Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 6 December 2018 at 4.30 pm
Room 1, Civic Centre, Silver Street, Enfield, EN1 3XA

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Please note meeting time

MEMBERSHIP

Cabinet Member for Health and Social Care (Chair)
Leader of the Council
Cabinet Member for Public Health
Cabinet Member for Children's Services
Chair of the Local Clinical Commissioning Group – Dr Mo Abedi (Vice Chair)
Healthwatch Representative – Parin Bahl
Clinical Commissioning Group (CCG) Chief Officer – John Wardell
NHS England Representative – Dr Helene Brown
Director of Public Health – Stuart Lines
Director of Adult Social Care – Bindi Nagra
Executive Director People – Tony Theodoulou
CEO of Enfield Voluntary Action – Jo Ikhelef
Voluntary Sector Representatives: Vivien Giladi, Litsa Worrall (Deputy)

Non-Voting Members

Royal Free London NHS Foundation Trust – Natalie Forrest
North Middlesex University Hospital NHS Trust – Maria Kane
Barnet, Enfield and Haringey Mental Health NHS Trust – Andrew Wright
Enfield Youth Parliament representative

AGENDA – PART 1

1. WELCOME AND APOLOGIES

2. DECLARATION OF INTERESTS

Members are asked to declare any pecuniary, other pecuniary or non-pecuniary interests relating to items on the agenda.

3. INFLUENZA UPDATE (16:35 - 16:40) (Pages 1 - 16)

To receive the report of the Executive Director People, LBE, to provide a briefing on influenza and health protection assurance.

4. FINANCE (16:40 - 17:25)

To receive a presentation from Fay Hammond, Director of Finance, on behalf of LB Enfield.

5. HEALTHY WEIGHT STRATEGY UPDATE (17:25 - 17:40) (Pages 17 - 44)

To receive the report of the Assistant Director of Public Health in respect of the Healthy Weight Strategy and action plan.

6. ENFIELD'S NEW LOCAL PLAN 2036 (17:40 - 18:10)

To receive a presentation from Neeru Kareer, Planning Consultant, LBE.

REPORTS FOR INFORMATION

The following reports are for noting and support.

7. VOLUNTARY SECTOR REPRESENTATIVE APPOINTMENT / SELECTION PROCESS

To receive a verbal update from Mark Tickner (Senior Public Health Strategist) / Niki Nicolaou (Voluntary Sector Manager).

8. VISIT TO BOROUGH BY DUNCAN SELBIE (CHIEF EXECUTIVE, PUBLIC HEALTH ENGLAND)

To receive a verbal update from Stuart Lines (Director of Public Health).

9. PROPOSED LGA WORK WITH BOARD

To receive a verbal update from Stuart Lines (Director of Public Health).

10. PROGRESS UPDATE ON JOINT HEALTH AND WELLBEING STRATEGY (JHWS) (Pages 45 - 68)

To receive an update on the proposal for a new Enfield Joint Health and Wellbeing Strategy 2019 – 2022 from Stuart Lines (Director of Public Health) and Harriet Potemkin (Strategy and Policy Hub Manager).

11. MINUTES OF THE MEETING HELD ON 27 SEPTEMBER 2018 (Pages 69 - 76)

To receive and agree the minutes of the meeting held on 27 September 2018.

12. INFORMATION BULLETIN

TO FOLLOW

13. HEALTH AND WELLBEING BOARD FORWARD PLAN

The current version of the Forward Plan TO FOLLOW.

14. DATES OF FUTURE MEETINGS

Members are asked to note the dates of meetings of the Health and Wellbeing Board:

- Wednesday 16 January 2019 – 4:30pm Development Session

- Wednesday 20 March 2019
  – 4:30pm Development Session & 6:30pm HWB Board

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Agenda Item 3

MUNICIPAL YEAR 2017/2018 - REPORT NO.

MEETING TITLE AND DATE **Health and Wellbeing Board** **6 December 2018**	**Agenda - Part: 1** **Item:** **Subject: Influenza and health protection assurance** **Wards: All**
Executive Director of People Services	**Cabinet Member consulted:** **Cllr Brett**
Contact officer Dr. Tha Han Tha.han@enfield.gov.uk	**Approved by:** **Stuart Lines**

1. EXECUTIVE SUMMARY

Influenza (flu) is an acute viral infection that can be easily transmitted. The best way to prevent influenza is by getting vaccinated each year, and by observing hand hygiene. The risk of severe illness or complications from flu is higher in some people, such as older people, young children, pregnant women and people with certain health conditions. Therefore in UK, free flu vaccination is given for the above groups, and this year in London, the NHS flu vaccination is extended to front line staff and carers. In Enfield, LBE also made flu vaccination available free to all of its members of staff.

Every borough has a Multi-Agency Pandemic Influenza Plan which outlines the arrangements for the management of the response to a pandemic influenza and the provision of guidance to all relevant agencies and organisations so that they respond effectively. It is prepared, maintained and updated by LBE Public Health on behalf of the Enfield Borough Resilience Forum (EBRF). This plan has a major update and review every three years. In September 2018, a multiagency exercise was carried out to test the plan and feedback were received so that the plan is fit for purpose in the current situation.

This report is to provide a briefing on

- Inflenza surveillance and monitoring,
- Influenza Pandemic Multiagency plan, and
- Seasonal influenza vaccine uptakes by priority groups and frontline staff.

2. RECOMMENDATIONS

The board is asked to note the following

2.1. Enfield Multi-agency Pandemic Influenza Plan

- New risk assessment, lessons identified from incidents or exercises, restructuring of organisations or changes in key personnel should also prompt updates to the plan. Therefore all key responders listed in the plan must advise the LBE Public Health team and EBRF of any

changes in circumstances that may materially affect the implenetation of the plan in any way.

- Council departments and teams regular update of their business continuity plan, and it is important that the link to these documents are available to EBRF.
- Voluntary sector contribution in the event of pandemic flu is significant; therefore strengthening voluntary sector will form a key part of a viable pandemic influenza plan, and business continuity of relevant public sector agencies in the event of an emergency situation such as an influenza pandemic.

2.2 Flu vaccination of

- **Children** Pre-school vaccination uptake is low in Enfield as in most parts of London. Parental attitude, beliefs and awareness do matter on childhood flu vaccination. Thus, continuous engagement with parents and faith communities, with the support of elected members could improve the acceptance and uptake.
- **Pregnant women**: requires substantial improvement.
- **At risk groups**: the awareness of the need of flu vaccination in this high-risk population could be raised through many routes such as formal and informal carers, primary care and secondary care to alleviate the current low uptake in this group.
- **Front line staff uptake**: The number and proportion of staff vaccination continues to improve.
- Multiple channels (staff newsletters, staff bulletins, staff seminars, social media, intranet, internet) are used to promote free flu vaccination for LBE staff, the uptake is hopeful to improve in 2018/19.

2. BACKGROUND

Influenza is a viral infection of the respiratory tract characterized by fever, chills, headache, muscle and joint pain, and fatigue. Flu is easily transmitted, and some with infection may not have clear symptoms and can still infect others. Flu viruses spread mainly by droplets made when people with flu cough, sneeze or talk. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs. A person might get flu by touching a surface or object that has flu virus on it and then touching their own mouth, nose, or possibly their eyes. The risk of serious illness or complications from flu is greater in children under six months of age, older people, pregnant women and those with underlying health conditions and can, therefore, have a significant impact at

the population level[1]. Therefore, influenza is under health protection surveillance although it is not a notifiable disease.

Most healthy adults may be able to infect others beginning 1 day before symptoms develop and up to 5 to 7 days after becoming sick. Children and some people with weakened immune systems may pass the virus for longer than 7 days.

Flu is a key factor in NHS winter pressures. The impact of flu on the population varies from year to year and is influenced by changes in the virus that, in turn, influence the proportion of the population that may be susceptible to infection and the severity of the illness. Flu does, however, occur every winter in the UK[2].

To reduce the spread of flu, personal hygiene is key: catch it, bin it, kill it. However vaccination is the best method for the prevention and control of influenza. Although vaccination does not give total protection, it can reduce illness and lessen the severity of the infection[3].

Priority groups for flu vaccination to prevent from severe illness are[4]:

- People aged 65 years of over
- People aged from six months to less than 65 years of age with a severe medical condition
- All pregnant women (including those women who become pregnant during the flu season)
- All children from 2 years to school children of Year-5
- People living in long-stay residential care homes or other long-stay care facilities

This report is to provide a briefing on

- Inflenza (Flu) surveillance
- Influenza Pandemic Multiagency plan, and
- Seasonal influenza vaccine uptakes by priority groups and frontline staff.

3.0 Report

3.1 Flu surveillance

Public Health England's (PHE's) influenza surveillance section in Colindale co-ordinates and collates flu surveillance for the UK.

Surveillance of influenza has important practical uses for controlling the spread and the severity of epidemic episodes[i]. In short, the occurrence of flu and its complications over time and place, the nature of the virus (e.g., type, drug sensitivity) and the disease severity (hospitalisation, mortality) were monitored

[1] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/09/phe-sw-flu-review-2017-18.pdf
[2] www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/09/phe-sw-flu-review-2017-18.pdf
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4362519/

weekly together with international situation. Vaccination uptake and coverage of those clinically at-risk, children and front-line healthcare workers are alos under surveillance.

https://www.gov.uk/government/publications/weekly-national-flu-reports-2018-to-2019-season/national-flu-report-summary-22-november-2018-week-47

Fig. Influenza-like infection consultation rate, London and England. Source PHE.

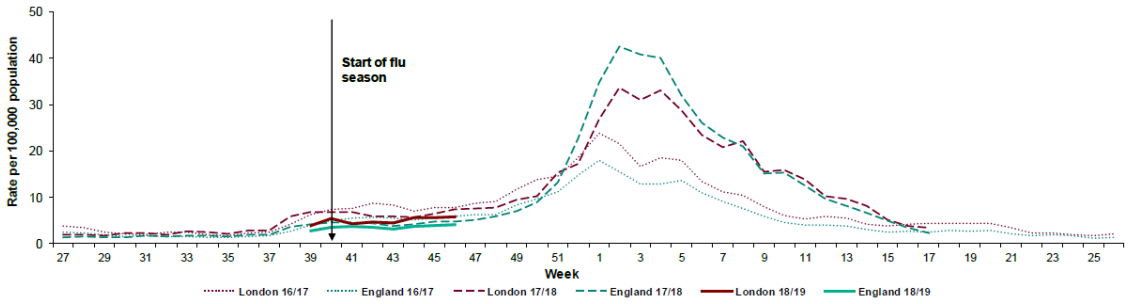
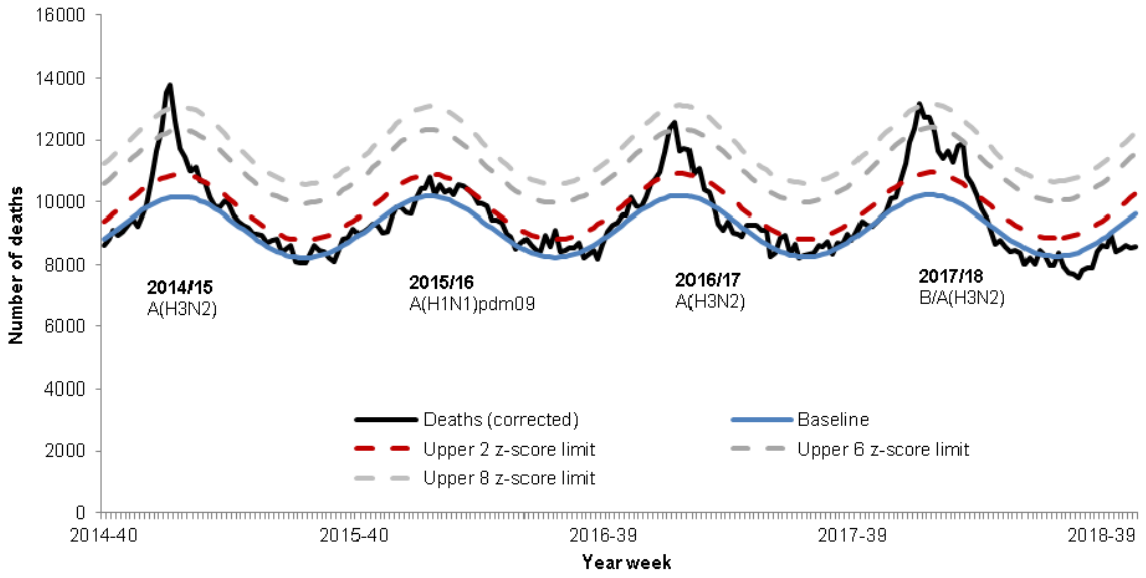


Fig. ILI GP consultation rates, Northeast and North Central London, Source: PHE.

