Draft Enfield Joint Health and Wellbeing Strategy 2020 – 2023

Making the healthy choice the first choice for everyone in Enfield

Scope	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.
Approved by	To be taken to Joint Health and Wellbeing Board for approval 26th September 2019; Cabinet on 13th November 2019 and CCG Governance Board November/December 2019 (dates TBC)
Approval date	The dates of approval at Health and Wellbeing Board, Cabinet and CCG Governance Board
Document Author	Enfield Council Policy, Partnership, Engagement and Consultation Hub and Public Health, on behalf of Enfield Health and Wellbeing Board
Document owners	All organisations represented on the Health and Wellbeing Board are responsible for the development, finalisation and delivery of the strategy. This includes: • Enfield Council • NHS Enfield CCG • Enfield Voluntary Action • Elected representative from the voluntary and community sector • Healthwatch Enfield • Royal Free London NHS Foundation Trust • North Middlesex University Hospital NHS Trust • Barnet, Enfield and Haringey Mental Health NHS Trust • Representative from Enfield Youth Parliament
Review	Our Health Improvement Partnership (HiP), a sub-group of the Board, will be responsible for the operational delivery of the strategy, and will report back to the Board on progress. The delivery of the strategy will be monitored by the Board through a review of the action plan on a six-monthly basis and a review of the outcome measures on an annual basis. These reviews will be coordinated by Public Health and the HiP and reported to the Health and Wellbeing Board for discussion and decision-making as required.

Contents

Introduction

This strategy sets out our long-term vision for reducing health inequalities in Enfield. Over the next three years, we are focusing our partnership work on making the healthy choice the first choice for everyone in Enfield.

It is fully acknowledged that in order to make an impact on the deep-rooted health inequalities seen in Enfield we must take a system-wide approach and work as an effective partnership to improve the wider determinants of health. Key to this is developing, aligning and coordinating preventative actions and services across the system to maximise impact and tackle the barriers to healthy behaviours. The places we live in and how we work with our communities are vital in supporting good health.

While this strategy focuses on how behaviours like smoking, lack of exercise, poor diet and drinking cause preventable deaths, we know that the conditions in which people live, work and age can make it harder for people to live healthier lives and drive these huge differences in avoidable deaths. Dealing with these issues can only be achieved by changing the local environment so that we remove barriers to healthier behaviours.

This joint strategy focuses on the ***collective*** action we are taking to prevent negative health outcomes, by focusing on making the healthy choice the easy choice. Underpinning the priorities set out in this strategy to help people make healthy choices, is the commitment from the Board to work together to deliver good housing, support people into secure employment which takes them out of poverty, create a child-friendly borough and deliver accessible, responsive and high quality health services. These wider determinants of health - **housing, education, welfare, work and poverty** - influence and underpin the health of our residents. Chief amongst these is poverty, which is both a cause and a consequence of poor health; poverty increases the chances of poor health and poor health in turn traps communities in poverty.

The Health and Wellbeing Board will support the Council in the delivery of their Housing and Growth Strategy; their Preventing Homelessness and Rough Sleeping Strategy; and emerging strategies to build our local economy, support people into sustainable employment, and create a thriving place.

The organisations on the Health and Wellbeing Board also continue to focus on improving the health and wellbeing services delivered by our organisations and commissioning and providing the right services to meet the health needs of Enfield residents. By facilitating all members of the Board to work collectively to tackle the borough's health and wellbeing challenges and health inequality, this strategy is going to play an important part in enabling the Council to deliver its Corporate Plan to create a lifetime of opportunities for everyone in Enfield, as well as helping the CCG and NHS health trusts to deliver the NHS Long Term Plan.

Cllr Alev Cazimoglu, Cabinet Member for Health and Social Care, Chair of Enfield Health and Wellbeing Board

Dr Mo Abedi, Chair of Enfield Clinical Commissioning Group (CCG) and Vice Chair of Enfield Health and Wellbeing Board

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

This strategy is about preventing the preventable. The vast majority of NHS resources are consumed by conditions that need not have developed. Most of these conditions are known as noncommunicable diseases (NCDs), or chronic diseases, which are the result of a combination of genetic, physiological, environmental and behaviours factors. An example is Type 2 Diabetes, which accounts for around 90% of all Diabetes cases spending, which in turn accounts for 10% of the NHS budget nationally.[1]

There is a stark difference in the risk of avoidable death between people who live in poverty, and those who do not. This is the case nationally and locally. Inequalities in health in Enfield have a long and avoidable history. In **2010-2012** the difference in **male** life-expectancy between the most deprived and least deprived areas in Enfield was **8.39 years. In 2015-17 the difference was 7.48 years.** In **2010-2012** the difference in female life-expectancy between the most deprived and least deprived areas in Enfield was **5.86 years**. In **2015-17** the difference was **5.2** years.[2] While the difference has declined slightly, it is still too high, and we need to work harder to close the gap by doing more to prevent ill-health.

There are two approaches to prevention. Firstly, at the individual level. This means treating people at the early stages of a disease occurring, by identifying those who are high-risk or more susceptible and offering them some individual intervention. This is often termed 'secondary prevention'.

The other 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 therefore takes this population level approach through attempting to control and shape the determinants of poor health, particularly the local physical 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 behaviours and conditions more common.

[1] https://www.diabetes.co.uk/cost-of-diabetes.html https://www.nhs.uk/news/diabetes/diabetes-cases-and-costs-predicted-to-rise/ https://www.england.nhs.uk/blog/type-2-diabetes-and-the-importance-of-prevention/

2 https://new.enfield.gov.uk/healthandwellbeing/topics/life-expectancy-healthy-life-expectancy-and-mortality/

Shifting the population's health

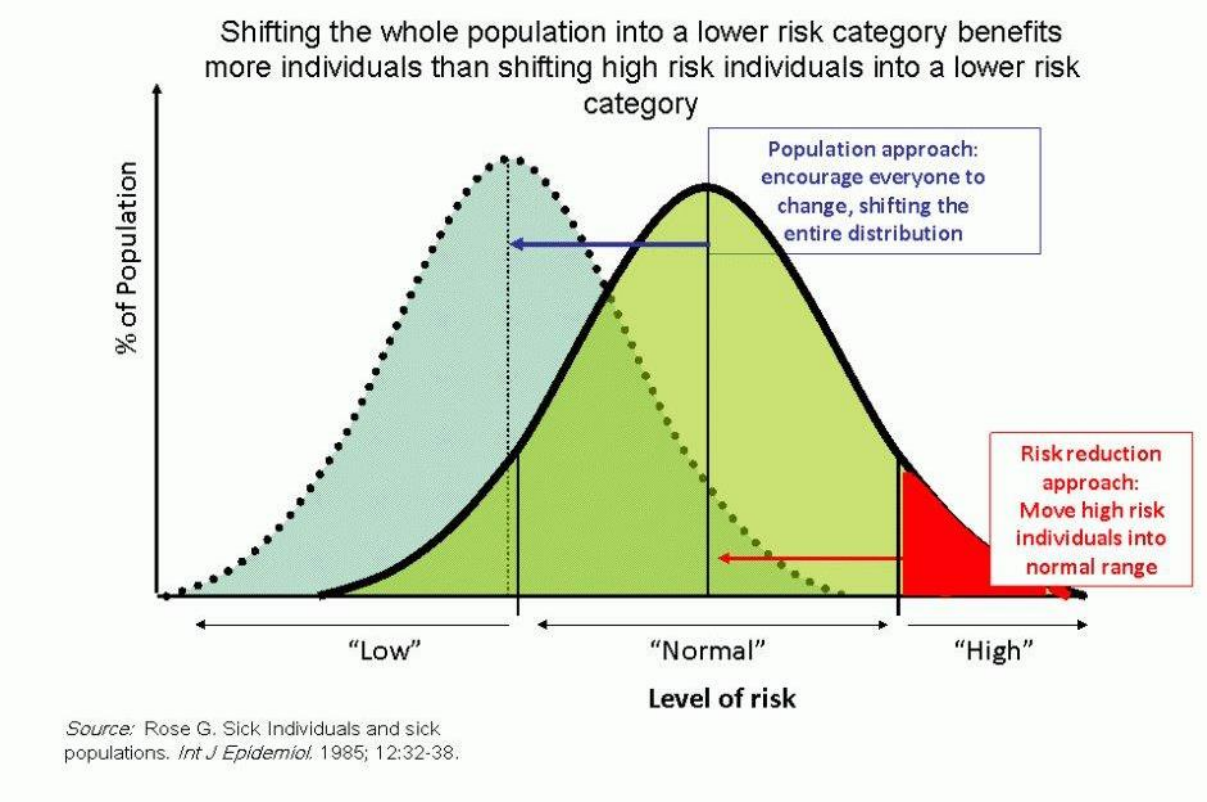


Figure 1.

