

# Improving Health and Wellbeing in Enfield

The Annual Report of the Director of Public Health 2012



North Central London



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### **Your comments**

Comment and feedback about this report would be appreciated.

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# Welcome

We would like to welcome everyone to Enfield's Annual Public Health report.

We hope that the data and analysis in this report will be influential in guiding the work of the Health and Wellbeing Board. The report also provides information about local public health issues and will point Enfield's residents to places and people who can help them improve their health and wellbeing.

This report focuses on health in Enfield but has also been influenced by the wider changes in the NHS. The Health and Social Care Act 2012 means that, this year, public health departments are in transition from the NHS to being managed by local authorities from 1 April 2013. This is the first time since 1974 that local authorities have had the responsibility of delivering health improvement and Enfield Council is committed to ensuring that the NHS continues to play a vital partnership role in supporting the public health team.

We know that nationally there is a financial crisis and the full effects of this are likely to be felt in the years ahead. This will certainly affect health and wellbeing and there are likely to be significant effects on mental health and the health and wellbeing of children.

In the present financial climate, the work we plan to do must be cost effective to ensure we get the best return for our money and consequently the action we take will take account of the key public health data in this report which shows us where we need to intervene and invest.

Our Annual Public Health Report has four chapters.

Chapter one gives a description of the determinants of health and wellbeing.

Chapter two gives an overview of the transition. It will be important this year to ensure that everyone develops an understanding of the new structures and responsibilities for public health. This will give us the opportunity to ensure that health and wellbeing is taken into consideration when developing policies and to influence the range of work conducted by the Council. The NHS will also continue to play a major role in delivering the health improvement agenda with the Enfield Clinical Commissioning Group leading for the NHS and working closely with Enfield Council.

Chapter three of the report presents key public health data. It is notable that in Enfield we have very wide health inequalities. We agreed our first Joint Health and Wellbeing Strategy in 2009, and it is pleasing to see just how much some key indicators have improved since then. It is particularly encouraging that life expectancy in the borough is increasing.

The final chapter of the report celebrates the work of a range of colleagues in the wider public health workforce who are taking active steps to improve health and wellbeing. We have just had a wonderful summer where across London people are feeling inspired by the Olympic and Paralympic Games. It is incumbent on us all to build on this legacy and use the Games as an opportunity to inspire people in Enfield to improve their health and wellbeing.

We want to focus on supporting wellness rather than treating illness and this means genuinely engaging with residents so they can be involved in their own health and recovery rather than just considering themselves as passive patients to be treated. To do this we are looking to create radical new ways to deliver better health outcomes by working together with all our local partners.

We would like to thank the Director of Public Health and his team for producing this excellent report which will guide the next Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.



**Cllr. Christine Hamilton**  
*Cabinet Member for  
Community Wellbeing  
and Public Health*



**Karen Trew**  
*Vice-Chair, Enfield – NHS  
North Central London*

# Foreword

This Annual Public Health Report is being published in the summer when London hosts the 2012 Olympics and Paralympics. Our hope and expectation is that the Olympics and Paralympics will leave a lasting legacy for Londoners and lead to improvements in health and wellbeing.

2012 is also the year in which we finalise arrangements for the transfer of Public Health functions from the NHS to Local Government. We have a collective responsibility to ensure that we use this opportunity to improve health outcomes for our residents.

This Annual Public Health Report is aimed at a wide audience, particularly those people with a direct or indirect responsibility for making Enfield a healthier place to live. The health challenges of Enfield are enormous. We have high rates of child poverty, infant mortality and childhood obesity. Physical activity rates are low and obesity rates for adults are high. For those living in our most deprived areas, life expectancy is low, with stroke and heart disease remaining our biggest killers, followed by cancer.

The new Health and Wellbeing Board, with its responsibilities for producing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, has a real opportunity to improve health outcomes for Enfield's population. The Clinical Commissioning Group, especially through its Primary Care Strategy and Implementation Plan has the opportunity to improve health outcomes too.

A former Chief Medical Officer described the Wider Public Health workforce. These are people who although they don't have a formal responsibility to improve community health, still make an enormous contribution to improving health. There are about 10,000 such people in Enfield and in this report we describe some of their work.

It is unlikely that many people will read this report from cover to cover. It is more likely that people will dip into sections which particularly interest them. However experience shows that whilst people may be attracted to particular parts of the report, they often will then dip into other parts too.

In Chapter 1 of this report we describe the determinants of health and wellbeing. In particular we describe the importance of the wider determinants of health and wellbeing and the findings of the Marmot Review, Fair Society, Healthy Lives.

Chapter 2 describes the new Public Health System. In particular it talks about the role of local government, Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

Chapter 3 describes what we know about health outcomes in Enfield. In particular this chapter highlights the high level of health inequalities faced by Enfield residents.

Chapter 4a describes some, but by no means all, of the work done by our partners to improve Enfield's health and wellbeing. Chapter 4b describes some of the work either done or commissioned by the Public Health Directorate.



**Dr. Shahed Nizam Ahmad**  
*Joint Director of  
Public Health*

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Enfield produced its first Joint Health and Wellbeing Strategy in 2009. It has five key themes; a healthy start for children, narrowing the gap, healthy lifestyles, healthy places and strengthening partnerships and capacity. Overall, I am delighted at the progress of the last three years. There is a much increased understanding of what works to improve health and tackle health inequalities. We have established a tobacco control alliance and made significant progress in helping people stop smoking, control high blood pressure and high cholesterol levels. Our cancer screening performance has improved dramatically over the past few years and we are now the best in North Central London. There is an increased understanding that to tackle the life expectancy gap, we must focus on the over 50s, particularly in areas where life expectancy is lowest. All this has led to major reductions in death rates in Enfield. We are making a real effort to tackle child and family poverty and our immunisation rates have improved significantly in the last 6 months. It is pleasing to see that residents are choosing the Residents' Priority Fund to commission health improvement interventions such as green gyms and health trainers.

Whilst progress has been made in the above areas, we cannot afford to be complacent as there is still much to do. In particular we need to do much more to tackle obesity and increase physical activity. Working with communities will be essential to this and all health improvement programmes.

The main purpose of this report is to support the fifth theme of the Joint Health and Wellbeing Strategy: Strengthening Partnerships and Capacity. The Wider Public Health Workforce extends way beyond the public health directorate. The intention of this report is to serve as a valuable tool to support and empower this workforce.

I would like to thank Glenn Stewart, Cath Fenton, Gill Harrison and the whole Public Health Directorate for the production of this report, along with the authors of the items in chapter 4. I would also like to thank the Public Health Action Support Team for their support in producing this report. Finally I would like to thank both the Public Health Directorate and Enfield's wider public health workforce for making Enfield a healthier place to live.



London 2012



Cllr Kate Anolue, Mayor of Enfield with London 2012 Games Makers from Enfield. Photograph taken by Lewis Freeth



# Chapter 1

## Health and its Determinants

# Introduction

What does ‘health and wellbeing’ mean to you? A widely used definition of health is that given by the World Health Organisation<sup>1</sup> as a ‘state of complete physical, mental and social wellbeing not merely the absence of disease or infirmity’. This definition suggests that promoting good health or helping an ill person back to health needs to go beyond addressing physical needs; meeting psychological, social, spiritual and environmental needs are important.

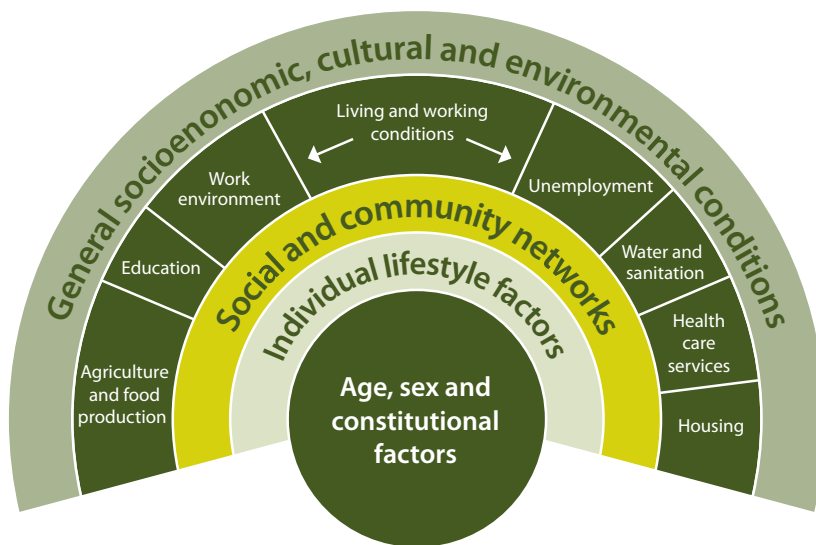
A review by the Prime Minister’s Strategy Unit<sup>2</sup> found that poor health in deprived neighbourhoods is in part driven by a range of social and environmental factors, including poor housing and local environments, limited social networks, income, poverty and worklessness, poor local transport and access to services, low educational attainment and drug and alcohol misuse.

## The Determinants of Health and Wellbeing

The range of personal, social, economic, and environmental factors that influence health are known as the determinants of health: the circumstances into which we are born, grow up, live, work and age. These factors are not usually direct causes of illness but have been described as “the causes of the causes of illness”.<sup>3</sup>

Determinants of health fall under several broad categories and are often represented using Dahlgren and Whitehead’s<sup>4</sup> model (Figure 1).

Figure 1.1: The determinants of health model



The model suggests that a wide range of stakeholders will be engaged in improving population health and wellbeing. In this chapter we consider the determinants of health; using the Dahlgren and Whitehead model as a framework we start from those factors closest to the individual.

## Age, gender and constitutional factors

The health challenges we face through life also vary depending upon our age, genetic makeup, gender and sexual orientation. Your health will clearly change over time as you age; older adults are biologically prone to being in poorer health than adolescents due to the effects of aging.

Certain biological and genetic factors affect specific populations more than others. Sickle cell disease is a common example of a genetic determinant of health. It is a condition that people inherit when both parents carry the gene for sickle cell. The gene is most common in people with ancestors from West African countries, Mediterranean countries, South or Central American countries, Caribbean islands, India, and Saudi Arabia.

Examples of biological and genetic social determinants of health include: age; sex; inherited conditions, such as sickle-cell anaemia, haemophilia, and cystic fibrosis; carrying the BRCA1 or BRCA2 gene, which increases risk for breast and ovarian cancer and family history of heart disease.

## Individual Lifestyle factors

Individual behaviour plays a major role in determining our health; the lifestyle choices we make can have a great impact on our health and wellbeing. For example, when an individual quits smoking, his or her risk of developing heart disease is greatly reduced.

Examples of individual lifestyle factors that impact on health include:

- Diet
- Physical activity
- Alcohol
- Tobacco smoking



## Diet – the food we eat

A good diet is central to health and wellbeing. Not enough food or a lack of variety in the food we eat will cause malnutrition and deficiency diseases. At the other end of the spectrum, excessive intake of food contributes to a range of chronic conditions such as cardiovascular diseases, diabetes, cancer and obesity. Economic growth and improvements in housing and sanitation have led to the ‘epidemiological transition’ from infectious to chronic diseases. This change includes a nutritional transition, with a shift to eating too many energy-dense fats and sugars.

Whilst there is wide agreement on what we should eat (see Box 1), being able to buy the right food is, for many, a real issue. Wilkinson and Marmot<sup>5</sup> note that “the importance of access to good, affordable food makes more difference to what people eat than health education”.

### Box 1.

Dietary goals to prevent chronic diseases emphasize eating more fresh vegetables, fruits and pulses (legumes) and more minimally processed starchy foods, but less animal fat, refined sugars and salt. Over 100 expert committees have agreed on these dietary goals.

## Physical activity

“The scientific evidence is compelling. Physical activity not only contributes to wellbeing, but is also essential for good health. People who are physically active reduce their risk of developing major chronic diseases by up to 50 per cent, and the risk of premature death by about 20-30 per cent”<sup>6</sup>.

Physical inactivity is a major causal factor in the development of chronic disease. We know that a physically active lifestyle can lead to improved social, physical and mental health and wellbeing for all ages, yet overall we are becoming less and less active.

The estimated cost of physical inactivity to the NHS and the economy is £8.2 billion annually. While it is recognised that getting sedentary people more active constitutes a huge challenge it is one that will provide huge gains for public health<sup>6</sup>.

Mechanisation has reduced the exercise involved in jobs and house work and added to the growing epidemic of obesity; people need to find new ways of building exercise into their lives. Transport policy can play a key role in combating sedentary lifestyles by reducing reliance on cars, increasing walking and cycling, and expanding public transport. Regular exercise protects against heart disease and, by limiting obesity, reduces the onset of diabetes. It promotes a sense of wellbeing and protects from depression.

The Olympics and Paralympics provide an opportunity to inspire a generation and leave a lasting legacy and produce economic, social, health and environmental benefits for the whole of the UK.

## Alcohol

Regularly drinking more than the recommended daily limits of alcohol risks damaging your health. Whilst this is widely known, drinking above daily limits is becoming more common.

In 2007, 33% of men and 16% of women (24% of adults) were classified as hazardous drinkers. This includes 6% of men and 2% of women estimated to be harmful drinkers, the most serious form of hazardous drinking, which means that damage to health is likely. Among adults aged 16 to 74, 9% of men and 4% of women showed some signs of alcohol dependence. The prevalence of alcohol dependence was slightly lower for men than it was in 2000 when 11.5% of men showed some signs of dependence<sup>7</sup>.

### Box 2.

**Problems with alcohol:** Many of these problems are caused by having too much to drink at the wrong place or time. Alcohol affects your judgment, so you do things you wouldn't normally think of. It makes you less aware of risks and so more vulnerable. You are more likely to have fights, arguments, money troubles, family upsets, or spur-of-the-moment casual sex. Alcohol helps to cause accidents at home, on the roads, in the water and on playing fields.