Local Authority	Rate of ILI per 100,000[1]		Change from last week	10-week trend[2]
	Week 45	Week 46		
Barking and Dagenham	7.6	9.3	↑	
Barnet	4.9	3.3	↓	
Camden	4.6	6.4	↑	
Enfield	6.5	5.6	↓	
Hackney (inc. City of London)	12.7	8.2	↓	
Haringey	2.9	3.7	↑	
Havering	-	-	-	
Islington	8.3	7.1	↓	
Newham	7.1	6.1	↓	
Redbridge	3.2	3.6	↑	
Tower Hamlets	6.9	8.1	↑	
Waltham Forest	-	3.6	-	

Fig. Weekly observed and expected number of all-age all-cause deaths, with the dominant circulating influenza A subtype, England, 2014 to week 46 2018.



3.2 Pandemic flu multiagency plan

Pandemic flu multiagency plan provides the framework for coordinating London Borough of Enfield's multi-agency response to an influenza pandemic. The flu pandemic plan one of the emergency plans that are overseen by the Enfield Borough Resilience Forum (EBRF). In the event of a pandemic the director of public health will call Influenza Pandemic Committee (IPC) to help deal with the execution of response to pandemic and engage with wider stakeholders. The information within this plan is designed to complement individual agencies own arrangements and is aligned to the London Resilience Partnership Pandemic Influenza Framework. It aims to ensure all agencies and organisations that will be involved to respond effectively.

This Multi-Agency Pandemic Influenza Plan is prepared, maintained and updated by LBE Public Health on behalf of the Enfield Borough Resilience Forum (EBRF).

The intended audience of this plan is all Category 1 and Category 2 Responders under the Civil Contingencies Act 2004 and key voluntary response organisations.

Purposes:

- Provide strategic leadership as part of a multi-agency response
- Identify the trigger points for escalation
- Identify the roles and responsibilities of key agencies
- Provide a communication framework for responding agencies in order to guarantee that the response is co-ordinate

There are planning assumptions such as

- Health and care system disruption
- Staff shortage, and critical infrastructure ,first response
- Overwhelmed demand for service and limited opportunity for mutual aid.
- Use the exercise scenarios help us develop appropriate response at all stage of the pandemic

Enfield Public health leads on the Multi-Agency Flu Pandemic planning. Every three years, we test and revise the plan in partnership with Category 1 and Category 2 responders, such as blue light services, NHS providers, commissioners, council department and voluntary sector organisations. Thus, on 25th of Sept 2018, Enfield Public Health organised a multi-agency flu pandemic exercise to test the existing plan with the responders.

Public Health is in the process of updating the existing plan with comments received from all delegates. We will ensure the new plan will reflect changes in the structure within the council and comments and suggestion made by partners in at multi-agency exercise on the existing plan. The new plan will also refer to the Business Continuity Plans of all council departments, NHS, council providers, and private health care provider and where feasible the voluntary sectors.
In the recent multi-agency flu pandemic exercise workshop, it has been noted the role of the voluntary sector is important in reaching out to a different section of the community and support the work of the statutory organisations.

3.3 Vaccination uptake of those at risk of severe illness under free NHS Flu vaccination in Enfield

Influenza vaccine uptake data is collated by the Influenza Surveillance section at PHE Colindale. The vaccine uptake data include:

- those aged 65 and over;
- 6 months to 65 years in clinical risk groups;
- pregnant women;
- Childhood programme for those of pre-school and primary school age (reported on a monthly throughout the influenza season).
- Frontline healthcare workers (reported monthly October to February)

3.3.1 Over 65 flu vaccine uptake, 1 Sept 2017 to 31 Jan 2018

65+ Age group	Number registered with GPs	Flu vaccine uptake (%)
Age 65+ without long-term conditions	43,728	29,710 (67.9%)
Age 65+ with long term conditions	37,742	16,030 (42.3%)

The flu vaccine uptake of 65 years and above-year-old Enfield residents with long-term conditions is much below 75% for over 65 age group. This population is at increased risk of infection during the winter months. Invitation by GPs and awareness through carers, friends and family may be helpful.

3.3.2 Pregnant women flu uptake Enfield, 1 Sept 2017 to 31 Jan 2018

Pregnant women	Registered with GPs	Flu vaccine uptake (%)
Pregnant women without long-term conditions	4,325	1258 (29.3%)
Pregnant women with long-term conditions	306	163 (53.3%)

Pregnant women with a long-term condition took up flu vaccines just under 55% target.

3.3.3 Flu vaccination among those with medical conditions/ at-risk individuals

	Enfield	London	England
Flu vaccination coverage (target 55%)	42.5%	48.9%	45.4%

The improvement of coverage among this group will help reduce exacerbation of long-term conditions. It is also important their carers and professionals looking after them get vaccinated to prevent cross infection.

3.3.4 Children immunisation uptake

Seasonal influenza is a common infection among infants and children. The influenza vaccine programme was extended to include children, following the recommendations of the Joint Committee on Vaccination and Immunisation (JCVI) in 2012. From the 2013/14 season, a phased pediatric influenza vaccination programme was introduced in England involving a new cohort being introduced each season to cover all children 2-16 years of age eventually[5]

Table. Flu vaccination for 2-year olds with and without clinical risk Enfield, 1 Sept 2017 to 31 Jan 2018[6]

Age group	Registered with Enfield GPs	Uptake (%) Enfield	London	England
Age-2 years in NON-clinically at risk	4,747	1247 (26.3%)	33.2%	42.8%
Age-2 years in clinically at risk	75	29 (28.7%)		

Source: NHS digital 2018

Table. Flu vaccination for 3-year olds with and without clinical risk Enfield, 1 Sept 2017 to 31 Jan 2018

Age group	Registered with Enfield GPs	Uptake (%) Enfield	London	England
Age-3 years in NON clinically at risk	4,591	1163 (25.3)	33.3%	44.2%
Age-3 years in clinically at risk	104	38 (36.5%)		

Source: NHS digital 2018

[5] JCVI. Joint Committee on Vaccination and Immunisation Meeting Minutes 5 October 2011. http://webarchive.nationalarchives.gov.uk/20120907090205/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@ab/documents/digitalasset/dh_133598.pdf; 2011

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/684554/Seasonal_flu_vaccine_uptake_GP_patients_2017_2018_01_September_31_January_CCG_AT.pdf

Table. Percentage of children in school years reception, 1, 2, 3, 4 who were vaccinated with influenza[ii] by, 2017 - 2018[iii]

	School age children uptake (2017/18)				
	Reception	Year 1	Year 2	Year 3	Year 4
Enfield	2,039 (45.1%)	1,999 (42.0%)	1,995 (42.3%)	1,833 (38.0%)	1,652 (35.5%)
NCL	50.0%	50.3%	48.5%	45.1%	42.3%
London	51.6%	49.6%	48.2%	45.6%	43.8%
England	62.6%	61.0%	60.4%	57.6%	55.8%

Source: NHS digital 2018

The flu vaccine uptakes of all age groups of children are comparable to the figures other parts of London, but still short of the 75% national target set to reduce the risk of transmission[7].

Progress made to improve children flu uptake

- The flu consent form and letter to parents have been amended and we now include images of children to elicit a caring mindset, use of social norming to encourage parents to follow desired behaviours.
- Engagement of the Parent Engagement Panel to promote immunisations amongst parents.
- Catch up clinics – both in the school and in the community.
- Following up on consent forms that are not returned.
- Working with schools to promote the benefits of flu vaccination to encourage the schools to be more proactive with parents.
- A member of the Immunisation Team being allocated to each school to increase communication before, during and after the planned immunisation sessions.
- Advertising– including social media, Enfield Council webpage, Healthwatch website and posters using the five reasons to vaccinate your child campaign
- Addition funding was requested to NHS England to reconcile child health information system (CHIS) and to provide vaccination sessions at GP extended access sites.

3.4 Health and Care Front-line staff flu vaccination

Health and social care workers who have regular close contact with patients, residents, and clients are likely to have more exposure to infection, and can spread to their family members or their patients/ clients. Influenza immunisation is highly effective in preventing the disease in working-age adults; Immunisation is also recommended for staff directly involved in social care, especially for staff in nursing and care homes that look after older people. Staff immunisation may reduce the transmission of influenza to vulnerable residents, some of whom may have impaired immunity and thus reduced protection from any influenza vaccine

[7] http://www.qualitywatch.org.uk/indicator/adult-flu-vaccination-coverage-england-and-internationally

they have received themselves.[8] Until this year, this is the responsibility of the employer, but this year NHS England in London commissions free flu vaccination for all health and care workers across NHS, local authorities and private sector in London.

3.4.1 NHS providers staff flu uptake

Last year, all NHS providers operating in Enfield have been making good progress in vaccinating frontline staff. Both Royal Free and North Middlesex University Hospital, vaccine uptake by staff has been higher than the London average.

Table. Flu Vaccine Uptake (Healthcare Workers) 1 Sep 2017 – 28 Feb 2018[iv]

Providers	Flu Vaccine Uptake % (2017/18)
London region	63.70%
BEH	48.70%
North Middlesex	72.50%
Royal Free	71.80%

Source NHS digital 2018

The staff flu uptake at BEH was lower than the other two trusts, but this was much progress from previous years thanks to a strong emphasis from the leadership on improving the rate.

Within staff group flu vaccination, the uptake by qualified nurses and doctors vary depending on the site.

Table. Seasonal Flu Vaccine Uptake by Staff Groups 2017/18, 1 Sep 2017 – 28 Feb 2018

NHS provider Staff group	Doctors	Qualified nurses (including GP Practice Nurses)
BEH	91 (39.1%)	393 (42.8%)
North Middlesex	409 (79.4%)	618 (53.9%)
Royal Free	921 (50.7%)	1,710 (60.2%)

Source: NHS digital 2018

3.4.2 Flu vaccination for council staff

LBE as a responsible major employer has been commissioning flu vaccines for its own staff since 2016/17. 126 staff vaccinated under the council' scheme between Oct 16 - Mar 17, and 201 vaccinated between Oct 17 - Mar 18. It is to be noted that staff also received flu vaccination through NHS schemes or self-payment.

[8] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/09/care-home-toolkit-18-19.pdf

We hope the uptake this year will be much increased under the council funded flu vaccination thanks to the commitment by the leadership and communication. Data for the current year will be released after April 2019.

3.5 Local promotion of flu vaccination this year

NHS England has commissioner local pharmacies to offer frontline line care workers to access flu vaccination free in Enfield.

Public Health England analysed vaccine uptake by each of the population characteristics. They found[9]:

- Flu vaccine uptake is significantly and independently associated with increasing deprivation, ethnicity and areas with the largest Muslim populations

We will consider these factors in the promotion of flu vaccination in Enfield.

London Borough of Enfield issued a press release to flu vaccination in the borough, with the support of the Cabinet Member for Public Health, Cllr Yasemin Brett (Appendix-1) https://new.enfield.gov.uk/news-and-events/flu-jab-does-the-job/

Public Health has been promoting the flu vaccination working with GPs, Health the member organsiations of health Protection Forum and LBE social care staff through leaflets (Appendix 4), display screens at corridors and canteens, intranet, internet, staff seminaras and staff bulletins.
http://enfieldeye/news/article/4299/get_your_free_flu_jab

9

ttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/742678/Childhood_flu_vaccination_programme_England_2017_to_2018.pdf

4. **ALTERNATIVE OPTIONS CONSIDERED**
NO

5. REASONS FOR RECOMMENDATIONS

Multiagency Pandemic Flu Plan and flu vaccination are key components for local system resilience.

6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

6.1 Financial Implications

Not directly from the report.

6.2 Legal Implications

Health and Social care Act 2012 mandated local authorities to assure health protection.