To make change happen at this scale, we need to make healthy behaviours easier than unhealthy behaviours. 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 how long someone will live for, and whether they live in good or poor health. 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:

Eat well

Be active

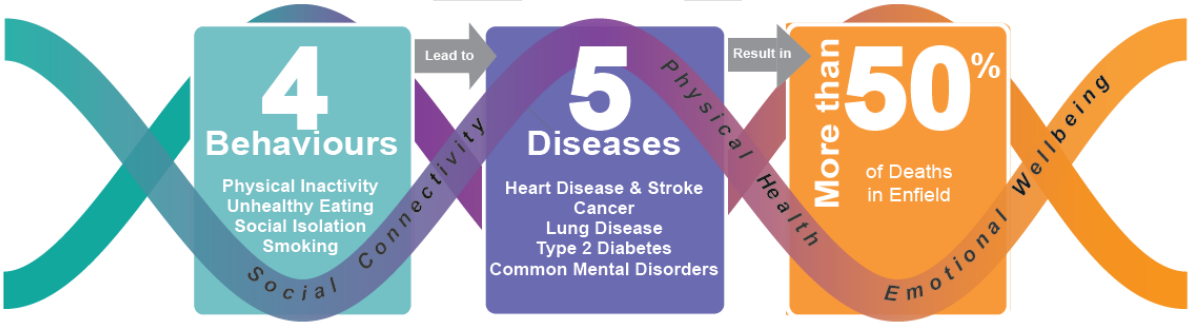
Be smoke free

Be socially connected

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** and reduce the prevalence of mental health conditions
- **reduce inequality** in health outcomes.

Our Framework: 4, 5, 50



There is international, national and Enfield-specific data which shows that the behaviours of **physical inactivity**, **unhealthy eating**, **smoking and being socially isolated** can lead to the increased risk of developing **cancer, heart diseases and stroke, type 2 diabetes, lung disease and mental health conditions**, and that these diseases are responsible **for more than 50 percent of early** deaths in Enfield.

In Enfield, cancer, heart disease and lung disease account for 73% of all deaths and 66.3% of deaths under 65 years of age.[3] A large proportion of these diseases are preventable. It should be noted that these behaviours impact on all 'long-term conditions' (LTCs) which collectively cost the NHS 70% of its budget[4] and make significant contributions to the demands placed on social care.

[3] Data from 2016, JSNA
[4] Five Year Forward View, NHS England (2014)

Using this framework 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.

Prevalence of ill-health in Enfield

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

7,265 people have **cancer**, which is 2.3% of the population (2017/18)

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

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

With earlier diagnosis and better treatments, the number of our residents living with cancer is increasing. Of those who have cancer around 4,500 have been living with the disease for more *than 5 years*.

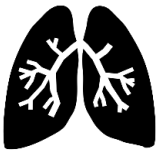
There are 651 hospital admissions for **heart disease** every 100,000 of the population (2017/18)

There are 7,477 people recorded with heart disease (2.3%) (2017/18)
There are 3,816 people recorded as having a stroke (1.2%) (2017/18)

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

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

19,821 people aged 17 and over in Enfield have **type 2 diabetes, which is** 8.0% of the population, with potentially another 4,439 people undiagnosed (2017/18).



896 people died due to **smoking- related illnesses** in Enfield between 2015 and 2017

1.1% of the population have COPD (**chronic obstructive pulmonary disease**) and 4.6% have **asthma** (2017/18).

19,261 people aged 16 and over are estimated to have a common **mental disorder**, defined as any type of depression or anxiety. This is 19.2% of the population (2017)

5,298 (9.9%) of children and young people aged 5-16 are estimated to have a mental health disorder, which includes emotional, conduct and hyperkinetic disorders. This is 9.9% of the population (2015).

24.9% 4 to 5 -year olds are **overweight or obese**.

41.1% of 10 to 11-year olds are overweight or obese

56.7 % of all adults are overweight or obese. (2017/18)

As well as being a major risk factor for developing Type 2 diabetes, which in turn is a risk factor for developing cardiovascular disease, obesity can also have a negative impact on mental wellbeing, quality of life, and has significant cost implications for social care as well as for health services.

It is recognised that the causes of obesity are multifactorial and that the responses required are complex, requiring a whole system response[5]. Key actions in reducing obesity and promoting a healthy weight lie in addressing the obstacles people face in being physically active and eating healthily.

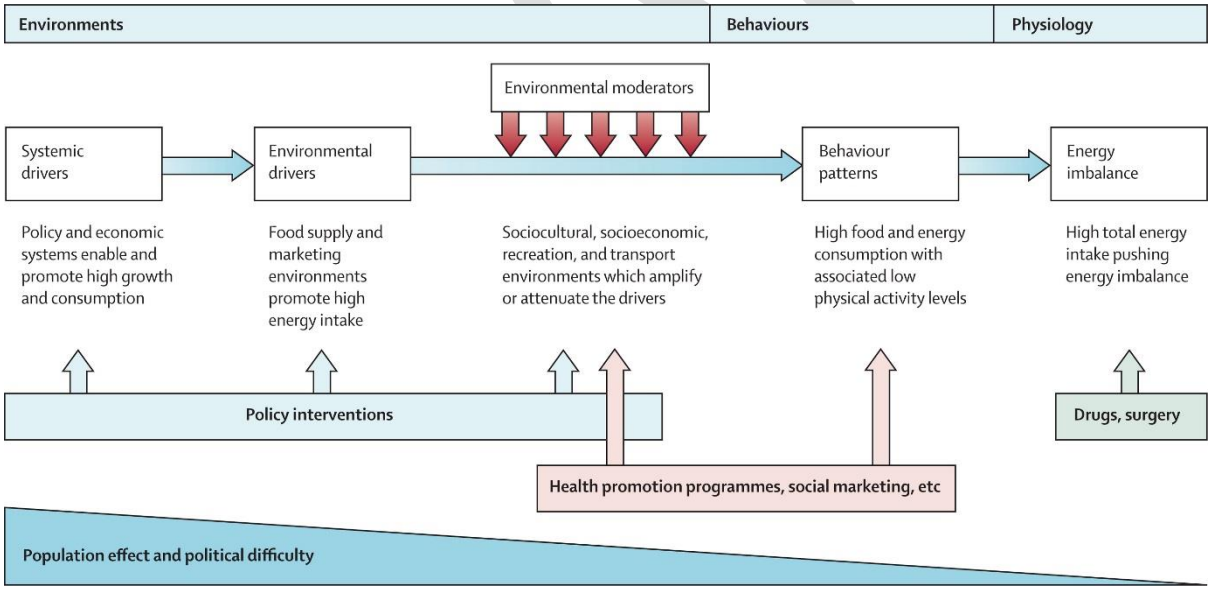


Figure 3: A framework to categorise obesity determinants and solutions[6]

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

[5] https://www.gov.uk/government/publications/health-matters-whole-systems-approach-to-obesity/health-matters-whole-systems-approach-to-obesity

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

The Health and Wellbeing Board is committed to helping ensure that mental and emotional wellbeing is everyone's business and to putting in place a whole system response to supporting individual and community resilience. 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 (defined as any type of depression or anxiety) in Enfield £98.1m. this includes depression, panic disorders, anxiety, obsessive-compulsive disorder and post-traumatic stress disorder.
- Depression presents an annual cost of £44.8m; and psychosis £69.4m in Enfield
- It has been estimated that the costs of poor mental health to Enfield employers is £142m per annum.[7]

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,[8] including dementia, and around 30 percent of all people with a long-term physical health condition also have a mental health problem.[9] Reducing the prevalence of long-term physical health can therefore be expected to remove some of the risk factors associated with mental ill-health.

