Progress report for the Joint Health and Wellbeing strategy 2019 - 2022

Report to the Health and Wellbeing Board March 2019

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For Board meeting: 20th March 2019

This report contains a working draft of the emerging Enfield Joint Health and Wellbeing Strategy 2019 – 2022. This draft is based on the research and stakeholder engagement to date.

The recent public consultation broadly supports our overarching approach. Further work is now needed to refine the strategy further and develop the detail of the action plan using the results of the consultation. For example, we need to consider what the public consultation is telling us regarding barriers to healthy behaviours and how we can remove them through tangible action across all Board member organisations.

The action plan will translate our priorities into tangible action on the ground, and is therefore a vital, and challenging, part of finalising the strategy.

Board members are asked to consider the results of the public consultation (Healthwatch report and public consultation survey report) and:

- provide feedback on the draft strategy narrative and suggest any changes;
- provide a commitment to action from your organisation in relation to the priority areas. These commitments will then be included in the strategy action plan. Some proposed Council actions have been included in this draft to start this conversation.

The final strategy and year one action plan will be on the agenda for the next Health and wellbeing Board meeting, scheduled for May, for approval. Following this, organisations will need to take the strategy through their own organisation's formal approval process – including Cabinet approval; and CCG Governing Board approval.

Draft Enfield Joint Health and Wellbeing Strategy 2019 – 2022

Scope	This joint strategy sets 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.
Approved by	*To be taken to Joint Health and Wellbeing Board for approval May 2019; Cabinet and CCG Governance Board July 2019 (dates TBC)*
Approval date	*The date of approval at Health and Wellbeing Board, Cabinet and CCG Governance Board*
Document Author	Strategy, Partnership, Engagement and Consultation Hub
Document owners: Health and Wellbeing Board	Elected Members • Chair - Cabinet Member with responsibilities for Health and Social Care • Cabinet Member with responsibilities for Education, Children's Services • Cabinet Member with responsibilities for Public Health Officers • Vice Chair - Chair of the local Clinical Commissioning Group (CCG) • HealthWatch Representative • CCG Chief Officer • Director of Public Health • Director of Adult Social Care • Director of Children's Service • Elected Representative(s) of the Third Sector • Representative from Enfield Voluntary Action Non Voting Members • Director of Planning from the Royal Free London NHS Foundation Trust • Chief Executive from the North Middlesex University Hospital NHS Trust • Director of Strategic Development from the Barnet, Enfield and Haringey Mental Health NHS Trust • Enfield Youth Parliament Representatives x 2 • Strong & Safer Communities Board representative • Enfield Strategic Partnership representative Additional members to represent Housing, Regeneration and Environment to be included following revision of terms of reference to extend membership
Review	The delivery of the strategy will be monitored through a review of the action plan on a 6 monthly basis and a review of the outcome measures on an annual basis. These reviews will be coordinated by Public Health and reported to the Health and Wellbeing Board for discussion and decision-making as required.

Making the healthy choice the first choice for everyone in Enfield

Introduction

This strategy sets out our long-term vision to make the healthy choice the first choice for everyone in Enfield. It is a three year strategy and includes our year one action plan for change.

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. All organisations represented on the Board are responsible for the development, finalisation and delivery of the strategy. Our Health Improvement Partnership (HiP), a sub-group of the Board, will be responsible for the operational delivery of the strategy, and will report back to the Board on progress.

By facilitating all members of the Board to work collectively to tackle the borough's health and wellbeing challenges, the strategy will also help the Council to deliver its Corporate plan to create a lifetime of opportunities in Enfield as well as enabling the CCG and NHS health trusts to deliver the NHS Five Year Forward View.