7. KEY RISKS

LBE hosts EBRF and influenza outbreaks and pandemic influenza can have major disruption of council services such as staff absences and financial loss.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

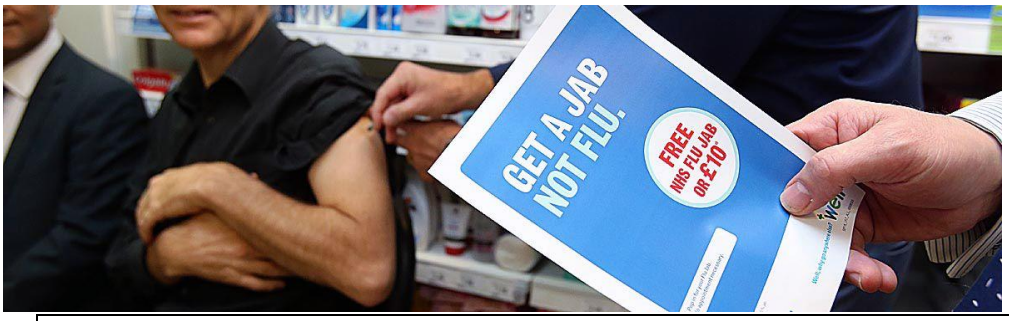
8.1 Enabling people to be safe, independent and well and delivering high quality health and care services
8.2 Creating stronger, healthier communities
8.3 Reducing health inequalities – narrowing the gap in life expectancy
8.4 Promoting healthy lifestyles

9. EQUALITIES IMPACT IMPLICATIONS

Not required.

Background Papers

Appendix 1. Press release:



Older people, pregnant women and children are being urged to get their flu vaccination this year to help stay well this winter.

Enfield Council is leading by example, with officers and the Cabinet Member for public health Cllr Yasemin Brett gathering to get their flu jab at a local pharmacy to show how simple and painless the procedure is.

Flu can be a potentially fatal illness. People will often carry and spread the disease without knowing they have it, therefore it's important to get vaccinated not just for yourself but for your loved ones. The flu jab is one of the best forms of protection against the virus. You are eligible for a free flu jab if you:

- Are 65 years of age or over
- Are pregnant
- Are a child aged 2 and 3 on 31 August 2018 (nasal spray vaccination)
- Are a child in reception class or in school year 1,2, 3, 4 and 5 (nasal spray vaccination)
- Have certain medical conditions
- Are living in a long-stay residential care home or other long-stay care facility
- Are a social care worker or hospice worker
- Receive a carer's allowance, or you are the main carer for an elderly or disabled person whose welfare may be at risk if you fall ill.

As Enfield Council's officers will agree, the side effects to the flu vaccine are mild or non-existent! If you had the vaccine last year, you will still need it again this winter so you are protected against the new strains of flu that are circulating. An estimated 8,000 people die from flu in England each year.*

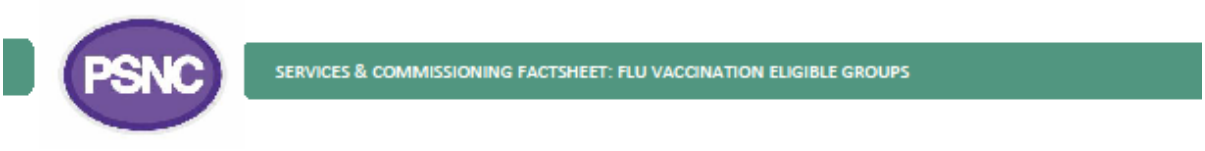
Enfield Council's Cabinet Member for Public Health, Cllr Yasemin Brett, said: "We want to build a Healthy Enfield where everyone plays their part and takes sensible precautions against sickness. The vaccine really is the best way to protect yourself and your children from a really nasty health condition and it can also help prevent the spread of the flu to other vulnerable people. Don't delay, get your jab today."

As well as getting vaccinated at your GP clinic or local pharmacy, there are other things people can do to help keep themselves well during the winter. It's important to have a healthy, varied diet, drink warm fluids, keep yourself active and take your regular medications. Keep an eye on friends and neighbours, particularly those that are more vulnerable. If you need to see your GP urgently, don't forget Enfield's primary care access hubs have appointments in the evenings and at weekends. Call the out of hours GP service on 03000 333 666.

Appendix-2 Enfield pharmacies that take part in NHS Flu Vaccination

Well Enfield - Silver Street 66 Silver St Enfield Middlesex, EN1 3EP Phone: 02083630823	Healthfare Chemist 9 Coleman Parade, EN1 1YY Phone: 020 83675456
Lloyds Pharmacy 304 Baker Street Enfield Middlesex, EN1 3LD Phone: 02083633210	Sainsburys Pharmacy (LLoyds) 3 Crown Road Enfield Middlesex, EN1 1TH
Hayward Chemist Ltd 10 Queen Anne's Place Bush Hill Park Enfield Middlesex, EN1 2PT Phone: 020 8360 2614	**Well Enfield - 255-257 Hertford Road** 255-257 Hertford Road, Enfield EN3 5JL Phone: 02088055821
Lloyds Pharmacy 226-228 Hertford Road Enfield Highway Enfield, EN3 5BH Phone: 020 8804 2074	Lloyds Pharmacy 4 Florey Square Highlands Village Winchmore Hill L, N21 1UJ Phone: 02083608560
Reids Pharmacy 1 Cambridge Terrace Bury Street West Edmonton London, N9 9JJ Phone: 02083602653	Tesco In-Store Pharmacy 288 High Street , EN3 4DP Phone: 0203 801 5166
Well Enfield - 417 Hertford Road 417 Hertford Road Enfield Middlesex, EN3 5PT Phone: 02088054154	C Atkinsons Chemist 750 Green Lanes, Winchmore Hill, London, N21 3RE Phone: 020 8360 1037
VMS Pharmacy Ltd 291 Hertford Road Edmonton London, N9 7ES Phone: 02088042363	Sainsbury's Pharmacy (LLoyds) 681 Green Lanes Winchmore Hill London, N21 3RS Phone: 020 8360 0482
Well Enfield - 644 Hertford Road 644 Hertford Road, EN3 6NA Phone: 01992764476	Asda Pharmacy Edmonton Green Shop Cntre, N9 0AL Phone: 020 8884 5310
Ronchetti Pharmacy 619 Hertford Road, EN3 6UP Phone: 01992710749	Skot Dispensing Chemists 139 Victoria Road Edmonton London, N9 9BA Phone: 02088033221
Superdrug Pharmacy 21 Market Square Edmonton Green London, N9 0TZ Phone: 02088031919	Walker Chemists 410-412 Green Lanes, N13 5XG Phone: 020 88862561

Appendix 3. Eligibility criteria for free NHS flu in London

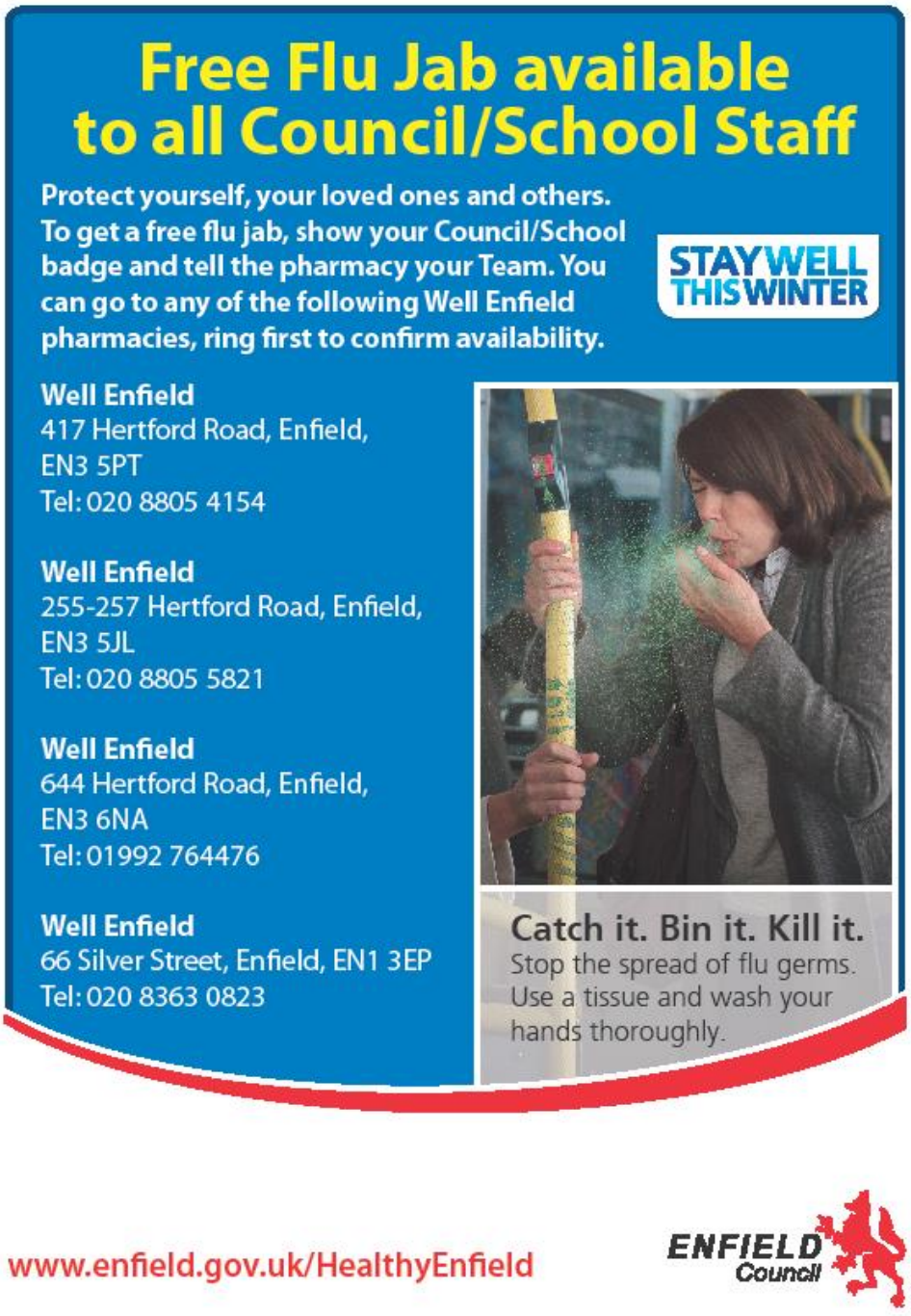


Factsheet: Eligible groups for the Flu Vaccination Service 2018/19

The national Flu Vaccination Service covers the following patients most at risk from influenza aged 18 years and older.

Eligible groups	Further details
All people aged 65 years or over	Including those becoming age 65 years by 31 March 2019.
Pregnant women (including those women who become pregnant during the flu season)	Pregnant women aged 18 or over at any stage of pregnancy (first, second or third trimesters).
People living in long-stay residential care homes or other long-stay care facilities	Vaccination is recommended for people aged 18 or over living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. This does not include, for instance, prisons, young offender institutions, or university halls of residence.
Carers	People aged 18 or over who are in receipt of a carer's allowance, or those who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill.
Household contacts of immunocompromised individuals	People who are household contacts, aged 18 and over, of immunocompromised individuals, specifically individuals who expect to share living accommodation on most days over the winter and, therefore, for whom continuing close contact is unavoidable.
Social care workers and hospice workers	Health & social care staff, employed by a registered residential care/nursing home or registered domiciliary care provider or a voluntary managed hospice provider, who are directly involved in the care of vulnerable patients/clients who are at increased risk from exposure to influenza, meaning those patients/clients in a clinical risk group or aged 65 years and over.
People aged from 18 years to less than 65 years of age with one or more serious medical condition(s) outlined below:	
Chronic (long term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis	Asthma that requires continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission. Chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema; bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD).
Chronic heart disease, such as heart failure	Congenital heart disease, hypertension with cardiac complications, chronic heart failure, individuals requiring regular medication and/or follow-up for ischaemic heart disease.
Chronic kidney disease at stage three, four or five	Chronic kidney disease at stage 3, 4 or 5, chronic kidney failure, nephrotic syndrome, kidney transplantation.
Chronic liver disease	Cirrhosis, biliary atresia, chronic hepatitis.
Chronic neurological disease, such as Parkinson's disease or motor neurone disease, or learning disability	Stroke, transient ischaemic attack (TIA). Conditions in which respiratory function may be compromised due to neurological disease (e.g. polio syndrome sufferers). Clinicians should offer immunisation, based on individual assessment, to clinically vulnerable individuals including those with cerebral palsy, learning disabilities, multiple sclerosis and related or similar conditions; or hereditary and degenerative disease of the nervous system or muscles; or severe neurological disability.
Diabetes	Type 1 diabetes, type 2 diabetes requiring insulin or oral hypoglycaemic drugs, diet controlled diabetes.
Immunosuppression, a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)	Immunosuppression due to disease or treatment, including patients undergoing chemotherapy leading to immunosuppression, bone marrow transplant, HIV infection at all stages, multiple myeloma or genetic disorders affecting the immune system (e.g. IRAK-4, NEMO, complement disorder). Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone at 20mg or more per day. It is difficult to define at what level of immunosuppression a patient could be considered to be at a greater risk of the serious consequences of influenza and should be offered seasonal influenza vaccination. This decision is best made on an individual basis and left to the patient's clinician. Some immune-compromised patients may have a suboptimal immunological response to the vaccine.
Asplenia or splenic dysfunction	This also includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
Morbid obesity (class III obesity)	Adults with a Body Mass Index ≥40kg/m².

