Health Inequality Workstream

REPORT

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Foreword

The transfer of the responsibility for public health from the NHS to local authorities in April 2013 heralded a momentous change in healthcare provision. Councils now have a tremendous opportunity to more effectively promote health & wellbeing; tackle health inequalities; and provide a more holistic approach to the health of their local communities with a focus towards prevention rather than cure.

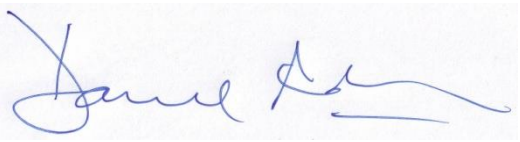
This report is the culmination of an extensive scrutiny review into Enfield's Public Health function. Initiated back in October 2014 at the instigation of the Overview & Scrutiny Committee, it was initially intended to be of a relatively short duration and look at ways of supporting the Public Health Department's identified priorities. However, its purpose and direction changed as a result of its preliminary investigations and reference to government guidance.

On behalf of the Workstream, I'd like to take this opportunity of thanking all those who cooperated with us and helped either directly or indirectly in the development of this report.

Particular thanks must go to Dr Shahed Ahmad, Enfield's Director of Public Health, and Dr Allison Duggal, Consultant to Public Health, who appeared before the Workstream on two separate occasions, as well as providing considerable supporting evidence before, during and after our formal deliberations. I'd also like to put on record our thanks to former councillor, Rohini Simbodyal, and note the deep commitment that she displayed in carrying out her responsibilities in this area. We wish her every success in her future endeavours.

Thanks are also due to Claire Johnson, Scrutiny Manager, for her help and support in directing the work of the Workstream.

Finally, I'd like to thank my fellow colleagues on the Workstream for their various contributions, comments, suggestions and advice throughout.



Daniel Anderson, Chair
July 2015

Executive Summary

This report details the findings, conclusions and recommendations of the Health Inequality Workstream whose initial aims were to look into Enfield Council's Public Health Department's key priorities, namely reducing child poverty, reducing the gaps in inequality and finding ways of reducing the demand for adult social care.

However, as a result of our preliminary investigations, and after reviewing government guidance on the statutory duties of local authorities for Public Health, the focus of the Workstream necessarily shifted towards the role of the Public Health team itself, primarily The Public Health Annual Report (2014); the remit and budget allocated to the department; the existing contractual arrangements; and the child poverty strategy and draft action plan. We also looked at the smoking cessation programme targeted at the Turkish community as this provided a good 'snapshot' of the work of the Public Health Department in practice.

Our investigations involved both formal and informal meetings with various representatives from the Public Health team and officers from other departments, where necessary, to discuss these areas in detail and to get some idea as to the scale of the problems, together with the nature and impact of interventions. We also reviewed some material on behavioural economic approaches and considered how this could potentially assist the public health agenda.

Historically, Public Health in Enfield has been under-funded. Nonetheless we question the balance of funding and the allocation and distribution of existing funds, focused as they are mainly on sexual health and drug & alcohol treatments. We note that the former is a demand-led service and less open for local decisions, whilst the latter is a discretionary spend. We are, however, particularly concerned over the considerable amount of money, spent on Public Health Leadership and CCG core health & intelligence, the benefits of which are not clearly evidenced, and which seemed to be non-aligned with the stated priorities of the department. Though the spending allocation, which is lower per head than many authorities, may well be in line with Public Health England guidance~~,~~ we remain unconvinced that spending is being allocated in the best way.

We believe that, as with other councils across London, the controllable spend on existing sexual health contractual arrangements, inherited from the PCT, has failed to deliver measurable results. It is unable to demonstrate the effectiveness of interventions and value for money, whilst the focus appears to be more on outputs than outcomes. However, moving forward, we are reassured that new contractual arrangements will be in place to address these concerns.

Though we feel that the Public Health Annual Report was well put together and illuminating, we are concerned about the lack of context, the use of statistics contained within, and the failure to highlight the importance of or demonstrate community engagement. In addition, there appears to be a lack of synergy between this and the Health & Wellbeing Board's Joint Health and Wellbeing Strategy. Furthermore, the five objectives contained within the latter are not completely aligned with the Public Health team's three priorities.

Turning to the high numbers of pupils in schools who don't take-up the healthy meals on offer, this is of considerable concern and mitigates against the overall objective, i.e. ensuring

that ALL children eat, rather than just have access to, healthy school meals. We are concerned that schools appear reluctant to enforce restrictions on packed lunches, preferring instead to rely on advisory guidance. This we believe works against any attempt to maintain a uniform approach to healthy eating. We are also concerned that some secondary schools allow pupils to leave the premises during lunch breaks as the tendency is for them to go off and purchase unhealthy options from takeaways and newsagents.

Though causality between these behaviours and childhood obesity is hard to prove, it is equally hard for us to overlook the fact that obesity is linked to 30 diseases and estimated to cost Enfield £78.6m a year and that childhood obesity in Enfield is amongst the highest in London.

With regards to smoking cessation, we are concerned at the failure to follow through on past initiatives aimed at seeking to better engage the Turkish community.

Turning to child poverty, instead of building on the firm basis of an already comprehensive and well written strategy, the Public Health team have initiated an extensive review and second draft strategy. Time and resources - both human and financial - have been spent on producing an ongoing and extensive range of material that the panel found confusing. In addition, we believe that whilst there is no definitive evidence base yet as to the most effective interventions to sustainably tackle child poverty the idea of developing a 30 to 40-year plan to eradicate child poverty is unrealistic and unachievable. It is also our view that the child poverty strategy requires a more corporate steer as many of the central features are not within the purview of the public health mandate and we question the likelihood of it having an impact, in the short and medium term, on children's health and wellbeing.

In conclusion, we believe that the Public Health Department's own priorities need to be recalibrated away from the socio-economic and wider determinants of health, such as improving the quality of housing; raising aspirations amongst children; and improving parenting skills, which are the responsibilities of other council departments, towards what have been shown to be the most effective public health interventions, such as increasing home care visits; pre and post natal nursing support; encouraging physical activity of mums; improving health and wellbeing; smoking cessation, improving nutrition and improving physical activity.

Meetings

October 7th 2014 (closed meeting). Dr Allison Duggal (Consultant to Public Health) and Estella Makumbi (Public Health Strategist) were invited to provide members with an overview together with background information on health inequality, infant mortality, child obesity and child poverty.

23rd October 2014 (closed meeting). Councillor Anderson, together with Claire Johnson, met with Una Archer (Curriculum & Access Strategy Manager) and Julia Dowsett (Schools' Food & Quality Manager) to gain an understanding of our approach to healthy school meals.

6th November 2014 (closed meeting). Councillor Anderson, together with Claire Johnson, again met with Estella Makumbi to discuss Enfield's current approach to tackling infant mortality.

17th November 2014 (invited participants). Councillor Anderson, together with Claire Johnson, attended the Child Poverty Conference, organised by the Public Health Department and held at the Dugdale Conference.

25th November 2014 (closed meeting). Councillor Anderson met Dr Naheed Rana (Interim Head of Intelligence) and Miho Yoshizaki (Senior Public Health Analyst) to look at the data intelligence presented at the Child Poverty Conference.

1st December 2014 (open meeting). Councillor Rohini Simbodyal (Cabinet Member for Public Health), Dr Shahed Ahmad (Director for Public Health) and Dr Duggal were invited to a public meeting of the Workstream to discuss the recently published Public Health Annual Report (2014) titled 'Mind the gap: Reducing the gap in life expectancy'; explore the remit and budget allocated to the department, which is currently ring-fenced; and review the existing contractual arrangements, which had been presented to Cabinet back in June 2014.