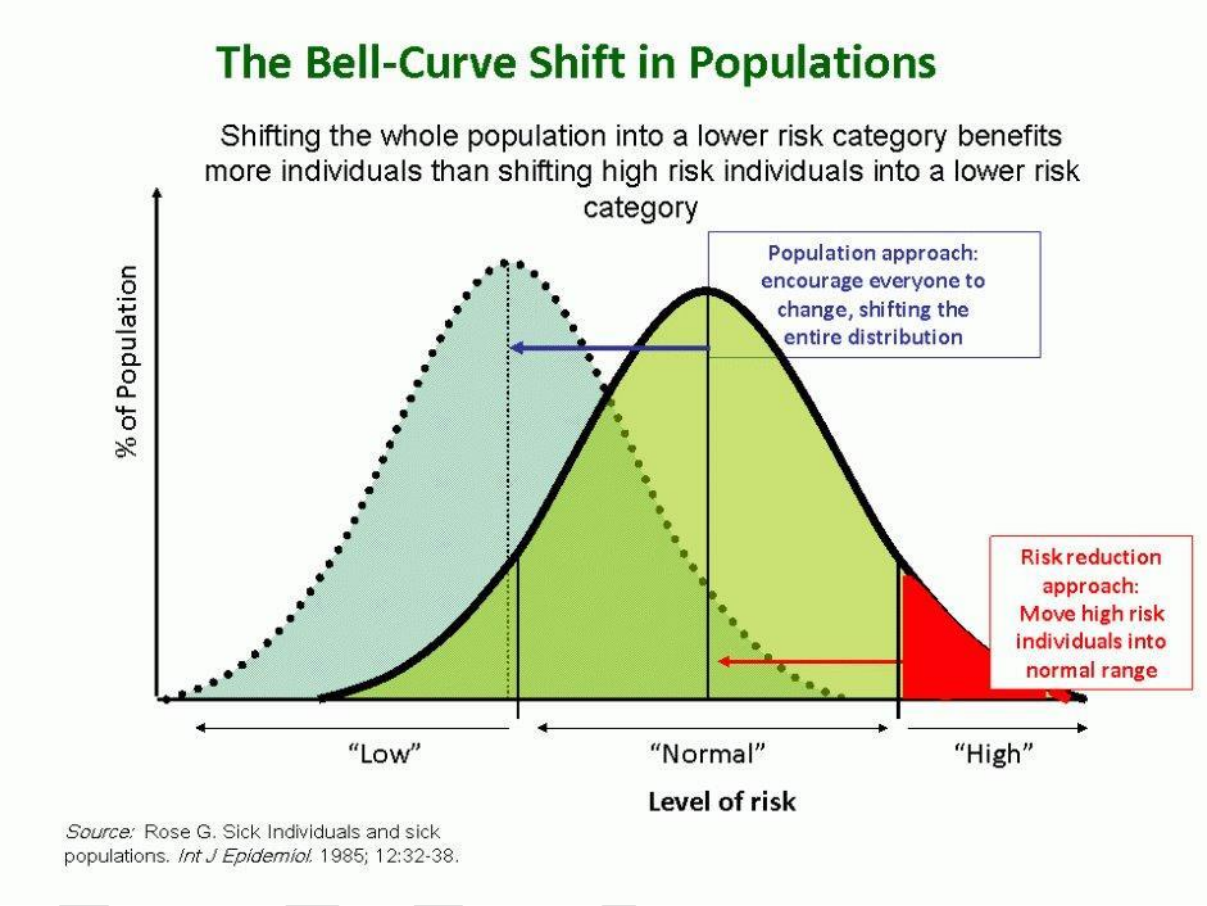
In addition to this strategy, the collective organisations on the Health and Wellbeing Board continue to focus on improving the services delivered by their organisations and commissioning and providing the right services to meet the health needs of Enfield residents. Rather than being a strategy which sets out everything all organisations do, this joint health and wellbeing strategy focuses on the collective action we are taking to prevent negative health outcomes and improve the health and wellbeing of all residents in Enfield.

Vision: Making the healthy choice the first choice for everyone in Enfield

This strategy is about prevention – 'preventing the preventable'. The vast majority of NHS resources are consumed by conditions that need not have developed. The majority of these are the non-communicable diseases, such as Type 2 Diabetes or cardiovascular disease (CVD). For example, around 10% of the NHS budget is accounted for by diabetes and its complications.

There are two approaches to prevention. Firstly, at the individual level, which means treating people at the early stages of the disease process by identifying those who are high-risk or more susceptible and offering them some individual protection. This is often termed 'secondary prevention'. The second approach is taken at the population level, by seeking to control the determinants of poor health and disease in the population, enabling the whole community to benefit through improved behaviours and lifestyles. This is usually termed 'primary prevention.' If successful, large-scale behaviour change is more effective than tackling the risk of disease for a small number of high-risk individuals.

Our strategy takes this population level approach through attempting to control and shape the determinants of poor health, such as the local environment, to help reduce risk factors and so shift the whole distribution of risk in a favourable direction. This means we are attempting to alter some of society's norms of behaviour and remove the underlying causes that make certain diseases common.



To make change happen at this scale, we need to make healthy behaviours easier and more accessible than unhealthy behaviours. To do this, we need to first understand what causes unhealthy behaviours and what can be done to prevent them. We need to be ambitious about making policy change collectively, as a partnership – making positive influences on physical and emotional health and wellbeing everyone's business.

Importantly, we need to think about the opportunities to do this with our most deprived communities, including groups who currently experience far worse health outcomes than others. Currently income, ethnicity, gender, having a disability or where someone lives are hugely significant in determining health outcomes. Our strategy will be ambitious about working together, with our communities, to find ways to shift this.

We will do this through three focused priorities, to help people in the borough to:

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

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

- reduce the chances of people developing non-communicable diseases such as cancer, heart disease, Type 2 Diabetes or lung disease
- improve emotional and mental health and wellbeing
- reduce inequality in health outcomes.

Our Framework: 3, 4, 50

Graph to be updated, using the results of the consultation, to include mental health – and also any other changes as a result of the consultation – potentially using '5 ways to wellbeing.'