**Problems with alcohol – physical health:** Being very drunk can lead to severe hangovers, stomach pains (gastritis), vomiting blood, unconsciousness and even death. Drinking too much over a long period of time can cause liver disease and increases the risk of some kinds of cancer.

**Problems with alcohol – mental health:** Although we tend to think of alcohol as something we use to make us feel good, heavy drinking can bring on depression. Many people who kill themselves have had drinking problems. Alcohol can stop your memory from working properly and can cause brain damage. It can even make you hear noises and voices – a very unpleasant experience which can be hard to get rid of.

Source: Royal College of Psychiatrists<sup>8</sup>

While there is no guaranteed safe level of drinking, drinking less than the recommended daily limits means the risks of harm to health are low. The harmful effects of alcohol consumption tend to be long-term – alcohol's hidden harms usually only emerge after a number of years by which time serious health problems might have developed; liver problems, reduced fertility, high blood pressure, increased risk of various cancers and heart attack are some of the numerous harmful effects of regularly drinking more than the recommended levels.

The effects of alcohol on your health will depend on how much you drink. The more you drink, the greater the health risks.

### Box 3.

#### The NHS recommends:

- Men should not regularly drink more than 3 to 4 units of alcohol a day.
- Women should not regularly drink more than 2 to 3 units of alcohol a day.

'Regularly' means drinking these amounts every day or most days of the week.

## Tobacco smoking

Smoking is the biggest preventable cause of death in England, accounting for more than 80,000 premature deaths each year. Tobacco use is one of the most significant causes of health inequalities and one of our most significant public health challenges. About 21% of adults in England smoke, although rates are much higher in some areas.

Healthy Lives, Healthy People: a Tobacco Control Plan for England<sup>9</sup> sets out how tobacco control will be delivered in the context of the new public health system. This focuses on the action that the Government will take nationally over the next five years to drive down the prevalence of smoking and to support comprehensive tobacco control in local areas. Key initiatives include implementation of legislation to end tobacco displays in shops; promotion of effective local enforcement of tobacco legislation, particularly on the age of sale of tobacco; and to encourage more smokers to quit by using the most effective forms of support, through local stop smoking services.

These measures build on legislation introduced in England in July 2007 prohibiting smoking in workplaces and enclosed public places. The primary aim of this was to reduce the well documented health impacts of exposure to second hand smoke; a recent evidence review found benefits for health, changes in attitudes and behaviour and no clear adverse impact on the hospitality industry, concluding that “the law has had a significant impact”.<sup>10</sup>

## Social and community networks

Our social and community networks provide emotional, tangible (financial/material), informational and companionship support; these are referred to as social support and are linked to health in a number of ways.

### Box 4.

#### Health and social support links

- Social support may protect health by buffering against the effects of damaging life events. There may also be direct effects in promoting a sense of control of one's life and self worth;
- Social support may have physiological effects through the body's response to stress and functioning of the immune system;
- Social support reducing social isolation is associated with reduced levels of mortality from cardiovascular disease, accidents, suicide;
- Better social support is associated with reduced risk of cardiovascular disease. People with better social support may cope with illness better and have better prognoses when ill; and
- Better social support is beneficial to mental health; associated with lower levels of anxiety, depression. There may be gender differences in the importance for health of social support from different sources.

## Empowering individuals and communities

Empowering individuals and communities to take part in decision-making that affects their health, and to have control over the way that health services are delivered, enables them to take greater responsibility for their own health and for the health of their community more generally<sup>11</sup>. This has important implications for reducing health inequalities. Research suggests that strengthening community involvement in decision-making and governance arrangements can build social cohesion, increasing levels of trust and tolerance between local people. This is particularly important for the wellbeing of deprived and excluded groups.

## General socioeconomic, cultural and environmental conditions

This outer layer of the determinants model is concerned with the natural and built environments and social constructs (such as culture, laws and policy) that make up our living and working conditions. In this section we focus on the interaction between public health and the following key socioeconomic conditions:

- Education
- Work and unemployment
- Transport
- Our habitat – where we live
- Culture
- Access to health services.

### Education

Education plays a key part in shaping the futures of children and providing ongoing opportunities for adults to develop their skills. Education impacts on health and wellbeing in a number of ways:

1. Through education in general, and school based **instruction** in particular, society conveys knowledge, skills and values to “enable children to become successful learners, confident individuals, responsible citizens and effective contributors to society”<sup>12</sup>
2. Providing sources of **information**, instruction and support to promote healthy lifestyles
3. As centres for **training** in the skills needed for health and social care
4. Educational institutions as exemplar **healthy places** – setting examples in terms of food availability, encouraging relaxed, social eating, access to water, 5-a-day promotion etc; encouraging participation in food growing and skills in food hygiene and preparation. The ‘Healthy Schools’ initiative is a key part of addressing health issues in the school setting
5. Education establishments can serve as **Community assets** providing opportunities for social activities clubs. Extended schools services provide a core offer of activities, advice and opportunities including healthy school meals and healthy vending strategies as well as travel-to-school schemes (encouraging safe walking and cycling) and active play projects.

Educational attainment and further education and employment opportunities, leading to enhanced quality of life are among the most important determinants of health in later life<sup>13</sup>. The British Medical Association notes that “Poor educational achievement will often lead to poorly paid and often insecure work. These are also frequently linked to unemployment and both lead to low income, poor housing and fewer opportunities to make decisions for oneself about the way one would want themselves and their families to live”<sup>3</sup>.



## Work and unemployment

There is overwhelming evidence that being in work is a key component of mental and physical wellbeing. The relationship between work and health can be summarised as follows:

- Work that provides fulfilment, job satisfaction and allows individuals discretion and control over their work appears to have a positive impact on health<sup>14</sup>
- Jobs that are lacking in self-direction and control appear to confer far fewer health benefits and the rates of mortality and morbidity among these workers appear to be consistently higher<sup>15</sup>.

Unemployment results in loss of income which impacts on health through a resulting lack of daily routine, social contact and self-esteem. At the national level, unemployment represents a significant economic impact; at any one time around three per cent of the working-age population is off work due to illness or incapacity, costing the economy over £100 billion per year<sup>16</sup>.

Unemployment is associated with a large number of health risks and inadequate employment is also associated with poor health outcomes. Income inequality affects health and the degree of control that employees exercise over their work influences health<sup>17</sup>.

Healthy work places make sense at the individual and company level – a fit, healthy workforce is a precondition for a successful business. Health at work programmes have been shown to lead to improved productivity, performance and reduced absences leading to substantial cost savings as well as improved mental wellbeing<sup>18</sup>. Employers have health and safety responsibilities to ensure the safety of staff whilst working and can facilitate wellbeing through green travel plans.





## Housing and neighbourhoods

Housing has a major impact on health and wellbeing. Over-crowding, lack of privacy, lack of safe play areas, damp and inadequate food storage and preparation areas all have specific impacts on health.

Poor housing conditions often coexist with other forms of deprivation, for example, income, unemployment, poor education, ill health, and social isolation. Research shows that housing and the immediate neighbourhood environment can impact on health in a number of ways, see Box 5.

### Box 5.

#### Housing and Health

Poor quality housing can exacerbate respiratory conditions like asthma. Indoor air quality, dust mites and other allergens, house type and overcrowding are further examples of risk factors associated with housing. Other less direct risks to health include neighbourhood effects such as a broad range of anti-social behaviour, which can have a negative impact on mental wellbeing, and the general quality of local environments, which includes the capacity to build positive social networks, income, poverty and worklessness, poor local transport and access to services, low educational attainment and drug and alcohol misuse<sup>19</sup>.

The housing charity Shelter has found links between overcrowded family housing and depression, anxiety, sleep problems and strained relationships.

The number of families experiencing housing stress is likely to increase during the current economic difficulties. Housing payment problems, especially insecurity and debt, can lead to significant health stressors. These financial difficulties in meeting housing costs impact on family relationships and can impact on other areas of life, like children missing out on school activities<sup>20</sup>.

Fuel poverty is defined as the need for a household to spend over 10% of its income to achieve temperatures required for health and comfort. It arises from a combination of three factors: low income, fuel costs and energy efficiency, and is therefore intimately linked to housing condition and costs since households on low income tend to live in poorer quality housing.

Our focus in this section has been on the issues faced by people in housing. Of course, some people face the challenges of being homelessness. No Second Night Out<sup>21</sup> sets out the Government's ambition to put an end to rough sleeping by pledging to work with councils and the voluntary sector to ensure that nobody spends a second night sleeping rough on the streets. The report outlines six joint commitments:

- Helping people off the streets
- Helping people to access healthcare
- Helping people into work
- Reducing bureaucratic burdens
- Increasing local control over investment in services
- Devolving responsibility for tackling homeless

## Transport and health

Transport plays a major role in shaping our health and wellbeing. Transport provides health and wellbeing opportunities by connecting us to facilities outside of our immediate living place. Most of us use transport on a regular basis to access health care facilities and other resources important to health and wellbeing: employment; leisure; commerce; green space; social networks.

How we make these journeys – our mode of transport – will also impact on our health and wellbeing. Transport may be health promoting in itself in the case of ‘active’ transport modes (walking, cycling, etc) that promote physical activity. Cycling, walking and the use of public transport promote health in a number of ways. They provide exercise, increase social contact and reduce air pollution.

Transportation options also present to varying degrees, a range of adverse impacts on health and wellbeing:

- Air pollution through emissions leading to and/or exacerbating respiratory conditions
- Noise effects
- Risk of transport related injuries.



The adverse health effects fall disproportionately on the most vulnerable groups in our societies, generally those living in poorer communities who suffer from more obesogenic environments which discourage active travel and active play, and who experience more accidents.

A child from a low income family is five times more likely to be killed in a road traffic incident than a child from a high income family and road traffic injuries have huge implications for the NHS, the police and other public services. Traffic calming strategies will result in safer communities

for all but especially for children, young people and older people<sup>22</sup>. Education, road design, traffic management and smarter enforcement can be used to enhance road safety and thereby encourage people to use healthier means of transport.

The development of built environments requires an integrated approach to planning to ensure health considerations are factored in to maximise health promoting opportunities. We know it is necessary to reduce the need to travel long distances, tackle congestion and improve road safety and air quality. This will also address greenhouse gas emissions and noise. Having nearby services, open space, jobs and play areas/centres reduces the need to travel, improves air quality and so helps improve and prevent respiratory conditions from developing and helps to reduce inequalities<sup>23</sup>. Furthermore, people living in walkable neighbourhoods are more likely to know their neighbours, participate politically, trust others, and be socially engaged<sup>24</sup>.

### Our habitat – the environment we live in

The environment we live in is typically diverse and includes both built and natural spaces.

The mental, physical and emotional benefits of access to a good quality environment and green space are increasingly being documented<sup>25</sup>. Health related benefits of the environment include:

- Opportunities for sport and recreation
- Creating healthier communities
- Supporting and enhancing biodiversity
- Reducing the impact of noise and air pollution.

The wider environment may also present threats to health and wellbeing through for example flood risks and conditions arising from extreme temperatures and over exposure to sun. Local Authority and other partners have long been engaged in the provision of environmental services of vital importance to protect our health and promote wellbeing:

- Air quality control
- Water quality and purification
- Street cleaning, litter collection and management of waste
- Food hygiene.

Looking to the future, strong action is required to tackle climate change and make significant cuts in greenhouse gases in order to reduce potential social, environmental and economic effects of climate change. Climate change will have significant health and health equality implications. In the UK, the positive health impacts of climate change, such as a reduction in cold-related deaths, are likely to be outweighed by negative impacts such as an increase in heat-related deaths, increased cases of skin cancer and cataracts, injuries and infectious diseases caused by flooding, anxiety and depression from physical and economic insecurity and increased respiratory disease, insect-borne disease and food poisoning. Poorer social groups are likely to be more exposed to these risks and suffer more serious health impacts as a result. It will become increasingly necessary to predict and reduce the impacts of climate change on mental and physical health (e.g. heat-related illness and skin cancer); to increase resilience and support the most vulnerable e.g. with winter warmth, fuel consumption and to reduce the impact of heat-waves on them.

## Cultural facilities

Cultural facilities such as theatres, libraries, museums, community and leisure centres, music venues and tourist attractions provide a huge opportunity to promote wellbeing. For example through community programmes and volunteering opportunities, the provision of healthy eating options for customers and staff, encouraging 'active travel' when visiting the facility, and providing opportunities for local social interaction.



Pubs, restaurants and nightclubs are also important parts of social life, providing opportunities for social interaction, the development of community cohesion and the local economy. There are links between the health, community safety and the cultural sectors in ensuring that these opportunities are maximised and that adverse behaviours like eating unhealthily, binge drinking, substance misuse, fighting and street crime are tackled through coherent, joined up approaches.

Community safety and health are mutually self-reinforcing. A safe environment encourages people to take a more active part in the life of the community and thereby become healthier, and in turn, better health encourages wider participation in efforts to promote community safety. Freedom from crime and violence and from fear of violence is an essential pre-requisite for good health and wellbeing<sup>26</sup>. There has been much progress in reducing levels of crime and the British Crime Survey estimates that crime is 50% lower than it was in the mid-90s<sup>27</sup>. Anti-social behaviour is a major concern for communities as high incidences can impact very negatively on individuals' health and wellbeing, particularly mental health<sup>28</sup>.

Alcohol related violence and the disorderly behaviour of binge drinkers in town centres late at night is a matter of concern to many communities.

## Access to health services

The importance of being seen promptly by a healthcare professional is recognised in national policy and in the priority placed on national waiting time indicators.

