing levels of inequality mean that access to healthy food choices is less available for some parts of the population and they experience food poverty. Additionally, Enfield is considered to have an obesogenic environment where highly calorific food is constantly available and where physical activity is being progressively eliminated from modern life. An obesogenic environment could be one of the factors in poor accessibility to affordable healthy foods and the likelihood of experiencing food poverty.

While anybody could experience food poverty at any point in life, people in low income jobs or on benefits are more likely to suffer from food poverty. In 2017/18, 6,746 people accessed the North Enfield Food Bank. This represents a 12.6% increase compared to the previous year.
Poor accessibility to affordable healthy foods also plays a role in the likelihood of experiencing food poverty. The development of out-of-town supermarkets and the closure of many shops in more deprived areas might lead to increased costs and decreased quality of available foods in the remaining shops. Action in this regard, needs to focus on changing the 'food environment' – that is, accessibility and affordability of healthy food – in which people live.[15]

[12] Global Burden of Disease (GBD) 2016 Risk Factors Collaborators (2017) Global, regional, and national comparative risk assessment of 84 behavioural, environmental and occupational, and metabolic risks or clusters of risks, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016 Lancet 2017; 390:1345-1422.
[13] Dauchet, L. et.al (2006) Fruit and Vegetable Consumption and Risk of Coronary Heart Disease: A Meta-Analysis of Cohort Studies J. Nutr. 136: 2588–2593, 2006.
[14] Boeing, H. et.al (2012) Critical review: vegetables and fruit in the prevention of chronic diseases. European Journal of Nutrition September 2012, Volume 51, Issue 6, pp 637–663
[15] JSNA

What measurable outcomes do we want to improve over the course of the strategy?

- 41.8% of adults in Enfield are not meeting '5 a day' (2017)
- 41.3% of 15-year olds not meeting '5 a day' (2017)
- 226 fast food outlets in Enfield, making our rate 82.0 per 100,000 population
- 24.8% 4 to 5 -year olds; 41.5% 10 to 11 year olds; and 61.4% of adults are overweight or obese in Enfield (2016)
- 30.5% of children with one or more decayed, missing or filled teeth

Strategic priorities to consider

1. Create working environments that support a healthy, balanced diet[16]

2. Create environments in early years settings, schools, health and social care that support a healthy, balanced diet

3. Create healthy neighbourhoods and town centres that support a healthy, balanced diet

4. Tackle inequality: area-based initiatives to increase take up of '5 a day' in the most deprived wards in Enfield.

Priority 3: Being smoke-free

What do we know about this behaviour in Enfield?

Smoking is the leading cause of preventable illness and premature death in England, accounting for 21% of deaths in men and 13% of deaths in women aged over 35 in 2014. It is also the biggest cause of health inequalities accounting for approximately half of the difference in life-expectancy between the richest and poorest groups[17]. In 2014/15 there were approximately 1.7 million hospital admissions by those aged 35+ for smoking related illnesses[18]. It is estimated that smoking cost the NHS £2.6 billion in 2015[19]. HM Treasury estimates that the total cost to the economy in England is £12.9 billion per year[20].

Between 2012 and 2016, smoking prevalence fell in Enfield from 19.3% to 13.1% of the 18+ population, making smoking prevalence in Enfield the 10th lowest rate of the 32 London boroughs. In 2017, it rose slightly to 14.9%. Although smoking prevalence amongst the adult population in Enfield is lower than both the national and England averages, more than 32,000 adults in the borough still smoke. Furthermore, smoking prevalence is much higher amongst some groups, including pregnant women, adults with serious mental illness, and the Turkish community.

[16] With reference to Public Health England and Business in the Community Toolkit for Employers
[17] Office for National Statistics (2016). Health Survey for England 2015. Trend tables commentary.
[18] Action on Smoking and Health (ASH) (2017) The economics of tobacco.
[19] Public Health England (2017) Cost of smoking to the NHS in England: 2015. https://www.gov.uk/government/publications/cost-of-smoking-to-the-nhs-in-england-2015/cost-of-smoking-to-the-nhs-in-england-2015. Site accessed 28th May 2018.
[20] HM Treasury (2014) Tobacco levy consultation.

Concerted efforts are required across the health and care systems and the Council to reduce smoking prevalence further overall, and to reduce prevalence amongst groups where this behaviour is particularly dominant.

The greatest gain to be made in stopping smoking prevalence, is in making sure people do not start in the first place. A national survey carried out in 2014/15 provided local level data that 3.5% of 15-year olds in Enfield were smokers – lower than London and national averages. This positive behaviour amongst young people is something we will want to continue to encourage and facilitate. It is also behaviour which we could explore using to positively influence others.

What measurable outcomes do we want to improve over the course of the strategy?