There is international, national and Enfield-specific data which shows that the three behaviours of **physical inactivity**, **unhealthy eating** and **smoking** can lead to four chronic conditions of **cancer, diabetes, heart disease and lung disease**, and that these diseases are responsible **for 50 percent of deaths**.

In Enfield, cancer, heart disease and lung disease account for 73% of all deaths and 66.3% of deaths under 65 years of age.[1] A large proportion of these diseases are preventable. This is known as the 3-4-50 framework. It should be noted that these behaviours impact on all 'long-term conditions' (LTCs) which collectively cost the NHS 70% of its budget[2].

Using this as a basis for our joint strategy gives us the opportunity to bring about large-scale behaviour change at a population level, tackle health inequality and improve associated health outcomes.

Mental health

While the framework clearly helps us to prevent physical health problems, we know that physical activity, eating healthily and being smoke free have a positive impact on mental health and wellbeing as well.[3] The activities we want to encourage to increase physical activity, such as walking and cycling, can encourage more social interaction, which itself also contributes toward positive wellbeing.

In addition, there are clear links between mental and physical health. Enduring long-term physical health challenges has an associated adverse impact upon mental health and wellbeing,[4] and around 30 percent of all people with a long-term physical health condition also have a mental health problem.[5] Reducing the prevalence of long-term physical health

[1] Data from 2016, JSNA
[2] Five Year Forward View, NHS England (2014)
[3] https://www.nhs.uk/conditions/stress-anxiety-depression/mental-benefits-of-exercise/; https://www.mentalhealth.org.uk/a-to-z/d/diet-and-mental-health;https://www.mentalhealth.org.uk/publications/how-to-using-exercise; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/292453/mental-capital-wellbeing-summary.pdf
[4] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity
[5] 1.Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012). Research paper. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study The Lancet online

can therefore be expected to remove some of the risk factors associated with mental ill-health.

Inequalities

The framework also allows us to focus activity on tackling poverty and inequality. We know that being part of certain population groups, such as having a low income or a disability, can make it much harder to be physically active, eat healthily or be smoke-free. This increases the likelihood of developing chronic diseases or having mental ill-health. By basing our strategy on behaviour change and focusing on a small number of behaviours which we know have the biggest impact on health outcomes, we are aiming to take focused action to tackle inequality in the opportunities people in Enfield have to make choices which have a positive impact on their health.

Why 3-4-50 for Enfield?

The prevalence of cancer, heart disease, diabetes, lung disease and mental ill-health is such that the case for preventative action seems clear.

2.1% of population have cancer (2016/17).

Under 75 mortality rate due to cancer 123.1 per 100,000 population (2015-17)

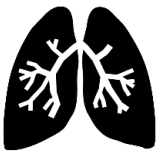
Under 75 mortality rate due to cancer considered preventable 71 per 100,000 population (2015-17)

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

Under 75 mortality rate due to cardiovascular disease (2015-17) 71.1 per 100,000 population

Under 75 mortality rate due to cardiovascular disease considered preventable 42.9 per 100,000 population (2015-17

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



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

4.6% have asthma (2016/17)

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

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

How will this framework help us to tackle obesity?

One of the reasons why physical inactivity and an unhealthy diet can lead to the chronic diseases discussed above, is because they cause people to become overweight or obese. Obesity also has a negative impact on mental health, quality of life, and has significant cost implications for social care as well as for health services.[6] This is a significant issue in Enfield, with 40% of 10 to 11 year olds; and two-thirds of all adults being overweight or obese. By focusing our joint strategy on the behaviours that can help people maintain a healthy weight, and the environmental factors that influence those behaviours, we are aiming to take a whole systems approach to tackling obesity in Enfield.

