Proposal for a new Enfield Joint Health and Wellbeing Strategy 2019 onwards

Discussion paper for Health and Wellbeing Board September 2019

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

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

Introduction

This paper sets out a proposal for a new Joint Health and Wellbeing Strategy 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 Board is asked to provide feedback on the proposal and agree for the Council's coordinating officers to develop and launch a public consultation on the approach set out in the paper.

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.

The existing Enfield Joint Health and Wellbeing Strategy expires at the end of 2019 and a new strategy is being produced by the Enfield Health and Wellbeing Board (EHWB) for 2019 onwards.

The 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. The Board will oversee the development, delivery, monitoring and evaluation of the strategy, which will be delivered by all organisations and departments represented on the Board. The 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.

Question for the Board: Do we need an end date for the strategy eg 2024? Or should this be a 'live' document which will be implemented through an annual action plan, and reviewed and evaluated annually to determine whether the strategy should continue for the following year?

Summary of Board Member discussion in July 2018

The Enfield Health and Wellbeing Board (EHWB) considered what the new strategy should achieve at their development session on 26th July 2018. The Board was asked to consider

the approach taken during the current strategy, which ran from 2014 to 2019 and the outcomes achieved during that time period. This strategy had four priorities:

- 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
- Promoting healthy lifestyles and making healthy choices.

In December 2016, the Board re-prioritised activity to focus on:

- Best Start in Life
- Obesity
- Emotional/ mental resilience

To evaluate the impact of our previous approach, we have considered key outcome measures set out below. The table below shows the outcomes which have either worsened since 2014, or where we are performing worse than the national average.

Priority	**Outcome measures where we are below national, and/or have worsened since 2014**
Ensuring the best start in life	• School readiness (reception year) • Breastfeeding initiation • Smoking at time of delivery • Hospital admissions caused by unintentional and deliberate injuries in children • Children's oral health (dental decay) • Chlamydia detection rate
Enabling people to be safe, independent and well and delivering high quality health and care services	• Diabetes prevalence • Cancer screening coverage • Childhood immunisation (MMR) uptake • Flu vaccination uptake (65+) • HIV late diagnosis • Learning Disability Health Check
Creating stronger, healthier communities	• Violent Crime • First-time offenders • Statutory homelessness – households in temporary accommodation
Promoting healthy lifestyles and making healthy choices	• Overweight and obesity • Inactive adults

The Board was asked what we could do collectively that would make the biggest impact over the next five years. Board members made the following observations:

- We should be ambitious and outcome-driven.
- We need to focus on prevention and on tackling inequality.

- We need to adopt a Health in All Polices (HiAP) approach.
- We could consider place-based approaches - by focusing on areas within Enfield with specific identified need.
- Making Every Contact Count and Social Prescribing are approaches all partners could commit to and could make a real impact.
- We need to work with the community and actively engage with them.
- We need to have a positive narrative. “Do something good” is better than saying “stop something bad.” The strategy needs to be driven by the need to achieve large-scale behaviour change.
- We need to promote healthy habits by making the healthy choice the easy choice.
- Health road shows have been well-received by communities and are an inclusive platform for disseminating health related messages.
- Taking a life course approach works well, with a continuing focus on the best start in life (BSIL) – e.g. a focus on maternal smoking.
- We need to ‘sweat our assets’ better. Assets include:
    - our power as commissioners – with contracts being an opportunity to make policy changes
    - ourselves as leaders of the health system
    - our staff and office spaces – staff as potential examples of and drivers for positive change and our ability as employers to facilitate healthy behaviours e.g. smoke-free work places, healthy food choices in staff canteen
    - community spaces such as schools, libraries, cycle ways, communal areas in housing blocks where we can facilitate healthy environments
    - people in our community, including parents and carers at the school gate, parents and carers who are members of consultation forums e.g. Parents Engagement Panels (PEP); Health Champions; Over 50s Forum; Faith groups; and voluntary organisations
    - other parts of the Council, such as housing, transport or licensing teams, and other organisations, which have the potential to help us promote and facilitate healthy behaviour, including housing providers, the Fire Service, Police Service, and local businesses such as supermarkets and eateries.

A new strategy centred on behaviour change: 3-4-50

A simple, understandable and memorable message can help the Board make a tangible impact. A strategy centred on behaviour change, which focuses on a small number of behaviours which we know have the biggest impact on health outcomes, helps us to develop a simple narrative. A strategy focused on behaviour change allows us to tackle inequality in the opportunities people in Enfield have to make choices which have a positive impact on their health.