Appendix 4. LBE Poster for all LBE Staff



[i] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3250752/

[ii] https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-children-of-primary-school-age-winter-2017-to-2018

[iii] https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-winter-2017-to-2018

[iv] https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-healthcare-workers-winter-2017-to-2018

Agenda Item 5

MUNICIPAL YEAR 2018/2019 - REPORT NO.

MEETING TITLE AND DATE **Health and Wellbeing Board** 6/12/2018	**Agenda - Part:** **Item:** **Subject:** Healthy Weight **Wards:** **Cabinet Member consulted:**
REPORT OF Assistant Director of Public Health Glenn Stewart Contact officer and telephone number: Ailbhe Bhreathnach, 0208 379 3690 Email: Ailbhe.bhreathnach@enfield.gov.uk	**Approved by:**

1. EXECUTIVE SUMMARY

Addressing obesity and promoting healthy weight are the Council's priorities for reducing health inequalities and improving health and wellbeing. Increasing healthy weight is also one of the Health & Wellbeing priorities for 2017 – 2019 and therefore a major component of the Public Health's workstream. The Enfield Healthy Weight Strategy and action plan sets out how obesity will be tackled. It is proposed that progress on the implementation of the action plan is reported back to the Board in six months.

2. RECOMMENDATIONS

It is recommended that the Board:

2.1 approves the Healthy Weight Strategy and action plan
2.2 considers what actions their respective organisations can take to meet the strategic objective to 'Make tackling obesity everybody's business'
2.3 requests an initial implementation report in 6 months

3. BACKGROUND

3.1	The prevalence of year 6 pupils with excess weight in 2017/18 (41.1%) is significantly higher than London (37.7%) and England (34.3%). This has remained similar to the previous year (41.5%). Enfield is ranked 5th highest out of all London boroughs.

	6.2% of year 6 pupils measured were identified as being severely obese, which is significantly worse than London (5.2%) and England (4.2%). This has not changed since the previous year (6.1% in 2016/17).
3.2	The prevalence of reception year pupils with excess weight in 2017/18 (24.9%) is significantly higher than England (22.4%) and London (21.8%). This has remained similar to the previous year (24.8%). Enfield is ranked 5th highest for excess weight out of all London boroughs. 3.9% of reception year children measured were identified as being severely obese, which is significantly worse than London (2.9%) and England (2.4%)
3.3	3-year data from 2014/15 – 2016/17 showed that 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%)
3.4	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%)
3.5	Tackling obesity effectively will require the development of a sustained whole systems approach (WSA), joining up the many influences on obesity and tackling them through transformative, coordinated action across a wide variety of sectors and Council departments. A WSA recognises the range and complexity of causes of obesity and supports a system wide approach to understanding and addressing health inequalities. Taking this approach is enabled in Enfield by the commitment to embed a Health in All Policies approach (HiAP) as stated in both the draft JHWS and the Enfield Council Corporate Plan.
3.6	The Healthy Weight Partnership led the development of the strategy. The strategy was informed by national and local learning and proposes taking a whole systems approach to tackling obesity.
3.7	The **vision of the strategy** is that Enfield becomes a place *where all residents can easily make healthy food choices, stay physically active and maintain a healthy weight throughout their lives.*
3.8	The strategic objectives are to: 1. Ensure all local planning and policy decisions have a focus on creating and preserving health-promoting environments, thereby making the healthy choice the easy choice 2. Ensure that all health, social care, educational and workplace settings encourage and support healthy eating, active travel and physical activity, particularly in early years to enable children to have the best start in life 3. Provide residents with the knowledge, skills and opportunities to eat healthily, be active and maintain a healthy weight 4. Make tackling obesity everybody's business by working in partnership across sectors, and by developing a local workforce that is confident and

	competent in supporting people to make healthier choices
3.9	Two implementation groups (People & Place) will be established to support the implementation of the strategy.
3.10	The intended outcomes are: - A sustained downward trend in the level of excess weight in children by 2024 - A downward trend in the level of excess weight averaged across all adults by 2024 Progress towards these outcomes will be monitored using data from the National Child Measurement Programme in Reception Year and Year 6 pupils, and the Active Lives Survey for adults.

5. KEY RISKS

5.1 Failure to address the increase in obesity in the Borough will place at risk the sustainability of Enfield's health and social care provision.

6. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

6.1 Ensuring the best start in life
Healthy physical activity and eating habits are developed early in life and can set the foundation for life-long behaviours and disease risk. Supporting and enabling all age groups to eat better and move more is central to the strategy.

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

6.3 Creating stronger, healthier communities

6.4 Reducing health inequalities – narrowing the gap in life expectancy
The strategy acknowledges that some communities and individuals are more likely to become overweight and the action plan will appropriately target these communities in order to reduce health inequalities.

6.5 Promoting healthy lifestyles
Healthy lifestyles will be promoted by supporting and enabling residents to eat better and move more.

7. EQUALITIES IMPACT IMPLICATIONS

Appendix

- Healthy Weight Strategy and Action Plan

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Enfield Healthy Weight Strategy- DRAFT

Tackling Obesity is everybody's business

2018 – 2021

'Modifying the environment in a sustainable manner that makes healthy behaviours the most natural, easy, and rewarding response, is the only effective way to change behaviours' (JM Boris et al., 2012: 35)

Version Control

Version	Author(s)	Date	Changes
1.0	AB	25/06/2018	First Draft
2.0	GS, MT, GM, DC	2/07/2018	Edited
3.0	Healthy Weight Partnership	3/10/2018	Further development of action plan

Introduction

i) Obesity- why does it matter?

Obesity is a major problem in Enfield; in 2016/17 1093 five year olds and 1711 eleven year olds were overweight or obese, and an estimated 152,040 adults carry excess weight.

Obesity is having an impact on our residents lives now, across the generations. Overweight and obese children are more likely to struggle with low self-esteem, bullying and have problems achieving their potential in school. They are also more likely to become obese adults; children who are overweight or obese at age four to five years tend to remain so at age ten to eleven years and are more likely to enter adulthood being overweight or obese[1], putting them at an increased risk of long term conditions. What used to be referred to as 'adult onset diabetes' is now 'Type 2diabetes' and is increasingly diagnosed at younger ages.

There is a strong but complex relationship between socioeconomic status and childhood obesity. Low incomes directly constrain the diet and physical activity choices families can make. Education levels, along with the cognitive burden of living under financial strain, are also associated with behaviours that lead to higher rates of childhood obesity. In Enfield, there are stark inequalities in levels of child overweight and obesity, with prevalence among children in the most deprived parts of the Borough nearly double that of children in the least deprived areas.

Obesity has significant health and social care costs associated with its treatment and consequences, as well as costs to the wider economy arising from chronic ill health. It's linked to over 30 diseases including type 2 diabetes, heart disease and cancer, with associated health problems estimated to cost the borough some £84.1 million per year[2]. Even this may be optimistic; the National Obesity Forum is now reporting that the previous projections of 'only' 50% of the adult population in the UK will be obese by 2050 (and associated national costs of £50 billion) may be unrealistic[3].

[1] https://local.gov.uk/sites/default/files/documents/15.6%20Obesity-05.pdf

[2] The UKs Faculty of Public Health (2008) Healthy Weight, healthy lives: A toolkit for developing local strategies

[3] National Obesity Forum (2013) State of the Nation's waistline. Obesity in the UK: Analysis and expectations

Crucially, obesity is preventable. So how is it that obesity has tripled in the UK in the past 30 years? Genetic change occurs over hundreds or thousands of years, potentially indicating the cause of this increase as being primarily environmental and societal. Therefore, our strategy to tackle obesity will focus on taking a whole systems approach, reflecting that obesity is a complex problem. This approach requires multiple, coordinated actions to change the food, physical activity and social environments from one that is 'obesogenic' e.g. that promotes an unhealthy diet and discourages physical activity to one which promotes a healthy weight. Doing nothing is not an option; tackling obesity must be everybody's business.

ii) Health in All Policies

Enfield Council has set out a commitment in the Corporate Plan 2018-2022 to build measures into all strategies and projects that help improve people's health; Health in all Policies (HiAP) makes health a priority in decision making. It is an approach that seeks to ensure that the Council is doing all it can to create and improve people's physical and social environments. It also makes the best use of existing community assets so that residents feel empowered to mutually support each other to improve their lifestyles and reach their full potential.

HiAP seeks to make 'the healthy choice the easy choice', linking environmental changes into behavioural changes for individuals. This will mean that people will walk and cycle because their streets are safe and pleasant; children will eat more healthily because they have better access to fruit and vegetables; and tobacco consumption will become increasingly abnormal.

The obesity epidemic can be best tackled by taking a whole systems approach, which is enabled by HiAP. It recognises the range and complexity of causes of obesity and supports a system wide approach to understanding and addressing health inequalities. It draws on the strengths of the Local Authority, fitting with its business priorities and recognising that councils can achieve better and more effective results by engaging their community and local assets.

iii) Vision for Enfield

Our vision is that Enfield will be a place where all residents can easily make healthy food choices, stay physically active and maintain a healthy weight throughout their lives.

iv) Strategic objectives

The strategy will achieve this by taking a whole systems approach to tackling obesity across the local system. This means

1. Ensuring all local planning and policy decisions have a focus on creating and preserving health-promoting environments, thereby making the healthy choice the easy choice
2. Ensuring that all health, social care, educational and workplace settings encourage and support healthy eating, active travel and physical activity, particularly in early years to enable children to have the best start in life
3. Providing residents with the knowledge, skills and opportunities to eat healthily, be active and maintain a healthy weight
4. Making tackling obesity everybody's business by working in partnership across sectors, and by developing a local workforce that is confident and competent in supporting people to make healthier choices

v) Outcomes

- A sustained downward trend in the level of excess weight in children by 2024
- A downward trend in the level of excess weight averaged across all adults by 2024

Prevalence of Overweight and Obesity in Enfield

Data collected from academic years 2014/15 – 2016/17 shows that the average prevalence of excess weight in reception year pupils is 24.2%. This is significantly higher than London (22.2%) and England (22.2%) averages. 3.0% of reception year pupils are severely obese, equating to 130 pupils.

29.9% of children in the top 10% most deprived parts of the Borough are overweight or obese, compared to 16.6% of children in the 10% least deprived parts of the Borough.

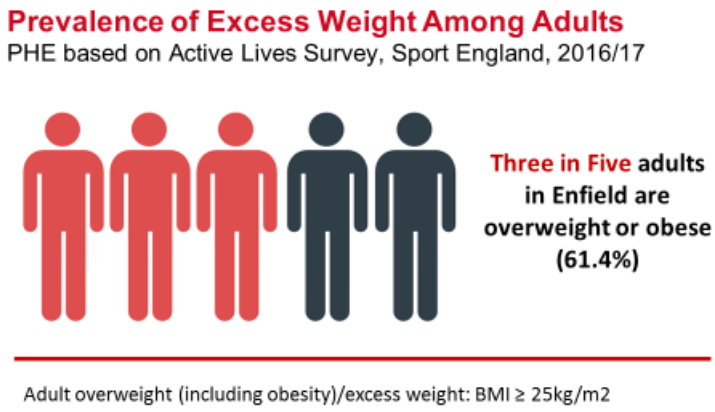
Edmonton Green (29.3%) and Enfield highway (29.3%) had a significantly higher prevalence of excess weight in pupils compared to the Enfield average (24.2%). The prevalence of excess weight by ethnicity in this year group is significantly higher in African (32.6%) and Turkish/Kurdish (31.9%) pupils compared to the Enfield average (24.2%).

Academic year 2014/15 to 2016/17 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%).



There is no robust local information on adult BMI in Enfield, however the *Active Lives Survey* (2016) estimated that 61.4% of adults (approximately 152,040 adults) in Enfield are overweight or obese. This is similar to England (61.3%) and significantly higher than London (55.2%).

Without intervention, it is estimated that about 75% of men and women in the UK will be overweight or obese by 2030.[4] It's likely that the prevalence of overweight and obesity in Enfield will increase in line with national predictions.

Health Survey for England[5] data indicates that by the age of 55 some 70% of the adult population is either overweight or obese. Data would therefore indicate that by Reception Year 25% of pupils are either overweight or obese, by Year 6 40% and by age 55 70%. This would suggest that the influences of childhood obesity are the same as adult obesity. It would also suggest that work to reduce prevalence of obesity needs to take place across the entire population.