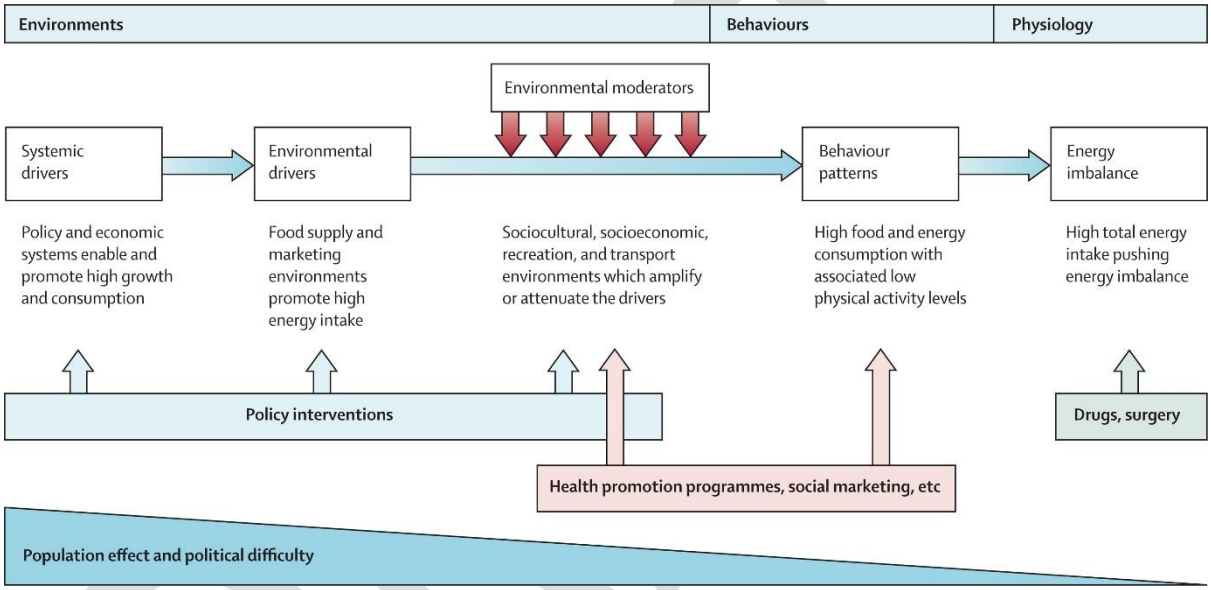


Figure 3: A framework to categorise obesity determinants and solutions[7]

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

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

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

- The estimated annual cost of common mental disorders in Enfield £98.1m.
- Depression presents an annual cost of £44.8m; and psychosis £69.4m in Enfield

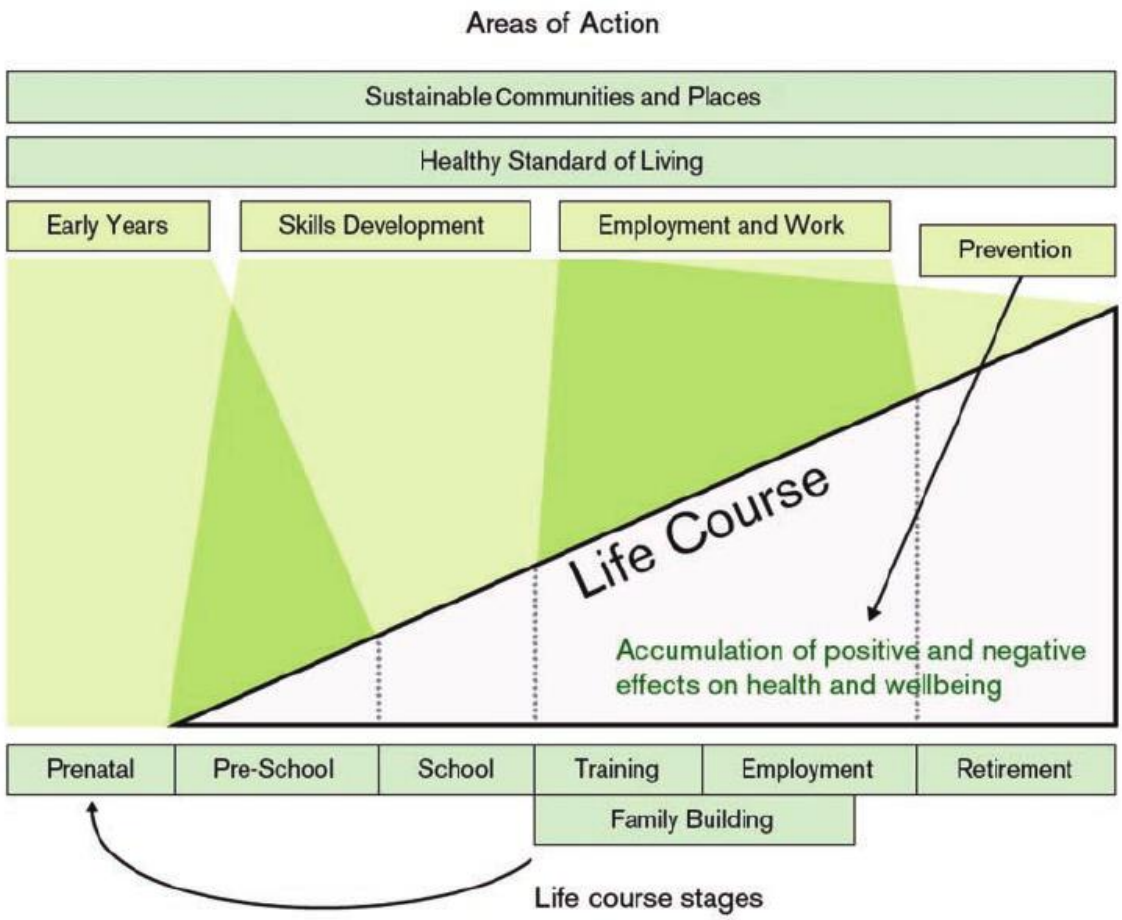
[6] Making obesity everybody's business: A whole systems approach to obesity, LGA November 2017; and Obesity and Mental Health; National Obesity Observatory, NHS, March 2011

[7] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60813-1/fulltext

- It has been estimated that the costs of poor mental health to Enfield employers is £142m per annum.[8]

Relatively simple physical or environmental interventions or changes can make significant improvements in emotional health and wellbeing. These interventions are considered in our priority for being active – interpreting this as both physical and mental activity and thinking about the environmental factors which can facilitate healthy activity. Adults undertaking daily physical activity have a 20-40% risk reduction of all long-term conditions including Type 2 diabetes, depression, distress and dementia.[9]

How will this framework help us to take a life course approach?