27th January 2015 (closed meeting) Councillor Anderson and Councillor Pite met up with Bindi Nagra (Assistant Director for Strategy and Resources) and Christine Williams (Public Health Commissioning Manager) to discuss future sexual health contracting arrangements.

16th February 2015 (closed meeting). Councillor Anderson attended a meeting to discuss engagement with the Turkish community on smoking cessation. Convened by Julie Boyd (Public Health Manager) and chaired by Glenn Stewart (Assistant Director for Public Health). In attendance were Bob Griffiths (Assistant Director Planning, Highways & Transportation), Martin Rattigan (Public Health Public Manager), Sheila Lahey (Fair Trade Officer), Ilhan Basharan (Communities Manager) and Niki Nicolaou (Voluntary Sector Manager). Also in attendance was a cardiologist from the North Middlesex Hospital.

16th March 2015 (open meeting). Councillor Simbodyal, Dr Ahmad and Dr Duggal were again invited back to provide evidence, this time to specifically discuss the development of, and thinking behind, the child poverty action plan; and the make-up and purpose of both the child prosperity board and the child poverty operational group. Also invited were Glenn Stewart, Assistant Director for Public Health, and Julie Boyd, Public Health Manager, in order to discuss the smoking cessation programme that had been specifically targeted at the Turkish community.

24th March 2015 (closed meeting). Councillor Anderson and Councillor Pite again met up with Bindi Nagra (Assistant Director for Strategy and Resources) and Christine Williams (Public Health Commissioning Manager) to discuss the revised sexual health provisional contracting arrangements.

8th April 2015 (open meeting). Bindi Nagra (Assistant Director for Strategy and Resources) and Christine Williams (Public Health Commissioning Manager) appeared before the Overview & Scrutiny Committee to discuss the revised sexual health provisional contracting arrangements and present a formal report.

Introduction

Public Health is now a local government responsibility and has been since 1st April 2013. Councils are now tasked with seeking to improve the health of their local population and the delivery of a variety of public health services, split between mandatory and non-mandatory responsibilities.

The Health Inequality Workstream was set up in October 2014 by the Overview and Scrutiny Committee and chaired by Councillor Daniel Anderson. Vice-Chaired by Councillor Andy Milne, together with councillors Vicki Pite, Suna Hurman, Christiana During and Nick Dines, the initial aims were to look into 4 priorities that Councillor Rohini Simbodyal, Cabinet Member for Culture, Sport, Youth and Public Health, had identified, namely,

- tackling infant mortality;
- addressing child poverty;
- confronting child obesity; and
- addressing the wide variations in life expectancy between those living in the eastern and western parts of the Borough

Dr Shahed Ahmad, Director of Public Health, later summarised his key objectives as being threefold, namely to:

- Reduce child poverty;
- Reduce the gaps in inequality; and
- Find ways of reducing the demand for adult social care

Dr Ahmad believed that the first two priorities were a significant contributory factor to both high levels of infant mortality and the growing child obesity crisis. Enfield, he told us, is an extreme outlier with regards to child poverty, arguing that childhood is the most important part of a person's life and there is a strong evidence base for the success of early, as opposed to late, interventions. He also maintained that deprivation is the strongest underlying determinant of good health and wellbeing. Hence, addressing child poverty is, from Dr Ahmad's perspective, Enfield's biggest long-term health issue.

With regards to the life expectancy gap, Dr Ahmad argued that there was an enormous body of evidence from The National Support Team for Health Inequalities (NSTHI) about effective interventions to narrow this in the short-term. These interventions are also evidenced as highly cost effective. For example, Enfield used to have one of the largest female life expectancy gaps in the country, which, encouragingly, has now been reduced, though there is still some way to go and therefore remains a top priority.

The third priority was based on the so-called *'Barnet Graph of Doom'*, a presentation by the London Borough of Barnet, which had claimed that unless the ever increasing demands on adult social care are addressed, within 20 years Barnet, along with most councils, will be unable to deliver anything other than adult social care and children's services.
http://engage.barnet.gov.uk/consultation-team/corporate_plan-consultation

Dr Ahmad added that early in 2015 the Health and Wellbeing Board would be discussing at a development session how it delivers these themes and how it structures itself. The costed plans will then be developed as part of the next steps towards delivering the Joint Health &

Wellbeing Strategy. Narrowing the life expectancy gap and addressing child poverty (i.e. ensuring the best start to life) are two of the 5 themes contained therein. There is also a theme on enabling people to be safe, independent and well, delivering high quality health and care services, which covers dementia. Interventions include tackling smoking; promoting physical activity and a healthy diet; and preventing harm caused by excessive alcohol consumption.

To this end, initial investigations involved both formal and informal meetings with various representatives from the Public Health team and officers from other departments, where necessary, to discuss these areas in detail and to get some idea as to the scale of the problems, together with the nature and impact of interventions. We also reviewed some material on behavioural economic approaches and considered how this could potentially assist the public health agenda.

However, as a result of our preliminary investigations, and after reviewing government guidance on the statutory duties of local authorities for Public Health, the focus of the Workstream necessarily shifted towards the role of the Public Health team itself, primarily The Public Health Annual Report (2014); the remit and budget allocated to the department; the existing contractual arrangements; and the child poverty strategy and draft action plan.

1) Overview of Public Health priority areas

Dr Allison Duggal (Consultant to Public Health) and Estella Makumbi (Public Health Strategist) were invited to provide members with an overview together with background information on health inequality, infant mortality, child obesity and child poverty.

The main arguments they presented were as follows:

a) Health Inequality

- Health inequalities are a reflection of wider social inequalities
- The annual cost of health inequalities is estimated to be between £36bn and £40bn through lost taxes, welfare payments and costs to the NHS
- Enfield is the 14th (out of 32) most deprived London borough and 64th (out of 326) most deprived local authority in England
- Three Edmonton wards are within the most deprived 10% of wards in England
- 12 (out of 21) wards in Enfield are in the most deprived 25% of wards in England
- Outcomes should be viewed in terms of short (0-5 years), medium (0-10 years) and long-term (10+ years) interventions
- Medium term interventions seek to alter lifestyle factors, such as stopping smoking, increasing physical activity and improving nutrition. Long-term interventions seek to address the so-called 'wider determinants of health' i.e. tackling deprivation, improving housing, employment, education etc.

b) Infant Mortality

- Enfield's infant mortality rate is above the London and England average and is the 4th highest in London (2009-11). Though the level is not in itself statistically

significant, Upper Edmonton demonstrates a significantly higher level than within other wards

- Major risk factors include infant sleep position, adult/infant sleeping and tobacco smoke
- Other risk factors include low-socio-economic status, maternal age, marriage status, late booking for antenatal care, lack of access to early screening, smoking during/after pregnancy, alcohol/substance misuse, nutrition, obesity, domestic violence, not breast feeding, mental health issues
- There is also a socio-economic correlation with those in the lowest level of deprivation being at a higher risk

(Subsequent to the above, a further briefing from Estella Makumbi was provided that discussed Enfield's current approach to tackling infant mortality. This was focused around the Parent Engagement Panel (PEP), whose aim it is to recruit and train parent volunteers to work within various communities. It was later agreed that the PEP would be scrutinised by the Standing Health Scrutiny Workstream.)