Causes and solutions to obesity

[4] European Society of Cardiology (2014), Adult obesity predicted in almost all European countries by 2030.
[5] http://www.hscic.gov.uk/catalogue/PUB16077

What causes overweight and obesity?

At a simple level obesity is an imbalance of energy in and energy out. However, obesity has no single cause and is the result of many factors operating at several levels, at different stages in an individual's life. Evidence from the '*Foresight Tackling Obesities: Future Choices – Project Report*'[2] was used to summarise over 100 factors that directly or indirectly influence energy balance and this was presented in a complex obesity system map. This complex obesity map has been simplified and divided into seven predominant themes (see Figure 2):

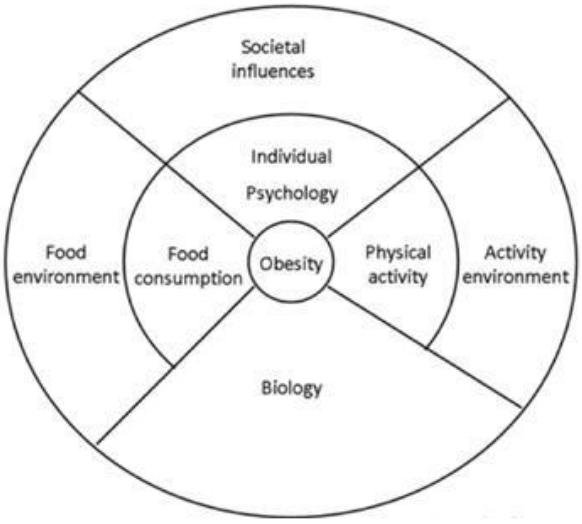


Figure 2: Simplified Foresight obesity map, 2007

The 'obesogenic environment' is a term which has been used to describe the range of social, cultural and infrastructural conditions that influence an individual's ability to adopt a healthy lifestyle. This includes the way that towns and cities are designed, the availability of safe, pleasant and direct walk and cycle ways, the prominence of escalators rather than stairs, access to well-maintained parks and recreational resources and the proliferation of fast food outlets. While some of these influences are within the control of local authorities, they are not simple to change and changes to them will only be achieved over the long term. Enfield has already made some progress over the past few years with extensive investment in Cycle Enfield, restriction of take-aways within 400m of schools and achievement of Food for Life Silver Catering Mark for school meals. However, tackling obesity effectively will require the development of a sustained 'whole systems approach', joining up the many influences on obesity that promotes transformative, coordinated action across a wide variety of sectors.

Addressing the causes of obesity

- **Moving Upstream**

In the Lancet review of global obesity, Swinburn et al., (2011) also called for more upstream action; depicting the key drivers of the global obesity epidemic and presenting an overview framework for understanding population level obesity determinants and solutions (Figure 3). The more distal drivers are to the left and the environmental moderators that have a lessening or heightening effect are shown, along with some examples. The usual interventions for environmental change are policy based, whereas health promotion programmes can affect environments and behaviours. Drugs and surgery operate at the physiological level. The framework shows that the more upstream interventions that target the systemic drivers might have larger effects, but their political implementation is more difficult than health promotion programmes and medical services.

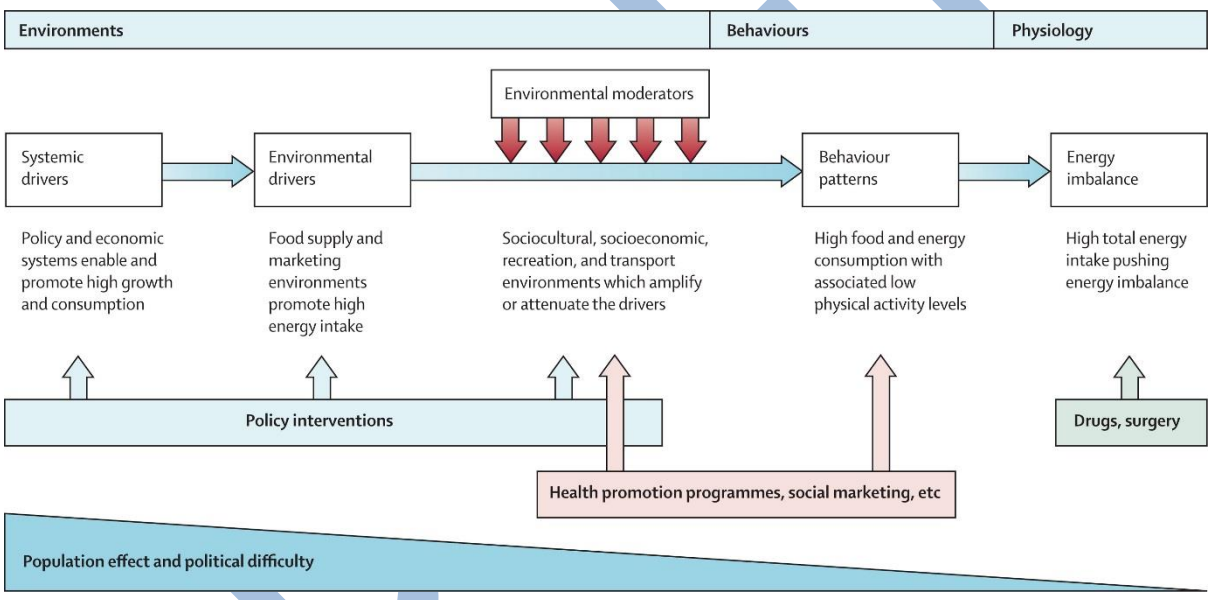


Figure 3: A framework to categorise obesity determinants and solutions[6]

Early learnings from the Leeds Beckett Whole Systems Approach project[7], commissioned by PHE in partnership with the LGA and the ADPH, also stresses the importance of moving interventions

[6] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60813-1/fulltext
[7] https://publichealthmatters.blog.gov.uk/2015/10/14/designing-a-whole-systems-approach-to-prevent-and-tackle-obesity/

upstream, and of the need to combine approaches that address the wider environment at the same time as meeting the needs of those most at risk, including those already overweight and obese. If these two elements are not combined, there is a risk that the environment that drives obesity will remain unchanged making it harder for those at risk to maintain any changes to their lifestyles; conversely, if only the environment is changed without investing in tackling existing excess weight, then only those with greater social capital and other advantages will respond to campaigns and improve their health and the inequalities gap is likely to grow. [8]

- **Taking a Whole Systems Approach**

A Whole Systems Approach to Obesity (WSO) moves away from silo working on isolated short-term interventions to working with stakeholders across the whole system to identify, align and review a range of actions to tackle obesity in the short, medium and long term.[9]

It's suggested that a WSO has the following characteristics[10]

- Recognises that obesity is the product of a complex web of interacting and changing causes and influences and as such requires a cross sector approach, not just a public health response
- Combines bringing together all the partners that can have a bearing on obesity with using "systems thinking" to identify the most important factors and make sense of changing dynamics – passage of time, multiple levels, complex influence
- For significant improvements to be made, we need to look at not just the individual contributions of each organisation but also how the whole system works together and can be more than the "sum of its parts"
- Creates a map of moving and interacting drivers and recognises that tackling a single driver in isolation cannot work
- Acknowledges the need for both individual and organisational action
- By moving the interventions upstream, it creates the environment for more effective societal change

The following features may also be required for a successful WSO[11]

- Time is allowed to develop and maintain the WSO

[8] http://www.leedsbeckett.ac.uk/wholesystemsobesity/news-and-resources-drafting-the-route-map/ Accessed 25.05.2018
[9] https://local.gov.uk/sites/default/files/documents/15.6%20Obesity-05.pdf
[10] http://www.leedsbeckett.ac.uk/wholesystemsobesity/a-whole-systems-approach/ Accessed 25.05.2018
[11] http://www.leedsbeckett.ac.uk/wholesystemsobesity/a-whole-systems-approach/

- Considers the wider determinants of health and the complex web of drivers and influences
- Joined up co-ordinated action across a range of partners in both design and implementation
- Maximises opportunities throughout the life course
- Grounded in the Local Authority's wider priorities and policies
- Uses local intelligence to understand options and how change impacts on others in the system
- A comprehensive portfolio of effective policies and interventions of all sizes combining to maximum effect
- Includes actions in the short, medium and longer term
- Identifies and fills gaps across breadth of system
- Universal- tackling the wider environment- but also addressing the vulnerabilities of key groups
- Dynamic element- goes beyond collaboration and focuses on how the system works as a whole
- Maintains and nurtures relationships, creating a robust, owned and sustainable approach, that refreshes thinking to reflect passage of time and new influences and opportunities
- Includes methods to provide on-going feedback into the system

ACHIEVEING OUR STRATEGIC OBJECTIVES

Taking a whole systems approach will be central to our efforts to tackle obesity in Enfield. Interventions will include both local implementation of national initiatives and local activity specific to the needs of the Borough.

- **The Whole Systems Obesity programme**

The Leeds Beckett *Whole Systems Obesity programme* will provide local authorities with a different approach to tackling obesity. This involves the whole local system of stakeholders recognising that it is a problem that goes far beyond any single department or organisation. It makes tackling obesity everybody's business. The programme is developing guidance and tools to help councils set up a WSA in their local area, which Enfield eagerly awaits.

A key lesson that is emerging from the programme is that taking a WSO requires the right mind set across the council. Practitioners at a local level will need support to think, adapt and work in a way that enables them to work in a whole systems way.[12]

1. **Ensuring all local planning and policy decisions have a focus on creating and preserving health-promoting environments, thereby making the healthy choice the easy choice**

The Built Environment- why it's important:

- Objective data from the Health Survey for England (2008) showed that up to 95% of the population of Enfield may not be physically active enough to maximise benefits to their health. Reasons for this include the progressive elimination of physical activity from everyday life over the past 60 years; there are fewer physical jobs, the home is littered with labour saving devices, leisure is more likely to be sedentary and the transport system has been built around motorised transport rather than walking and cycling.
- By improving the environment in which residents live, work and play, we can make the healthy choice the easy choice.

[12] https://local.gov.uk/sites/default/files/documents/15.6%20Obesity-05.pdf

Examples of what we will do to achieve this	
The Healthy Streets Approach[13] The Healthy Streets Approach puts people, and their health, at the heart of decision making. This results in a healthier, more inclusive borough, where people choose to walk, cycle and use public transport. The best way to get more people out walking, cycling and using public transport is to improve the quality of the experience of being on streets. The Healthy Streets Approach focuses on creating streets that are pleasant, safe and attractive, where noise, air pollution, accessibility and lack of seating and shelter are not barriers that prevent people - particularly our most vulnerable people - from getting out and about.	
Health in Planning A healthy environment promotes physical activity of all sorts and ensures that sustainable transport and active travel is built into everyone's daily life. It helps people to access and choose healthier goods (such as food and drink) and services (such as healthcare) that support them in choosing a balanced diet, leading an active lifestyle and maintaining a healthy weight[14]	**'The health and well-being of communities cannot be an afterthought. It must begin with the planning process.' (Chang et al 2010)**

The Food Environment- why it's important:

- In the UK in the past 100 years, food has become increasingly available whilst its promotion has become increasingly sophisticated. The norms of eating have changed with grazing, snacking and eating on the go, and outside of the home, becoming common. Sugary drinks, savoury snacks and confectionary, often high in fat and sugar, and served in larger portions are increasingly available and promoted. Fruit and vegetables are often either expensive, difficult to find or used as a 'gateway' purchase to encourage purchasing other foods.
- In Enfield, we will focus on changing the food environment in which people live, ensuring healthy food is accessible and affordable.

[13] https://tfl.gov.uk/corporate/about-tfl/how-we-work/planning-for-the-future/healthy-streets
[14] https://www.tcpa.org.uk/Handlers/Download.ashx?IDMF=7166d749-288a-4306-bb74-10b6c4ffd460

Examples of what we will do to achieve this

Declaration on Sugar Reduction and Healthier Food

The Council has signed the Local Government Declaration on Sugar Reduction and Healthier Food, committing to act across six key areas.