Providing ongoing support and management of long-term conditions in primary care, the community and the patient's home is increasingly seen by policy makers as a better approach than waiting for acute flare-ups and subsequent emergency hospital admissions<sup>29</sup>.



The organisation of, and patient access to, hospital services will depend on how services in the community are organised. A key challenge for the NHS is how community and primary care facilities can provide alternative local services for treating conditions that do not require admission to an acute hospital.

## Marmot review

The importance of the wider determinants of health and wellbeing have been given increased profile in recent years with the publication in 2008 of the World Health Organisation (WHO) Global Commission on the Social Determinants of Health report and the subsequent commissioning by the Secretary of State for Health for England of the Review of Health Inequalities Post-2010 in England<sup>30</sup>. These highlight the importance of addressing the conditions of everyday life that lead to health inequities. Indeed, the WHO Commission argues that for reasons of social justice, action to achieve health equity is imperative.

The Marmot Review on health inequalities Fair Society, Healthy Lives (February 2010)<sup>30</sup> details the need for social justice, material, psychosocial and political empowerment. Health inequalities are not inevitable and can be significantly reduced. They stem from avoidable inequalities in society: of income, education, employment and neighbourhood circumstances. Inequalities present before birth set the scene for poorer health and other outcomes accumulating throughout the life course.

The central tenet of the Marmot Review is that avoidable health inequalities are unfair and putting them right is a matter of social justice (see Box 6). The review notes that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is referred to as proportionate universalism.

### Box 6.

#### Marmot recommendations

Fair Society, Healthy Lives recommended action on the six following policy objectives:

- A – Give every child the best start in life
- B – Enable all children, young people and adults to maximise their capabilities and have control over their lives
- C – Create fair employment and good work for all
- D – Ensure healthy standard of living for all
- E – Create and develop healthy and sustainable places and communities
- F – Strengthen the role and impact of ill health prevention.

# Chapter 2

## The New Public Health System

## Introduction

In this chapter we provide an overview of the new public health system in England. This begins with a short review of public health from the Victorian era to date, before looking at the vision for how public health will move forward in England. Local government has a key role in the new public health system and this is explored before outlining the other elements that will also contribute to public health in England.

### Public health in England from the Victorian era to date: a look back...

The Victorian era included important milestones in the development of public health in the UK. Many will be familiar with the contribution of John Snow to public health through his work in tracing the source of a cholera outbreak in 1854 in Soho, London. Public concern grew during the cholera epidemic of 1831-32 and with high mortality rates from other communicable diseases like dysentery and TB. These concerns became transformed into actions following publication of 'The Report on the Sanitary Conditions of the Labouring population of Great Britain' by Edwin Chadwick in 1842. Chadwick was convinced that the suffering of the poor was due to the dreadful conditions in which many of them lived. His report led the way for the era now called 'the sanitary movement' where water supply, drainage and sewage systems were improved radically and the Public Health Act of 1848 was enacted.



The following highlights key milestones in UK public health from Chadwick to recent times (Figure 2.1).

**Figure 2.1: Historic milestones in public health<sup>31</sup>**

- Edwin Chadwick's report "The Sanitary Conditions of the Labouring Population of Great Britain" published in 1842.
- The first Medical Officer of Health (MOH), Dr William Henry Duncan, was appointed in 1847.
- The first of the Public Health Acts was introduced in 1848 to enable local authorities to take control of their environment.
- By the end of the Nineteenth Century, a central government Department of Public Health and local departments of public health in every local government district had been established.
- The school health service was formed in 1907 and arrangements for improving antenatal and postnatal care were developed.
- Public provision of health care was extended by the introduction of the National Insurance Act 1911.
- By the 1920s and 1930s Medical Officers of Health (MOH) occupied a pivotal role in the provision of health care to the population with responsibility for monitoring water supplies, sewage disposal, food hygiene, housing and control of infectious diseases.
- In 1929 MOHs took on the administering of municipal hospitals.
- The NHS Act 1946 set up three distinct controlling bodies for health care. NHS hospitals were administered by Regional Hospital Boards, public health services became the responsibility of local authorities and local executive councils administered general medical services which provided primary medical care to the population.
- 1963 The Buchanon Report 'Traffic in Towns' was published fundamentally influencing the design of the urban landscape.
- 1974 the post of MOH was abolished and responsibility for monitoring environmental determinants of health passed to Directors of Environmental Health who were employed by local authorities.
- Doctors trained in public health medicine became Community Medicine Specialists employed by health authorities. They fulfilled three basic functions: medical administrators who assisted in planning and managing clinical services; advisers on the medical aspects of environmental health to the local authority and they continued to have a role in epidemiology and the evaluation of health status and programmes of health care.
- In 1988 a committee of inquiry into the future development of public health medicine was set up under the chairmanship of Sir Donald Acheson. The Acheson Committee recommended a return to the name Public Health for the specialty. Public health specialists became involved in reshaping health services as purchasers within the internal market and are increasingly involved in the development of evidence-based healthcare within the NHS. More recently the Faculty has recognised that non-medics can become Directors/Consultants and equally influential in improving public health.

Local government has a long and proud history of promoting and protecting the public's health which dates back to Victorian times. Indeed, it was only in 1974 that the NHS took over responsibility for most public health functions<sup>32</sup>.

## ...and moving forward

The White Paper “Healthy lives, healthy people”<sup>33</sup> published in November 2010 provides strategic direction, setting out the Government’s long-term vision for the future of public health in England.

The return of public health to local government is a key feature of the new public health system in England. Local government is seen as the appropriate place for responsibility for improving public health. This is because local government has:

- a population focus;
- a wide portfolio of services and partnerships making it ideally placed to shape services to meet local needs;
- influence over the wider determinants of health and wellbeing such as environment, education and housing (as discussed in Chapter 1); and
- the ability to tackle health inequalities.

In the next sections we describe the new landscape of public health in England and key milestones in the transformation of public health.

## The new landscape – the role of local government

Public Health is often described as having three key domains:

- **Health improvement** – including contributing to increased life expectancy and healthier lifestyles as well as reducing inequalities in health and addressing the wider social determinants of health
- **Health protection** – including protection from infectious diseases, environmental hazards and emergency preparedness
- **Health services** – including assisting those who plan health care to understand the health profile and health needs of the local population, and plan services to meet those needs, as well as evaluating how successful services are in meeting needs<sup>34</sup>.

An overview is provided below describing how the three domains are currently delivered:

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### Figure 2.2: Overview of how the three public health domains are currently delivered<sup>35</sup>

- Department of Health – setting policy and funding a number of health intelligence programmes including the Observatories, cancer registries
  - Government Offices
  - National Treatment Agency – drug treatment monitoring
  - Strategic Health Authorities – strategic oversight and performance of each region
  - Primary Care Trusts – commissioning of programmes to deliver health service outcomes/joint commissioning with local authorities
  - Provider Trusts – delivery of public health programmes e.g. community services
  - Local authorities – a number of different services provided by local government will have an impact on the public’s health such as environmental health, leisure, planning, housing
  - Health Protection Agency – health protection services
- 

As mentioned above, local government will have a key role in the new public health system in England. Key features of this role are outlined below before considering the other main components of the new system.



## The public health role of local government

The vision of public health in England set out in Healthy Lives, Healthy People, is enabled by The Health and Social Care Bill which received Royal Assent on 27th March 2012. The Act places a new duty on (upper tier and unitary) local authorities in England to *“take such steps as it considers appropriate for improving the health of the people in its area”*.<sup>36</sup>

Local authorities will be responsible for taking the lead for improving health and co-ordinating local actions to protect the public’s health and wellbeing, and for ensuring that health services effectively promote population health.

There is a clear role for local political leadership in maximising the beneficial impacts of the new system. The transfer of public health to local government provides opportunities for councillors, council staff and public health specialists to work together to transform the way public health is delivered to improve health and wellbeing.

The context for local visions of public health is likely to be influenced by Professor Marmot’s report on reducing health inequalities in England, ‘Fair Society, Healthy Lives’<sup>37</sup>. The Marmot Review looks at the differences in health and wellbeing between social groups and describes how the social gradient on health inequalities is reflected in the social gradient in educational attainment, employment, income, quality of neighbourhood etc. In addressing health inequalities the Review asserts that it is not sufficient just to focus on the bottom 10% in terms of poor health because there are poorer outcomes all the way down from the top. Universal action is needed to reduce the steepness of the social gradient of health inequalities, but with a scale and intensity that is proportionate to the level of disadvantage.

Key to Marmot’s approach to addressing health inequalities is the creation of the conditions for people to take control of their own lives. This requires action across the social determinants of health which local authorities are well placed to influence.

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### Figure 2.3: “Fair Society, Healthy Lives” six policy objectives

The final report, ‘Fair Society Healthy Lives’, was published in February 2010, and concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life
  2. Enable children, young people and adults to maximise their capabilities and have control over their lives
  3. Create fair employment and good work for all
  4. Ensure healthy standard of living for all
  5. Create and develop healthy and sustainable places and communities
  6. Strengthen the role and impact of ill-health prevention
- 

The Marmot review relates strongly to the core business of local councils as leaders for health improvement and the reduction of health inequalities. The Local Government Association (LGA) has argued for clearer recognition of this key role and welcomes the proposed transfer of responsibility for public health from the NHS to local government<sup>38</sup>.

## How will the local government public health role be delivered

Guidance from the Department of Health<sup>39</sup> points to key means by which the local authority will deliver public health benefits. We summarise here the key features of the transfer of public health to local government, focusing on:

- The new role of the Director of Public Health;
- Health and Wellbeing Boards, Strategic planning and commissioning across local partnerships;
- Public Health support to Clinical Commissioning Groups (the new body for local NHS Commissioning);
- Commissioning services to meet local needs;
- Making sure “public health is everyone’s business” becomes a reality; and
- Public Health Outcomes Framework.

## The new role of the Director of Public Health

The Health and Social Care Bill makes clear that each authority must have an individual to have responsibility for its public health functions – the Director of Public Health (DPH).

The Director of Public Health will have a key leadership position within the local authority and will be able to work with others right across the organisation to ensure policies help improve the health of the local population and reduce health inequalities.

The Health and Social Care Bill makes it a statutory requirement for the Director of Public Health to produce an annual report on the health of the local population, and for the local authority to publish it.

Directors of Public Health will also be statutory members of health and wellbeing boards. These will be made up of local commissioners across the NHS, public health and social care, elected representatives, and representatives of local HealthWatch (Healthwatch will play a role at both national and local level and will make sure that the views of the public and people who use services are taken into account). The health and wellbeing boards will work together to improve the health and wellbeing outcomes of the people in their area; they are intended to be a key formal mechanism for promoting integrated, effective delivery of services.

Through the health and wellbeing board the DPH will lead the development of joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies (JHWSs). These are important levers for integrating local commissioning strategies and ensuring a community-wide approach to promoting and protecting the public's health and wellbeing.

### Health and Wellbeing boards in London...

Within London, Health and Wellbeing boards are being established at borough level and a pan-London Health Improvement Board<sup>40</sup> has been established by the Mayor.

NHS London has established the London Health and Wellbeing Board Support programme<sup>41</sup> as a joint initiative with London Councils and the Adult Social Care Joint Improvement Partnership (JIP) to support localities in London in establishing Health and Wellbeing Boards. It aims to focus, in particular, on supporting developmental work and relationship building to ensure effective change and enhance partnership working at a local level.

### *The Director of Public Health and Health Protection*

In the current system, Directors of Public Health are part of the Primary Care Trust. They have a key leadership role in planning for, and responding to, health protection incidents, with support from local Health Protection Agency units. In the new public health system, local authorities are required to take steps to ensure that plans are in place to protect the local population. Under this duty, local authorities (and Directors of Public Health on their behalf) will need to ensure that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks to full-scale emergencies, and to prevent as far as possible those threats arising in the first place. The scope of this duty will include local plans for immunisation and screening, as well as the plans acute providers and others have in place for the prevention and control of infection, including those which are healthcare associated<sup>42</sup>.

The Director of Public Health will be the lead officer in a local authority for health with a key role in championing health across the whole of the authority's business. The Director of Public Health will be the person elected members and other senior officers will consult on a range of health and wellbeing related issues.

## Health and wellbeing boards: Strategic planning and commissioning across partnerships

Health and wellbeing boards will have a duty to encourage integrated working between decision makers and service providers in health and social care. They will be the “focal point for decision-making about local health and wellbeing”<sup>43</sup>, facilitating joint working between Clinical Commissioning Groups (CCGs), local authorities including social care and community stakeholders. **These boards are key vehicles for service transformation.** They will oversee the development of area based Joint Strategic Needs Assessments (JSNAs) and the Joint Health and Wellbeing Strategies (JHWS) that will set out how the identified needs will be prioritised and met.

Public Health will have a key role to play in helping shape the Health and Wellbeing boards’ JSNA and JHWS in a local area; as these arrangements mature it is anticipated that JHWS will become aligned with (and inform) commissioning plans for healthcare services developed by Clinical Commissioning Groups (CCGs). Influencing partners to make best use of system wide resources will be a key area where public health can add value.

## Commissioning services to meet local needs: Mandatory vs discretionary

In the new system local authorities will have responsibilities for commissioning specific public health services<sup>44</sup> (such as tobacco control and smoking cessation services, increasing levels of physical activity and interventions to tackle obesity) and will be supported with a ring-fenced public health grant. Local authorities may choose to commission a wide variety of interventions under their health improvement duty, and are encouraged to innovate to best meet local needs.

While local authorities will be largely free to determine their own priorities and services, they will be required to provide a small number of mandatory services (sexual health services, NHS health checks, National Child Measurement Programme, providing public health advice to NHS Commissioners and ensuring plans are in place to protect the health of the public).