c) Child Poverty

- The Child Poverty Act 2010 focuses on relative low incomes, combined low income and material deprivation, absolute low income, and persistent poverty
- Deprivation can be measured in a number of different ways, though the Index of Multiple Deprivation is the most commonly used
- Deprivation in Enfield varies widely with the highest rates in the East of the borough. The overall rate in Enfield is similar to the London average, but higher than England
- Male life expectancy in Upper Edmonton is 75.7 years, compared with 84.4 years in Grange; Female life expectancy in Upper Edmonton is 78.5 years, compared with 87.1 years in Grange
- The National Child Poverty Strategy (2014-17) published by the Department for Work and Pensions suggests that poverty correlates with long-term worklessness and low incomes, low qualifications, single-parents and large families, and ill-health/disability
- Enfield's Child and Family Poverty Strategy (2012) identified, in addition to the above, debt, housing issues, population churn, lack of affordable childcare, low skills, transport issues
- The Marmot Review (2010) suggests that priority should be given to
    - The early development of physical and emotional health, cognitive, linguistic and social skills
    - Ensuring high quality maternity services, parenting programmes, childcare and early years education
    - Building the resilience and well-being of young children

d) Childhood Obesity

- Obesity is linked to over 30 diseases and was estimated back in 2008 to cost Enfield £78.6 m per year, though this is expected to rise to at least £84.1m in 2015. Its prevalence has tripled in 30 years
- In the academic year 2012/13:

- 26.2% of Enfield children aged 4-5 (Reception) were classed as either obese or overweight, as compared to the London and England average of 23% and 22.2% respectively. This is the 6th highest in London
- 39.1% of Enfield children aged 10-11 were classed as either obese or overweight, as compared to the London and England average of 37.4% and 33.3% respectively. This is the 13th highest in London
- Though there is no robust information on adult obesity, estimates suggest that 64.2% of Enfield residents are either obese or overweight and the figure nationally has risen over the last 20 years from 15% (1993-95) to 25% (2010-12)

- There is a strong relationship between deprivation and obesity with the most deprived being twice as likely to suffer obesity as those living in least deprived areas

Discussions took place on how we might help support the Public Health team in delivering its objectives in these areas.

2) Tackling obesity within schools

Una Archer (Curriculum & Access Strategy Manager) and Julia Dowsett (Schools' Food & Quality Manager) provided an overview of the Council's approach to providing healthy school meals.

We were informed that most schools follow the Government's nutrition standards as set out by the Children's Food Trust and all meals are nutritionally-balanced. Breakfast clubs and all other school food provision have to legally conform to these standards. Enfield Catering Services (who cater for 80% of the Borough's schools), has received the Soil Association's Silver Catering Mark demonstrating commitment to using seasonal and locally-sourced produce, animal welfare standards, freshly cooked food, as well as sustainable fish and nutritious menus.

As of September 2014, all Infants (i.e. reception, years' one and two) are entitled to a free school meal, eligibility across other years is around 30% and work has been done to promote the uptake of free meals.

Findings and conclusions

The Workstream learnt that schools which were set up as academies prior to the new arrangements being in place are not subject to the Government's nutrition standards, thereby creating an unhelpful anomaly especially as the Government has made clear its intention to increase the number of academies and free schools.

A more significant problem we identified was that that the take-up of school meals is not compulsory and the rate varies considerably depending on age-group. For instance, though 85% of reception school pupils eat school meals - no doubt helped by the government decision to provide free school meals to children in reception, year one and two - that percentage falls to 50-55% of primary school pupils and only 35-40% of secondary schools pupils.

Furthermore, we were equally concerned that schools appear reluctant to enforce restrictions on packed lunches, preferring instead to rely on advisory guidance. This we believe surely works against any attempt to maintain a comprehensive and effective approach to healthy eating.

Likewise, we were equally concerned that some secondary schools allow pupils to leave the premises during lunch breaks. Putting aside the obvious health & safety issues and questions of who is responsible for the pupils' welfare during this period of the school day, the tendency is for them to go off and purchase unhealthy options from takeaways and newsagents. The same happens at the end of the school day, compounding the problem.

Though we were informed that the introduction of cashless payment systems has helped increase the take-up of healthy meals, nonetheless the fact that high numbers of pupils don't do so is of considerable concern and surely mitigates against the overall objective, i.e. ensuring that ALL children eat, rather than just have access to, healthy meals. Offering healthy school meals is one thing, pupils' eating them is another, and clearly the first doesn't automatically lead to the other.

3) Public Health in Enfield

As a result of our preliminary investigations, and after reviewing government guidance on the statutory duties of local authorities for public health, the focus of the Workstream necessarily shifted towards the role of the Public Health team itself. To that end, Councillor Simbodyal, Dr Ahmad and Dr Duggal were invited to appear before a public meeting of the Workstream.

The aims of the meeting were to:

- Discuss the recently published Public Health Annual Report (2014) titled 'Mind the gap: Reducing the gap in life expectancy';
- Explore the remit and budget allocated to the department, which is currently ring-fenced; and
- Review the existing contractual arrangements, which had been presented to Cabinet back in June 2014

a) Mind the gap: Reducing the gap in life expectancy: The Report of the Director of Public Health for Enfield 2014

Dr Ahmad explained that the focus of the report, which he reported was based on a solid evidence base, helped inform the development of his strategy. He drew attention to a three-pronged approach to public health based on short, medium & long-term interventions, which were all based around the acronym of MEDS, i.e. **M**ovement (encouraging exercise), **E**ating (encouraging diets with less sugar/salt/calories), **D**rinking (reducing alcohol and sugary drinks) and **S**moking (seeking to stop people smoking).

Dr Ahmad acknowledged that the short-term interventions e.g. controlling blood pressure or cholesterol etc. were easier to implement with more tangible and immediate outcomes. Medium-term interventions were aimed at tackling smoking; improving diet and tackling obesity; alcohol and substance misuse. Long-term interventions were far harder to achieve given that they were about addressing social and economic factors, i.e. the wider determinants of health as identified by the Marmot Report (2010), such as enhancing the quality of housing, reducing poverty and improving education.

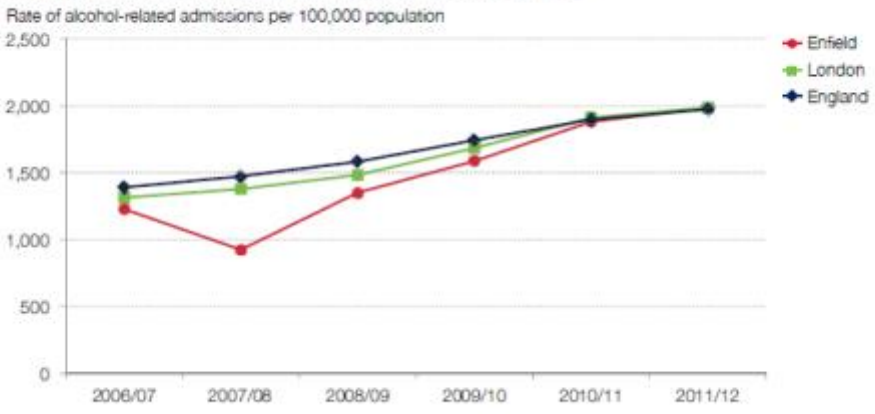
Findings and conclusions

Though we accept that there is no standard guidance on the production of an Annual Report and authorities differ in their scope and detail, nonetheless we feel that though The Annual Report of the Director of Public Health for Enfield is well put together and illuminating, it fails to highlight the need for, or demonstrate, community engagement. There also appears to be a lack of synergy between The Annual Report and the Health & Wellbeing Board's Joint Health and Wellbeing Strategy (2014 – 2019). Furthermore, the five objectives contained within the latter, i.e. ensuring the best start in life; enabling people to be safe, independent and well and delivering high quality health and care services; creating stronger, healthier communities; reducing health inequalities – narrowing the gap in inequality; and promoting healthy lifestyles and making healthy choices, are not completely aligned with the three priorities identified by the Director of Public Health to the Overview and Scrutiny Panel, though they are not in the Annual Report.