- 14.9% of Enfield adults smoke (2016)
- 3.5% of 15-year olds in Enfield currently smoke (2014/15)[21]
- 7% Enfield mothers smoke during pregnancy (2016/17)
- 40.7% of adults with serious mental illness in Enfield smoke (2014/15)
- 50% of adults in the Turkish community smoke (and 28% of young people) (2014)
- £60.5M estimated costs of smoking in Enfield

Strategic priorities to consider

1. Enforce current smoke-free environments including around Council buildings and healthcare sites

2. Consider increasing the number of smoke-free community spaces in Enfield.

3. Work in partnerships to de-normalise smoking throughout the borough.

Cross-cutting strategic priorities to facilitate change for all three behaviours

Prevention

A strategy which focuses on changing the negative behaviours of smoking, poor diet and physical inactivity is inherently a strategy focused on **prevention**, which was one of the key themes emerging from the EHWB development session in July. The entire strategy will be geared around preventing the three behaviours which local, national and international research shows are linked to poor health outcomes and earlier death.

The life course

We have the opportunity to prevent and control diseases at key stages of life from preconception through pregnancy, infancy, childhood, adolescents, through to adulthood. The Marmot Review[22], which focused on the importance of the life course, stressed that disadvantage accumulates throughout life, leading to poor outcomes. This cycle can only be broken by taking action to reduce health inequalities before birth and continuing these throughout the life of the child. We will use the focus on the three healthy behaviors of being active, having a healthy diet and being smoke free to consider how these behaviours can be facilitated at each life stage, recognising the importance of the best start in life and the early years.

[21] This data is from a national survey carried out in 2014/15, and we do not know when it might be repeated.
[22] http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

Health in Policies (HiAP)

A health in all policies approach involves all organisations represented on the Health and wellbeing Board considering what influences they can exert on the three behaviours of being active, having a healthy diet and being smoke free in all actions their organisation takes. This will include what happens in their own organisations, what is included in their commissioning intentions and contracts and what leadership they provide to the general public.

Care Closer to Home Integrated Network (CHINs)

A CHIN is a way of working that aims to bring together primary care, local authorities, community services, voluntary and community sector, mental health services, acute and specialist providers and local people to work in partnership to deliver more integrated and holistic care for individuals. It will be more effective and easier to implement if local people are increasingly taking part in their self-care and being proactive in adopting healthy behaviours. According to NHS, 'self-care is about keeping fit and healthy, understanding when you can look after yourself, when a pharmacist can help and when to get advice from your GP or another health professional. If you have a long-term condition, self-care is about understanding that condition and how to live with it'.[23]

Throughout 2017, Healthwatch Enfield got involved in conversations in a workshop about delivering a Care Closer to Home Integrated Network model that could work in the borough. According to all participants of this workshop there is a significant role for people to take responsibility for self-car which in itself promotes the CHIN agenda in the borough. When asked the question about what self-care meant to them, they defined it as a way of living that 'involves individuals looking after themselves; that makes them proactive; taking responsibility and being responsible; that empowers individual to take action; to be clear about their limits and to ask for help'. The results of this consultation should be used to develop an approach to CHINs in Enfield through the Joint Health and Wellbeing Strategy, which, among other outcomes, will help to bring about behaviour change by bringing health professionals into better contact with residents. CHINs make the healthy choice the easy choice, by making it easier to engage with health professionals at an earlier stage.

Communication and empowerment

We need to use every opportunity to provide residents with the knowledge, skills and opportunities to stop smoking (or not start smoking), to eat healthily, be active and maintain a healthy weight. Making the healthy choice may be difficult if people do not feel control over their environment and their personal circumstances. Health professionals can help people to see a connection between their efforts and health outcomes and can improve and facilitate health literacy.[24]

Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. As a partnership, we need to commit to building this approach into all contact we have with residents – be it as a GP, health visitor, school nurse or family support practitioner.

[23] https://www.england.nhs.uk/blog/what-does-self-care-mean-and-how-can-it-help/

[24] *Making healthy choices easy choices: The role of empowerment*, European Journal of Clinical Nutrition · September 2005

We also need to work with people within the community who influence others and develop strong role models to help influence positive behaviours and change habits, particularly amongst communities currently experiencing the worst outcomes. We can use our public consultation to better understand who or what within the community may have the biggest influence on people decisions around healthy behaviours. This may include businesses and corporations, as well as individuals, faith groups and other community groups.

Social prescribing

Social prescribing is a means of enabling GPs and other frontline healthcare professionals to refer people to 'services' in their community instead of offering largely medicalised solutions. Often the first point of referral is a link worker who can talk to each person about the things that matter to them. Together they can co-produce a social prescription that will help to improve their health and wellbeing. The community activities range from art classes to singing groups, from walking clubs to gardening, and to many other interest groups. It is therefore particularly relevant in regard to helping people start more healthy behaviors. In particular, it can help make people more active.