[10]

We have the opportunity to prevent and control diseases at key stages of life from preconception through pregnancy, infancy, childhood, adolescence, through to adulthood and older age. The Marmot Review[11], which focused on the importance of the life course approach, stressed that disadvantage accumulates throughout life, leading to poor outcomes. This cycle can only be broken by taking action to reduce health inequalities before birth and continuing these throughout the life of the child. We will use the focus on the three healthy behaviors of being active, having a healthy diet and being smoke free to

[8] Enfield Psychiatric Needs Assessment 2016
[9] Start Active, Stay Active. A report on physical activity in the UK. Dept of Health (2011); and
[10] http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf
[11] http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

consider how these behaviours can be facilitated at each life stage, recognising the importance of Starting well, Living well and Ageing well.

How will this framework help us to achieve 'Health in Policies' (HiAP)?

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

Frequently it is the environment which is much more influential on health than any other factor. This is recognized by national policy-makers as evidenced by the recommendation in the 2018 annual report of the Chief Medical Officer for the health environment to be health-promoting, incentivising and normalises healthy behaviours.[12] Across the partnership, we will be reviewing and improving what health choices we are facilitating or denying in our buildings and the built environment over which we have control or influence. This will include initiatives such as increasing smoke-free areas; reviewing and improving what the food offer is and how people travel. This approach is reflected in our priorities under each of the three behaviours.

How will this framework help us tackle poverty and inequality?

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

We need to think about how we improve healthy life expectancy through supporting positive health behaviours amongst those who currently have the lowest life expectancy. The three behaviours of being inactive, eating a poor diet and smoking are more likely for those living on low incomes, or those already managing another health challenge. By focusing on changing the three behaviours, we will therefore be working to tackle inequality in outcome and the effects of poverty on people in the borough.

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

What influences people's behaviour? Understanding the links between poverty, employment, education and health outcomes

In order to identify what action to take to help people make healthy choices, we need to understand what influences people's ability to be active, eat healthily and be smoke-free. We know that income is strongly linked to both health behaviours and health outcomes. This may be due to choice – where higher incomes allow people to choose healthier food from a range of options, or chose physical activities which best suit their interest and needs. However, by facilitating people with lower incomes to participate in healthy activities, we also recognise that health behaviours can be cost-saving. For example, walking and cycling

[12] Annual report of the Chief Medical Officer, Better Health within Reach, Department of Health and Social Care, 2018

rather than driving increases physical activity, avoids air pollution and is a low-cost alternative to the cost of a car.

Research indicates that beyond a certain level of Gross Domestic Product (GDP) it is inequalities in income that have a greater effect on health than actual income[13].

To develop further using the results of our public consultation, and also with further reference to published research, including:

- *Marmot http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf*
- *https://www.health.org.uk/infographic/poverty-and-health?gclid=EAIaIQobChMIs_bPl6P14AIVYbHtCh1DMQQMEAAYASAAEgLvevD_BwE*

Priority 1: Being active

What do we know about this behaviour in Enfield?

Physical inactivity is the second main risk factor (after diet) for being overweight or obese, as keeping active is the most effective way of burning calories. Physical activity and a healthy diet can also positively impact on good mental health and wellbeing.[14]

The NHS recommends at least 150 minutes of moderate aerobic activity or 75 minutes of vigorous intensity per week. In 2016/17, 27.7% of Enfield adults were found to engage in less than 30 minutes of physical activity a week, higher than both the national and London averages.[15]

Active travel is a convenient way of performing physical activity as it allows people to incorporate it in their daily routine, as walking or cycling to work would be an easy way to reach the recommended levels of physical activity. People who cycle for active travel purposes are four times more likely to meet physical activity recommendations than those who do not[16]. However, 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.

What are the barriers to and opportunities for physical activity in Enfield?

To develop using the results of the local consultation and further reference to published research.

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)

[13] Wilkinson, R. (1996) Unhealthy Societies. The Afflictions of Inequality. Routledge.
[14] https://www.mentalhealth.org.uk/a-to-z/d/diet-and-mental-health and https://www.mentalhealth.org.uk/publications/how-to-using-exercise
[15] JSNA
[16] Stewart et.al. (2015) Assessing the contribution of utility cycling to population levels of physical activity; An analysis of the Active People Survey. Journal of Public Health. doi:10.1093/pubmed/fdv182

- 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)

Our priorities for being active

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

2. Increase active travel amongst children and young people travelling to early years settings and schools and promote physical activity throughout the school day.