We were concerned about the lack of context and the use of statistics contained within the report. For example, it states that between 2007/08 and 2011/12 the rate of alcohol related hospital admissions in Enfield had increased by 114%, but no baseline figure was provided within. Subsequent to the meeting this was provided by Dr Duggal. However, she acknowledged that the 2007/08 starting point appeared to be a blip. If 2006/07 had been used as a baseline this would been consistent with an upward trend across Enfield, London and England (see below).

The data comparison below shows 925 admissions per 100,000 in 2007/8 and 1,986 per 100,000 in 2011/12.

Figure 4.2: Trend in the Rate of Hospital Admissions due to Alcohol Related Harm, for all ages per 100,000 population in Enfield, London and England: 2006/07-2011/12



Source: Local Alcohol Profiles for England, North West Public Health

For some reason admissions in the 2007/08 year fell. Dr Duggal herself suggested that it was quite possible that the data collection for that period was unreliable and she was equally concerned over the accuracy of the data recording methods in general. In addition, she confirmed that the criteria used to compile these figures has changed and future data would not be comparable, thus making it nigh on impossible to evaluate improvements in treatments or the effectiveness or otherwise of preventative strategies. The 114% increase should not therefore be relied upon.

The wider determinants of health I: 'The Roseto effect'
Dr Ahmad regularly cites the Dahlgren & Whitehead model on the wider determinants of health (1992) which is endorsed by the World Health Organisation and many leading health experts, e.g. Michael Marmot. As well as talking about individual lifestyle factors it also draws attention to the importance of considering social and community networks, and general socioeconomic, cultural and environmental conditions.

To that end, Dr Ahmad made particular reference to what has become known as *'the Roseto effect'* named after the community of Roseto, Pennsylvania, and made famous by Malcolm Gladwell's book *'Outliers'*. In Roseto, a village made up of Italian immigrants, no one died of a heart attack, or showed any sign of heart disease for a number of years. For men over 65 the death rate was less than half the United States average, and the overall death rate was 35% lower than usual.

Findings and conclusions
Dr Ahmad cited *'the Roseto effect'* as a good example of the impact of the wider determinants of health such as the significant impact of strong social networks on longevity in Roseto. Notably, diet was *not* a factor in their longevity. Rosetans cooked with lard, pizza was bread dough plus sausage, pepperoni, salami, ham and eggs. Sweets like biscotti and taralli were eaten all year round and, when their typical eating habits were analysed, it was found that 41% of their calories came from fat. In addition, the Rosetans were heavy smokers and many were obese. The conclusion was that the reasons for their good health therefore had nothing to do with diet, exercise – of which they did little, their genes or even their physical environment. It was to do with their strong social networks. Given that this is so, we remain unclear as to what practical strategies would therefore be required to replicate *'the Roseto effect'* in Enfield and, further, the evidence completely contradicts the standard advice embraced by health experts.

The wider determinants of health II: 'The Edmonton effect'
Figures in the report also seemed to indicate that life expectancy was improving in the areas of the biggest concern, namely Upper and Lower Edmonton and Edmonton Green, which had seen significant improvements between the period of 2006-2010 and 2008-2012, based on a 5-year rolling average.

Findings and conclusions
Clearly, 'The Edmonton effect' was far too short a timeframe to suggest that there had been any significant changes to the wider determinants of health. Migration may well have had an impact, i.e. gentrification, whereby the areas have seen an

improvement in health outcomes not because individuals' lifestyles have necessarily improved, but because new housing developments have seen a change in the demographics thereby positively impacting on the data. Drs' Ahmad and Duggal accepted that this was indeed possible, but was hard to verify. Though we acknowledge this, it nonetheless leaves a question mark over the reasons behind the improvements.

b) The remit and budget allocated to Public Health

The Public Health budget, as from 1st April 2013, is delegated to local authorities and currently ring-fenced. Enfield's budget for 2014/15 is £14.2m and this will remain the same for 2015/14, which is a reduction in real terms. The main objectives for the funding are to improve the health and wellbeing of the population alongside existing budgets, both within the Council and in the NHS as determined by the Clinical Commissioning Group (CCG). Dr Ahmad viewed the role of the Public Health Team as one of advocacy and leadership in seeking to influence a holistic approach to service delivery, which considers the health impacts of developments whether that be housing, planning, licensing etc.

Dr Ahmad based his budget priorities on the statutory obligations, contractual arrangements, Enfield's own public health objectives (stated below) and Enfield's Joint Health & Wellbeing Strategy (2014-19).

I. Statutory obligations

- Sexual health services;
- Public health advice and support for NHS commissioners (CCG);
- The National Child Measurement Programme (NCMP);
- NHS Health checks assessment; and
- Responsibilities around health protection

II. Discretionary services

In addition to the above, there are also a wide range of services that public health can choose to support, which include:

- Tobacco, smoking, alcohol and drugs;
- Children and young people aged 5-19;
- Obesity, nutrition, physical activity;
- Oral health promotion;
- Accidental injury prevention;
- Reducing and preventing birth defects;
- Behavioural and lifestyle campaigns to prevent cancer and long-term illnesses;
- Local initiatives on workplace health;
- Supporting, reviewing and challenging delivery of NHS services (which are funded by PH);
- Actions to help reduce excess winter deaths;
- Community safety promotion, violence prevention and response;
- Tackling social exclusion; and
- Environmental risks

III. Existing contractual arrangements

- Sexual Health services (£4,576,000)
- Drug and Alcohol Services (£3,726,000)
- Children & Young People services (including School Nursing) (£1,392,000)
- Smoking cessation services (£360,000)
- Health checks (£454,000)

IV. Other spending is allocated as follows:

- Public Health Leadership, which covers other staff in the department and who are responsible for Joint Strategic Needs Assessment and other needs assessments, such as Female Genital Mutilation. They also run health promotion campaigns and work with CCG commissioners on contracting public health services, such as stop smoking initiatives (£1,607,000)
- Funding initiatives in other departments, which has included the funding of residential placements for drug users; paying towards staff in environmental health, particularly those dealing with air pollution, food and tobacco control; and some children's centre activity (£741,000)
- Other health improvement schemes, including mental health (£560,000)
- Cancer, CVD and diabetes (£442,000)
- CCG Core health and intelligence, which is about conducting health needs assessments for the CCG; reviewing the evidence for the effectiveness of treatments; providing data for planning; helping the CCG prepare business cases for pathway redesign; and ensuring that the CCG activity is focused on key priorities. Dr Ahmad illustrates the value of intelligence work with the HiLo Project, which was targeted at patients with high blood pressure and cholesterol that had been hard to control. A partnership was forged with UCL Partners, funded by the CCG who then identified the practices for delivery and then managed it. The project led to a 10mHg reduction in blood pressure and a 0.5mmol/l drop in cholesterol. (£407,000)
- Obesity (£388,000)

Spending allocations

Enfield faced historical and chronic under-funding for its public health remit. Though Dr Ahmad and Enfield Council have lobbied for this imbalance to be redressed, part of the problem is that the funding allocation is based on how much money the previous Primary Care Trusts (PCTs) spent, which in Enfield's case tended to be low. However, though there were indications that this would be addressed, the Government recently announced cuts in public health funding that, in Enfield's case, is likely to amount to a further 7% reduction, which is a serious concern.