A ring-fenced public health grant will support local authorities in carrying out their new public health functions. Shadow allocations for local authorities in 2012/13 have been published to support planning for the transition, ahead of local authorities taking on formal responsibility in 2013/14.

## Public health support to CCGs

The need to secure provision of public health expertise for healthcare commissioners (and to support health and wellbeing boards in producing the joint strategic needs assessment and joint health and wellbeing strategy) was a key theme of the consultation on the public health white paper *Healthy Lives, Healthy People*.

It is envisaged that public health teams will provide a largely strategic population focus, synthesising data from a wide variety of sources and applying their public health skills to draw the implications of that data for the local population. Guidance will be provided but the detail of the arrangements will need to be locally agreed<sup>45</sup>.

## Making sure “public health is everyone’s business” becomes a reality

One of the most exciting aspects of the new public health system in England is the increased potential for harnessing the breadth and depth of the local authorities’ workforce to work on the public health agenda; to improve the wider determinants of health and wellbeing and tackle health inequalities.

In recent work to develop a resource to assist the transfer of public health to local authorities<sup>46</sup>, the Local Government Association highlighted the importance of mainstreaming an awareness of and strategic approach to public health across the council’s functions. It was noted that some councils already carry out health impact assessments for all significant policy decisions. Others have devised ways of ensuring that councillors and all staff from directors to frontline community workers understand the potential health impact of their work.

There is clearly a challenge, and great potential benefits, in training and developing staff and encouraging them to see that “public health is everyone’s business”.

### Making public health everyone’s business

NHS London has run a series of Health and Wellbeing Challenge Events. These encouraged Elected Members, Directors of Public Health, Directors of Adult Social Care, Directors of Children’s Services, Voluntary Sector representation and Board Support Officers to explore partnership working across the system and to test how some of the more difficult decisions and challenges will be managed.

For further information see NHS London website<sup>47</sup>.

## Public Health Outcomes Framework

The Public health outcomes framework<sup>48</sup> includes indicators relating to the wider determinants of health and to health improvement. This framework is important as it details the outcomes public health is seeking to achieve; the indicators it contains will help us understand how well the public’s health is improving and how effective the new public health system is in protecting health.

The Public Health Outcomes Framework (PHOF) also places a new emphasis on shared indicators. Links between the PHOF, the refreshed NHS outcomes framework and social care outcomes framework will need to be made. These will need to be aligned and brought together into jointly developed needs assessments and strategies.

## The new landscape – introducing the team

The previous section focused on the responsibilities of local government in the new public health system in England and within that the role of the DPH, this being a key feature of the new system. But it’s not all down to local authorities; there are other key members of the new public health team.

### Public Health England

A new executive agency, Public Health England will be established. This will be at arm’s length to the Department of Health. It will be established in April 2013 and is anticipated to have three structural elements:

1. A national office and four hubs overseeing local facing services;
2. Local units that deliver locally facing services and support local authorities and other organisations in local areas; and
3. A distributed network for some functions such as information and intelligence and quality assurance to enable these to work closely with NHS and academic partners<sup>49</sup>.

The main functions of PHE will be:

- Delivering services to national and local government, the NHS and the public;
- Leading for public health; and
- Supporting the development of the specialist and wider public health workforce.

It is envisaged that approximately 5,000 staff from within existing organisations will transfer across into Public Health England in April 2013. The staff coming together to form PHE are shown below.

#### Figure 2.4: Staff transferring to Public Health England

Staff transferring to PHE includes those working in:

- Health Protection Agency
- National Treatment Agency for Substance Misuse
- Department of Health
- Regional and specialist public health observatories
- Cancer registries and the National Cancer Intelligence Network
- National End of Life Care Intelligence.

### The NHS

Providers of NHS services will continue to make important contributions to the health of the public across all three domains of public health: health improvement, health protection and health services.

The NHS will play a full role in providing care and tackling inequalities; providers will be expected to “make every clinical contact count” towards improving the health of the population.

### NHS Commissioning Board

The NHS Commissioning Board (NHS CB) will be established in October 2012 before it takes on full statutory responsibilities in April 2013. It will have overall responsibility for a budget of £80 billion, of which it will allocate £60 billion directly to local clinical commissioning groups (CCGs). It will directly commission a range of services including primary care and specialised services and have a key role in improving broader public health outcomes<sup>50</sup>. The NHS Commissioning Board will be an independent, statutory body accountable to the Secretary of State. Some commissioning will be required to be undertaken at national level and the NHS CB will be responsible for commissioning such specialised services.

The NHS CB commissioning brief includes a number of services to be funded from the public health budget<sup>44</sup>:

- The NHS Commissioning Board will be accountable for delivery of the national screening and immunisation programmes – Directors of Public Health will provide challenge and advice to the NHS Commissioning Board on the performance of screening and immunisation programmes, for example through the joint strategic needs assessment and discussions at the health and wellbeing board;
- Public health funded services for children under five in the first instance, including health visiting, the Healthy Child Programme and Family Nurse Partnership. This reflects the government commitment to a 50% increase in the health visiting workforce and a transformation in the health visiting service by 2015, and to ensure associated improvements in support for families;
- Commissioning effective Child Health Information Systems; and
- Sexual assault services, including sexual assault referral centres (SARCs,) at least in the short to medium term.

The NHS Commissioning Board will also play a key role in emergency planning and preparedness. It will appoint a lead director for NHS emergency preparedness and response at the Local Resilience Forum (LRF) level, and provide necessary support to enable planning and response to emergencies that require NHS resources. Local Health Resilience Partnerships (LHRPs) will bring together the health sector organisations involved in emergency preparedness and response at the LRF level. The lead director appointed by the NHS Commissioning Board and the lead Director of Public Health will act as co-chairs at the LHRP during emergency planning.

## Within government

The Government's Chief Medical Officer will continue to provide independent advice to the Secretary of State for Health and the Government on the population's health.

The Department of Health will continue to set the legal and policy framework for health and wellbeing. It will seek to secure resources and champion public health across government departments.

### Next steps towards the new public health system in England

- SHAs will not exist beyond the end of March 2013.
- PCTs will not exist beyond the end of March 2013.
- Public Health England which will be up and running from April 2013 and will encompass the NTA, HPA and be responsible for a number of health intelligence functions including the cancer registries and Regional observatories, former Government Office functions.
- Setting up ring-fenced budgets for public health which will be allocated to local authorities.
- Clinical Commissioning Groups which will be responsible for commissioning of secondary and community-based health care.
- NHS Commissioning Board which will be accountable for Clinical Commissioning Groups and will, itself, oversee specialised services commissioning and the commissioning of primary care services.

Source: PHORCAST<sup>51</sup>

## Summary of issues and opportunities

The new public health system in England raises a number of short term issues and presents potential longer term opportunities for public health.

In the short term, many local public health staff will see their roles transfer to either the local authority or PHE.

Leading up to, and beyond April 2013 when PCTs are abolished and responsibility for public health is formally transferred to local authorities, there is an important training and leadership agenda to be addressed to ensure that "public health is everyone's business".

The development of Health and wellbeing boards provides an important opportunity for local partnerships to align commissioning plans to reflect local needs; public health, analytical and qualitative research skills will be required to ensure JSNAs provide the best possible expression of local needs.

# Chapter 3

## The Data

## Introduction

This chapter develops further the themes introduced in Chapter 1 – the determinants of health. The health challenges faced in Enfield will be determined by the nature of the population, the lifestyle choices made by residents and the general socioeconomic and environmental conditions within which they live. The impacts of these determinants in terms of health and wellbeing outcomes are then considered in a profile of the health of the borough. Finally we consider key health protection indicators for Enfield.

## The Population of Enfield

The London Borough of Enfield was formed in 1965 by an amalgamation of the former boroughs of Edmonton, Enfield and Southgate. It is located on the northern edge of Greater London, bordering the London boroughs of Haringey and Barnet to the south and the rural boroughs of Hertfordshire and Essex to the north.

The London Borough of Enfield is divided into three parliamentary constituencies, which are coterminous with seven of each of the twenty-one borough electoral wards:

<b>Edmonton</b>	Comprised of the Bush Hill Park, Edmonton Green, Haselbury, Jubilee, Lower Edmonton, Ponders End and Upper Edmonton wards.
<b>Enfield North</b>	Comprised of the Chase, Enfield Highway, Enfield Lock, Highlands, Southbury, Town and Turkey Street wards.
<b>Enfield Southgate</b>	Comprised of the Bowes, Cockfosters, Grange, Palmers Green, Southgate, Southgate Green and Winchmore Hill wards.

Enfield can be divided into the north-western area (Cockfosters, Hadley Wood and Crews Hill), characterised by expensive housing in green belt land; the southern part which is notable for suburban, semi-detached housing served by small shopping centres; and the eastern area, once part of the 'Lee Valley manufacturing heartland' of London, which is characterised by a remaining industrial corridor and a legacy of low cost housing. The poorer parts of the borough are to the north, east and south, including 4 wards that are among the most deprived in England.

Enfield experienced large population growth in the early half of the 20th century due to a general flight to the suburbs from inner London. The population increase was also driven by the migration and subsequent settlement of workers from Cyprus, Turkey and Greece in the western side of the borough. There has been a significant population decline from the 1960s through the 1980s.

As at 2011, Enfield was the seventh most populated borough in London<sup>52</sup>. GLA demographic projections for London boroughs highlight a below average (across London) population growth in Enfield such that by 2031 it will be the twelfth most populated borough (Figure 3.1).



Figure 3.1: Population projections

Borough	2011			2031			Population growth 2011-2031 as % of base	
	Population	Households	Economically Active	Population	Households	Economically Active		
City of London	9.7	5.5	6.1	12.9	7.7	8.4	33	40
Barking and Dagenham	177.8	73.8	81.7	229.7	103.9	107.8	29	41
Barnet	330.6	134.4	168.7	404.2	179.5	209.5	22	34
Bexley	217.4	92.6	113.2	224.9	99.3	114.6	3	7
Brent	279.6	108.7	138.6	307.7	130.0	152.2	10	20
Bromley	302.4	132.5	157.6	317.0	143.9	162.5	5	9
Camden	210.9	98.8	114.9	236.1	112.1	127.0	12	13
Croydon	342.9	149.6	178.0	377.1	176.2	191.8	10	18
Ealing	319.5	124.9	164.4	347.9	142.7	175.7	9	14
Enfield	294.2	118.7	144.7	312.4	129.9	149.9	6	9
Greenwich	238.1	107.0	116.2	313.8	158.9	157.7	32	48
Hackney	231.5	98.9	111.6	265.7	122.1	132.8	15	23
Hammersmith and Fulham	180.6	80.6	102.4	197.1	92.9	114.1	9	15
Haringey	237.2	98.8	123.0	265.2	115.2	140.5	12	17
Harrow	220.7	85.7	115.2	227.8	92.7	115.9	3	8
Havering	231.6	97.1	120.2	272.4	121.8	142.1	18	25
Hillingdon	261.8	106.6	136.9	284.6	119.0	145.4	9	12
Hounslow	237.2	94.1	123.9	253.8	103.6	128.4	7	10
Islington	208.8	99.0	114.8	242.4	122.4	135.4	16	24
Kensington and Chelsea	169.9	83.1	92.6	185.6	94.8	101.7	9	14
Kingston upon Thames	155.3	65.1	85.5	169.6	72.6	90.1	9	12
Lambeth	300.2	131.6	169.0	336.9	156.7	192.2	12	19
Lewisham	272.7	116.3	147.4	316.6	138.4	169.9	16	19
Merton	198.7	84.1	107.2	207.5	90.5	107.9	4	8
Newham	267.9	102.6	120.4	353.6	152.6	172.2	32	49
Redbridge	258.8	100.5	129.1	283.7	115.7	139.9	10	15
Richmond upon Thames	186.4	80.8	101.7	193.9	85.7	103.3	4	6
Southwark	285.5	123.2	151.2	353.6	163.3	188.8	24	33
Sutton	185.9	81.0	101.4	191.8	85.2	101.1	3	5
Tower Hamlets	248.7	107.5	120.2	332.7	165.2	168.0	34	54
Waltham Forest	229.4	96.3	112.9	248.2	111.5	119.5	8	16
Wandsworth	297.5	133.3	176.8	331.6	158.9	196.2	11	19
Westminster	217.2	109.9	123.6	231.1	125.3	130.6	6	14
<b>London</b>	<b>7,806.8</b>	<b>3,322.8</b>	<b>4,071.2</b>	<b>8,828.8</b>	<b>3,990.3</b>	<b>4,593.0</b>	<b>13</b>	<b>20</b>

Source: Greater London Authority, 2009 Round of Demographic Projections

Recently released 2011 census figures estimate the current population of Enfield to be 312,500, therefore it will be necessary to re-examine future population growth in Enfield when revised projections are released.

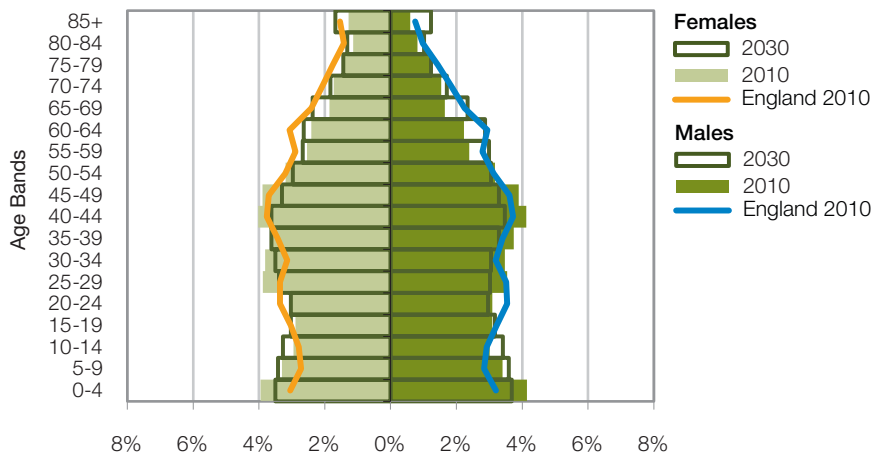
The growth in population and household numbers is projected to be lower for Enfield than the other outer London boroughs and than for London as a whole. However, the change to welfare benefits, particularly for housing, is likely to encourage population move into borough from other boroughs with more expensive housing.