3. *Ageing well priority to be developed from social isolation and loneliness strategy*

4. Promote active travel and physical activity through all decisions we make regarding planning, housing and the environment.

5. Tackle inequality: area-based initiatives to increase physical activity in the most deprived wards in Enfield

Priority 2: Having a healthy diet

What do we know about this behaviour in Enfield?

In 2016 poor diet was the second leading risk factor for mortality worldwide[17]. A nutritionally inadequate and unhealthy diet has been associated with an increase in the risk of Coronary Heart Disease (CHD), cancer, obesity and diabetes , cancer and obesity and diabetes. Fruit and vegetable consumption is inversely associated with the risk of CHD, reduced by 4% for each additional piece of fruit eaten per day and 7% for each additional piece of vegetable[18]. 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)[19].

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

Enfield data also indicates significant differences in excess weight between ethnicities in the borough, and between wards. Increasing levels of inequality mean that access to healthy food choices is less available for some parts of the population and they experience food poverty. Additionally, Enfield is considered to have an obesogenic environment where highly calorific food is constantly and easily available and where physical activity is being

[17] 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.

[18] 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.

[19] 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

progressively eliminated from modern life. An obesogenic environment could be one of the factors in poor accessibility to affordable healthy foods and the likelihood of experiencing food poverty.

While anybody could experience food poverty at any point in life, people in low income jobs or on benefits are more likely to suffer from food poverty. In 2017/18, 6,746 people accessed the North Enfield Food Bank. This represents a 12.6% increase compared to the previous year.
Poor accessibility to affordable healthy foods also plays a role in the likelihood of experiencing food poverty. The development of out-of-town supermarkets and the closure of many shops in more deprived areas might lead to increased costs and decreased quality of available foods in the remaining shops. Action in this regard, needs to focus on changing the 'food environment' – that is, accessibility and affordability of healthy food – in which people live.[20]

What are the barriers to and opportunities for physical activity in Enfield?

To develop using the results of the local consultation and further reference to published research.

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

Our priorities for having a healthy diet

6. Create working environments that support a healthy, balanced diet[21]

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

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

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

Priority 3: Being smoke-free

What do we know about this behaviour in Enfield?

Smoking is the leading cause of preventable illness and premature death in England, accounting for 21% of deaths in men and 13% of deaths in women aged over 35 in 2014. It

[20] JSNA
[21] With reference to Public Health England and Business in the Community Toolkit for Employers and the Mayor of London's Healthy Workplace Charter

is also the biggest cause of health inequalities accounting for approximately half of the difference in life-expectancy between the richest and poorest groups[22]. In 2014/15 there were approximately 1.7 million hospital admissions by those aged 35+ for smoking related illnesses[23]. It is estimated that smoking cost the NHS £2.6 billion in 2015[24]. HM Treasury estimates that the total cost to the economy in England is £12.9 billion per year[25].

Between 2012 and 2017, 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 still, and to reduce prevalence amongst groups where this behaviour is particularly high.

The greatest gain to be made in smoking related health is to make 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.

What encourages people to smoke in Enfield, or discourages them to do so?

To develop using the results of the local consultation and further reference to published research.

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)[26]
- 7% Enfield mothers smoke during pregnancy (2016/17)
- 40.7% of adults with serious mental illness in Enfield smoke (2014/15)
- 50% of adults in the Turkish community smoke (and 28% of young people) (2014)
- £60.5M estimated costs of smoking in Enfield

Strategic priorities

10. Enforce current smoke-free environments including around Council, NHS and voluntary sector buildings

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

[22] Office for National Statistics (2016). Health Survey for England 2015. Trend tables commentary.
[23] Action on Smoking and Health (ASH) (2017) The economics of tobacco.
[24] 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.
[25] HM Treasury (2014) Tobacco levy consultation.
[26] This data is from a national survey carried out in 2014/15, and we do not know when it might be repeated.

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

Communication and empowerment by making every contact count (MECC)

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.[27] Similarly, other professionals having contact with residents about other issues - whether that is about housing, their children's wellbeing, or requests for information about leisure activities or library services – have an opportunity to connect people to opportunities to improve their health.

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

MECC is about using routine and daily contact with the residents of Enfield to spot opportunities to help and encourage people to take positive steps to improve their own health and wellbeing. We are delivering a two-tiered training programme focussing on health, wellbeing, housing, employment and income. It will have a high degree of flexibility and is aimed at all frontline staff, including council, NHS, emergency services and community and voluntary sector staff. The programme aims to increase the skills and confidence of staff to deliver simple evidence-based interventions to promote the health, wellbeing and quality of life of residents within Enfield.

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.