Dr Ahmad saw the Public Health budget addressing health concerns in combination with other departmental spends within the council, and that of the NHS, and not seen as a standalone. Citing Cycle Enfield as an example, which is an environment project, For instance he saw Cycle Enfield, which is an environment project, as being part of the solution to the obesity crisis. So the

small amount spent directly on tackling obesity and increasing physical activity should be seen in that wider context.

Dr Ahmad's approach whenever he is asked to agree funding is to first look at the evidence, taking into account local data. He favours, wherever possible, schemes which are co-designed with the local population. These have been shown to work, and he cited smoking rates in Edmonton which have declined on a par with New York because of co-designed programmes, and Dr Ahmad explained that Enfield had achieved above the national trend in this respect. The Overview and Scrutiny Committee endorsed this approach and expressed the view that community engagement could usefully have had a higher profile in the Annual Report.

Dr Duggal argued that the Public Health mandate was one of leadership, citing the work she had undertaken in tackling female genital mutilation (FGM). This involved reviewing the evidence, working with the Somali community, and bringing on board the acute trusts and various council services to work together in addressing the problem.

Councillor Simbodyal added that it was her intention to see public health embedded across all service areas, citing the forthcoming Sport & Culture Strategy, which will have a 5-year plan and will be targeted at those most susceptible to poor health outcomes. Going forward, public health was now a standing evaluative principle when council reports are drafted, ensuring that it is given a central platform in policy shaping, as long as it is not simply given lip service.

Dr Ahmad stated that the Public Health agenda works best when it is used as an intellectual resource, e.g. by the NHS in helping to find the best value for finite resources. For instance, the Chief Executive of the local NHS might ask Dr Ahmad to help in tackling a local problem, as she did with tackling Cardio Vascular Disease (CVD), where he was surprised to find that there was no strategy in place, so he sought to develop one by providing the evidence of what works. Tower Hamlets had a successful scheme in place, which he then adopted and trialled in two practices (see the reference to the HiLo Project in the notes above). The results, he suggested, were impressive and the Public Health team is now looking to roll the programme out across the borough.

Dr Ahmad explained that the biggest assets Public Health can bring to the table are a) to review the evidence base b) to integrate any national findings and c) to provide data intelligence. The budget pays for developing Enfield's skills base in these respects, as well as complementing existing spends of the NHS, such as sexual health.

Findings and conclusions

Notwithstanding the historical under-funding and the 7% reduction going forward, the Workstream nonetheless questions the balance of funding and the allocation and distribution of existing funds, focused as they are mainly on sexual health (£4,576,000) and drug & alcohol treatments (£3,726,000), the latter of which is a

discretionary spend. We note that the former is a demand-led service and less open to local decisions, whilst the latter is a discretionary spend.

We are particularly concerned over the considerable amount of money, over £2m, spent on Public Health Leadership and CCG core health & intelligence, the benefits of which are not clearly evidenced, whilst only £388k was dedicated to tackling the growing obesity crisis, which seem to be non-aligned with the stated priorities of the department. Though the spending allocation, which we acknowledge is lower per head than many authorities, may well be in line with Public Health England guidance, we remain unconvinced that spending is being allocated in the best way. Indeed, we are yet to see any evidence of the more integrated approach cited by Dr Ahmad, where the public health budget complements other departmental spends. We would also like to see spending aligned with the Health & Wellbeing Board's stated priorities, namely tackling obesity and increasing physical activity. It would therefore be helpful if there was greater clarity on the local decision-making process.

We also question the logic that assumes that by spending more money to encourage people to exercise will necessarily lead to more people exercising, citing the disparity that currently exists across the borough between those who exercise and those who don't. If exercise is not part of the cultural fit then without additional action aimed at changing attitudes then the pay off may not be as extensive as imagined. Therefore we would also like to see both strategic and financial commitment to the community engagement process necessary for the co-construction of effective strategies

We recognise the health benefits of exercise, such as the impact on life expectancy. Nevertheless we also believe that the evidence shows that the growing obesity problem is not simply because of a lack of exercise, but also because calorific intake has significantly increased. A position acknowledged by Dr Duggal.

c) Sexual health contracting arrangements

- **Pan-London arrangements: Spend per patient, unit costs and clinical effectiveness**

  The current pan-London sexual health contracting arrangements enable providers across the capital to treat Enfield residents, determine their own rates, and then retrospectively invoice Public Health. Dr Duggal acknowledged that it was not possible to calculate how many patients are seen and what the actual spend per patient currently is. For example, some patients will be seen once for a check-up and some may be seen a number of times for complex problems. However, the data supplied does not allow us to make any distinction.

  With regards to unit costs, Enfield pays the same unit cost for first and follow-up appointments. However, because of market forces there were geographical variations to the cost of each appointment according to the clinic the patient

attended. In addition, some providers have accepted a 'cap and collar' arrangement, i.e. an agreement in which an upper (= the cap) and a lower (= the collar) limit on charging has been set. Others do not.

Dr Duggal added that patients have free choice as to where they access services, but information regarding the effectiveness of services and efficiencies of treatment for which we pay are protected under clinical governance arrangements. The department is making efforts to overcome the potentially bottomless pit of expenditure by controlling expenditure where it can. So, if, for instance, invoices are presented to the Authority that does not meet the criteria for services specified as Genitourinary Medicine they are rejected.

Findings and conclusions

We have deep concern over the current pan-London guidelines as they are currently drawn up, which appear to be less concerned with the effectiveness of the treatments and more concerned with what the treatments are.

As things stand, providers across London can treat Enfield residents, determine their own rates, and then retrospectively invoice Public Health. This appears to be an opened-ended financial commitment without any evaluative criteria and no means, other than past experience, for determining what the potential demand on the budget would be. It is not currently possible to calculate how many patients are seen and the actual spend per patient. We nonetheless accept that this is the statutory basis of the funding and acknowledge that this is not currently within Enfield's control. However, we were assured that public health teams across the capital are cognisant of the weaknesses of the current system and hope that a pan-London solution can be found to change the approach when re-contracting.

- **The local position: Enfield's approach**

  With regards to the position in Enfield, the current arrangements were acknowledged as being unsatisfactory. For example, in spite of the significant amount of expenditure with regards to HIV prevention, according to the Health & Wellbeing Board's Joint Strategic Needs Assessment, Enfield has the 10th highest rate of late diagnosis in London. Dr Ahmad agreed that early diagnosis was crucial with Dr Duggal adding that 'population churn', was part of the problem. Black African and gay/bisexual communities who had higher risks of HIV were less likely to go for testing. Dr Ahmad stated that they were working with GPs to raise awareness in these communities and encouraging them to test more rigorously.

  However, in light of concerns raised at the public meeting, and at the suggestion of Councillor Simbodyal herself, I met with Bindi Nagra (Assistant Director for Strategy and Resources) and Christine Williams (Public Health Commissioning Manager) on 27th January 2015, together with Councillor Pite, to discuss future sexual health contracting arrangements. It was recognised that the current contracting arrangements, which had been inherited on integration from the PCT were not fit for purpose. The revised contracting arrangements, which would go out to tender, would be aimed at improving access, increase opening hours and

be in more accessible locations.

A further meeting was convened on the 24th March 2015 to review the revised provisional contracting arrangements. In addition to the above, changes to the contract would ensure that they would

- be tailored to reach the hard-to-reach and student population
- be aimed at reducing the borough's late HIV diagnosis rate, and the rate of STIs amongst the prevalent groups;
- develop strong partnerships with affected groups;
- ensure that the service would be delivered from static and mobile clinics across the borough.