Area 1 Tackle advertising and sponsorship
Area 2 Improve the food controlled or influenced by the council and support the public and voluntary sectors to improve their food offer
Area 3 Reduce prominence of sugary drinks and actively promote free drinking water
Area 4 Support businesses and organisations to improve their food offer
Area 5 Public events
Area 6 Raise public awareness

Sustainable Food Cities

The SFC programme takes a holistic approach to food issues, focusing on six areas:

1. Promoting healthy and sustainable food to the public
2. Tackling food poverty, diet-related ill health and access to affordable healthy food
3. Building community food knowledge, skills, resources and projects
4. Promoting a vibrant and diverse sustainable food economy
5. Transforming catering and food procurement
6. Reducing waste and the ecological footprint of the food system

2. **Ensuring that all health, social care, educational and workplace settings encourage and support healthy eating, active travel and physical activity, particularly early years to enable children to have the best start in life**

Why it's important:

- Schools and Early Years settings have an important role in enabling physical activity, influencing healthy food choices, and promoting good oral health.
- Workplace health is a significant public health issue. Each year more than a million working people in the UK experience a work-related illness. Promoting a culture that improves the health and wellbeing of employees is good management and leads to healthy and productive workplaces.
- Older people are at greater risk of obesity.

Examples of what we will do to achieve this	
Healthy Early Years MAYOR OF LONDON'S HEALTHY EARLY YEARS LONDON	Healthy Early Years London is a new programme that aims to reduce health inequalities by supporting a healthy start to life across themes that include healthy eating, oral and physical health and early cognitive development. The Unicef UK Baby Friendly Initiative supports breastfeeding and parent infant relationships by working with public services to improve standards of care.
Healthy Schools The Daily Mile Supported by INEOS children fit for life	We will continue to develop work in schools that promote healthy eating, physical activity and emotional health and wellbeing. We will offer all primary schools in Enfield support to embed The Daily Mile, aiming to improve the physical, emotional and social health and wellbeing of children.
Healthy Workplaces HEALTHY WORKPLACE ACHIEVEMENT 2016	The London Healthy Workplace Charter provides local businesses with a framework aimed at improving the health and well-being of employees. Among other benefits, successful implementation results in greater staff productivity, a better company reputation and, of course, larger financial benefits (either through cost savings or additional revenue generation).

3. **Providing residents with the knowledge, skills and opportunities to eat healthily, be active and maintain a healthy weight**

Why it's important:

- Individual choices of food and activity behaviours are determined by many factors including parental and family influence, personal beliefs and attitudes, religious and cultural background, the control or perceived control people have over their health and wellbeing, education, income, workplace culture, where people live, their motivation to take up physical activity opportunities and to access healthier food and drinks.
- The best way to help people live longer and healthier lives is to prevent illness in the first place, through action on common risk factors.

Examples of what we will do to achieve this	
Obesity care pathway	We will develop an obesity care pathway
Social Prescribing 	We will work with Enfield Clinical Commissioning Group to link patients in primary care with sources of support within the community. It provides General Practitioners with a non-medical referral option alongside existing treatment to improve health and wellbeing with a particular focus on obesity.

4. **Making tackling obesity everybody's business by working in partnership across sectors, and by developing a local workforce that is confident and competent in supporting people to make healthier choices**

Why it's important:

- One particularly successful example of a community-based intervention is EPODE (Ensemble Prévenons l'Obésité Des Enfants / Together Let's Prevent Childhood Obesity). EPODE has been described as a 'coordinated, capacity-building approach aimed at reducing childhood obesity through a societal process in which local environments, childhood settings and family norms are directed and encouraged to facilitate the adoption of healthy lifestyles in children'.[15] The key to its success is co-ordinated activity of a number of food and physical activity initiatives which tackle obesity at the individual, community and environmental level. JOGG is an adopted version of EPODE in the Netherlands. In Amsterdam, a JOGG site, levels of childhood obesity have reduced.
- We will therefore use community engagement and capacity-building methods to identify networks of local people, champions and advocates who have the potential to co-produce action on obesity.

	What we will do to achieve this
Health & Wellbeing Board	The Enfield Health & Wellbeing Board will commit to • Visible and vocal **political leadership** • A **vision** shared by all parties • **Commitment** from senior leaders and influential figures, with regular **engagement** • **Priorities** which are clear, shared and ambitious that

[15] EPODE – A Model for Reducing the Incidence of Obesity and Weight-related Comorbidities, Borys et al., *European Endocrinology,* 2013;9(2):116–20

	stimulate **debate**
Making Every Contact Count (MECC)	MECC is an approach to behaviour change that utilises the day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing.[16] We intend to adopt a strategic approach to the introduction of MECC as part of the daily practices of the whole Council.

What we need to do- An evidence-based approach

The evidence is very clear that policies aimed solely at individuals will be inadequate, costly and that simply increasing the number or type of small-scale interventions will not be sufficient to reverse the trend. We need significant effective action to prevent obesity at a population level targeting elements of the obesogenic environment as well as improving nutrition and physical activity in individuals.

There are a number of guidance documents associated specifically with healthy weight, physical activity or diet (see Appendix 1). The guidance is explicit that reducing prevalence of obesity will require senior and strategic support across all sectors and agencies. This includes adopting a coherent, community-wide, multi-agency approach integrated with a health and well-being strategy and regeneration and environmental strategies. There is also an onus on briefing local members, ensuring that obesity prevention is integrated across the Local Authority, CCG and Voluntary and Community sector.

Monitoring and Evaluation

In order to monitor the progress of an ongoing action plan, a robust and realistic reporting framework will be established. Progress of the action plan will be reported to the Health and Wellbeing Board.

[16] https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources

Healthy Weight Action Plan – Year 1

Objective 1: Ensuring all local planning and policy decisions have a focus on creating and preserving health-promoting environments, thereby making the healthy choice the easy choice			
Outcome	**Action**	**Lead**	**Success Measure**
The physical environment facilitates a healthy weight	1. Public Health and Planning to work together to ensure all planning decisions support healthy weight environments: • Agree process on Public Health input into planning applications, including at the pre-application stage • Public Health to input into Local Plan and large-scale developments such as Meridian Water • Include a chapter on *Places and Spaces* in the Joint Strategic Needs Assessment • Agree S106 spending priorities for health across the Borough, including ill-health prevention	Public Health / Planning	1.1 Development of an agreed process to ensure Public Health is consulted in the development management process and all local planning applications are assessed to ensure they support a healthy weight environment 1.2 An effective consultation process between Public Health and Planning is developed to ensure coordination of major Planning and Public Health policies to ensure all future Council-led strategies and plans are developed to support a healthy weight environment
Healthy streets and places created	2. Adopt the Healthy Street approach by: • Ensuring that where appropriate all transport projects consider the Healthy Street Approach • Delivering a programme of interventions and activities to encourage the use of sustainable transport in preference to private cars. • Develop a Wayfinding strategy to improve movement on foot and by cycle across the borough with a focus on linking places of interest such as town centres, education facilities, employment areas and leisure opportunities including our abundant green spaces.	Traffic and Transport	2.1 Increase in active, efficient and sustainable (walking, cycling and public transport) mode share (by borough resident) based on average daily trips.
	3. Pilot the School Super Zone project to protect children's health and encouraging healthy behaviours through targeted interventions and restrictions on unhealthy foods, advertisements, alcohol, smoking, gambling and vehicle emissions.	Public Health	3.1 Action plan developed, feasibility tested, plan implemented and learnings shared across London
Nutritious, affordable	4. Local restrictions are placed on Hot Food Take-away outlets within 400m of all schools	Planning	4.1 The Local Plan states that a restriction will be placed on Hot Food Take-away outlets within 400m of all

food is available throughout LBE			schools
	5. Through the Enfield Food Partnership • Ensure the action plan for *The Declaration on Sugar Reduction* and *Healthier Food* (2018/19) is delivered, and a new action plan is developed and agreed • Implement the Enfield Food Poverty action plan • Develop a Food strategy for Enfield • Apply to become a member of the Sustainable Food Cities Network	Public Health	5.1 All actions within the plans for the Declaration and Food Poverty are delivered and new action plans are developed 5.2 Enfield improves its scoring in the Good Food for London report and *Beyond the Foodbank: London Food Poverty Profile report* 5.3 Food poverty is measured annually
Key decisions are consistent with healthy living ethos	6. Public Health, Commissioning and procurement officers to explore whether wider health benefits can be considered as 'added value' when awarding contracts	Public Health / Procurement/ Commissioning	6.1 Development of agreed local guidance to support healthy procurement
	7. Develop a more coordinated policy approach across health and wellbeing, physical activity and green infrastructure using existing policy and guidance more frequently and to better effect.	Public Health/ Active Enfield/ Parks	7.1 A coordinated approach is taken to ensure all relevant strategies and plans are developed to support a healthy weight

Objective 2: Ensuring that all health, social care, educational and workplace settings encourage and support healthy eating, active travel and physical activity, particularly in early years to enable children to have the best start in life

• **Increasing physical activity and active transport**			
Outcome	**Action**	**Lead**	**Success Measure**
More children walk, cycle or scoot to school	8. Increase modal share of walking, scooting and cycling to school by - Continuing to deliver School Streets. - Increase number of schools with School Travel Plans and STARS accreditation, and support schools with STARS accreditation to improve it or retain it - Provide schools with grants to support measures which increase the use of sustainable transport such as scooter / cycle parking facilities - Provide cycle training for parents and children where possible focusing on those areas and groups with the worst health outcomes - Promote walk to school week and walk to school month, including early year settings - Address parental concern around perceived safety of walking and cycling - Encourage joint working within the Council to support the delivery of effective schemes which support cycling and walking to school	Traffic & Transport	8.1 Increase number of schools with School Travel Plans and STARS accreditation 8.2 Increase in the number of pupils getting to school in an active way via the Hands Up survey
More children are active for 30 minutes during the school day	9. Offer all schools support to implement The Daily Mile, targeting schools with highest obesity levels.	Physical Education Team	9.1 50% of primary schools delivering The Daily Mile a minimum of 3 days per week
	10. Work with schools to continue to improve playground physical activity environments, including the implementation of mile-a-day markings	Healthy Schools / Public Health	10.1 Mile-a-day markings in 15 schools in the East of the borough
	11. Continue to deliver workshops to showcase local best practice and new initiatives that promotes physical activity in school	Healthy Schools	11.1 Annual workshop delivered
	12. Deliver the Challenge You programme throughout the year targeting children identified as overweight via the NCMP.	Active Enfield	12.1 The Challenge You programme is communicated, evaluated and monitored for effective uptake by priority groups
Physical activity promoted in Early Years	13. Explore opportunities for using S106 THF Coaching Hours for delivery of physical activities in the early year, and upskilling EY professionals.	Public Health	13.1 Discussion between Publlc Health and Tottenham Hotspur Foundation
• **Promoting a healthy diet and healthier weight**			
Outcome	**Action**	**Lead**	**Success Measure**

Increased breastfeeding rates at 6-8 weeks	14. Implement and monitor the Unicef Baby Friendly Initiative to support mothers and babies to achieve the best start in life	Health visiting	14.1 Certificate of Commitment achieved 14.2 Plans in place to progress to Stage 1 BFI
	15. Ensure robust breastfeeding data is collected at 6 – 8 weeks	Health visiting	15.1 6-8 week breastfeeding data validated
Initiatives to promote a healthy diet delivered in early years	16. Promote and support early year's setting to achieve the London Healthy Early Years Award, with a focus on Sugar Smart and Oral Health. Nurseries to deliver Sugar Smart workshops to families	Early Year's service	16.1 50 settings achieve the HEYL award 16.2 50 settings state three actions to tackle sugar consumption
	17. Develop an action plan to increase uptake of the Healthy Start vitamins and food vouchers among eligible families, including promoting the scheme and training for relevant staff.	Health visiting/midwifery	17.1 Increase in the uptake of the Healthy Start vitamins and food vouchers
	18. Deliver 'Eat Better, Start Better', healthy eating in the early years training to early year professionals and other people supporting families with under 5s. To include the Healthy Start Scheme, healthy weight and raising the issue of weight with parents.	Paediatric Dieticians	18.1 Training provided to early year professionals
Initiatives to promote a healthy diet delivered in schools	19. Continue to deliver school meals at Food for Life Served Here Award- Silver standard	Enfield Catering	19.1 Silver Award maintained
	20. Integrate Public Health messages into Enfield Catering communications	Enfield Catering	20.1 Clear, consistent PH messages incorporated into catering communications
	21. Support schools to become Sugar Smart by committing to three actions to reduce sugar consumption amongst primary school children	Healthy Schools Lead	21.1 30 schools state three actions to tackle sugar consumption 21.2 30 schools supported to install water fountains
	22. Encourage more schools to join The Felix Project Schools Programme and evaluate the effectiveness of the programme	Healthy Schools/ Public Health	22.1 30 schools involved with the project and evaluation completed.
	23. Support schools to deliver healthy breakfast clubs by highlighting best practice and signposting to funding opportunities.	Healthy Schools Lead	23.1 30 schools involved with the project and evaluation completed.
	24. Continue to deliver workshops to showcase local best practice and initiatives that support healthy eating in schools	Healthy Schools Lead	24.1 Annual workshop delivered