To develop: how has our public consultation helped us to better understand who or what within the community may have the biggest influence on people decisions around healthy behaviours – and what can we do about this in our action plan?

Social prescribing

Social prescribing is a way to help 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.

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

Community activities can range from art classes to singing groups, from walking clubs to gardening, from volunteering to education and training, and many other interests. Social prescribing can lead, where appropriate, to employment, such as by supporting someone into a college course to build their employability skills. It is therefore particularly relevant in regard to helping people start more healthy behaviors and increase their social connectivity.

Develop further using the results of the consultation and with reference to:

- *https://www.gov.uk/government/publications/social-prescribing-applying-all-our-health/social-prescribing-applying-all-our-health*
- *https://www.local.gov.uk/sites/default/files/documents/just-what-doctor-ordered--6c2.pdf*

Social prescribing is becoming more popular 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 make frequent repeat visits to their doctor or to their local emergency department – effectively trapping them in a 'revolving door' of services.

Supporting people to be resilient and independent, through Care Closer to Home Integrated Networks (CHINs)

The aim of CHINs is to develop integrated support to keep older people out of hospital, living longer and more independent lives.[28]

A CHIN is a way of working that aims to bring together primary care, local authorities, community services, voluntary and community sector, mental health services, acute and specialist providers and local people to work in partnership to deliver more integrated and holistic care for individuals. It will be more effective and easier to implement if local people are increasingly taking control of their own health and care through adopting healthy behaviours. According to NHS, 'self-care is about keeping fit and healthy, understanding when you can look after yourself, when a pharmacist can help and when to get advice from your GP or another health professional. If you have a long-term condition, self-care is about understanding that condition and how to live with it'.[29]

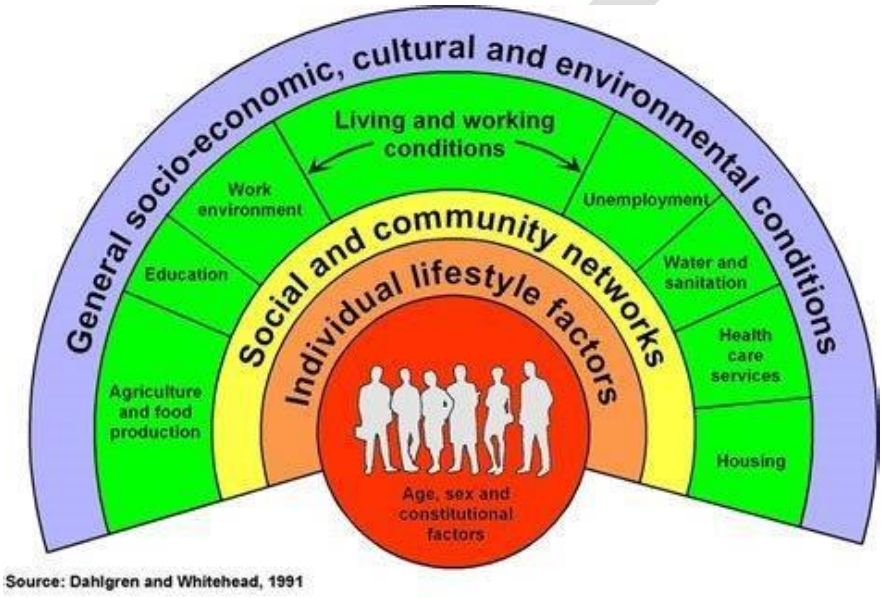
Throughout 2017, Healthwatch Enfield got people involved in conversations about delivering a Care Closer to Home Integrated Network model that could work in the borough. According to all participants of this conversation, there is a significant role for people to take responsibility for self-care which in itself promotes the CHIN agenda in the borough. When asked the question about what self-care meant to them, they defined it as a way of living that 'involves individuals looking after themselves; that makes them proactive; taking responsibility and being responsible; that empowers individual to take action; to be clear about their limits and to ask for help'. The results of this consultation are being used to develop an approach to CHINs, 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, particularly in supporting behaviour and lifestyle changes. This also links to MECC.

Addressing the wider determinants of health

[28] https://www.england.nhs.uk/2019/01/long-term-plan/
[29] https://www.england.nhs.uk/blog/what-does-self-care-mean-and-how-can-it-help/

The proposed new Joint Health and Wellbeing Strategy is focused on the three behaviours of eating healthily, physical activity, and being spoke-free. There is national and international evidence of the positive impact on health if people are helped and encouraged to live their lives participating in these behaviours. We have used local outcomes data, the public consultation on this strategy and national research and best practice to identify specific priorities in regard to facilitating these three behaviours.

However, we know that there are many wider determinants impacting on people's health and wellbeing. This includes people's access to decent housing, their level of income, their employment and their experience of crime and antisocial behaviour. Our consultation also demonstrates that these are important issues to Enfield residents when thinking about their health and wellbeing.