What is 3-4-50?

The 3-4-50 concept was originally developed by the Oxford Health Alliance, a partnership between Oxford University and Novo Nordisk A/S, under the original banner of 3FOUR50 in response to global concerns Long Term Conditions (LTC). In 2016, The Vermont Department of Health unveiled the results of data-based research showing that three behavioural factors of tobacco use, poor diet and a sedentary lifestyle 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 Vermont. The research also found 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. This data driven campaign was also called the 3-4-50.

The research is not only applicable to Vermont, and similar research has been done with different communities worldwide. The research is applicable to Enfield's population, where cancer, heart disease and lung disease account for 73% of all deaths in Enfield (2016)

The four diseases are long term health conditions, which account for around 70% of the health service budget in the UK, as well as more than 50% of deaths.[1] Diseases such as diabetes, cancer, and respiratory diseases are responsible for over 70% of deaths 66.3% of deaths under 65 years of age in Enfield.[2] In Enfield, 7.7% of people are known to have type 2 diabetes, plus there are an estimated 4,800 people who are undiagnosed. In 2014/15, there were 416 new diagnosis of cancer in this year alone. In 2016/17, there were 684 hospital admissions for heart disease for every 100,000 people in Enfield.

A large proportion of these diseases are preventable. There is also a link between these long-term conditions and mental ill-health. Enduring long-term physical health challenges has an associated adverse impact upon mental health and wellbeing.[3]

The 3-4-50 Framework is a strategic model that aims to align the efforts of health care providers, community organisations, businesses, schools and government to change behaviours and create a healthier community. It is based on the principles of transformational change in community health, which cannot just rely on the health care system. The core of the framework is to build communities and environments where healthy lifestyles are encouraged and supported. People can help reduce the risk of developing these diseases, or even prevent them, with positive lifestyle changes. However, factors such as education, income, environment, cultural norms and inconvenience all play a role in whether people are able to make these changes.

For the approach to be successful, there is a need for full commitment and buy-in from across the community. Different organisations, schools, and businesses as well as local government and health services can contribute to the implementation of 3-4-50. It requires a call to action for involvement – and strong leadership. The framework exists to encourage change, support change already being done, and help to bring disparate efforts together with the goal of creating greater collective impact.

Why is 3-4-50 the right approach for Enfield?

[1] NHS England (2014) Five year forward View
[2] ONS mortality file 2016 via PHE fingertips
[3] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

Using the 3-4-50 framework as a basis for our joint strategy gives us the opportunity to bring about large-scale behaviour change at a population level and improve associated health outcomes and tackle inequality through an ambitious strategy.

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.

Given the evidence that the three behaviours are also linked to certain populations such as those on low incomes, or those already managing another health challenge, the framework will also allow us to focus on tackling health **inequality**, another priority for Enfield. 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. 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.

By focusing on positive behaviour chance, we can work together to improve healthy life expectancy for everyone in the borough: over 15 years are currently lived in 'poor health' in Enfield. Again, this is worse for those in the most deprived areas, the gap between life expectancy and healthy life expectancy being wider in more deprived areas. In Edmonton Green, the average number of years that a female is expected to live in poor health is 28 years.

We need to use our multi-agency partnership to bring about change for populations who are currently facing worse health outcomes.

We know that a significant cause of death and therefore a significant cause of ill health in Enfield are the diseases which are linked to the three behaviours of smoking, poor diet and inactivity. We also know that these diseases impact more on deprived communities. 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

Centred around the 3-4-50 framework, a proposed vision for a new strategy **is to 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. 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. This is where the second part of the proposed vision comes in, to make the healthy choice the easy choice ***for everyone in Enfield***. Currently income, ethnicity, gender, having a disability or where someone lives are hugely significant in determining health outcomes. Our strategy can be ambitious about working together, with our communities, to find ways to shift this.

Questions for Board:

Is this the right vision? Do we talk about the healthy choice being the 'easy choice', or the 'first choice'? Does this capture what we want to achieve?

Priority 1: 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[4]. In 2014/15 there were approximately 1.7 million hospital admissions by those aged 35+ for smoking related illnesses[5]. It is estimated that smoking cost the NHS £2.6 billion in 2015[6]. HM Treasury estimates that the total cost to the economy in England is £12.9 billion per year[7].