Relatively simple physical or environmental interventions or changes can help make significant improvements in emotional health and wellbeing. As well as social connectiveness, physical activity, eating well and being smoke free also have a positive impact on mental health and wellbeing as well.[10] For example, adults undertaking daily physical activity have a 20-40% risk reduction of all long-term conditions including depression, distress and dementia.[11]

[7] Enfield Psychiatric Needs Assessment 2016

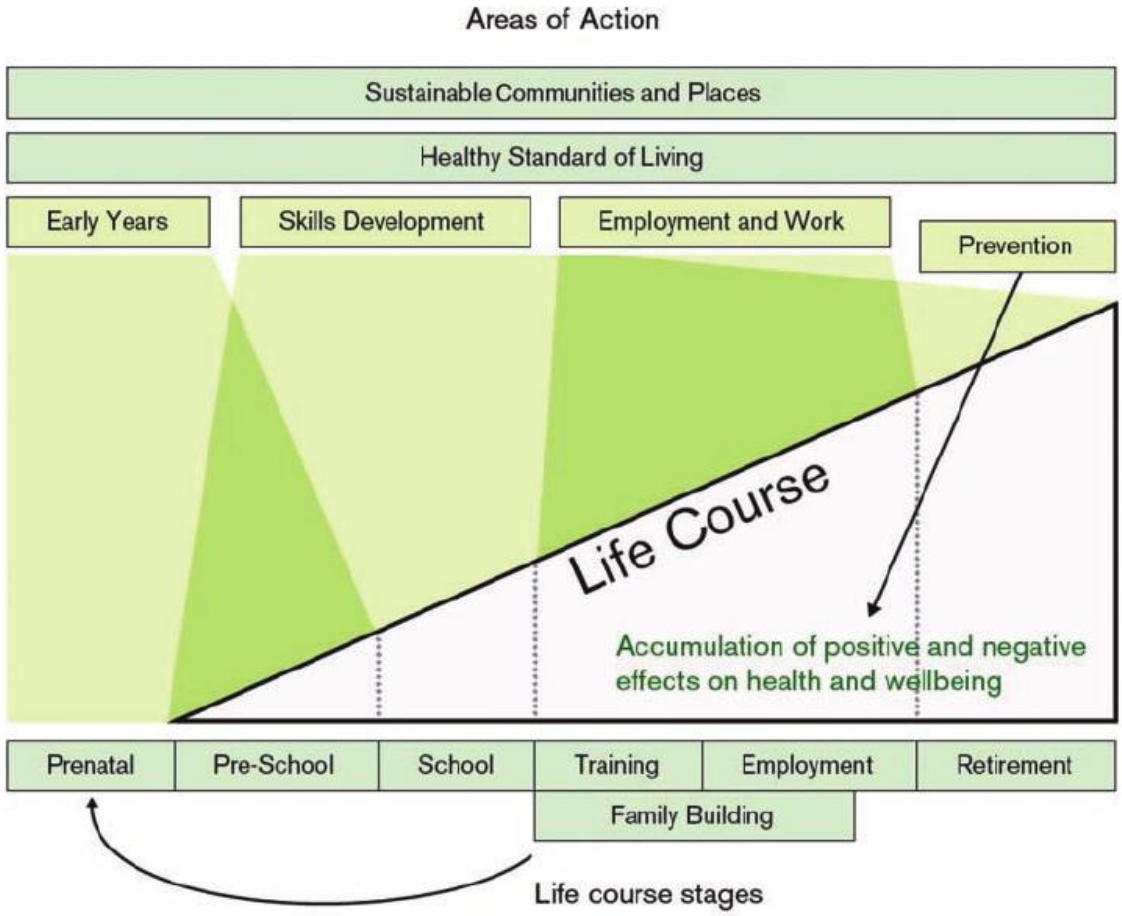
[8] https://www.kingsfund.org.uk/projects/mental-health-and-long-term-conditions-cost-co-morbidity

[9] 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

[10] 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

[11] Start Active, Stay Active. A report on physical activity in the UK. Dept of Health (2011); and

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



[12]

Source: Fair Society, Healthy Lives; the Marmot review 2010

We have the opportunity to prevent or reduce the impact of diseases and adverse life events at key stages of life from preconception through pregnancy, infancy, childhood, adolescence, through to adulthood and older age. The Marmot Review[13], which considered the importance of taking the life course approach, noted that disadvantage generally accumulates throughout life, leading to poorer health and social outcomes. However, this process is not inevitable and opportunities should be taken to reduce health inequalities from before birth and throughout life. We will use the emphasis on the three healthy behaviours to develop focused actions that facilitate change 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, or 'wellbeing in all decision-making', involves all organisations represented on the Health and Wellbeing Board considering what positive influences can be exerted on the four behaviours in all the actions and decisions our organisations take. This will include what happens within our own organisations, including with our workforce and for visitors to our buildings, what is included in our commissioning intentions and contracts and what leadership we can provide for our residents and communities.

[12] http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

[13] http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

We know that the environment in which we live is hugely influential on health. This is recognised 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.[14] 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 and increase access to sustainable and secure employment?

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 well, and be smoke-free. Itcan also increase the chances of being socially isolated. By facilitating people on lower incomes to participate in healthy activities, we want to start to break the links between lower income and poor health.

Healthy behaviours can also be cost-saving. For example, walking and cycling rather than driving increases physical activity, avoids air pollution and is a low-cost alternative to the cost of a car. The buying of cigarettes is another clear example. However, it is also acknowledged that higher calorific 'fast food' may also be cheaper than more healthy foods such as fruit and vegetables. We are aiming to better understand what can be done to address these barriers, real or perceived, due to income, at a local level.

Supporting people into higher quality employment, characterised by fair pay, security, good working conditions, a good work life balance and opportunities to progress, is another important way in which we can tackle healthy inequality.[15] Our priority to help people to be more socially connected therefore includes action to improve access to sustainable employment – aiming to help increase the income of local residents in such a way as to be good for their health and wellbeing.

The Health and Wellbeing Board also supports the Council in the delivery of it's strategies to improve housing, tackle homelessness, and develop the local economy. Alongside the priorities set out in this strategy, we will work collectively to tackle these wider determinants of health.

Priority 1: Having a healthy diet

What do we know about this behaviour in Enfield?

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

[15] www.health.org.uk/infographic/how-is-work-good-for-our-health

In 2016 poor diet was the second leading risk factor for mortality worldwide[16]. A nutritionally inadequate and unhealthy diet is associated with becoming overweight or obese and developing Type 2 Diabetes, which increases the risk of developing cancer and cardiovascular disease, including Coronary Heart Disease and stroke.

Fruit and vegetable consumption reduces the risk of Coronary Heart Disease by 4% for each additional piece of fruit eaten per day and 7% for each additional piece of vegetable[17]. 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[18].

In Enfield, 40% of adults, and 40% of 15-year olds have fewer than five portions of fruit and vegetables a day, similar to national trends.[19] The proportion of 5-year olds children with one or more missing decayed, or filled teeth, at 30.5%, is significantly higher than England (23.3%)[20].

As well as issues around dependency and its social effects, alcohol consumption is also linked to diet and calorific intake. Our alcohol policies and messages will be used to help inform, advise and support sensible drinking. This will include:

- Promoting government recommendations for alcohol
- Reduce your alcohol, reduce your calories
- Choosing alcohol with lower alcohol by Volume (ABV)

Data from Public Health England Adult Commissioning Support pack 2019/20 indicates that in 2016/17 there were an estimated 2,836 alcohol dependent adults in Enfield of which 396 were in treatment. This equates to an unmet need of 86% compared with 82% unmet need nationally. Data from 2011-2014 Health Survey for England highlights that the proportion of adults drinking less than 14 units per week (as per the Government recommended guidelines on alcohol), is 64.3% in Enfield compared to 59.1% nationally. Conversely the proportion of adults drinking more than14 units a week is 13.9% in Enfield which is just under 12% lower than the National average.

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, the extent to which Enfield, in common with most urban environments, is considered to be an 'obesogenic environment', where highly calorific food is constantly and easily available and where physical activity is being progressively eliminated from modern life, is an important consideration. Another factor may be 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. Food poverty is increasing year on year in Enfield. In 2018/19 **7,046** people accessed the North Enfield Food Bank. This

[16] 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.
[17] 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.
[18] 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
[19] What About YOUth (WAY survey 2014/15 and Active Lives Survey 2017/18
[20] Oral Health Survey 2016/17

represents a **10.7%** increase compared to the previous year. The previous year had seen a 12.6% increase on the year before that.

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.[21] This is often referred to as creating a 'healthy high street,' and detailed plans are underway by Enfield Council to reinvigorate our town centres to achieve this goal.