Schools supported to take a whole school approach to tackling obesity	25. Keep the Healthy Schools webpage and *Health & Wellbeing in Schools* brochure updated	Public Health	25.1 Webpage and brochure updated
	26. Support and promote Healthy Schools London programme, helping schools to - produce healthy weight action plans as part of the silver award. - develop the Staff Wellbeing section of the awards, and apply for the London Healthy Workplace Charter	Healthy Schools Lead	26.1 85% of schools registered and supported to gain bronze 26.2 5 schools accredited for the London Healthy Workplace Charter
	27. Support schools to develop and implement a good quality curriculum for Health Education	Healthy Schools	27.1 Health Education curriculum developed and implemented
	28. Continue to send NCMP school level feedback to participating schools outlining local support. Utilise the data fully to target specific schools and areas according to need.	School nursing/ Public Health	28.1 Schools with highest obesity levels targeted for interventions
	29. Pilot the Challenge You programme in two primary schools	Active Enfield	29.1 The Challenge You programme is communicated and evaluated
	30. Support schools to prioritise funding through the Healthy Pupils Capital Fund	Healthy Schools	30.1 Workshop and advice provided
	31. Explore opportunities to offer Youth Health Champions programme in secondary schools	Public Health	31.1 Business case developed
Workplaces support healthy choices	32. Promote the London Healthy Workplace Charter to the NHS, voluntary sector and local businesses and provide a range of resources to support implementation via the Healthy Enfield Website.	Public Health	32.1 Webpage developed and scheme promoted 32.2 10 local organisations awarded the Charter
	33. Council to develop a Workplace Health & Wellbeing strategy, and continue delivering and promoting workplace health activities	Human Resources / Public Health	33.1 Decrease in sickness absence
	34. The Civic Centre restaurant to continue offering healthy, sustainable food and share best practice with local businesses.	Culture, Sport & Arts	34.1 Sustainable Restaurant Association accreditation maintained

Objective 3: Providing residents with the knowledge, skills and opportunities to eat healthily, be active and maintain a healthy weight			
Outcome	**Action**	**Lead**	**Success measures**
Residents use local facilities and green spaces to be active and eat healthily	35. Support healthier weights on housing estates by - removing 'no ball games' signs - supporting food growing	Housing	35.1 New signs not installed 35.2 Old signs removed in consultation with residents 35.3 Food growing on estates project piloted on the Avenues estate and funding opportunities explored for further projects
	36. Promote use of Temporary Play Street Orders for Active Play	Public Health	36.1 Increase in number of Play Streets, including through schools, in the east of the borough
	37. Explore funding opportunities support people to be active and eat healthily in parks by installing water fountains and Mile-a-day marking	Parks / Public Health	37.1 Funding sought from the GLA for funding for water fountains 37.2 Mile-a-day markings piloted in one park
	38. All Council-owned buildings, parks and leisure services provide and promote healthy and affordable food and drinks where available.	Parks / Active Enfield	38.1 Continue work to identify levers for influencing Council owned buildings to support healthier food provision and advertising. 38.2 Caterers in all new Council parks and leisure centres are committed sign up to the Healthier Catering Commitment.
	39. Support and promote the activities provided at the leisure centres such as over 50s days and subsidised activity programmes to increase levels of physical activity particularly among inactive residents.	Active Enfield	39.1 Increase in levels of physical activity among inactive residents in the east of the borough
	40. Explore the opportunities to access funding to provide targeted physical activity programmes to those who need it most	Active Enfield	40.1 Funding opportunities explored
Communities provided with the tools to work towards a healthier weight	41. Map existing initiatives within the borough and actions being taken to help address obesity and build on these.	EVA / Public Health	41.1 Existing initiatives / actions mapped against local causes of obesity
	42. Ensure meaningful messages are disseminated from 'trusted' sources such as EVA and PEP	EVA / PEP	42.1 Clear, consistent, evidence-based messages communicated with our communities through 'trusted' sources
	43. Further develop the Health Champion network, ensuring that training needs are met so that healthy eating habits and active lifestyles are promoted	EVA / Public Health	43.1 Health Champions trained and working effectively in the community, and impact assessed
	44. Develop a communications plan to promote the Healthy Enfield website	Public Health	44.1 A clear communications plan is implemented to

			ensure our communities know about the Healthy Enfield website.
	45. Community groups aware of the potential support available through the S106 THF Coaching hours	Active Enfield / EVA	45.1 Allocated S106 coaching hours fully utilised to the benefit of our communities

Objective 4: Making tackling obesity everybody's business by working in partnership across sectors and developing a local workforce that is confident and competent in supporting people to make healthier choices

Outcome	Action	Lead	Success measures
The workforce supports behaviour change	46. Ensure the workforce across the Council, CCG and NHS, in addition to residents receive Making Every Contact Count (MECC) training with a focus on promoting healthy eating habits and active lives.	Public Health / HR	46.1 MECC training becomes mandatory for Council staff
Partners and stakeholders support the development of a whole systems approach to healthy weight	47. Use best practice from the Whole Systems Obesity Programme, define and develop a whole systems approach to tackle overweight and obesity	Public Health	47.1 Whole Systems Obesity approach adapted
	48. Engage the community in a comprehensive, innovative and effective contributory programme to ensure their input into future plans	EVA / Public Health	48.1 Communities effectively engaged and contributing to obesity plans
	49. Develop a clear, streamlined Healthy Weight Care Pathway.	CCG	49.1 Healthy Weight Care Pathway developed, implemented and monitored for effective uptake by priority groups
	50. Support members of the Health & Wellbeing Board to make Sugar Smart pledges that align with the Declaration on Sugar Reduction.	Public Health / HWB	50.1 Three actions to tackle sugar consumption identified and delivered by each member organisation

LBE & NHS Enfield lead by example	51. ***The Enfield 3-4-50 Challenge –*** Members of the Health & wellbeing board / Councillors / senior management challenged to promote one healthy behaviour each e.g. cycling to work	Public Health / Communications	51.1 Members of the Health & wellbeing board / Councillors / senior management promote one healthy behaviour

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

Update report for Health and Wellbeing Board

Report of: Stuart Lines, Director of Public Health, LB Enfield

Report author: Harriet Potemkin, Strategy and Policy Hub manager, LB Enfield

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.*

Health and Wellbeing Strategy 2019-22 consultation

Improving people's health and wellbeing is a top priority for Enfield.

The council, health services and the voluntary sector in the borough are together developing new ways to do this, and we want your views.

On average, this survey should take between 8-10 minutes to complete.

The vision

We are thinking about a new vision for making Enfield a healthier place. Our suggested vision is: **To make the healthy choice the first choice for everyone in Enfield**.

Q1 To what extent do you agree or disagree with this vision?

- ❑ Strongly agree
- ❑ Tend to agree
- ❑ Neither agree or disagree
- ❑ Tend to disagree
- ❑ Strongly disagree
- ❑ Don't know

Q2 Can you please explain your answer and suggest an alternative vision if you don't agree with the one we've suggested?

_____

_____

_____

_____

Q3 When you think about being healthy and living well which of the following do you think are important? *Please select all that apply*

- ❑ Feeling happy
- ❑ Knowing who to talk to if you feel stressed or worried
- ❑ Sleeping well at night
- ❑ Having friends, family and a support network that can help you
- ❑ Having a reduced risk of cancer, heart disease, lung disease and diabetes
- ❑ Living for a long time in good health
- ❑ Living without pain
- ❑ Having something meaningful to do every day
- ❑ Having somewhere suitable to live
- ❑ Having good sexual health
- ❑ Having a healthy weight
- ❑ Other

If other, please specify

_____
_____
_____
_____

Q4 What do you think you need to do to be healthy and live well? *Please select all that apply*

- ❑ Eating 5 portions of fruit and vegetables everyday
- ❑ Not eating too much processed food / takeaways and cook more from scratch
- ❑ Being physically active
- ❑ Not smoking nor being a passive smoker
- ❑ Not drinking too many sugary drinks

- ❑ Not drinking too much alcohol
- ❑ Other

If other, please specify

_____

_____

_____

_____

Q5 When you think about wellbeing, which of the following do you think is important? *Please select all that apply*

- ❑ Your home/where you live
- ❑ Your neighbourhood/ the places you spend time in outside your home
- ❑ How you travel/get around
- ❑ Your income/money
- ❑ Feeling safe/not worrying about crime
- ❑ Other

If other, please specify

_____

_____

_____

_____

We are looking at ways in which health care professionals could talk to you about community activities to help you improve your health, instead of only offering medical solutions. This could include helping you to access singing groups, art activities, walking, gardening, sports clubs or another activity in your community.

Q6 To what extent do you agree or disagree that this is a good approach to improving people's health?

- ❑ Strongly agree
- ❑ Tend to agree
- ❑ Neither agree or disagree
- ❑ Tend to disagree
- ❑ Strongly disagree

❑ Don’t know

Q7 Please explain your answer, so that we can better understand why this approach may or may not work.

_____
_____
_____
_____
_____

Eating healthily

We are now going to ask you some questions about eating healthily.

Q8 What did you have for dinner last night?

_____
_____
_____

Q9 When you decided what you had for dinner last night what influenced your decision? *Please select all that apply*

❑ What I felt like eating
❑ How much it cost
❑ What food I had available at home
❑ How long it took to prepare and cook
❑ Whether I felt like cooking
❑ Whether it was healthy
❑ Whether I was able to buy the meal/ingredients
❑ Ideas from friends or family
❑ Ideas from advertising
❑ My medical condition
❑ Other

If Other, please state

Being physically active

We are now going to ask you some questions about being physically active.

Q10 What does a typical week look like for you when it comes to physical activity? *Please select all that apply*

- ❑ I walk
- ❑ I cycle
- ❑ I go to the gym
- ❑ I play team sports
- ❑ I go swimming
- ❑ I go jogging/running
- ❑ I am physically active through my job
- ❑ I don't do any physical activity
- ❑ Other

If other, please specify

How many minutes a week do you walk?

- ❑ Less than 30 minutes
- ❑ 30-60 minutes
- ❑ More than 60 minutes

How many minutes a week do you cycle?

- ❑ Less than 30 minutes
- ❑ 30-60 minutes
- ❑ More than 60 minutes

How often do you go jogging/running a week?

- ❑ Once
- ❑ Twice
- ❑ More than 3 times a week

How often do you go to the gym?

- ❑ Once a week
- ❑ Twice a week
- ❑ More than 3 times a week

How often do you play team sports?

- ❑ Once a week
- ❑ Twice a week
- ❑ More than 3 times a week

How often do you go swimming?

- ❑ Once a week
- ❑ Twice a week
- ❑ More than 3 times a week

Q11 For the activity you took part in, where did you do it? *Please select all that apply*

- ❑ At home
- ❑ At school
- ❑ At work
- ❑ In a gym
- ❑ On a cycle path
- ❑ On the road/pavement
- ❑ In a park

- ❑ In a sports hall
- ❑ On a walking path
- ❑ Not applicable
- ❑ Other

If other, please specify

_____

_____

_____

Being smoke free

Q12 Have you smoked in the last week? (This does not include vaping or e-cigarettes)

- ❑ Yes
- ❑ No
- ❑ Not sure

Q12a Where were you when you last smoked?

- ❑ At home
- ❑ In the car
- ❑ Outside my home (e.g. outside my flat, on the stairs leading up to my flat)
- ❑ Outside my office
- ❑ Outside a public building (e.g. outside the library, outside the hospital)
- ❑ In a park
- ❑ On a street
- ❑ Other

If other, please specify

_____

_____

Would you like to receive more help in stopping smoking?

- ❑ Yes

❑ No
❑ Not sure

Q13 What do you think would stop more people from starting to smoke?

_____
_____
_____
_____

Q14 What do you think would encourage more people to stop smoking by themselves?

_____
_____
_____
_____
_____

About you

To help us better understand the information you have provided and to establish if the response to the questionnaire is representative of the borough, please respond to the questions in this section. Any information you provide will be collected, stored and managed in accordance with the General Data Protection Regulation (2018).

Q15 How old are you?

❑ 18-24
❑ 25-29
❑ 30-34
❑ 35-39
❑ 40-44
❑ 45-49
❑ 50-54
❑ 55-59
❑ 60 or over
❑ Prefer not to say

Q16 Are you

❑ Female
❑ Male
❑ Transgender
❑ Prefer not to say

Q17 In which postal district do you live?