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.

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.

Evidence shows that if 10 in every 100 people quit smoking, an area's healthy life expectancy would rise by 6 years one month in men and 7 years one month in women. However, 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)[8]
- 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

---

[4] Office for National Statistics (2016). Health Survey for England 2015. Trend tables commentary.
[5] Action on Smoking and Health (ASH) (2017) The economics of tobacco.
[6] 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.
[7] HM Treasury (2014) Tobacco levy consultation.
[8] This data is from a national survey carried out in 2014/15, and we do not know when it might be repeated.

Strategic priorities to consider

1. Create work environments which discourage smoking during the working day.

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

3. Tackle inequality: develop community-based interventions to decrease smoking prevalence amongst pregnant mothers; adults with serious mental illness and the Turkish community

Questions for Board

Where does your organisation successfully operate smoke-free spaces? Where are there community areas which are currently not smoke free?

Questions for the consultation

Where do people currently smoke in Enfield? This will help us to consider areas where we may want to introduce new smoke-free policies, where we could have the biggest impact.

Questions for the consultation: Capture equalities monitoring information, so we can analyse the results of the consultation to better understand the higher rates of smoking amongst certain communities.

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[9]. 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[10]. 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)[11].

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. The Active People Survey 2017 and the What About Youth (WAY) 2015 survey collected information on the consumption of fruit and vegetable of a sample of the population. The results indicated that 58.7% of 15- year olds and 58.2% of adults in Enfield regularly ate their recommended 5 portions a day. These figures are respectively higher and lower than the national and London. Enfield data also indicates significant differences in excess weight between ethnicities in the borough.

[9] 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.

[10] 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.

[11] 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

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. A nutritionally inadequate and unhealthy diet has been associated with an increase in the risk of CHD, cancer and obesity and diabetes. 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.[12]

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[13]

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

3. Create environments in early years settings, schools, health and social care 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.

Questions for Board

As a first step, we have more power to changes practices in our own organisations than those not represented on the Board. How does your organisation currently facilitate healthy food options for staff as part of their working day? What unhealthy food choices still exist and what measures could be taken to decrease those options? As agreed by the Board in Dec 2017, has your organisation pledged to become Sugar Smart?

[12] JSNA

[13] With reference to Public Health England and Business in the Community Toolkit for Employers

Questions for the consultation

For respondents who work within Enfield – what healthy food choices and unhealthy food choices exist in your place of work?

For all – what healthy food choices exist for you, and what unhealthy food choices exist for you?

Priority 3: 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. The NHS recommends at least 150 minutes of moderate aerobic activity or 75 minutes of vigorous intensity per week. In 2016/17, 60.1% of Enfield adults performed 150 minutes or more of physical activity a week. This was a lower percentage of what was observed both in London and at a national level. Conversely, in the same year 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.[14]

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 reaching 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, as 63.4% of respondents reported doing 'any walking' at least once a week, 42.6% reported walking for utility purposes at least three times a week and 33.8% reported walking as a way of travel at least five times a week.

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.

[14] JSNA

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.

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.

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

Health in Policies (HiAP)

A health in all policies approach involves all organisations represented on the HWB considering what influences they can exert on the three behaviours of smoking, eating and physical (in)activity 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. A CHIN can be 'virtual', meaning that it has no designated location, or 'physical', meaning that is has a specific location or locations.

Throughout 2017, Healthwatch Enfield got involved in conversations about delivering a Care Closer to Home Integrated Network model that could work in the borough. 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.[15]

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

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

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.

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 within the community have the biggest influence. This may include businesses and corporations, as well as individuals, faith groups and other community groups.

Questions for the consultation
Who and what influences choices and decisions around smoking, activity and food and diet in Enfield?

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.

Consultation

This paper has considered some of the questions we would like to answer through a public consultation, in order to further develop the proposed strategic priorities. We also need to ask some broader questions regarding the three behaviours to see whether there may be

other priorities we may wish to consider which we have not yet considered, in order to help change behaviours around smoking, diet and physical activity.

We propose to run a survey with the public, to be conducted both online and through face to face interviews in different areas of the borough.

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
- Housing Strategy and Preventing Homelessness Strategy (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)
- 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)
- Violence against Women and Girls Strategy 2017
- Safeguarding Adolescents from Exploitation and Abuse Strategy (under development)
- Enfield Travel Plan (under development)[16]

[16] 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