The successful provider would also be expected to

- raise awareness of sexual health services available in the borough
- lead on training and advice to clinicians
- focus on educating the borough's GPs on contraception and testing
- work with the CCG in developing a clear pathway for terminations
- work flexibly with the Commissioner in developing service specification to ensure it meets the needs of the borough's population to best effect.

It was also agreed that, given that the Workstream would not meet formally again before the end of the municipal year, prior to tendering, a formal report would be brought before the Overview & Scrutiny Committee meeting of the 8th April 2015, which it was, and was well received by members.

Findings and conclusions

With regards to the Enfield position we are concerned that the controllable spend on existing sexual health contractual arrangements fails to deliver effective results and is unable to demonstrate the effectiveness of interventions and value for money. For example, HIV prevention, which is a public health responsibility, has, according to the Health & Wellbeing Board's Joint Strategic Needs Assessment, the 10th highest rate of late diagnosis in London, which, as well as being a cause for some concern given the significant amount of money spent, seemingly indicates a poor return on investment. We do, however, accept that both 'population churn' and the Health & Social Care Act, which diffuses responsibility across the Secretary of State, NHS and local authorities, are partially to blame. For example, though HIV prevention is a public health responsibility, treatment remains the responsibility of the NHS.

Nonetheless, we remain concerned that there is insufficient evaluation on the effectiveness of the provision provided. Dr Ahmad's advice that Enfield's spend was nevertheless broadly in line with other boroughs seems to suggest a focus more on outputs rather than on outcomes.

We are, however, reassured that it has been accepted that the current contracting arrangements, inherited on integration from the PCT, are not fit for purpose. The revised contracting arrangements, which have recently been out to tender (to be operational by the autumn) will be more robust and appropriate to

the borough's needs.

4) Smoking Cessation Programme

Glenn Stewart, Assistant Director for Public Health, and Julie Boyd, Public Health Manager, were invited to appear before a public meeting of the Workstream in order to discuss the smoking cessation programme that had been specifically targeted at the Turkish community. The rationale being that this would provide a good 'snapshot' of the work of the Public Health Department in practice.

a. Smoking in the Turkish community

Smoking prevalence in the Turkish community is much higher than within the wider population, with recent reports indicating a prevalence of at least 50%. Shisha smoking is a particular concern and it was therefore recognised that there was a need to work with the community to address the problem. A workshop had been provisionally arranged for 16th February 2015, but was cancelled due to a lack of response from the Turkish organisations invited. As a result of which, a meeting was instead held with interested parties including Councillor Anderson, officers and a cardiologist from the North Middlesex Hospital. It was aimed at finding better ways of engaging with the Turkish community. A future workshop would then be arranged where the objectives would be:

- to help make smoking a less acceptable or appealing activity;
- to identify how Turkish smokers could be helped to stop smoking; and
- to understand how young Turkish people could be dissuaded from starting to smoke

Of particular interest to the Workstream was a slide presented that showed the risk factors leading to early death in Enfield, were:

- Smoking (20%);
- High blood pressure (14%);
- High cholesterol (9%); and
- Obesity (8%).

At the said meeting, questions were asked as to the methodology used to try and engage the community, i.e. who had been approached and in what way. It transpired that contact had been initiated via email and/or letter to community bodies and organisations with no attempt to engage any advocates within the council, such as elected members who are part of the community, which included 3 cabinet members, the then Chair of Health Scrutiny, the Mayor and also one elected member who was actually chair of one of the bodies that had been contacted. Neither was the community engagement team, members of whom are also from the Turkish community, consulted. Concerns were also raised as to the content of the letter/email, which seemed more likely to antagonise than to engage, i.e. implying that smoking is a problem and needs tackling, when many within the community do not accept the premise to begin with, hence the rationale for the engagement.

However, subsequent to the above meeting, it came to light that a similar initiative aimed at reducing smoking in the Turkish community was undertaken in 2006/07, led by Glenn Stewart, and that this had involved elected members and community leaders, media campaigns and other high profile initiatives. That being so, we wanted to understand why this had not been followed; why the relationships that had been established over 8 years ago were allowed to disintegrate; and why the public health team seemingly appeared to be starting all over again.

Glenn Stewart stated that, unlike the current programme, the previous NHS scheme was time and contract specific aimed at fulfilling the terms of a local area agreement target for which pump-primed funding was received. The target was successfully achieved six months early after which the programme ceased and a further payment was received, but this wasn't ring-fenced for Public Health. Glenn argued that it was difficult to maintain engagement activity once the programme ceased due to the limited staff resources available.

Findings and conclusions
We are concerned at the failure to follow through on past initiatives aimed at better engaging the Turkish community. Though it was argued that previous schemes were time and contract specific aimed at fulfilling the terms of a local area agreement target and difficult to maintain engagement activity once the programme ceased, we found this to be an unsatisfactory response. Though we accept that government funding had been withdrawn, nonetheless we believe that a way should have been found to build on the work that was undertaken rather than simply cease the programme.

b. Enforcement
There is currently an apparent lack of enforcement with regards to Shisha bars, which appear to be bypassing the law against smoking inside public buildings. Glenn believes that the way to reduce shisha smoking is to address the attitudes towards it because it is seen as a recreational activity. There is little awareness of the harmfulness of Shisha, which is estimated to contain up to 36 times more carcinogenic tar than cigarette smoke.

Findings and conclusions
We are also concerned over the apparent lack of enforcement on Shisha bars, which appear to be bypassing the law against smoking inside public buildings. The Council and Public Health Department in particular therefore need to actively engage with the community.

c. Measuring smoking cessation
Smoking cessation is currently measured using 'four week quitter' rates. Dr Ahmad explained that this is an inherited NHS target. However, he added that modelling based on this model is considered to be a good indicator of someone quitting smoking permanently. It also has two benefits. Firstly, it gives an indicator of service efficiency. Secondly, it acts as a marker for broader tobacco related strategy effectiveness.

The figures also exclude those quitting smoking without using the Stop Smoking Service. Dr Ahmad added that bringing public health under local authority control now enables them to take a broader approach and to shift focus onto reducing those who start smoking in the first place. He further added that the 'gold standard' of measuring is to track smoking cessation over twelve months, but this is difficult to follow up on; many people who have restarted fail to attend subsequent appointments, for example.

Findings and conclusions

With regards to smoking in general, we are concerned that cessation is measured using 'four week quitter' rates, which are a less reliable indicator than a 6-months or longer rate, not least because it is hard to monitor how many people quit, start, and then quit again and so are being double accounted. We accept that this is an inherited NHS target and that figures do not take into account those using the Stop Smoking Service. We welcome Dr Ahmad's assurance that bringing public health under local authority control will enable the Public Health team to take a broader approach and to shift focus onto reducing those who start smoking in the first place.

5) Child poverty

Following further investigations not least having had sight of a draft child poverty action plan, it was decided to convene a second public meeting and Councillor Simbodyal, Dr Ahmad and Dr Duggal were again invited back to provide evidence, this time to specifically discuss

- the development of, and thinking behind, the child poverty action plan; and
- the make-up and purpose of both the child prosperity board and the child poverty operational group

a) Child Poverty Conference

On the 17th November 2014, together with Claire Johnson, I attended a half-day conference on child poverty, which had been organised by the Public Health team. Attended by elected members, council officers, partner organisations and stakeholders across the voluntary and community sectors, its main objectives were to:

- Raise awareness of the existing child poverty strategy;
- Develop an enhanced child poverty strategy to complement the existing plan;
- Share good practice; and
- Promote networking

The conference set out the national, regional and local position and had presentations from Councillor Doug Taylor, Leader of the Council; Dr Ahmad; Councillor Simbodyal; Helen Beresford from 4Children, a charity that supports children and families; Marilena Korkodilos, from Public Health England; and Rob Leak, Chief Executive of the Council. There were also two workshop sessions, one

about agreeing priorities to address child poverty and another on the production of an enhanced delivery plan.