There were noticeable differences between Enfield and the population of London overall in 2010. The proportion of people aged 0-15 years was greater in Enfield (21.7%) than London overall (19.3%). At 62.7%, the percentage of the Enfield population between 16 and retirement age was smaller than that of London as a whole (66.9%). In Enfield 15.6% of the population were at retirement age and older, compared with 13.7% for London overall<sup>53</sup>.

The percentage of the population aged 40 yrs and over is expected to increase from 21.6% to 23.2% for males in 2010 and from 23.4% to 23.8% for females by 2030. This age group in the London Suburbs population is expected to increase from 20.6% to 22.2% for males and from 22.3% to 23.0% for females. In England it is expected to increase from 23.5% to 25.1% for males and increase from 25.8% to 26.8% for females. Population growth in this age group is important as this is the age group in which long-term conditions develop<sup>54</sup>.

The age profile and population projections for Enfield are shown in the following figure.

**Figure 3.2: Age profile and population projections in Enfield**



Source: Office for National Statistics (ONS) 2010 MYE & 2008-based subnational population projections



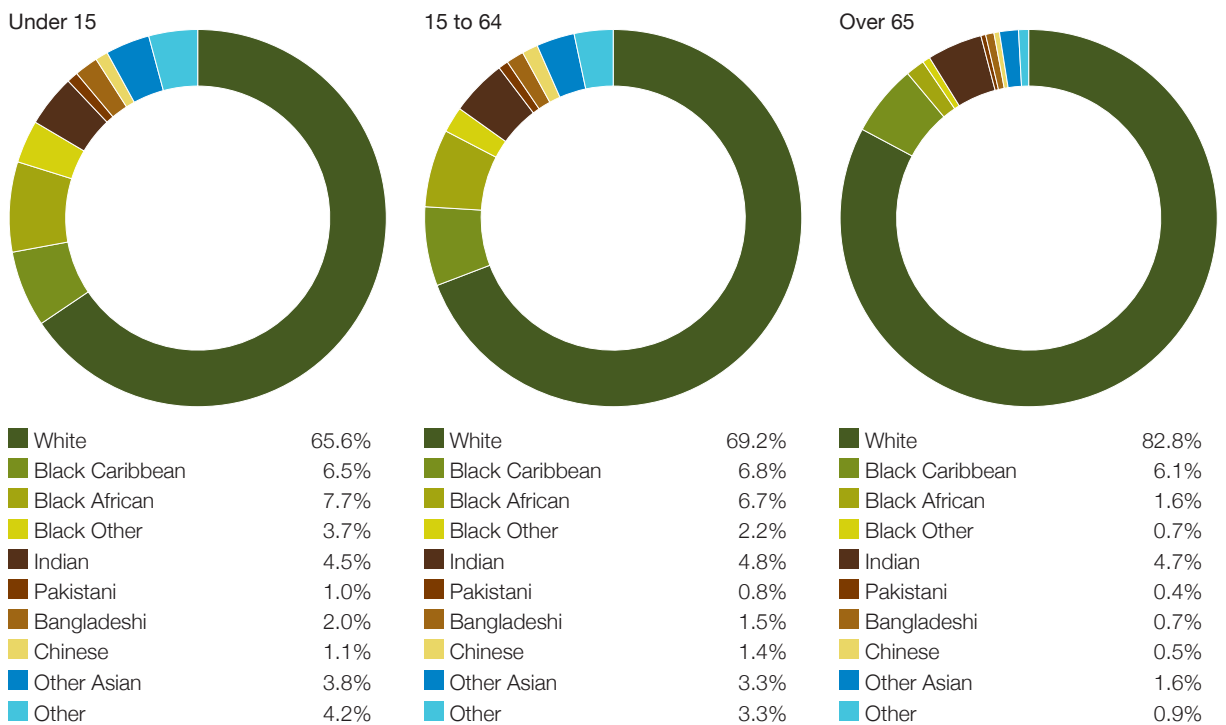
## Ethnicity

Enfield is an ethnically diverse borough. The 2007 Schools Census<sup>55</sup> found that just over 4 in every 10 primary school age pupils in Enfield had a first language other than English. This compares with 3 in 10 for outer London and 4 in 10 for London as a whole. A recent report<sup>56</sup> found that state school pupils in Enfield recorded themselves under 87 different ethnicities.

Population projections (GLA 2007 Round Ethnic Group Projections) suggest that the percentage of the overall Enfield population comprised of Black and Minority Ethnic groups is likely to rise steadily from 28.4% in 2006 to 37.2% in 2031.

As ethnic and cultural background may have a profound effect on health and wellbeing, analysis of different groups living in Enfield enables a better understanding of the health needs of the population. Population migration and higher birth rates amongst some ethnic populations result in higher proportions of the population being classed as non-white ethnic groups in the younger age groups (Figure 3.3) than in the older age groups.

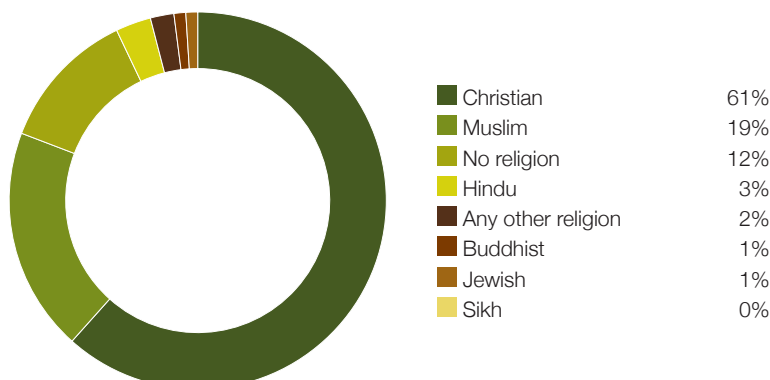
**Figure 3.3: Ethnicity (2011)**



Source: Greater London Authority, 2010 Round Ethnic Group Projections

In keeping with a diverse City borough population, there are a range of religious beliefs held by residents of the borough (Figure 3.4).

**Figure 3.4: Religious beliefs (2010)**



Source: Office for National Statistics

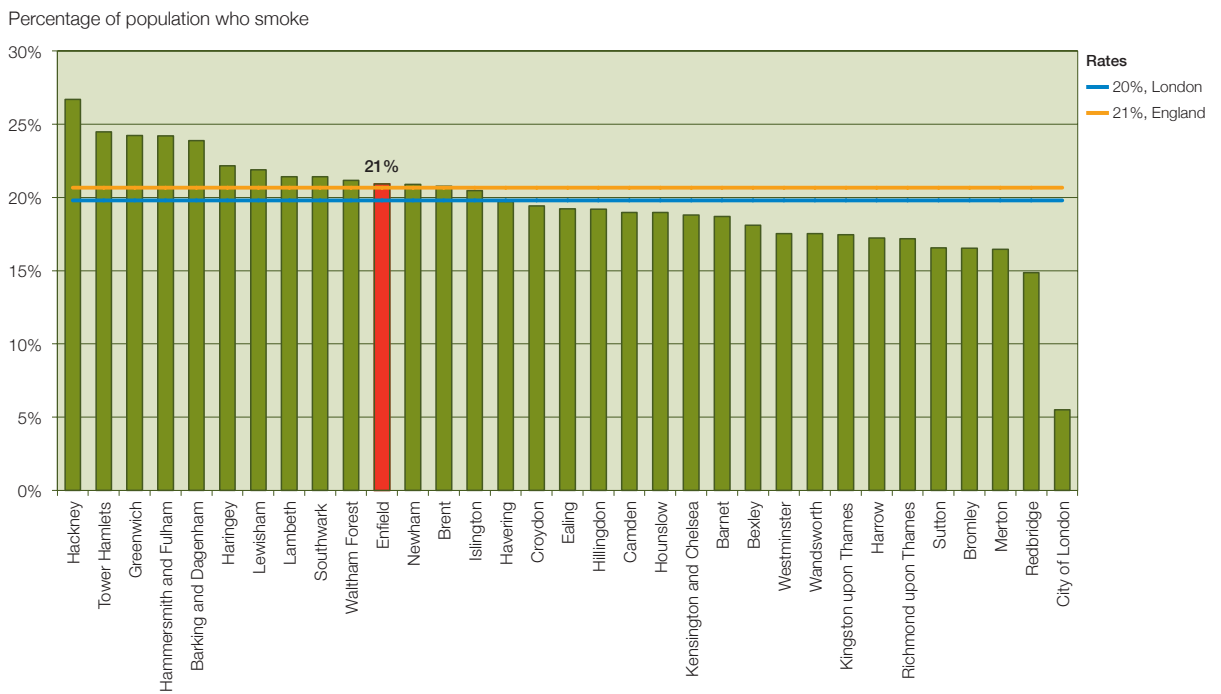
## Enfield lifestyle and wider determinants of health

This section considers a range of key lifestyle and wider socio-economic factors which, as outlined in Chapter 1, contribute to determining the health and wellbeing of the population. Key lifestyle factors are considered first – smoking, substance misuse, physical activity and diet. Reviews of these are followed by an overview of the deprivation and wider socioeconomic determinants of health in Enfield.

### Smoking

Smoking is the biggest single cause of preventable death and ill-health and accounts for approximately 5.5% of the NHS budget. The Integrated Household Survey (IHS) is the largest social survey ever produced by the Office for National Statistics (ONS); it is used to produce estimates for particular themes to improve the monitoring of important information between censuses for a range of policy purposes. Between April 2010 and March 2011, the IHS identified 1 in 5 adults in Enfield (21%) to be a smoker, in line with the national figure (Figure 3.5). Enfield ranks 11th highest out of the 33 Local Authorities in London for smoking prevalence amongst adults.

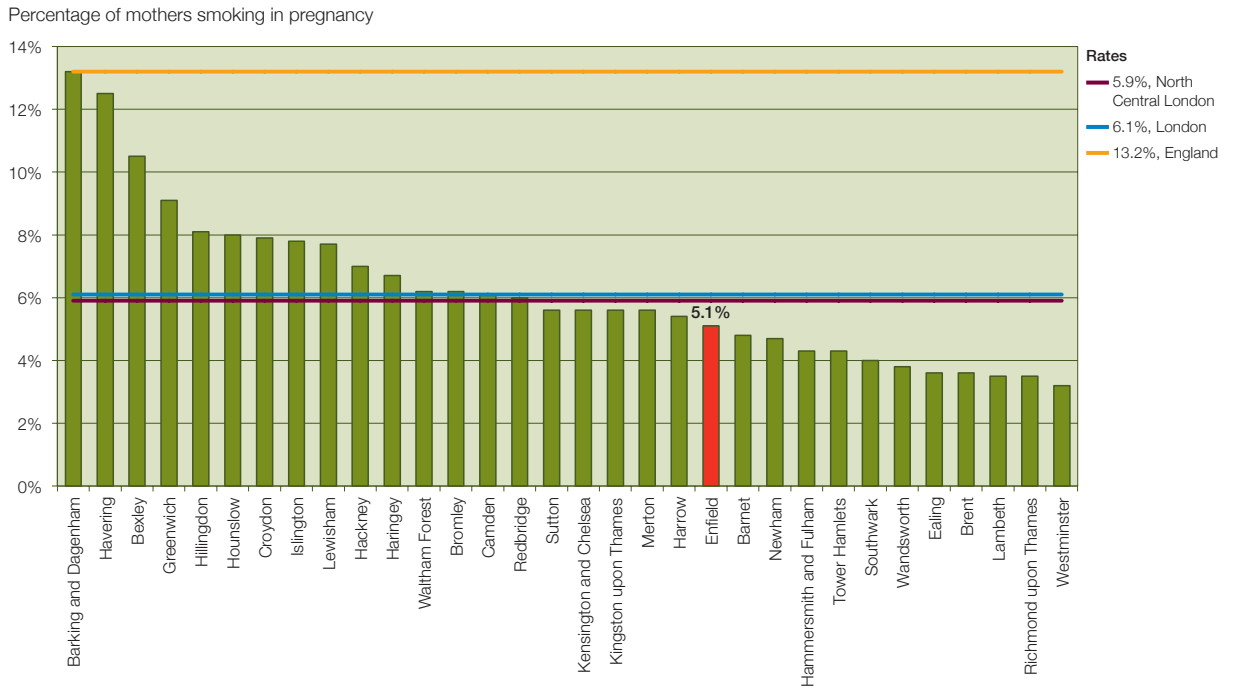
**Figure 3.5: Smoking prevalence (2010/11)**



Source: Integrated Household Survey, ONS

The Health Profile 2011<sup>57</sup> shows the percentage of mothers smoking in pregnancy (where status is known 2009/10) to be significantly lower in Enfield than the national average. Nationally, 14% of mothers smoke during pregnancy compared with 6.5% in Enfield. More recent data for the first quarter of 2011/12 suggests smoking rates at time of delivery are lower for Enfield mothers than the average for London as a whole (Figure 3.6).