Source: Dahlgren and Whitehead, 1991

There are many other activities and strategic programmes underway across the partnership to continue to tackle these wider determinants of health. The Health and wellbeing Board is committed to working together, and with our wider partnership of community, businesses and other organisations in the borough to deliver on improving access to good quality homes; to supporting people into training and secure employment; and to tackling crime

Relevant and related Enfield strategies include:

- Council Corporate Plan
- Enfield Local Plan
- Housing Strategy, Preventing Homelessness Strategy and Local Plan (New strategies under development)
- Children and Young People Plan
- Volunteering Strategy
- Violence against Women and Girls (VAWG) Strategy
- Enfield Children and Young People's Mental Health Transformation Plan
- Healthy Weight Strategy
- Loneliness and social isolation strategy
- Safeguarding Adolescents from Exploitation and Abuse Strategy
- Enfield Travel Plan
- Employment and Skills strategy (new strategy to be developed)
- Safe and stronger communities plan

- North area violence reduction plan[30]

[30] 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

Appendix 1: Consultation report

We consulted with members of the public across Enfield to inform the development of this strategy.

This included an online survey and face to face interviews with 643 residents, which took place between 19th December 2018 and 17th February 2019. It also included discussion with 152 residents at the Healthwatch annual conference on 14th February 2019. Participants of the conference were encouraged to share ideas, suggestions and challenges about how to improve health and wellbeing in Enfield, focusing on how we can better support and facilitate healthy behaviours.

Summary narrative of findings and how they shaped the strategy to be included here

Appendix 2: Action Plan

Being active					
Life stage	**Priority**	**Actions**	**Named lead**	**Timeframe** *Date at which report due to Health and Wellbeing Board*	**Measure of success**
Living well	As employers, increase active travel to and within work amongst employees.				
Starting well	Increase active travel amongst children and young people travelling to early years settings and schools and promote physical activity throughout the school day.	*Example action:* Offer all primary schools support to implement The Daily Mile, targeting schools with highest obesity levels.	Stuart Lines, Director of Public Health Clara Seery, Director of Education	December 2019	% of schools delivering the Daily Mile a minimum of 3 days per week
Ageing well	*Priority to be developed from social isolation and loneliness strategy*				
All ages	Promote active travel and physical activity through all decisions we make regarding				

	planning, housing and the environment.				
All ages	Tackle inequality: area-based initiatives to increase physical activity in the most deprived wards in Enfield				

Eating healthily

Life stage	Priority	Actions	Named leads	Timeframe *Date at which report due to Health and Wellbeing Board*	Measure of success
Living well	Create working environments that support a healthy, balanced diet				
Starting well	Create environments in early years settings, schools, health and social care that support a healthy, balanced diet				
All ages	Create healthy neighbourhoods and town centres that				

	support a healthy, balanced diet				
All ages	Tackle inequality: area-based initiatives to increase take up of '5 a day' in the most deprived wards in Enfield	Develop and implement an action plan to make Angel Edmonton high street as health promoting as possible, through action to increase availability of healthy food at low prices (Exploring options for a 'Local Pantry' in Fore Street) *Specific action from this to be identified with measure of success for this year one action plan*		December 2019	

Being smoke free

Life stage	Priority	Actions	Named lead	Timeframe *Date at which report due to Health and Wellbeing Board*	Measure of success
Living well	Enforce current smoke-free environments including around Council, NHS and voluntary sector buildings				
All ages	Increase the number of smoke-free community spaces in Enfield.			May 2020	

Cross cutting strategic priorities across all ages

Priority	**Actions**	**Named lead**	**Timeframe** *Date at which report due to Health and Wellbeing Board*	**Measure of success**
Making every contact count	Implement MECC training phase 1: all LBE new starters and housing staff Implement MECC training phase 2: all other client-facing LBE staff. *Implement MECC training for and with partner organisations – partners to confirm details and timeframes*	Mark Tickner, Public Health Strategist, LBE *Named leads to be confirmed from partner organisations*	By September 2019 By March 2020 *Timeframes to be agreed with partner organisations*	Number of staff trained. Recorded health signposted conversations with LBE residents Measurable outcomes to be determined via PH and CCG intelligence teams
Health in All Policies approach				
Social Prescribing				
CHINs				
Wider determinants: improving access to good	Housing Strategy	Joanne Drew, Housing Director, Enfield Council	Timeframes are set out in respective strategy action	Measures are set out in respective strategy action

quality housing	Preventing Homelessness Strategy		plans	plans
Wider determinants: improving access to training and employment	Employment and Skills Strategy (To be developed)	TBC		
Wider determinants: tackling crime and antisocial behaviour	Safer and Stronger Communities Plan North Area Violence Reduction Plan Safeguarding adolescents from exploitation strategy	Helen Millichap, Enfield and Haringey Borough Commander, Metropolitan Police Andrea Clemmons, Head of Community Safety, Enfield Council Anne Stoker, Director, Children's and Families Services, Enfield Council		