Subsequent to the conference, a report was produced that outlined:

- the key principles that participants believe should underpin the approach to tackling child poverty in Enfield;
- overarching strategic work;
- operational work; and
- specific activities

With regards to principles, participants suggested that these effort and resources should be focused on areas of greatest need; they should build capability within individuals and communities; whole families should be addressed; and the voluntary and community sectors should be engaged.

Strategically, participants suggested that the child poverty strategy should be led by a partnership board; that they needed a shared mission statement; there should be a clearer understanding of the costs and benefits of different interventions and Enfield should benchmark with other authorities; a refreshed child poverty strategy should take into account drug and alcohol misuse, gang membership, gambling, domestic violence and risky sexual behaviours; commissioning options should be reviewed; and there should be a child poverty champion programme.

Operationally, participants felt that there needed to be a communications strategy targeting staff and local people; expanded integrated health and wellbeing hubs; differential targets for agencies; improved websites. As regards to specific activities, participants felt that aspirations in education and employment should be raised and support should be localised.

The report also made reference to the existence of a Child Prosperity Steering Group made up of partner organisations and stakeholders across the borough that had, it claimed, set out the following challenging outcomes, 1) mitigate the impact of poverty on children today; 2) help families out of poverty today; 3) minimise the number of children born into poverty by 2020 and 2030; and 4) ensure that by 2040 no child will be born into poverty.

What was not made clear was why the existing child poverty strategy needed to be revised and access to it was not made available to participants in order for a more considered view to be taken.

Findings and conclusions

It was of concern that data intelligence, which included a document titled ‘Review of Interventions’ produced by Graham Allen MP, outlining a series of trials related to the 13 key factors that are said to adversely impact on child poverty, were not made a central part of the conference, but instead part of a sparsely attended optional pre-conference briefing.

b) The Child Poverty Strategy

In September 2012, the Council produced a comprehensive report, *'The Drive Towards Prosperity: Enfield's Child and Family Poverty Strategy'*, which was written by Neil Rousell, a former Director of Regeneration, and mapped out the position in Enfield. The report clearly defines child poverty, provides a vision, priorities and next steps. It also outlines the local, national and regional context, the local strategic framework, the drivers of child and family poverty, risk factors, consequences and how the impact can be mitigated.

The report defines child poverty using the Child Poverty Act 2010, which looks at it purely in financial and material terms, i.e. relative to low income, combined low income and material deprivation, absolute low income poverty, and persistent poverty. However, it also references HMRC national indicators data on the number of children in families in receipt of either out of work benefits or in receipt of tax credits where their reported income is less than 60% median income, cross referenced with child benefit data, and takes into account Frank Field MP's 'Independent Review on Poverty and Life Chances'. This suggested setting up national and local *'Life Chances Indicators'*, which would take into account an additional nine non-financial indicators focusing on the child, parent and environment.

The Public Health Department inherited the responsibility for taking forward the Child Poverty Strategy from the Enfield Strategic Partnership and there was a pre-existing lack of clarity as to how the strategy could be furthered. They were charged with refreshing the Child Poverty Strategy, but instead engaged in an extensive rewriting of the strategy. As a result, the former Child Prosperity Steering Group was disbanded and in its place was formed the Child Poverty Operational Group and Child Prosperity Board.

Findings and conclusions

Instead of building on the firm basis of the rather comprehensive report, *'The Drive Towards Prosperity: Enfield's Child and Family Poverty Strategy'* in 2012, the Public Health Department appeared to be engaging in an extensive rewriting of the strategy, time and resources - both human and financial - have been spent in producing an ongoing and extensive range of material that is confusing.

The Public Health team's view is that the impact of income inequality is causing health inequality. Though we believe and accept that tackling low incomes is important, we question whether there is an over reliance on this single element as it is not backed up by the available evidence. For example, the Joseph Rowntree Foundation Report *'Does income inequality cause health and social problems?'* itself suggests that it is likely to be more a correlation than causation. Likewise, the document 'Review of Interventions' produced by Graham Allen MP, which was presented at the Child Poverty Conference outlined a series of trials related to the 13 key factors that are said to adversely impact on child poverty, not only such as low earnings, but also worklessness, parental qualifications, family instability, poor housing and debt. However, the available evidence shows that tackling these areas does not in themselves eradicate child poverty.

We are concerned about the policy of developing a 30 to 40-year plan to eradicate child poverty, which we believe to be unrealistic and unachievable. The original strategy identified the importance of factoring in migration, but this was not apparent in the current strategy. For as well as seeing a significant rise in its population over the last decade (14.2%), and an annual population churn of approximately 11%, Enfield has seen a significant fall in those owning their own homes, a fall in social housing, a rise in private sector housing, and ever increasing numbers in temporary accommodation, changes which must be considered in any viable long term plan. Furthermore, we feel that with such a fluid population it is challenging to monitor and track long-term health outcomes, and even that appears to be an over-optimistic assessment. For example, unlike an area like housing, which is about a growth in population in general, public health is about specific improvements in health outcomes for individuals and communities, e.g. smoking reductions, diminishing child obesity etc. and is therefore far more complex to achieve.

An added complication is that unless there is a universally shared approach across the country, Enfield is unlikely to see, in measurable terms, the benefit of its interventions and would instead experience the impact or lack of interventions from other boroughs.

We are concerned over the inconsistent definitions of 'child poverty' having received conflicting evidence from the Public Health team. For example, in a presentation to the Child Poverty Conference, it was claimed to be based on 'a national median average', but at the Workstream meeting it was said to be based on the 'overall borough area median'. The problem with such an approach is that depending on whichever definition is used i.e. national, regional, borough or ward level the numbers being classed as being in poverty would necessarily differ.

A second problem with attempting to measure child poverty is that the median earnings figure is not itself a constant, but a relative measure, socially defined, dependent on social context and hence a measure of income inequality. Therefore, in a recession or a boom the median income will necessarily fall or rise, respectively, meaning that, perversely, in a recession fewer children would be classed as in poverty, whilst in a boom more would be, even if, in both scenarios, individual family circumstances have not in any way changed.

A clear example of this inconsistency was demonstrated with the figures presented to the Workstream. In a presentation to the Child Poverty Conference, Dr Duggal indicated that Enfield is home to over 27,000 children in poverty. This figure was based on children living in households where incomes are less than 60% of the national median average. However, Dr Ahmad in his own presentation to the Workstream produced a slide (sourced from HM Revenue and Customs) that indicated that the figure, as of 2011, was 23,210. Dr Duggal in a further draft evidence review (dated March 2015) quoting figures from 2012 indicated that the figure now stands at 21,410. All of which suggests that without any significant interventions to tackle the wider determinants of health, child poverty has seemingly declined in Enfield by approximately 5,500 or 21% over 7 years. Clearly, this is a problem for collective understanding.

Thirdly, and perhaps most significantly of all, if the objective is to eradicate child poverty within a generation then using the definition of *'of household income being less than 60% of median earnings'* irrespective of whether housing costs are included or excluded would make it impossible to achieve. For unless everyone was to be on or near to the same income, even if incomes were to rise, there would always be households earning less than 60% of median earnings. The level would just be pitched closer to 'poverty' in the City of London rather than 'poverty' in Newham.