**Figure 3.6: Maternal smoking at time of delivery (Quarter 1, 2011/12)**



Source: Department of Health

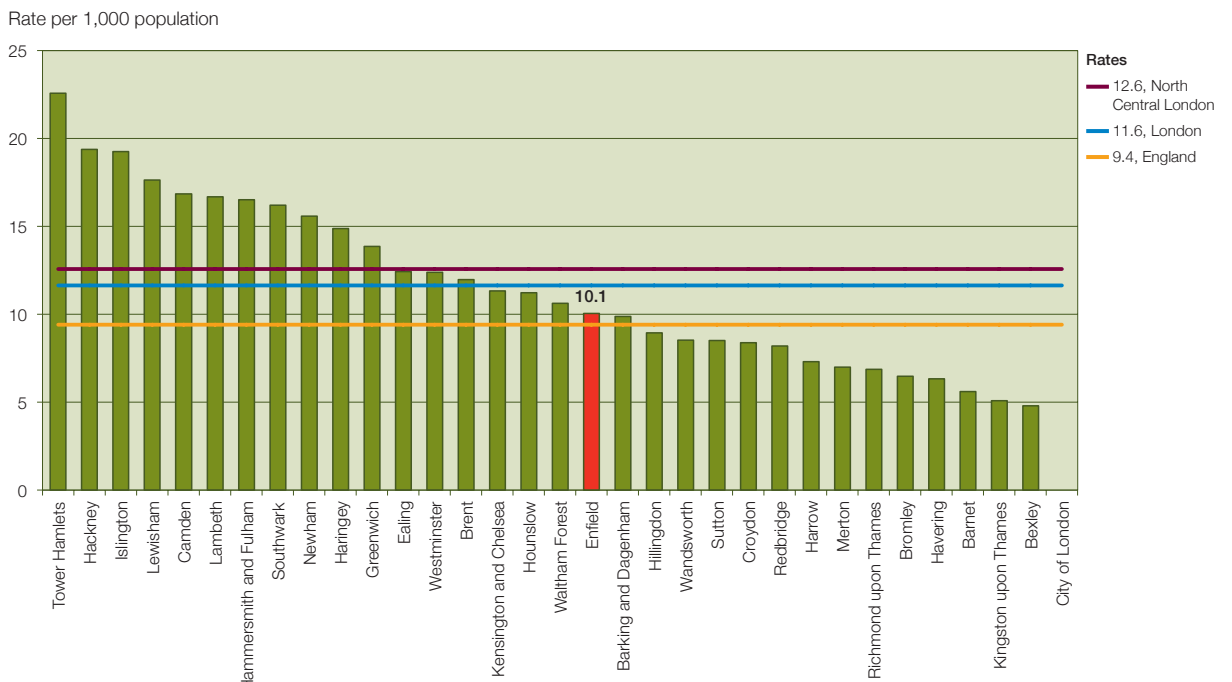
Admissions to hospital due to smoking related conditions not only represent a large demand on NHS resources, but can also be used as a proxy for variations in smoking related ill-health in the general population across England. The Local tobacco control profiles for England, (produced by London, Eastern region and East Midlands Public Health Observatories on behalf of the Public Health Observatories in England) contain information on a range of smoking indicators for comparison locally, regionally and nationally. These show smoking attributable admissions during 2009/10 in Enfield to be significantly lower than the average for England<sup>58</sup>.

### Alcohol use and Substance misuse

The Local Alcohol Profiles for England<sup>59</sup> detail a range of alcohol related mortality and morbidity indicators along with synthetic estimates of consumption. Overall, Enfield compares favourably with National and London averages across these measures. This is encouraging though we note the increasing risk that rising levels of consumption and related morbidity and mortality across the country are increasingly accepted as ‘normal’. The notable exception to this is alcohol-related recorded crimes which are significantly worse in Enfield than the national average, though still lower than the value for London as whole.

Use of illegal drugs is more difficult to establish. Estimates of Problem Drug Users (aged 15-64 years) using crack and/or opiates show the rate for Enfield to be 10.1 per 1,000 adults aged between 15 and 64 years. Whilst this is higher than the average for England as a whole, it is below the average for London; 11.6 per 1,000 adults aged between 15 and 64 years (Figure 3.7).

**Figure 3.7: Estimated problem drug users (2008/09)**



## Physical activity and diet

To avoid obesity, heart disease and other life-limiting conditions, the Chief Medical Officer (CMO) has recommended<sup>60</sup> that adults should do a minimum of 30 minutes moderate-intensity physical activity, five days a week (5 x 30 minutes). The 2004 report on physical activity says, “...for most people, the easiest and most acceptable forms of physical activity are those that can be incorporated into everyday life. Examples include walking or cycling instead of driving.”<sup>61</sup>

Physical activity levels are low in the UK: only 40% of men and 28% of women meet the minimum recommendations for physical activity in adults<sup>62</sup>. Estimates of levels of physical activity suggest that the majority of adults in Enfield are failing to undertake the recommended minimum of five thirty minute (5 x 30) sessions of physical activity each week. The estimate for Enfield is in the bottom quintile in the country<sup>63</sup> with an estimated 13.2 % of adults meeting the minimum recommended level of 5 x 30 minutes compared with an overall estimate for London of 17.9%.

Good nutrition is vital to good health. Whilst many people in England eat well, a large number do not, particularly among the more disadvantaged and vulnerable in society. In particular, a significant proportion of the population consumes more than the recommended amount of fat, saturated fat, salt and sugar. Such poor nutrition is a major cause of ill health and premature death in England. In 2010, 25% of men and 27% of women in England consumed the recommended five or more portions of fruit and vegetables daily<sup>64</sup>.

The percentage of healthy eating adults (number of adults estimated to eat at least five portions of fruit and vegetables a day expressed as a percentage of the resident adult population, 2006-2008) in Enfield (32.5%) is significantly better than the average for England (28.7%) though still less than the London average<sup>65</sup>.

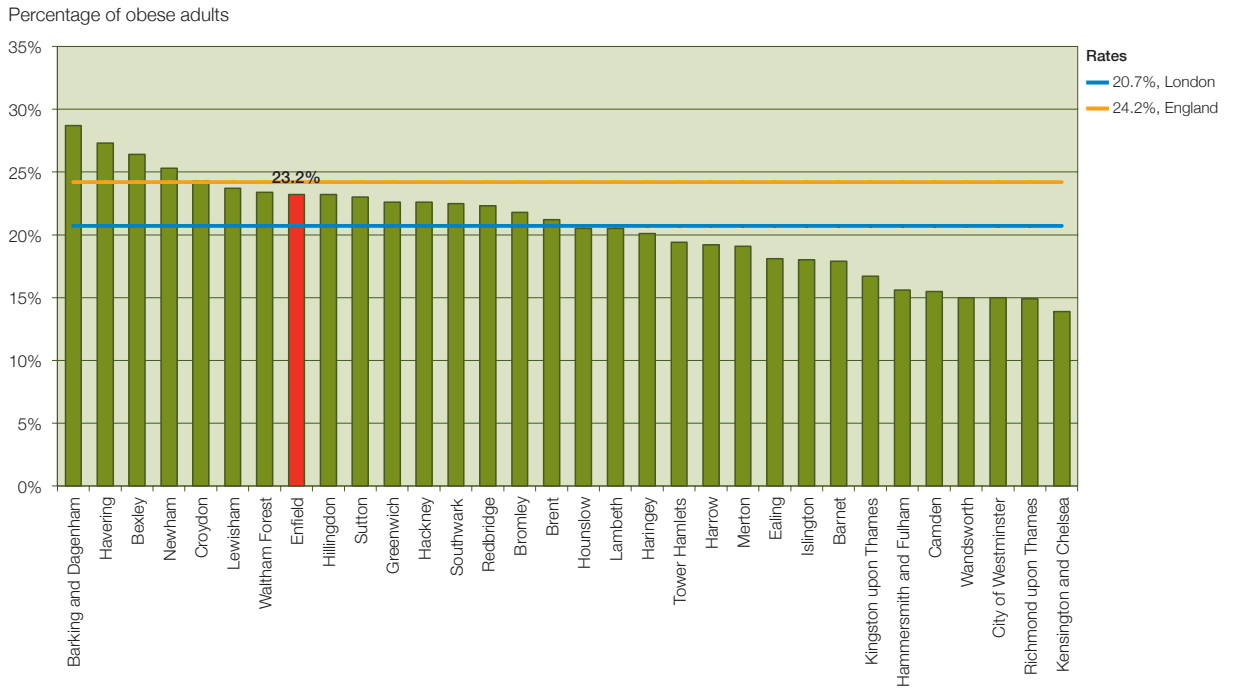
The TNS-BMRB PE and Sport Survey on behalf of the Department for Children, Schools and Families (now Department for Education) found that, in 2009/10, 63.6% of year 1-13 pupils in Enfield spent at least 3 hours per week on high quality PE and school sport. This was significantly higher than the England average of 55.1%<sup>64</sup>.



The number of people who are overweight or obese are increasing rapidly. In England the percentage of adults aged 16-64 who are obese has doubled in the past decade. Obesity “doubles the risk of all-cause mortality, coronary heart disease, stroke and type 2 diabetes, and increases the risk of some cancers, musculoskeletal problems and loss of function, and carries negative psychological consequences”<sup>61</sup>. In England, the proportion of adults categorised as obese (BMI over 30) increased from 13.2% of men in 1993 to 23.7% in 2006 and from 16.4% of women in 1993 to 24.2% in 2006. Around 44% of men and 35% of women in England (2006) were overweight<sup>62</sup>.

Obesity levels for adults in Enfield (2006-2008) were better (lower) than the England average (though not statistically significantly so) and higher than the average for all London authorities (Figure 3.8).

**Figure 3.8: Adult obesity (2006-2008)**

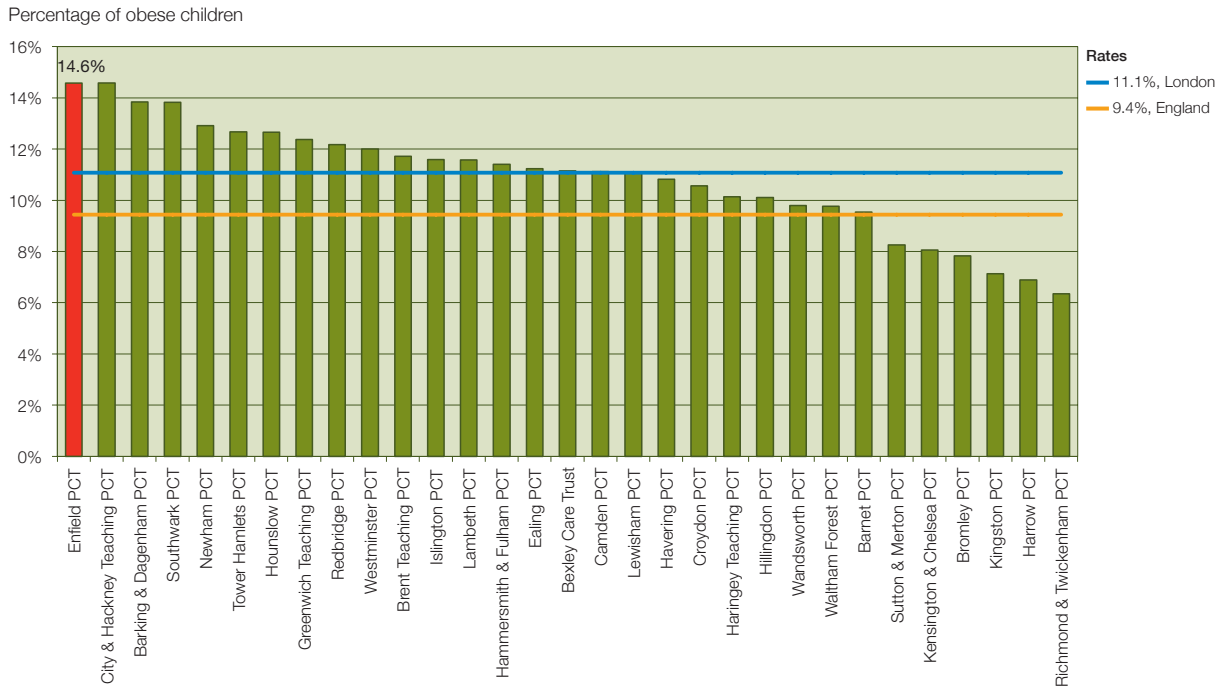


Source: Association of Public Health Observatories

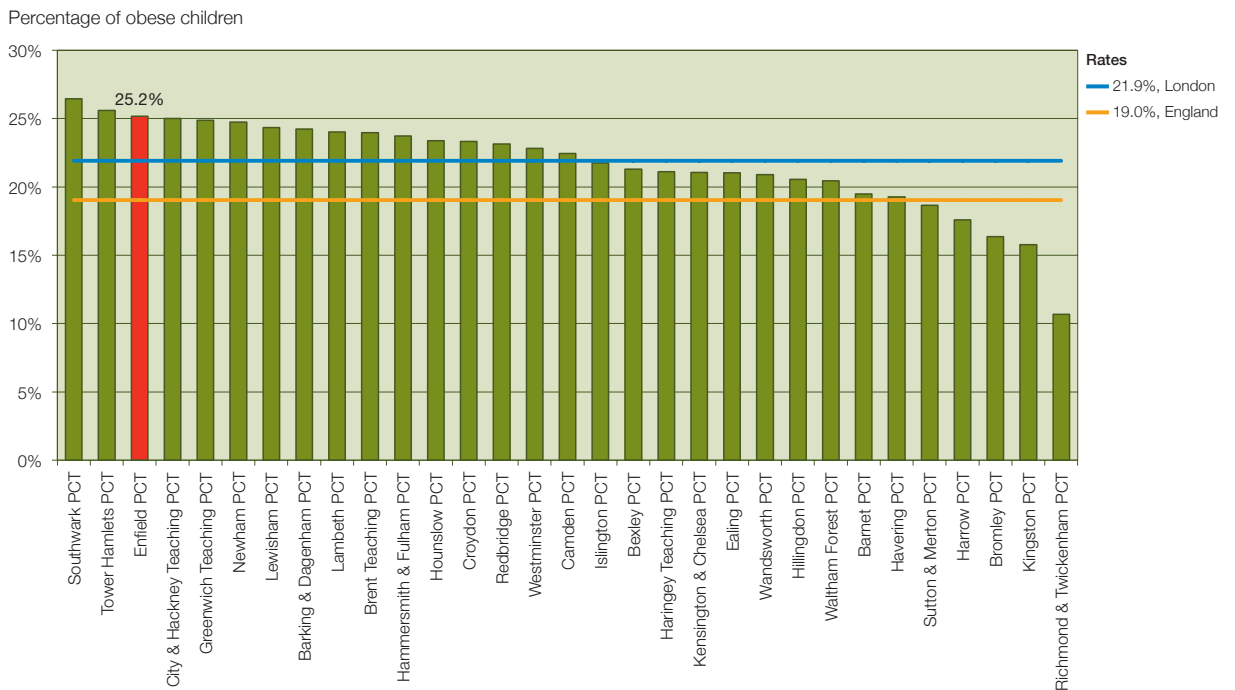


The Government's National Child Measurement Programme (NCMP) for England reports on the prevalence of 'underweight', 'healthy weight', 'overweight', 'obese' and 'overweight and obese combined' children, in Reception (aged 4-5 years) and Year 6 (aged 10-11 years), measured in state schools in England. Enfield has the highest prevalence of obese children at reception age in London (Figure 3.9), and a much higher prevalence than found nationally. By Year 6, the obesity prevalence is one in every four children in Enfield (Figure 3.10).