What have local people told us?

Local people have told us that we should be working toward making Enfield a '**healthy food borough'**. People in the community have suggested:

- Working with shops, supermarkets and fast food outlets to offer healthy alternatives/ choices, introducing healthy food ratings, and exploring what further incentives we could offer to encourage them to offer healthy choices
- Working to reduce vending machines locally or replacing options available within them for healthier alternatives
- Removing cakes and unhealthy desserts from school meals
- Having accessible information and communication materials about healthy eating, underpinned by consistent messaging and narrative.

Local people also told us we should do more to make healthy eating affordable and have suggested:

- Helping local people access 'healthy cooking made easy on a budget' classes to introduce concepts such as leftover vegetables being made into a soup
- Having access to lunch clubs / supper clubs where people can socialise, learn from one another and support to batch cook

643 local people responded to our survey about health and wellbeing.

81% of the people we surveyed said they had enough of the kinds of food they want to eat

15% said they had enough food, but not always the kind they wanted to eat.

3% said that sometimes or often they didn't have enough to eat.

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

- 41.3% of adults in Enfield are not meeting the recommended 5 portions of fruit and vegetables a day - '5 a day' (2017/18)
- 41.3% of 15-year olds are not meeting '5 a day' (2017)
- 305 fast food outlets in Enfield.
- 24.9% 4 to 5 -year olds; 41.1% 10 to 11-year olds; and 56.7% of adults are overweight or obese in Enfield (2017/18)
- 30.5% of children have one or more decayed, missing or filled teeth (2016/17)
- 387 children and young people (aged 0-18) were admitted to hospital for dental caries (438.2 per 100,000). (2017/18)

[21] JSNA

- 13.9% of adults are drinking more than 14 units of alcohol per week (2011-2014)
- 61.4% of adults are overweight or obese (2017/18)

Our priorities for having a healthy diet

1. Create working environments that support a healthy, balanced diet[22]

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

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

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

Priority 2: 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.[23]

The NHS recommends at least 150 minutes of moderate aerobic activity or 75 minutes of vigorous intensity per week. In 2017/18, 26.4% 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.[24]

Physical activity does not require the membership of a gym or participation in organised sport. It is often about making small changes to daily routines that can build up over time.

Active travel is a convenient way of achieving adequate levels of physical activity as it allows people to incorporate it into their daily routine, as walking or cycling to work or to the shops 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[25]. However, according to the Active Lives Survey, in 2015/16, 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 have local people told us?

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

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

[24] JSNA

[25] 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

Local people have told us that we should be helping people to build activity into their daily routine and helping to motivate people to take physical exercise. People in the community have suggested:

- Employers introducing initiatives such as ‘activity at work’ or a ‘one hour per week’ programme encouraging 10 minutes of physical activity per day
- Providing people with clear information about different types of exercise and its benefits such as climbing stairs, doing housework or incorporating more walking into a journey by bus
- The importance of providing respite for carers so that they can have time to take part in physical activity
- Introducing a ‘gym buddy’ system where individuals can make contact with like-minded people to attend a gym or physical activity sessions together
- Providing more group activities that are culturally appropriate to encourage uptake
- Deploying, promoting and marketing Enfield-wide community campaigns such as a ‘mile a day’, ‘Zumba day’ or ‘car-free day’
- Having a social prescribing offer in Enfield that would make exercise free for individuals requiring it to improve their health and wellbeing outcomes

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

- 63% of Enfield adults are performing 150 minutes or more of physical activity a week (2017/18)
- 26.4% of Enfield adults are engaging in less than 30 minutes of physical activity a week (2017/18)
- 66.3% of Enfield adults are walking once a week (2016/17)
- 18.1% of Enfield adults are walking as a means of travel 5 times a week (2016/17)
- Less than 5% of Enfield adults used cycling once per week as a means of transport for utility purposes (2016/17)
- 43 schools taking part in the Daily Mile 2019

Our priorities for being active

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

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. Create healthy homes, streets and neighbourhoods that facilitate and encourage physical activity and active travel.

4. Tackle inequality: area-based initiatives to increase physical activity in the most deprived wards in Enfield, building on our community assets.

Healthy Streets

Enfield Council is committed to delivering healthy streets across the borough. Working in partnership with Transport for London and the Mayor of London, Enfield is actively engaged in the re-design of our streets as we work towards the Mayors Transport Strategy for 8 out of 10 journeys to be by walking, cycling or public transport by 2041.

Reducing the reliance on the private motor car, in particular for short journeys, will bring a range of health benefits, increase community cohesion and help create better places to live.

Enfield Council has already delivered a number of transformative projects through the 'Cycle Enfield' programme, with more investment secured via the 'Liveable Neighbourhood' initiative. The Council are also committed to a rolling programme of measures in residential neighbourhoods to help increase the levels of active travel as part of a normal daily routine. In addition to infrastructure changes, the healthy streets programme is delivering a range of supportive measures, including community walks and rides, free bike repairs, cycle training and partnering with 'Beryl' to bring a bike sharing system into the borough.

Priority 3: Being smoke-free

What do we know about this behaviour in Enfield?

Smoking is the leading cause of preventable illness and premature death in England, accounting for 21% of deaths in men and 13% of deaths in women aged over 35 in 2014. It is also the biggest cause of health inequalities accounting for approximately half of the difference in life-expectancy between the least and most deprived groups[26]. In 2014/15 there were approximately 1.7 million hospital admissions by those aged 35+ for smoking related illnesses[27]. It is estimated that smoking cost the NHS £2.6 billion in 2015[28]. HM Treasury estimates that the total cost to the economy, including sickness absence and caring responsibilities, in England is around £12.9 billion per year[29].

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% but overall this is a huge success. However, 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 remains stubbornly higher in particular groups, including people with mental ill health and certain ethnic communities.

Concerted efforts are required across the borough, the health and care system and the Council to continue to reduce smoking prevalence further, and to reduce prevalence amongst groups where this behaviour is particularly high.

The greatest gain to be made in smoking related ill-health is to help make sure people do not start in the first place. A national survey carried out in 2014/15 provided local level data that

[26] Office for National Statistics (2016). Health Survey for England 2015. Trend tables commentary.
[27] Action on Smoking and Health (ASH) (2017) The economics of tobacco.
[28] 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.
[29] HM Treasury (2014) Tobacco levy consultation.

showed 3.5% of 15-year olds in Enfield were smokers – lower than London and national averages but an indication that uptake of smoking remains a threat to young people. Positive behaviour amongst young people is something we want to continue to encourage and facilitate with the aim of achieving the first smoke-free generation[30].

What have local people told us?

Local people have told us that we should be helping people to build activity into their daily routine and helping to motivate people to take physical exercise. People in the community have suggested:

- Raising awareness about the costs of smoking and cheaper alternatives
- Expanding smoking bans
- Increasing the opportunity for people to seek help to stop smoking, by making every contact count

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)[31]
- 7.5% Enfield mothers smoke during pregnancy (2017/18)
- 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

1. Increase the number of smoke-free community spaces in Enfield, including around Council, NHS and voluntary sector buildings to help make not smoking the norm.

2. Support young people in not starting to smoke

3. Support the most vulnerable, such as pregnant women, to stop smoking.

Priority 4: Being socially connected

What do we know about this behaviour in Enfield?

Social relationships affect physiological and psychological functioning and health behaviours, which can have a negative impact on morbidity and mortality. National evidence suggests a 50% increased risk of coronary heart disease among those who are socially isolated and/or lonely.[32] Amongst elderly people, loneliness has been linked to a 29%

[30] Towards a smoke-free generation: a tobacco control plan for England, DHSC, 2017 https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england

[31] This data is from a national survey carried out in 2014/15, and we do not know when it might be repeated.