Bola Akinwale, Health Equity Lead at Public Health England, in evidence submitted to the Workstream, confirmed that the 'less than 60% of median earnings' was simply a very loose comparative measure and recognised the complexities in seeking to address poverty practically. She reiterated principles already suggested within the original child poverty strategy, that a more useful approach would be to look at the likely impact on family units, which will depend on the size and type of family, e.g. one or two-parent family, the number of children, the cost of housing in the immediate locality, council tax, child and other benefits, etc. On this basis, the cost of living for a single parent with one child in Upper Edmonton would be very different from that of one living in Grange and therefore the impact of having a similar income would necessarily differ.

Nevertheless it is important to recognise that relative poverty measures are used as official poverty rates by the European Union, UNICEF and the Organisation for Economic Co-operation and Development (OECD). The main poverty line used in the OECD and the European Union is based on "economic distance", a level of income set at 60% of the median household income as described above.

Such is the topicality of the child poverty debate that the current Government have indicated that they intend revising the current definition away from one 'based on 60% of median income'. Legislation will be forthcoming that will include measures that will be focused on the levels of work within a family and improvements in education attainment, two key areas in terms of improving social mobility. A range of other indicators will be developed to include the impact of family breakdown, debt and alcohol dependency, reporting annually on how these indicators affect life chances.

However, a more significant concern we have is where the responsibility for driving forward the child poverty strategy should lie. Though we accept that Public Health had inherited the responsibility from the Enfield Strategic Partnership and that there was a pre-existing lack of clarity as how the strategy could be furthered, we are not convinced that they should be leading on what is effectively a corporate strategy.

Furthermore, we believe that the responsibility for the strategy has been diffused via the unnecessary creation of both the Child Poverty Operational Group and Child Prosperity Board, which have evolved from the former Child Prosperity Steering Group.

Our recommendations

Tackling obesity within schools: our recommendations

We call upon the Government to ensure that all schools are subject to national nutritional standards. Our local MPs could helpful raise this with ministers.

ACTION: Secretary of State for Education and local MPs

We would like to see a more coordinated approach to healthy eating in schools. The local authority should work with schools to ensure that ALL pupils eat healthy meals and not just be provided with the option. Advisory guidance on packed lunches has not worked. Schools should look at enforcing restrictions on what food children can bring in for lunch.

ACTION: Director of Education

We would like to see schools prohibiting pupils under the age of 16 from leaving school premises during lunch breaks so as to limit the opportunity of them accessing unhealthy options from takeaways and newsagents. **ACTION: Director of Education**

Public Health Report: our recommendations

We would expect that any future use of evidence used in the Annual Report should be reliable and that any statistics should be benchmarked with other authorities using standard methodologies. A failure to do so will make it impossible to evaluate improvements in treatments or the effectiveness or otherwise of preventative strategies.

ACTION: Director of Public Health

We would like to see more clearly defined outcomes, i.e. to reduce smoking, to vaccinate more children, early diagnosis of lung cancer and HIV etc., and it should then map out how this will be achieved, how it will be measured and over what timeframe. As it stands, there is no clear and identifiable plan to achieve the objectives.

ACTION: Director of Public Health

The wider determinants of health: our recommendations

Though nobody would argue against improving social and community networks, and general socioeconomic, cultural and environmental conditions, we do question the over-reliance on the wider determinants of health arguments to demonstrate improvements in health care in the short to medium term. We remain unclear as to what practical strategies would be required to replicate 'the Roseto effect' and, in many ways, the evidence completely contradicts the standard advice that the profession are at pains to maintain. We would therefore like to see clear, consistent, coherent and practical health advice.

ACTION: Director of Public Health

Public health spending allocations: our recommendations

We would like to see the amount spent on Public Health Leadership and CCG core health & intelligence, significantly reduced, not least because the benefits of which are not at all clear. We would like to see the money saved diverted to projects directly in the community with spending more closely aligned with the stated priorities, namely tackling obesity, increasing physical activity and stopping smoking. We do not consider £388k dedicated to tackling the growing obesity crisis as sufficient. We would also like to see evidence of the more

integrated approach cited by Dr Ahmad, where the public health budget compliments other departmental spends.

ACTION: Cabinet Member for Public Health and Director of Public Health

Sexual health contracting arrangements: our recommendations

We would like the Secretary of State for Health to ensure that the pan London arrangements for sexual health treatments are tightened up and that the rates charged are competitive. There should be measures in place to determine how many patients are seen, and the spend per patient. **ACTION: Secretary of State for Health**

Community engagement programmes: our recommendations

In light of the experience with the smoking cessation programme, we would expect to see a more consistent approach with regards to community engagement. The goal should be to effect sustainable, rather than short-term, behavioural change. This, we believe, can only be achieved in collaboration with communities. Relationships, therefore, need to be fostered and maintained in order to maximise finite human and financial resources.

ACTION: Director of Public Health

Though we agree that changing attitudes in the community is necessary, it should be done in conjunction with, and not in place of, enforcement against smoking in shisha bars.

ACTION: Director of Regeneration and Environment

We would like to see better joined-up approaches in tackling smoking, engaging other partners, such as pharmacies, that can help engage local communities, e.g. distributing literature in given areas and providing advice. We agree that bringing public health under local authority control facilitates a more strategic approach. We also agree that it is most important to engage the young and to shift focus on to prevention rather than cure, i.e. reducing the number of people smoking in the first place.

ACTION: Director of Public Health

Child Poverty: our recommendations

We believe that the child poverty strategy is a corporate strategy and, as such, the responsibility should reside with the Corporate Management Team and the Cabinet with public health feeding into its development in the same way that health & social care, housing & regeneration, education, and environment would do. Indeed, though the draft child poverty strategy talks about supporting families into work and increasing their earnings, improving living standards, and preventing poor children becoming poor adults etc., it says less about the focus on ill health as a driver of poverty. **ACTION: Chief Executive**

We believe that the original child poverty strategy provides a vision, priorities and next steps. It also outlines the local, national and regional context, the local strategic framework, the drivers of child and family poverty, risk factors, consequences and how the impact can be mitigated. We therefore believe it is a firm basis for pursuing a viable way forward. In addition, Government policy now appears to be moving in this direction.

ACTION: Chief Executive

Public Health priorities: our recommendations

We believe that the Public Health Department's priorities need to be recalibrated away from the socio-economic and wider determinants of health, such as improving the quality of housing; reading for school readiness and beyond; building resilience in families; raising aspirations amongst children; and improving parenting skills, all of which feature in Dr Duggal's most recent evidence-based review (dated March 2015). We do not doubt that they need to be addressed as part of a wider child poverty strategy, but evidence suggests that as well as being resource intensive there is very little proof of positive outcomes in terms of health improvements. This simply reiterates our view that the child poverty strategy requires a corporate steer as many of the central features are not within the direct purview of the public health mandate.

ACTION: Director of Public Health

The 'Review of Interventions' document had itself demonstrated what the most effective interventions were and we believe that the Public Health Department priorities should be on practical interventions that improve the health of the borough, such as:

- *increasing home care visits;*
- *pre and post natal nursing support;*
- *encouraging physical activity of mums;*
- *improving health and wellbeing;*
- *improving physical activity;*
- *tackling mental health;*
- *improving nutritional intake;*
- *improving dental health;*
- *improving access to immunisations; and*
- *home interventions*
- *stopping smoking*

ACTION: Director for Public Health

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