It is taking off across the country, particularly with people who are lonely or isolated; people with mild mental health issues who may be anxious or depressed; and, those who struggle to engage effectively with services. It is also relevant to people with wider social issues such as poverty, debt, housing, relationship problems, all of which impact on their health and wellbeing. Very often these people have frequent repeat visits to their doctor or to their local emergency department – effectively trapping them in a 'revolving door' of services.

As a partnership, we need to commit to this approach by working together to build this into our partnership with the community and to how we work with residents to make positive behaviour changes to improve health outcomes.

Structural changes

Frequently it is the environment which is much more influential on health than any other factor. Through the new strategy, organisations will need to consider what health choices they are facilitating or denying in their buildings and the built environment over which they have control. This will include initiatives such as increasing smoke-free areas and reviewing and improving what the food offer is and how people travel. This approach is reflected in the proposed priorities under each of the three behaviours.

Other relevant strategies to improve health outcomes in Enfield

To help the Board deliver on measurable health outcomes, the proposed new Joint Health and Wellbeing Strategy is focused on three behaviours, where there is national and international evidence of impact on health outcomes. We have used local data to propose specific priorities in regard to changing these three behaviours, which can be further explored through public consultation.

There are many other activities and strategic programmes underway across the partnership to continue to tackle the wider determinants of health. The Board may wish to consider their role in having oversight, and input, into these relevant strategies alongside the further development, finalisation and implementation of a new Joint Health and Wellbeing Strategy. Relevant strategies include:

- Council Corporate Plan 2018
- Enfield Children and Young People's Mental Health Transformation Plan 2015/2017 (refreshed October 2017)
- Healthy Weight Strategy 2018
- Food Strategy (new strategy under development)
- Housing Strategy, Preventing Homelessness Strategy and Local Plan (New strategies under development)
- Children and Young People Plan (New strategy to be developed 2019)
- Volunteering Strategy – new strategy has links to social prescribing (under development)
- Violence against Women and Girls Strategy 2017
- Safeguarding Adolescents from Exploitation and Abuse Strategy (under development)
- Enfield Travel Plan (under development)[25]

Public Consultation

We are proposing to run a survey with the public, to be conducted both online and through face to face interviews in different areas of the borough. The objective of this consultation is to seek the views and ideas of Enfield residents on the proposed vision and priorities for the new strategy. The findings of this consultation will help us ensure that the new strategy is in line with what matters the most for Enfield residents when it comes to improving their health and wellbeing.

We will conduct a 6-week online survey that will start around mid-December. We will advertise and promote the survey through council social media, local press and in council buildings. Board members are also asked to promote this survey through their organisations communication channels.

In addition to the online activity, we are planning to conduct **up to** 1,000 face to face interviews to ensure we capture the views of people who are less likely to respond to the online consultation, with a particular focus in wards where we have the poorest health outcomes.

We plan to run the consultation from mid-December 2018 until mid-February 2019. A preliminary analysis of data from the survey and the interviews will be undertaken in early February, with an aim to produce the final report by the end of February.

The draft survey questions are attached as an appendix to this report.

Healthwatch conference

In February 2019, Healthwatch will be running their annual conference. These conferences bring local people together with decision-makers and clinicians to develop and agree solutions / approaches that work for them. For example, last year, Healthwatch focussed on Care Closer to Home. Over 90 people attended a half day event where participants were encouraged to share ideas, suggestions and challenges. The scope and format of the conference was co-designed with local residents, Enfield Council, NHS Enfield Clinical Commissioning Group and Barnet Enfield and Haringey Mental Health NHS Trust. As a

[25] This list is not exhaustive, and partners may have other strategies they wish to discuss and develop collectively through the forward plan for the Board and the HIP

result, Healthwatch Enfield has developed and published a report, 'Making care closer to home work for Enfield'.

Healthwatch have proposed that they could work with Board Members to co-design their next annual conference, to take place in February 2019, so that local people's voices can further inform development of the final Health and Wellbeing strategy. This would be an opportunity to further explore the preliminary findings from the consultation survey and further co-design strategic priorities with the community.

Board members are asked to confirm whether their organisation can work with Healthwatch to co-design their annual conference in February to further consult on the strategy.

Health and Wellbeing Board decision required:

1. Board members are asked to confirm their agreement for launching the public consultation to run from December 2018 through to the end of February 2019.

2. Board members are asked to promote the consultation across their organisations and with service users.

3. Board members are asked to confirm whether their organisation can work with Healthwatch to co-design their annual conference in February to further consult on the strategy.

Appendix

Health and wellbeing Strategy Survey. *This is attached as a printable word version. The final survey will be available to the public as an online version; and also used for face to face interviews with a sample of the population.*