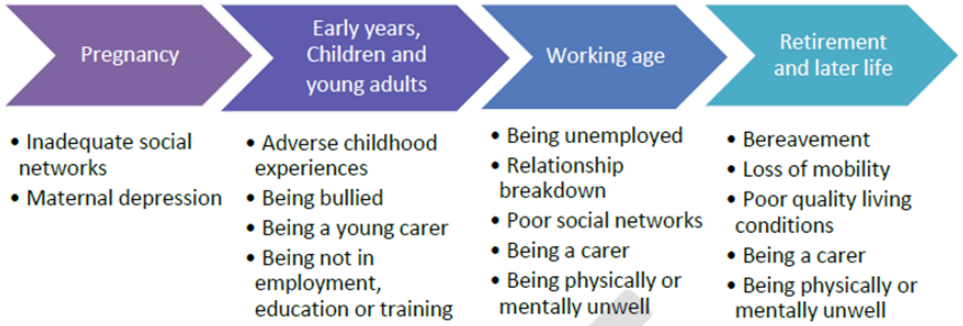
[32] Local action on health inequalities: Reducing social isolation across the lifecourse, PHE and UCL 2015

increase in the risk of developing cardiovascular disease and a 32% increase in the risk for stroke[33] and to an increase in the risk of accelerated cognitive decline.[34]

In Enfield, 10% of *all* households in Enfield are occupied by a single person aged 65 or over, with men in Enfield being expected to live the last 12 years of their life, and women the last 18 years, without being in "good health."[35] There is a clear link between social isolation and risk of falling in older people,[36] and reducing falls in Enfield is a high priority.[37]

Social isolation is not only a problem for elderly people, however. Anyone can experience social isolation and loneliness at any stage in the life course and this can be cumulative. Some life events are recognised as potential trigger points.

Figure 1: Risk factors for social isolation and loneliness along the lifecourse



Source: PHE & UCL, September 2015

Social relationships and in particular adequate social networks (in terms of quality and quantity) can promote health through four possible pathways:

- Providing individuals with a sense of belonging and identity
- Increasing knowledge about how to access material needs and services
- Influencing the behaviours of individuals, for example through support or influence from family or friends to quit smoking, reduce alcohol intake, or to access health care when needed
- Providing social support that enables individuals to cope with stress, such as pressures at school or work, redundancy, retirement or the death of a close relative. [38]

We want to work together to help people to be more socially connected, by providing more opportunities for social interaction, link people to positive social networks through social prescribing, and help people into high quality employment.[39] We want to support people to access employment which is good for their health and wellbeing, as being in paid work is not in itself enough to improve health. Jobs can be as bad for health outcomes as unemployment if they are of poor quality, offer limited autonomy, or leave workers in

[33] Valtora et al, 2016
[34] Donovan et al, 2017
[35] https://new.enfield.gov.uk/healthandwellbeing/topics/jsna/
[36] Pohl, Cochrane, et al 2017
[37] http://data.ageuk.org.uk/loneliness-maps/england-2016/enfield/
[38] *Local action on health inequalities: Reducing social isolation across the lifecourse*, Public Health England and UCL 2015
[39] www.health.org.uk/infographic/how-is-work-good-for-our-health

poverty.[40] Studies show that while there is some connection between unemployment and social isolation, that the primary causative factor of isolation associated with unemployment is in fact poverty. And poverty-while-working is as significant in this context[41]

.

"

What have local people told us?

Local people have told us that we should be making the best possible use of our community assets and helping people to take part in positive activities. People in the community have suggested:

- Having a social prescribing offer in Enfield
- Free activities for children and young people, in particular over the summer period
- Intergenerational activities such as visits to schools and homework clubs
- Access to a range of volunteering opportunities
- Introducing 'happiness cafes' or a 'happy to talk' table in cafes and restaurants where members of the public can engage in social interaction
- Utilising empty spaces / shops on the high street to deliver community or grassroots initiatives
- More peer support and befriending initiatives.

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

Measuring the subjective experience of loneliness can be both complicated and controversial and this is also a rapidly developing discipline. The Health and Wellbeing Board is developing an initial assessment tool as part of our Making Every Contact Count implementation plan, which will provide an initial baseline of loneliness and isolation within the borough and provide a was to measure the effectiveness of the action we are planning to take.

As a starting point, we have identified the following outcomes which we want to improve:

- 56.7% of adult social care users do not have as much social contact as they would like (18+) 2017/18
- 63.0% of adult carers do not have as much social contact as they would like (18+) (2016/17)
- Between April 2017 and March 2018, 805 people were admitted to hospital due to falls
- 30% of the population aged over 65 feel lonely[42]
- 31% of our over 65 population are assessed at being at risk of social exclusion.[43]

[40] [40] http://www.healthscotland.scot/health-inequalities/fundamental-causes/employment-inequality
[40] http://www.healthscotland.scot/publications/health-outcomes-and-determinants-by-occupation-and-industry-in-scotland
[41] D Gaillie, S Paugam, and S Jacobs 2010.
[42] http://www.enfieldccg.nhs.uk/Downloads/Equality-and-diversity/Equality%20information%20report%202016.pdf
[43] https://new.enfield.gov.uk/healthandwellbeing/topics/jsna/

Strategic priorities

1. Increase awareness across the local area of the availability of the many clubs and activities taking place in the borough

2. Help people who are lonely or isolated; people with mild mental health issues and people who struggle to engage effectively with services to take part in community activities through effective social prescribing.

3. Train and support staff across all organisations to be active listeners and responders and help local people to take part in community activities as part of our agenda to Make Every Contact Count.

4. Help local people to access high quality employment, which is characterised by fair pay, security, good working conditions, a good work life balance and opportunities to progress.

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.

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 behaviours and increase their social connectivity, so helping combat loneliness.

Approaches to social prescribing are developing 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.

Building our capacity 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 well, 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.[44] 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 residents 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 contacts 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. Enfield Council will be 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.

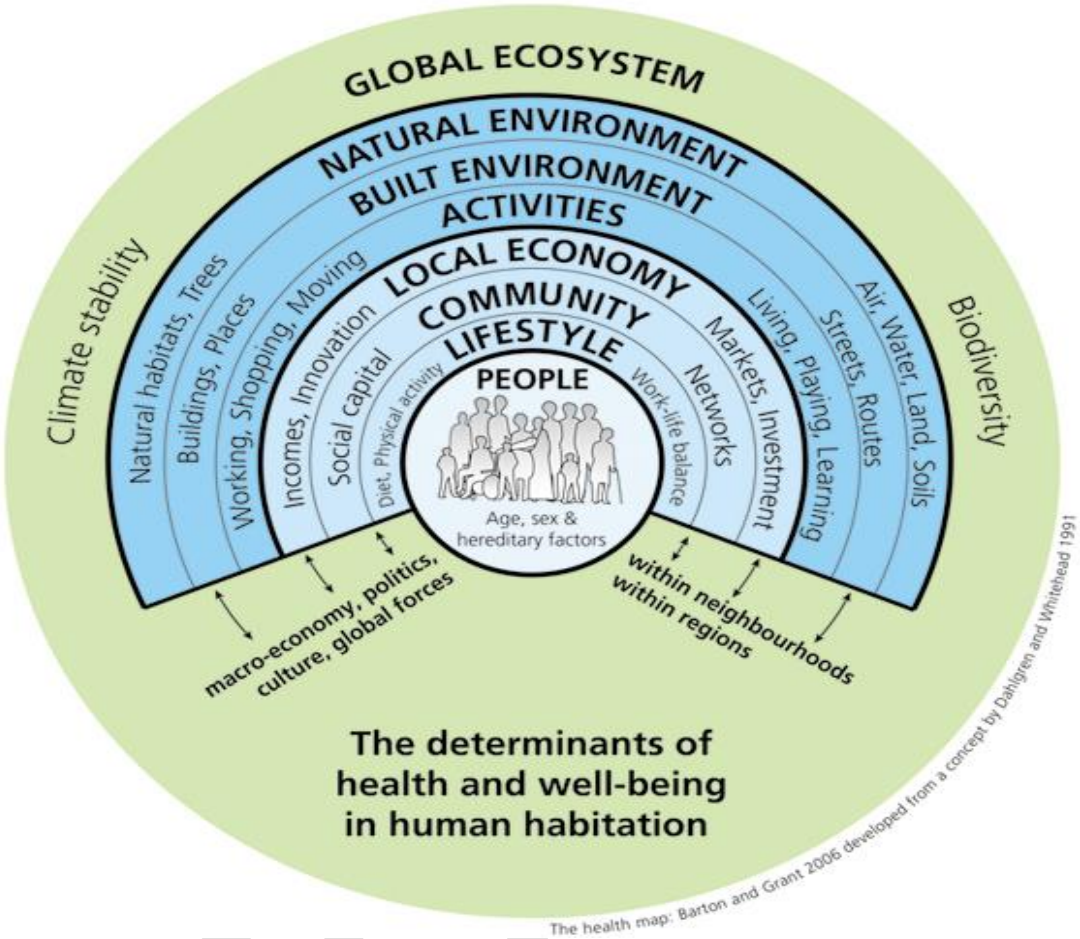
We also need to work with people within the community who influence others and develop strong role models to help influence positive behaviours and change habits, particularly amongst communities currently experiencing the worst outcomes. In short, this is about building the capacity within the community to help and support others in positive behaviour change to improve health. The Board will use its influence to drive community development in this area.