**Figure 3.9: Childhood obesity (reception year) (2010/11)**



**Figure 3.10: Childhood obesity (year 6) (2010/11)**



## Enfield wider determinants of health

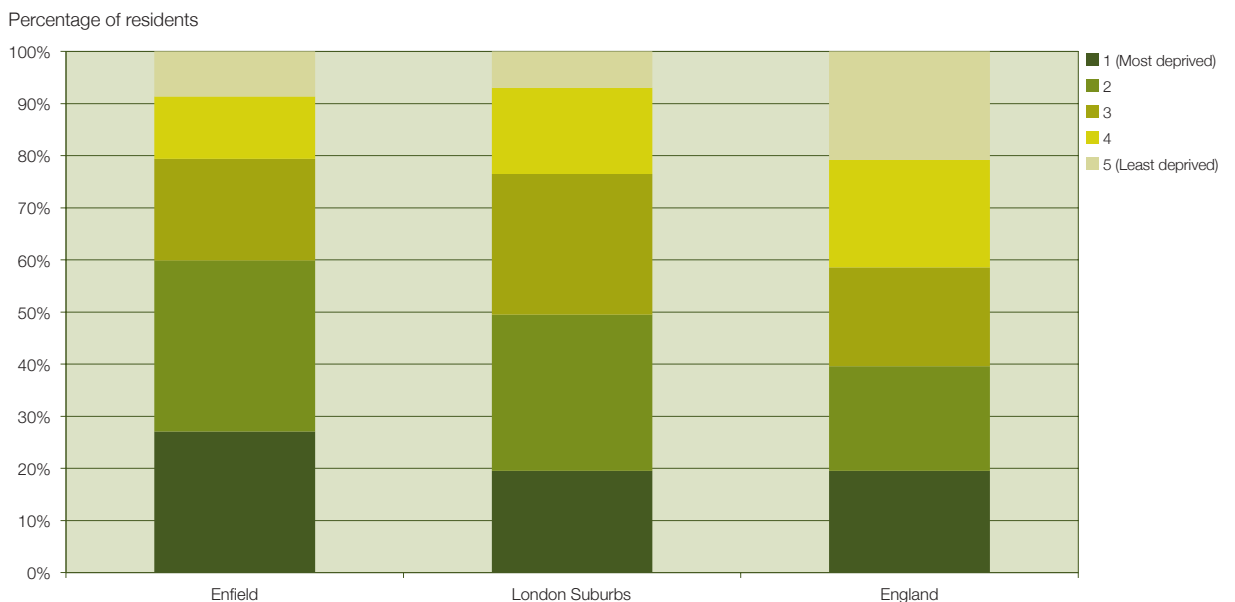
In this section we summarise the general socioeconomic and environmental conditions within which the population of Enfield lives. The section highlights key data for the major social determinants of health: overall deprivation; employment; housing; education and training; crime and physical environment.

### Deprivation

The Index of Multiple Deprivation 2010 produced by Department for Communities and Local Government (DCLG) combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. Indices of Deprivation 2010 have been produced at Lower Super Output Area (LSOA) level, of which there are 32,482 in the country and 181 in Enfield.

We can compare relative levels of deprivation by considering the distribution of LSOA rankings across all England LSOAs. Figure 3.11 shows the proportions of LSOAs for Enfield, London Suburbs and England falling in each Index of Multiple Deprivation quintile. The figure suggests deprivation is slightly worse in Enfield relative to both London suburbs and England as a whole.

**Figure 3.11: Enfield deprivation compared with London and England (2010)**



Source: IMD 2010 Department of Communities and Local Government (DCLG)

Figure 3.12 shows the proportions of LSOAs for each London borough falling in each Index of Multiple Deprivation quintile in England. The figure suggests deprivation is slightly worse in Enfield relative to London as a whole. Comparing the proportions for Enfield and the other peer Outer London boroughs of Croydon, Greenwich and Waltham Forest suggests that Enfield is more deprived than Croydon and considerably less so than Greenwich and Waltham Forest.

**Figure 3.12: Deprivation by borough (2010)**

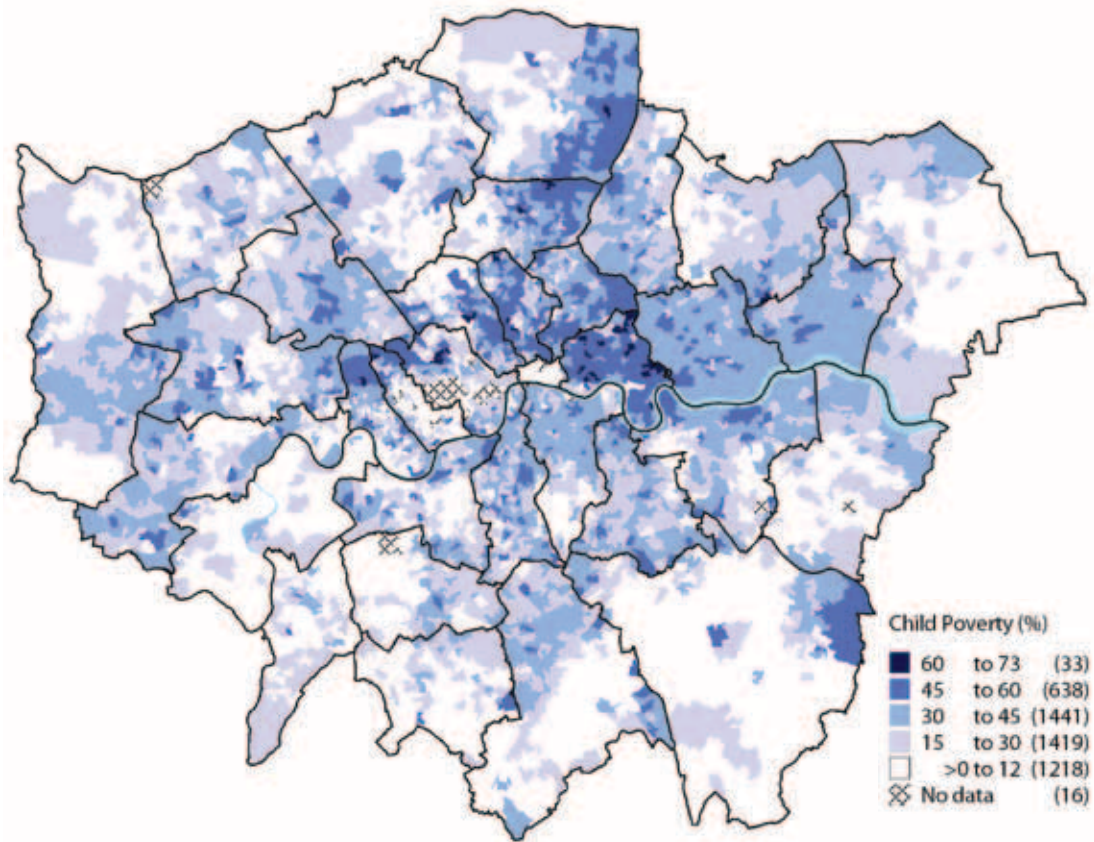
	% of LSOAs in				
	most deprived quintile			least deprived quintile	
	1	2	3	4	5
City of London	0	20	0	40	40
Barking and Dagenham	51	41	7	0	0
Barnet	6	17	32	33	13
Bexley	9	21	17	28	25
Brent	26	53	18	2	0
Bromley	8	18	13	26	36
Camden	24	35	22	17	2
Croydon	16	32	26	16	9
Ealing	20	34	33	10	3
Enfield	27	33	20	13	8
Greenwich	45	34	16	6	0
Hackney	80	20	0	0	0
Hammersmith and Fulham	26	44	19	11	0
Haringey	56	27	13	5	0
Harrow	2	16	36	28	17
Havering	7	19	21	35	17
Hillingdon	7	34	28	18	13
Hounslow	9	40	30	21	1
Islington	52	43	5	0	0
Kensington and Chelsea	23	23	18	34	1
Kingston upon Thames	1	6	19	43	31
Lambeth	37	52	10	2	0
Lewisham	38	48	13	1	0
Merton	2	22	25	19	33
Newham	84	16	0	0	0
Redbridge	7	29	41	19	4
Richmond upon Thames	0	5	11	36	47
Southwark	35	44	14	6	1
Sutton	5	17	23	33	22
Tower Hamlets	72	15	11	2	1
Waltham Forest	52	40	7	1	0
Wandsworth	11	35	32	17	0
Westminster	19	28	36	17	0
<b>London</b>	<b>26</b>	<b>30</b>	<b>20</b>	<b>15</b>	<b>9</b>

Source: 2011 Focus on London: Poverty Report data

Having sufficient income to access the resources needed for good health and wellbeing is a key issue. Nearly 35% of children in Enfield were estimated to be living in poverty in 2009. This was a slight decrease since 2006. The following map (Figure 3.13) shows high levels of children living in poverty in the eastern part of Enfield.

**Figure 3.13: Child poverty in London (2009)**

Percentage of children living in poverty<sup>66</sup>

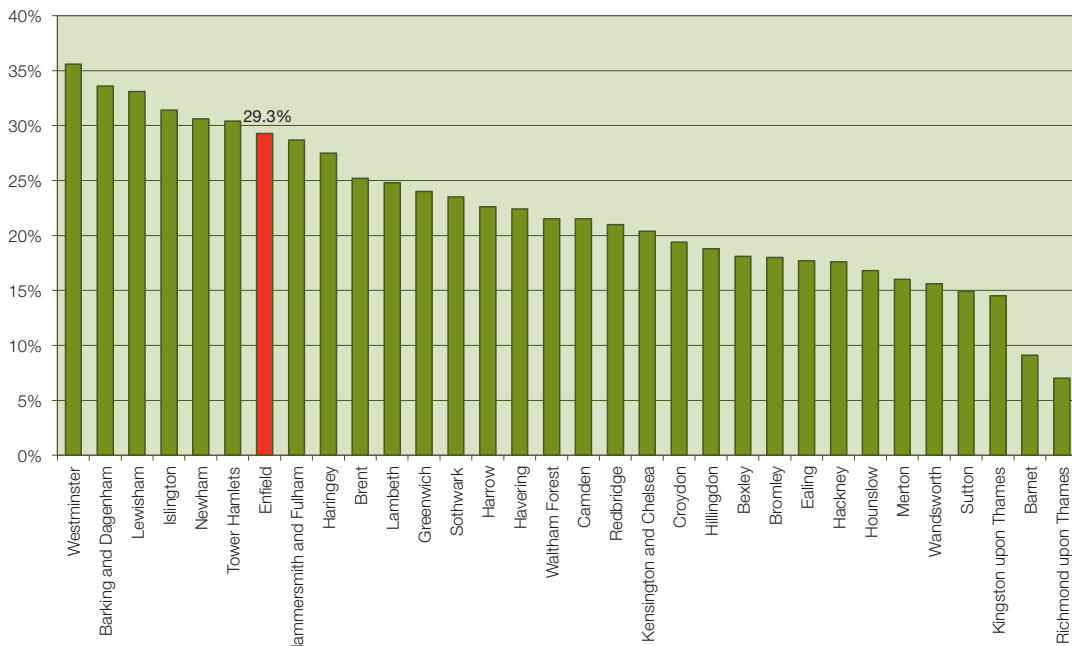


Source: HMRC Child Poverty Statistics 2009

Overall income levels in Enfield are low relative to other parts of London with 29% of children living in workless households; Enfield has the 7th highest percentage of children living in workless households across the London boroughs (Figure 3.14).