- ❑ EN1
- ❑ EN2
- ❑ EN3
- ❑ EN4
- ❑ EN6
- ❑ EN8
- ❑ N22
- ❑ N9
- ❑ N11
- ❑ N13
- ❑ N14
- ❑ N18
- ❑ N21
- ❑ Prefer not to say

Q18 Please let us know if you receive any of the following? *Please select all those that apply*

- ❑ Housing Benefit
- ❑ Council Tax Support
- ❑ Universal Credit
- ❑ Prefer not to say
- ❑ None of the above

Q19 Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

- ❑ Yes, limited a lot
- ❑ Yes, limited a little
- ❑ No
- ❑ Prefer not to say

Q20 What is your religion?

- ❑ No religion
- ❑ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ❑ Buddhist
- ❑ Hindu
- ❑ Jewish
- ❑ Muslim
- ❑ Sikh
- ❑ Prefer not to say
- ❑ Any other religion

If 'Other', please specify

_____

Q21 Are you

- ❑ Heterosexual
- ❑ Gay Man
- ❑ Gay Woman/Lesbian
- ❑ Bisexual
- ❑ Prefer not to say

Q22 How would you describe your ethnic origin?

- ❑ English / Welsh / Scottish / Northern Irish / British
- ❑ Irish
- ❑ Greek
- ❑ Greek Cypriot
- ❑ Turkish
- ❑ Turkish Cypriot
- ❑ Italian
- ❑ Russian
- ❑ Polish
- ❑ Kurdish
- ❑ Gypsy / Irish Traveller
- ❑ Romany
- ❑ Other Eastern European
- ❑ White and Black African
- ❑ White and Black Caribbean
- ❑ White and Asian
- ❑ Mixed European
- ❑ Indian
- ❑ Pakistani
- ❑ Bangladeshi
- ❑ Sri Lankan
- ❑ Chinese
- ❑ Caribbean
- ❑ Ghanaian
- ❑ Somali
- ❑ Nigerian
- ❑ Arab
- ❑ Prefer not to say
- ❑ Other

If 'Other', please specify

_____

Thank you for completing the survey

The website ‘landing page’ for the survey will include the following information:

Support to stop smoking
Free, proven support to **help you quit**! Join the millions of people who have used NHS Stop Smoking Services and StopsmokingLondon to **help** them **stop smoking**.

Leisure centres
Information on Leisure Centres in Enfield and ways to stay active can be accessed here.

Support for mental health
You can find information on improving your mental health and wellbeing by visiting Healthy Enfield and NHS Choices.

Healthy eating
All information on healthy eating on a budget, including cutting out sugar can be accessed here.

Enfield Food Bank
To access North Enfield foodbank there are a few simple steps to follow here.

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 27 SEPTEMBER 2018

MEMBERSHIP

PRESENT Alev Cazimoglu (Cabinet Member for Health & Social Care), Yasemin Brett, Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Parin Bahl (Chair of Enfield Health Watch), John Wardell (Clinical Commissioning Group (CCG) Chief Officer), Stuart Lines (Director of Public Health), Vivien Giladi (Voluntary Sector) and Bindi Nagra (Director of Adult Social Care)

ABSENT Nesil Caliskan (Leader of the Council), Achilleas Georgiou, Dr Helene Brown (NHS England Representative), Tony Theodoulou (Executive Director of Children's Services), Natalie Forrest (Chief Executive, Chase Farm Hospital, Royal Free Group), Maria Kane (Chief Executive North Middlesex University Hospital NHS Trust) and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust)

OFFICERS: Clara Seery (Assistant Director - Education, Schools and Children's Services), Dr Glenn Stewart (Assistant Director, Public Health), Harriet Potemkin (Strategy, Partnerships, Engagement & Consultation), Richard Eason (Cycle Enfield Consultation Manager) and Jayne Middleton-Albooye (Head of Legal Services) Jane Creer (Secretary)

Also Attending: 2 observers

1
WELCOME AND APOLOGIES

Councillor Alev Cazimoglu (Chair) welcomed everyone to the meeting. Apologies for absence were received from Councillors Caliskan and Georgiou, Dr Helene Brown, Andrew Wright, Maria Kane (represented by Richard Gourlay, Director of Strategic Development, NMUH), and Tony Theodoulou (represented by Clara Seery, Assistant Director, Education, LBE).

2
DECLARATION OF INTERESTS

There were no declarations of interest registered in respect of any items on the agenda.

3
PROGRESS UPDATE ON JOINT HEALTH AND WELLBEING STRATEGY (JHWS)

RECEIVED a discussion paper and a slide presentation from Harriet Potemkin (Strategy and Policy Hub Manager, LBE).

NOTED

Harriet Potemkin's presentation highlighted:
- The themes and approaches had been discussed at the development session in July.
- The new strategy centred on behaviour change, focussing on a small number of behaviours known to have the biggest impact on health outcomes, and followed the 3-4-50 concept. This approach was supported by evidence in Enfield, and would also tackle health inequality.
- There was also expected to be a positive impact on mental health as it was closely connected to physical health.
- The vision was to make the healthy choice the first choice, with the focus on the three behaviours: being smoke-free; having a healthy diet; and being active.
- Members were asked to consider the suggested strategic priorities in advance of a public consultation.

IN RESPONSE comments and questions were received, including:
1. Members were happy that the development session discussions had been successfully captured in the proposals.
2. Delivery of the plan was to be the responsibility of the Board.
3. Adopting the Health in All Policies (HiAP) approach was important, within members' organisations and in their commissioning decisions.
4. There had been some improvements in some outcome measures shown as 'below national and/or have worsened since 2014', particularly the Learning Disability Health Check where the CCG was now one of the top performers nationally, and the table should be corrected.
5. There should be a clear summary page of priorities and actions, and the emphasis should be about the people and communities of Enfield and their empowerment. Messaging should be targeted and direct. A simple narrative was good for communication. The strategy should be simple, deliverable and measurable.
6. The current strategy ends in March 2019 and the new JHWS would begin in April 2019. A 12-week public consultation was intended beginning at the start of December, with the results to be brought back to the Board. Board members requested the presentation to be circulated, and the proposed public consultation to be provided by email for comment and approval.

AGREED that Health and Wellbeing Board:
(1) noted the progress on the proposal for a new Enfield Joint Health and Wellbeing Strategy 2019 onwards;

(2) agreed to receive the proposed public consultation for comment and approval via email.

4
CYCLE ENFIELD - PRESENTATION AND PROGRESS

RECEIVED a presentation from Richard Eason (Lead Officer for Cycle Enfield, LBE).

NOTED the presentation highlighted the following:
● The funding for the Cycle Enfield scheme came from investment from the Mayor of London: it was external funding.
● The scheme's aims were behaviour change and promoting active travel – to make cycling integral to people's everyday lives.
● A fivefold increase in bike use was sought in Enfield. This would make the population more active, and would help reduce traffic congestion.
● 30% of car journeys currently were less than 2km, which could be walked or cycled but people often did not feel safe sharing the road with motor traffic.
● The first cycle lane was completed along Green Lanes. Work was now concentrated at Edmonton Green. This major project was being delivered with improvements to the public realm as well. There were also quieter routes through green spaces.
● Supporting activities included better access to bikes eg dockless bike hire, work with young people eg training in schools, and cycle parking hubs. There was also a vibrant website, social media presence and newsletters.
● Health and Wellbeing Board could provide support through travel plans, leading by example, and supporting bids for future external investment.

IN RESPONSE comments and questions included:
1. It was noted that the scheme had received a degree of hostility from some groups, and it should be promoted as a benefit to public health and not detrimental to local businesses. HWB Board had a role in relation to promotion of behaviour change and ensuring a positive message was heard.
2. Cycling in Enfield was not done by some minority communities and there was a need to provide encouragement. Cycling mentors were suggested.
3. Schools could be engaged more. Work was ongoing to provide safe cycle storage on school sites, and cycling routes to schools.
4. Cycling should be promoted as the easy choice.

AGREED that Health and Wellbeing Board noted the presentation and agreed to consider further what support could be provided by the Board.

5
HEALTH IMPROVEMENT PARTNERSHIP (HIP) UPDATE

NOTED the verbal update from Dr Glenn Stewart (Assistant Director Public Health, LBE) and the Board agreed re-commitment to the HIP sub group from all the organisations. A meeting date would be circulated.

6
NORTH CENTRAL LONDON (NCL) STRATEGY FOR GENERAL PRACTICE

RECEIVED a covering letter and slides, plus an executive summary circulated to members.

NOTED the introduction by Dr Mo Abedi, advising that the five NCL CCGs were tasked to engage with key stakeholders and that comments on the draft strategy were requested by 28 September. The final strategy was due to be submitted to the CCG governing body in November.

IN RESPONSE comments and questions included:
1. The document was welcomed, and it was important that the strategy for General Practice was refreshed from time to time, particularly in this situation of considerable change and of population churn, rising population, and decreasing assets. However, there was a disappointing lack of information regarding Enfield specifically. The general focus was on the whole STP NCL area, but Board members would like to know more about issues in Enfield in particular. The document seemed to give more detail on other boroughs on some aspects, and there should be parity of presentation.
2. It was acknowledged there was a shortage of GPs in NCL, but Board members would like to know how many GPs Enfield was short of. Similarly, there was information about poor GP premises and single-handed practices, but members would like to know how many such practices there were in Enfield.
3. Board members would like to see more detail in respect of the estates plan, and felt that GPs should be working with Trusts over estates.
4. It was rightly stated that appointments were offered between 8am – 8pm, seven days a week, but it was a greater concern to people in Enfield that they could not always get through to GP surgeries by phone, and when they did, they could not get an appointment for a long time. Patients were told they could go to hubs, but the difficulties of travel for patients should be factored in, and changes should not be made to services without adequate consultation about transport, and recognition of the problems with access that could arise.
5. The draft strategy contained no realistic or persuasive solution to the key issue of GP shortages.
6. Mention was made of new and alternative employment models for GPs, but it would be useful to give examples, and to show how outcomes would be achieved. Information was lacking about how to grow the workforce, and by when.
7. More could be done to reflect how primary care looks to, and is experienced by patients, especially those in deprived areas.

8. There were concerns about how the strategy was presented in the document. Information should be presented about each borough (as is the case in many NCL documents). There were too many words and small print. Some issues and strategies would be consistent across the area, but there was a need to analyse the differences in each borough, and what was going to be done to meet borough-specific issues. The tone of the language was inconsistent across the document.
9. There appeared to be an expectation that patients would do things differently, but more information was needed about the necessary messaging and how this behaviour change would be achieved.
10. There was mention of private companies in relation to Estates, but their role in the future strategy was not clear.
11. The Board would welcome consideration of equality issues and their implications for the strategy.
12. There was insufficient information and data in respect of the vision and strategy for General Practice in Enfield for the Health and Wellbeing Board to give full support to the document.

AGREED that the points made by Health and Wellbeing Board would be included in a formal letter of response to the consultation.

7
ANNUAL PUBLIC HEALTH REPORT (APHR)

RECEIVED for information a covering report and link to the Annual Public Health Report 2018 online.

NOTED
1. The production of this annual report was a statutory requirement, and an imaginative format had been used this year, including an interactive picture.
2. The report was welcomed as a very interesting summary of the wider determinants of health, and that improvements can only be achieved by all partners working together across the system.

AGREED that Health and Wellbeing Board noted the Annual Public Health Report.

8
VOLUNTARY SECTOR REPRESENTATIVE APPOINTMENT / SELECTION PROCESS

NOTED a verbal update from Niki Nicolaou (Voluntary Sector Manager) that two potential partners had been identified to carry out the appointment

process, that procurement was taking place, and until an election was held Vivien Giladi would remain the Voluntary Sector representative on the Health and Wellbeing Board.

9
MINUTES OF THE MEETING HELD ON 26 JULY 2018

AGREED the minutes of the meeting held on 26 July 2018, with a minor amendment to Minute 14 (2.) to read ‘could’ rather than ‘will’.

10
INFORMATION BULLETIN

NOTED the Information Bulletin items.

11
NORTH CENTRAL LONDON (NCL) SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) NEWSLETTER

NOTED

1. The NCL STP newsletter items.
2. Members’ concerns in respect of the Adult Elective Orthopaedic Service Review and wishes to be fully engaged in the consultation, and that the team should be invited to a development session with the Health and Wellbeing Board on 31 October 2018.

12
HEALTH AND WELLBEING BOARD FORWARD PLAN

NOTED the Health and Wellbeing Board Forward Plan.

13
DATES OF FUTURE MEETINGS

NOTED the dates of future meetings of the Health and Wellbeing Board and dates of future development sessions.

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