Addressing the wider determinants of health

This new Joint Health and Wellbeing Strategy is focused on the four behaviours of eating well, increasing physical activity, being smoke-free, and being socially connected. 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. This includes many actions to tackle availability of healthy food, improving the education, work and home environment for people in the borough, and creating healthy streets and neighbourhoods.

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

However, we know that there are many other aspects to the wider determinants of health impacting on people's health and wellbeing which we have not focused on within this



strategy. 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.

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 Enfield strategies. including those currently in development as at September 2019, include:

- Council Corporate Plan
- Local Plan
- Housing and Growth Strategy
- Preventing Homelessness and Rough Sleeping Strategy
- 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

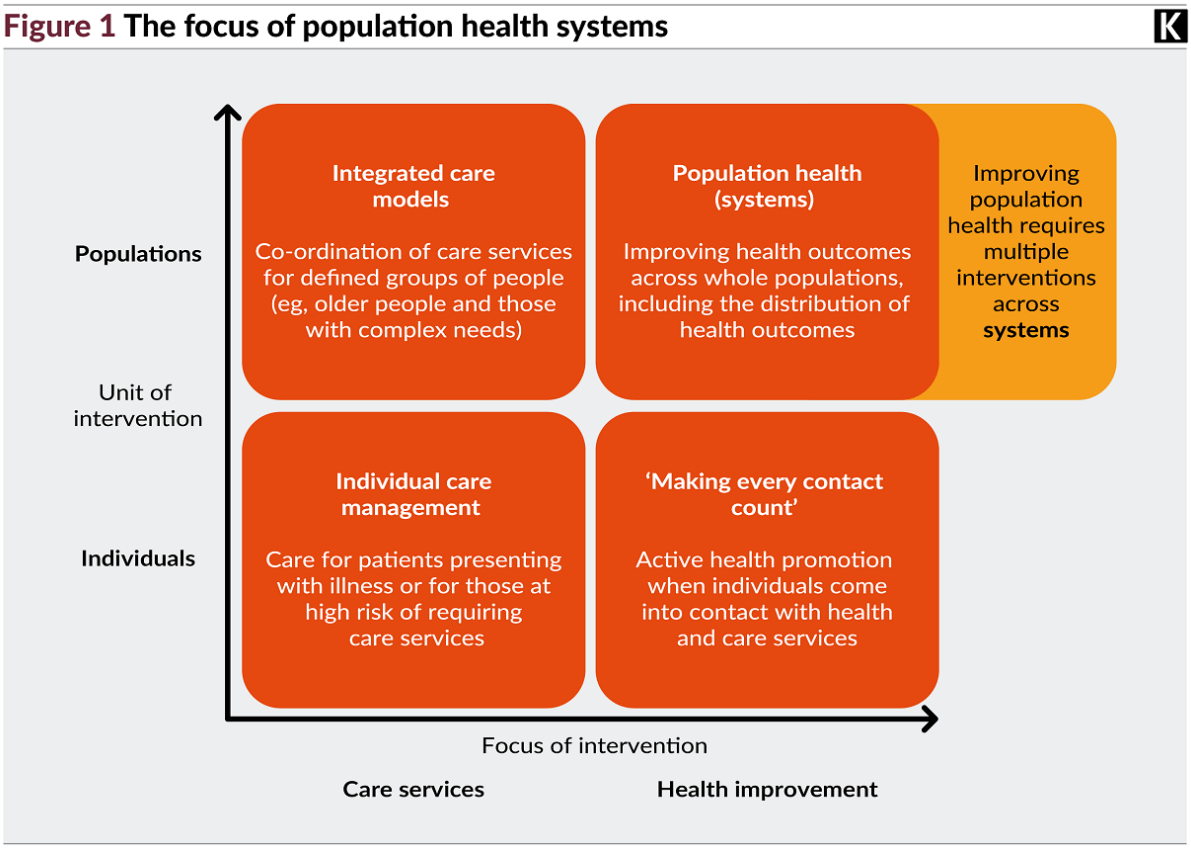
- Loneliness and social isolation strategy
- Safeguarding Adolescents from Exploitation and Abuse Strategy
- Enfield Travel Plan
- Economic Development strategy
- Safe and stronger communities plan
- North area violence reduction plan[45]

The health dividend offered by integration

Integrated care systems (ICSs) have evolved from STPs and take the lead in planning and commissioning care for their populations and providing system leadership. They bring together NHS providers and commissioners and local authorities to work in partnership in improving health and care in their area. [46]

Integrated care happens when NHS organisations work together to meet the needs of their local population. Some forms of integrated care involve local authorities and the third sector in working towards these objectives alongside NHS organisations. The most ambitious forms of integrated care aim to improve population health by tackling the causes of illness and the wider determinants of health.

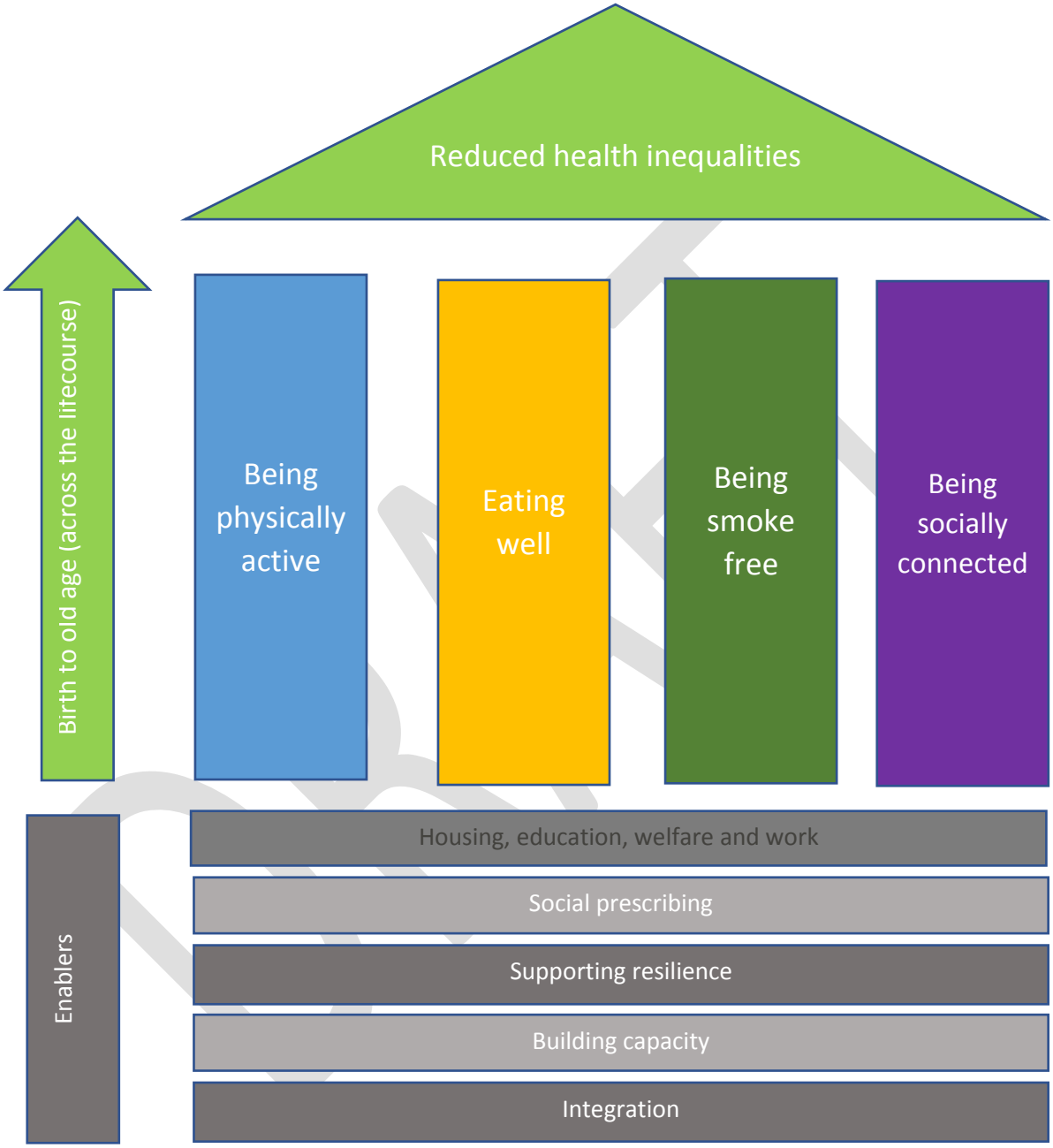
Figure 1 The focus of population health systems



[45] This list is not exhaustive, but gives an overview of key strategies Health and Wellbeing Board organisations are developing and implementing to tackle the wider determinants of health

[46] https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems#what

The four pillars of the Joint Health & Wellbeing Strategy for Enfield



How will we measure success?

The over-arching aim of this strategy is to reduce the unacceptable and persistent health inequalities experienced by Enfield residents.

Over the course of the next three years we will measure progress and achievements towards achieving this goal by tracking our progress in increasing the proportion of the population who are having the opportunity to participate in healthy behaviours.

These measures will be a mix of process measures (such as numbers of Council staff trained to deliver Making Every Contact Count) as well as outcome measures (such as the reduction in school-aged obesity in our high prevalence areas). These will all contribute towards reducing the health inequality gaps on life expectancy and healthy life expectancy

Priority	Indicator	Target for 2023
Priority 1: Having a healthy diet	305 fast food outlets in Enfield 2019	Halt the increase in the number of new fast food outlets in the borough
	92 food outlets signed up to the Healthy Catering Commitment (Jul 2019)	Increase the number of outlets signed up to the HCC by 20% by 2023
	Guidelines adopted within the local plan of how to restrict unhealthy fast food outlets	Regulations adopted
	Healthy Schools award currently 77 schools registered (88%) 53 bronze 27 silver 7 gold	By 2023 increase to: 85 schools registered (96%) 60 bronze 35 silver 10 gold
	24.9% 4 to 5-year olds are overweight or obese (2017/18)	Halt the increase of overweight/obese children by 2023
	41.1% 10 to 11-year-olds (2017/18)	Halt the increase of overweight/obese children by 2023
	61.4% of adults are overweight or obese (2017/18)	Halt the increase of overweight/obese adults by 2023
	63.0% of Enfield Adults performing 150 minutes or more of physical activity a week (2017/18)	Increase to 70% by 2023
	26.4% of Enfield adults engaging in less than 30 minutes of physical activity a week (2017/18)	Decrease to 20% by 2023

Priority 2: Being Active		Less than 5% of Enfield adults used cycling once per week as a means of transport for utility purposes (2016/17) *this includes Cycle Enfield Data	Increase to 10% by 2023
		51.3% of Enfield Adults walk for travel once per week (2016/17)	Increase to 60% by 2023
		43 schools taking part in the Daily Mile 2019	Increase from 43 to 60 by 2023
Priority 3: Being Smoke Free		13.7% of Enfield adults smoke (2018)	Under 12% by 2021 Under 10% by 2023
		10 Schools that have implemented stop smoking at school gates	Increase this to 20 schools by 2023
		7.5% Enfield mothers smoke at the time of delivery (2017/18)	<5% of mothers smoking at the time of delivery
		33.8% of Enfield residents with a long-term mental health condition smoke (18+) (2017/18)	Reduce smoking prevalence to 30% by 2021 25% by 2023
Priority 4: Being Socially Connected		56.7% of adult social care users do not have as much social contact as they would like (18+) 2017/18	Reduce by 10% by 2023
		63.0% of adult carers do not have as much social contact as they would like (18+) (2016/17)	Reduce by 10% by 2023
		Between April 2017 and March 2018, 805 people were admitted to hospital due to falls	Reduce by 10% by 2023
		30% of the population aged over 65 feel lonely	Reduce by 10% by 2023
		31% of our over 65 population are assessed at being at risk of social exclusion	Reduce by 10% by 2023
Long-term conditions	**Cancer**	72.1% of eligible females aged 53-70 were screened for breast cancer at least once in the previous 36 months (2018)	England = 74.9%
		68.8% of eligible females aged 25 to 64 years screened for cervical within the previous 3.5 years (2018)	England = 71.4%
		53.2% of eligible people aged 60-74 were screened for bowel cancer in the previous 30 months (2018)	England = 59.0%

	Diabetes	81.7% of people have been diagnosed with diabetes out of the estimated number of people with diabetes in Enfield (2018)	Aim 1 – to close the gap (i.e. get everyone diagnosed to get accurate prevalence data). This requires the CCG to case find. Aim 2 – to reduce recorded prevalence from 81.7% to 90%
	COPD	1.1% of patients (all ages) in Enfield are on the COPD register (QOF 2017/18). It is estimated that 2.4% of the population in Enfield have COPD (2015).	Close by 10%
	Hypertension	13.2% of people in Enfield (all ages) are diagnosed with hypertension (QOF 2017/18). It is estimated that 20.5% of people (aged 16+) have hypertension.	Close by 10% - document Caveat – exclude under 16-year olds QOF

Overarching Indicators	7.48-year gap in male life expectancy between the most and least deprived areas of Enfield. (2015/17)	Close the gap by 20% by 2023
Overarching Indicators	5.2-year gap in female life expectancy between the most and least deprived areas of Enfield. (2015/17)	Close the gap by 20% by 2023
	24.9% 4 to 5-year olds are overweight or obese (2017/18)	Halt the increase of overweight/obese children by 2023
	41.1% 10 to 11-year-olds (2017/18)	Halt the increase of overweight/obese children by 2023

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.

Our vision

Respondents to our online survey overwhelmingly agreed with the vision, with 91% stating that they either *strongly* agreed or *tended to agree*.

We asked people whether they thought the following factors were important when thinking about health and wellbeing, and the majority of respondents agreed they were, in all cases. Our strategy aims to help people achieve all these outcomes, by facilitating healthy behaviours which are shown to have a positive impact on these outcomes

1. Feeling happy (546 respondents) 85%
2. Sleeping well at night (535) 83%
3. Having friends, family and a support network that can help you (507) 79%
4. Having a healthy weight (498) 77%
5. Feeling that you/your family are safe from crime and ASB (495) 77%
6. Having reduced risk of cancer, heart disease, etc (487) 76%
7. Living for a long time in good health (482) 75%
8. Living without pain (480) 75%
9. Having somewhere suitable to live (480) 75%
10. Having something meaningful to do every day (446) 69%
11. Knowing who to talk to if you feel stressed or worries (426) 66%
12. Having a good income (412) 64%

Respondents also considered that a clean environment and air quality were important too. One of the important ways our strategy is aiming to address this is through increasing active travel, to minimise car use wherever possible. Enfield Council has also committed to making the authority carbon neutral by 2030 or sooner; and is establishing a Climate Emergency Task Force made up of officers and elected members.

Our priorities

Through the online consultation, we asked respondents whether they agreed that helping people to eat well, be physically active and be smoke free were important for helping people to be healthy and well. The majority agreed that these were all important. Respondents were also asked what else was important, and from these free text answers, the themes of mental health and socialising also emerged, which led to our inclusion of the priority of helping people to be socially connected.

The majority of respondents agreed that their home; their neighbourhood, their income and money; how they travelled/ got around and their job were all important when thinking about their health and wellbeing. Relationships/ support/ friends were also identified as important. This supports our approach of prioritising actions to help people to live healthily in their home and their neighbourhoods and focusing on the importance of focusing action on improving the ability do so for people on low incomes.

There was support for healthcare professionals promoting community activities instead of just medical solutions, with 86% strongly agreeing or tending to agree with this approach.

Eating well

- **81%** of the people we surveyed said they had enough of the kinds of food they want to eat
- **15%** said they had enough food, but not always the kind they wanted to eat.
- **3%** said that sometimes or often they didn't have enough to eat.

This finding is further evidence of the importance of understanding the links between poverty and health, and of increasing the availability of healthy and affordable food in all areas of the borough, particularly those where healthy food is currently less readily available.

The things that influenced people when making their decision about their evening meal included:

- what food they had available at home (42%)
- whether it was healthy (39%)
- how long it would take to prepare and cook (28%)
- who they were eating with (21%)
- what time they got home from work (13%)
- whether they felt like cooking (13%)
- how much it cost (11%)
- ideas from family/ friends (6%)
- their medical condition (4%)
- whether there were food stored/ eateries nearby (3%)

These are all important considerations when formulating actions over the three years of the strategy.

Being physically active

On a typical week…

- 9% of the people surveyed said that they did no physical activity at all
- 73% said they walked
- 27% said they go to the gym
- 15% said they are physically active through their job

- 13% said they went swimming
- 11% said they go jogging/ running
- 9% said they cycled
- 5% said they play team sports

For the people who had been active, they did so in the following places:

- On the road/ pavement (46%)
- In a park (32%)
- In a gym (28%)
- At home (18%)
- On a walking path (16%)
- At work (16%)
- In a sports hall (10%)
- On a cycle path (3%)
- At school (3%)

This finding is further evidence of the importance of active travel as a means of exercise, and of making healthy streets where people can more readily cycle and walk.

Being smoke-free

- 9% of the people we surveyed said they had smoked in the last week (excluding vaping and e-cigarettes)
- 90% said they had not smoked
- 1% were not sure

For 18 to 24-year olds, the percentage who had not smoked went up to 96%.

Of those who do smoke, 27% said they would like help to stop smoking.

Of those who answered the question about what would stop people smoking:

- 147 thought education
- 95 thought it should be made more expensive
- 50 thought more support
- 27 thought peer pressure
- 27 thought it should be banned in more public places.

This finding supports our priority to explore increasing the number of smoke-free areas in the borough.

How the consultation was used to inform the strategy

It is acknowledged that the consultation does not provide a statistically significant sample of the population and the results of the consultation were just one part of the research used to inform the final strategy.

The results of the online consultation have been used in combination with national research, analysis of local data, stakeholder analysis and the Healthwatch conference with members of the community, to determine the final vision, priorities and the year one action plan.

Appendix 2: Year One Action Plan: 2020

Priority 1: Eating well

Life stage	Priority	Actions in year one	Named leads	Measure of success
Living well	Create working environments that support a healthy, balanced diet	Continue to provide a healthy food environment in North Middlesex University Hospital by working with retail units to promote healthy options and continuing to make the fresh fruit and vegetable stall available for staff, patients and visitors.	Maria Kane, Chief Executive, North Middlesex University Hospital NHS Trust	
		Ensure Public Health England's Government Buying Standard for Food and Catering Services continues to be adopted across Enfield Council Buildings where food is provided.	Procurement Department LBE and Enfield HWB	Ensure internal review conducted by end of 2020
Starting well	Create environments in early years settings, schools, health and social care that support a healthy, balanced diet	Work with schools to ensure that children and young people have a healthy balanced meal during the school day.	Tony Theodoulou, Executive Director, People, LBE	Increase in school numbers from x to y by end of 2020
All ages	Create healthy neighbourhoods and town centres that support a healthy, balanced diet	Review the healthy food offer in commercial premises leased from the Council's Housing Revenue Account to identify ways of increasing the availability of healthy food.	Joanne Drew, Director of Housing and Regeneration, LBE	

All ages	Tackle inequality: area-based initiatives to increase take up of '5 a day' in the most deprived wards in Enfield	Increase the availability of fresh fruit and vegetables and access to support and information on healthy cooking in Upper Edmonton, linking in with the Enfield Care Network (Upper Edmonton area's new Primary Care Network).	Sarah Cary, Executive Director, Place, LBE Jo Ikhelef, Enfield Voluntary Action Dr Mo Abedi, Medical Director, Enfield CCG All HWB Board Members	

Priority 2: Being active

Life stage	Priority	Actions in year one	Named lead	Measure of success
Living well	As employers, increase active travel to and within work amongst employees.	Enable access to 'Beryl Bikes' for Council staff and help connect Beryl with other partner organisations to help expand the footprint of the scheme.	Sarah Cary, Executive Director, Place, LBE All Board members	Expansion of scheme
		Explore options for staff car parking arrangements to incentivise public transport and discourage car use where possible.	Sarah Cary, Executive Director, Place	Increase in proportion of staff walking, cycling and using public transport to travel to work by end of 2020
		All partner organisations to limit the availability of staff car parking and promote active travel on car free day 2020	All Board Members.	
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.	Offer all primary schools support to implement The Daily Mile, targeting schools with the highest obesity levels.	Tony Theodoulou, Executive Director, People Stuart Lines, Director of Public Health	Number of schools delivering the Daily Mile a minimum of 3 days per week to be increased from 43 to 50 by April 2020
		Continue to provide schools access to cycle training and start to deliver measures at 2 to 3 schools that restrict private cars at school gates during the	Tony Theodoulou, Executive Director, People	

		start and end of the school day.	Sarah Cary, Executive Director, Place, LBE	
All ages	Create healthy homes, streets and neighbourhoods that facilitate and encourage physical activity and active travel.	Continue to expand the Borough wide walking and cycling network through construction of the A1010 North project (subject to approval).	Sarah Cary, Executive Director, Place, LBE	Complete A1010 north project
		Promote walking and cycling as part of an active lifestyle throughout the engagement process for the Enfield Town Liveable Neighbourhood project.	Sarah Cary, Executive Director, Place, LBE	Involve active travel and health organisations in consultation.
		Develop a dynamic marketing campaign for promoting the use of Enfield cycle lanes, targeted at all ages.	Sarah Cary, Executive Director, Place, LBE All Board members	Campaign launched by end of 2020.
		Use healthy design principles in the development of Meridian Water.	Sarah Cary, Executive Director, Place, LBE	
	Tackle inequality: area-based initiatives to increase physical activity in the most deprived wards in Enfield	Increase awareness of walking and cycling routes in Upper Edmonton; and explore options for piloting a scheme to make 'Beryl Bikes' available for members of the community through social prescribing.	Glenn Stewart Deputy Director of Public Health Sarah Cary, Executive Director, Place	

			Jo Ikhelef, Chief Executive, Enfield Voluntary Action Dr Mo Abedi, Clinical Director, Enfield CCG	

Priority 3: being smoke-free

Life stage	Priority	Actions in year one	Named lead	Measure of success
All ages	Increase the number of smoke-free community spaces in Enfield, including around Council, NHS and voluntary sector buildings to help make not smoking the norm.	Explore options of increasing 'no smoking' signage around parks and playgrounds and outside school gates.	Sarah Cary, Executive Director, Place Glenn Stewart Deputy Director of Public Health	
		Explore options for incorporating smoke-free signage as part of the 'way finding' strategy developed for the Enfield Town Liveable Neighbourhood project.	Sarah Cary, Executive Director, Place Glenn Stewart Deputy Director of Public Health	
Starting well	Support young people in not starting to smoke	Enforce our Tobacco Control Strategy to restrict under-age and illicit tobacco sales.	Glenn Stewart Deputy Director of Public Health	
All ages	Support the most vulnerable, such as pregnant women, to stop smoking.	Re-focus our smoking cessation service on supporting high-risk groups including pregnant women to stop smoking	Glenn Stewart Deputy Director of Public Health Maria Kane, Chief Executive, North Middlesex University	Reduce percentage of Enfield residents who smoke to under 12% by 2021.

Priority 4: Being socially connected

Life stage	Priority	Actions in year one	Named lead	Measure of success
All ages	Increase awareness across the local area of the availability of the many clubs and activities taking place in the borough	Promote the MyLife directory across all organisations and community groups.	Bindi Nagra, Director of Adult Social Care, Enfield Council	
All ages	Help people who are lonely or isolated; people with mild mental health issues and people who struggle to engage effectively with services to take part in community activities through effective social prescribing.	Deliver a new social prescribing project to help residents find the right services and activities at the right time for them, linking in with the new Primary Care Networks to develop area-based approaches across the borough.	Jo Ikhelef, Chief Executive, Enfield Voluntary Action Dr Mo Abedi, Clinical Director, Enfield CCG	
All ages *All contributes towards priorities to help local people Eat well; Be physically active and Be smoke free*	Train and support staff across all organisations to be active listeners and responders and help local people to take part in community activities as part of our agenda to Make Every Contact Count.	Develop a community development and engagement offer to help the voluntary and community sector to become public health educators and enablers.	Glenn Stewart, Deputy Director of Public Health	
All ages	Help local people to access high quality employment, which is characterised by fair	Increase the number of Enfield residents accessing good quality employment through new	Director of Human Resources	

	pay, security, good working conditions, a good work life balance and opportunities to progress.	apprentices starting work at the council during 2020.		