**Figure 3.14: Children in workless households (2010)**

Percentage of children in workless households by borough



Source: Annual Population Survey Household datasets

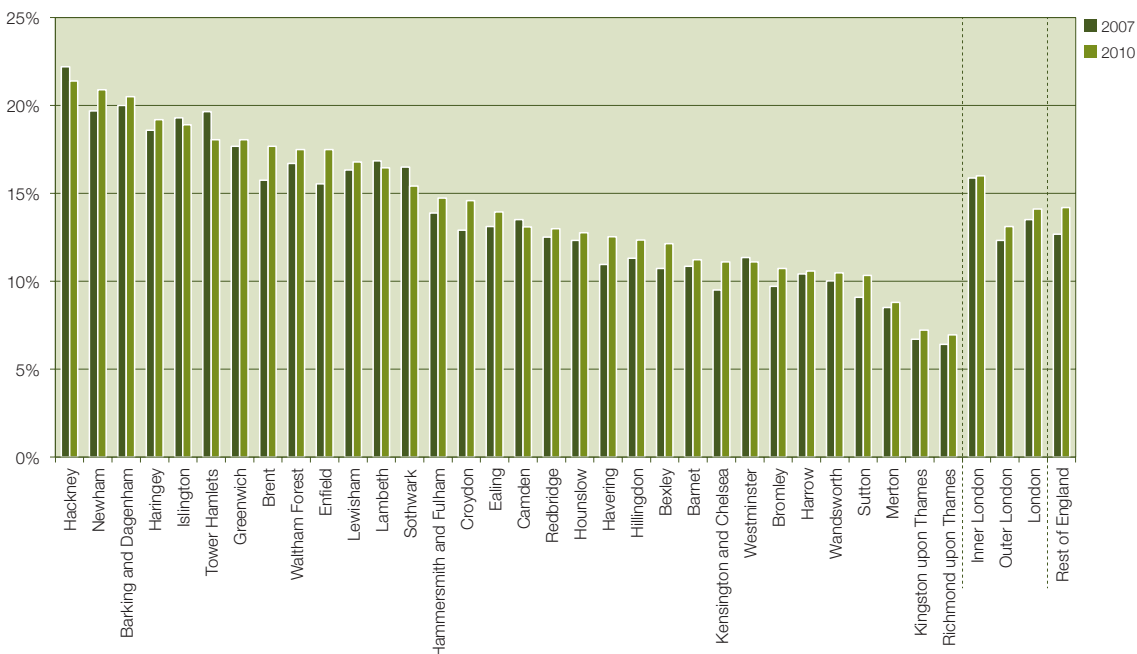
## Employment

Employment is important to health and wellbeing as both a means to accessing resources and as a social and developmental activity.

The proportion of working-age adults claiming an out-of-work benefit in London in 2010 was very similar to the level it was in 2007. This is in contrast to the rest of England, where the proportion rose. The proportions in London and the rest of England are now almost identical, at around 14%. Enfield is one of a number of outer London boroughs where the proportion of working-age adults claiming an out-of-work benefit rose between 2007 and 2010; this change includes boroughs where rates were already high such as Barking & Dagenham, Greenwich, Enfield, Brent and Waltham Forest. Enfield has the 10th highest proportion across the London boroughs (Figure 3.15).

**Figure 3.15: Receipt of out of work benefits (London Poverty Profile)<sup>67</sup>**

Percentage of people receiving out-of-work benefits by borough



Source: DWP WPLS series, the data is for February 2007 and February 2010



Figure 3.16 details employment and unemployment data for Enfield and London as a whole<sup>68</sup>. The table shows that, for the period October 2010 to September 2011, the proportion in economic activity in Enfield is higher amongst males than females, as is the case for London and the country as a whole. A higher proportion of males and females are unemployed in Enfield than for London as a whole.

**Figure 3.16: Employment and unemployment (October 2010 to September 2011)**

	Enfield (numbers)	Enfield (%)	London (%)	Great Britain (%)
<b>All people</b>				
Economically active*	141,100	72.1	75.0	76.1
In Employment*	125,400	63.9	68.0	70.0
Employees*	104,200	53.6	57.1	60.5
Self employed*	19,700	9.7	10.6	9.1
Unemployed (model-based)**	16,300	11.5	9.2	7.9
<b>Males</b>				
Economically active*	80,100	81.5	82.7	82.4
In Employment*	71,200	72.3	75.0	75.2
Employees*	55,000	56.5	60.1	62.0
Self employed*	15,900	15.4	14.5	12.8
Unemployed (model-based)**	8,900	11.1	9.2	8.5
<b>Females</b>				
Economically active*	60,900	62.6	67.7	69.9
In Employment*	54,200	55.5	60.8	64.9
Employees*	49,200	50.6	54.1	59.0
Self employed*	3,800	4.0	6.5	5.5
Unemployed (model-based)**	6,800	11.1	9.3	7.1

\* numbers are for those aged 16 and over, % are for those aged 16-64

\*\* numbers and % are for those aged 16 and over. % is a proportion of economically active

Source: ONS annual population survey

Five of the six boroughs with the largest numbers (as opposed to rates) of pensioners receiving the guarantee part of Pension Credit are in Outer London (Brent, Ealing, Enfield, Barnet and Croydon).

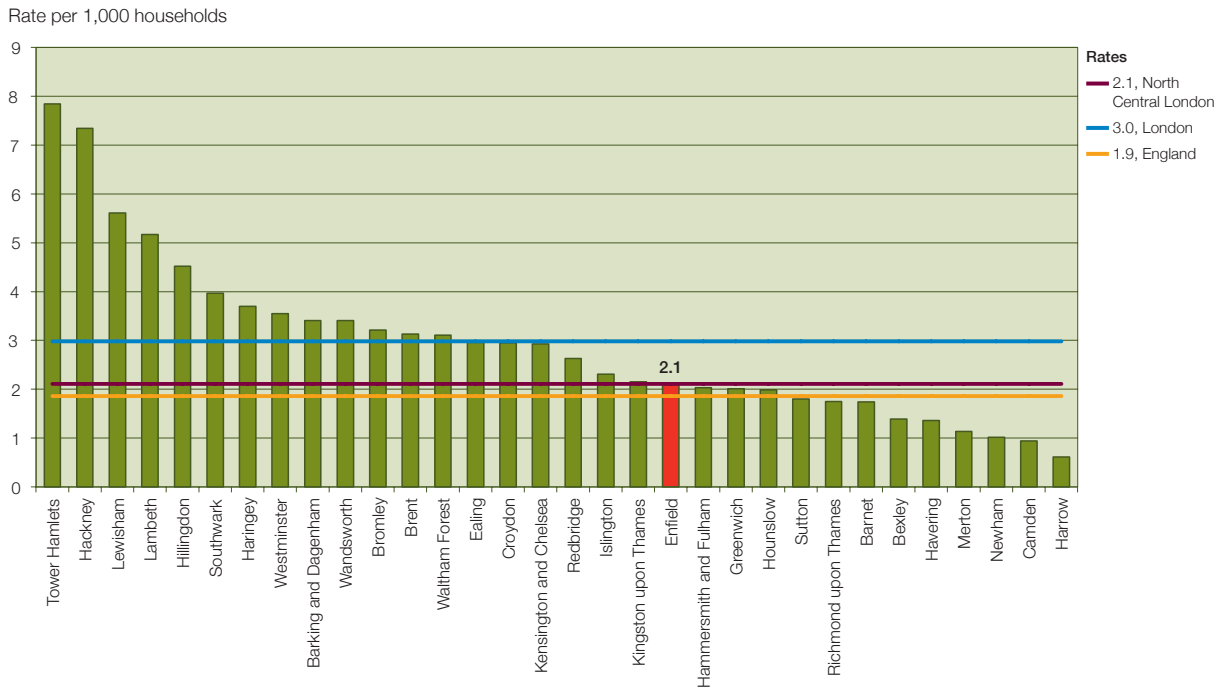
## Housing

Housing is important for many aspects of healthy living and wellbeing. The home is important for psycho-social reasons as well as its protection against the elements, but it can also be the source of a wide range of hazards (physical, chemical, biological). It is the environment in which most people spend the majority of their time.

Accommodation in Enfield is below the London average in terms of the percentage of overcrowding (at least one bedroom too few); 7.1% overcrowded households in Enfield compared with a London average of 7.5%<sup>69</sup>.

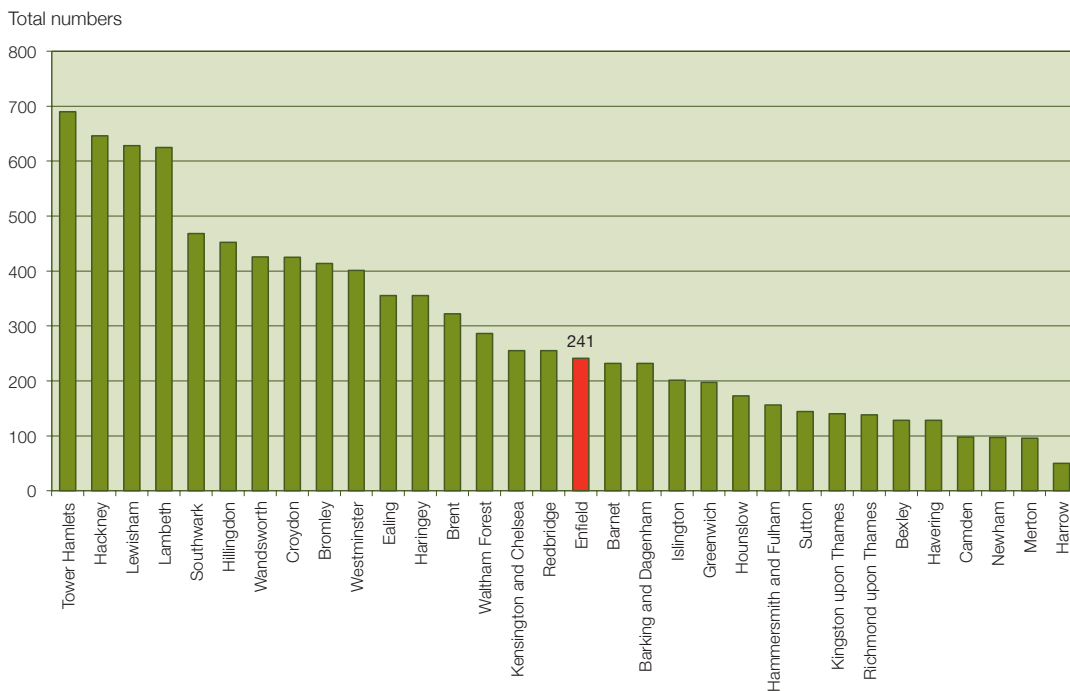
Lack of secure, permanent accommodation is a major stress factor and contributor to poor health and wellbeing. Whilst the rate of homelessness in Enfield is low compared with other London boroughs (Figure 3.17), the number of households is considerable (Figure 3.18).

**Figure 3.17: Rate of homelessness (2009/10)**



Source: Association of Public Health Observatories

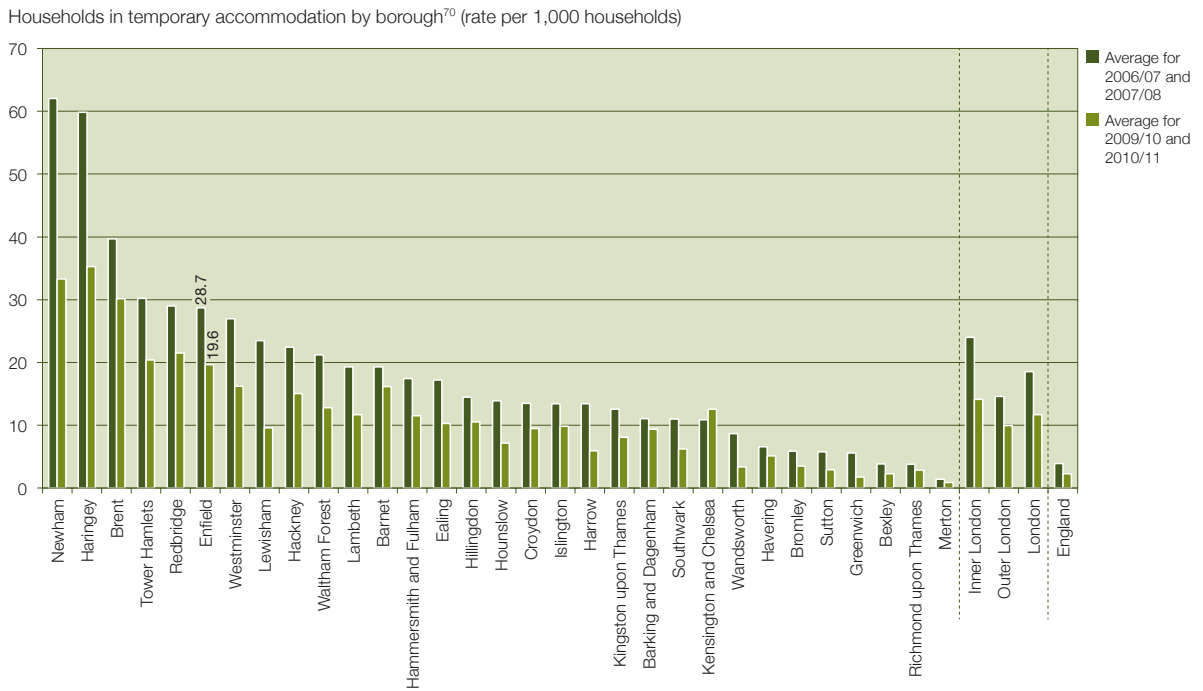
**Figure 3.18: Number of homeless households (2009/10)**



Source: Association of Public Health Observatories

Like homelessness acceptances, the proportion of households in temporary accommodation has declined in recent years. However there remains considerable difference between boroughs in London. Enfield is one of six London boroughs (along with Tower Hamlets, Redbridge, Brent, Haringey and Newham) with at least 20 times the national average rate of residents in temporary accommodation (Figure 3.19).

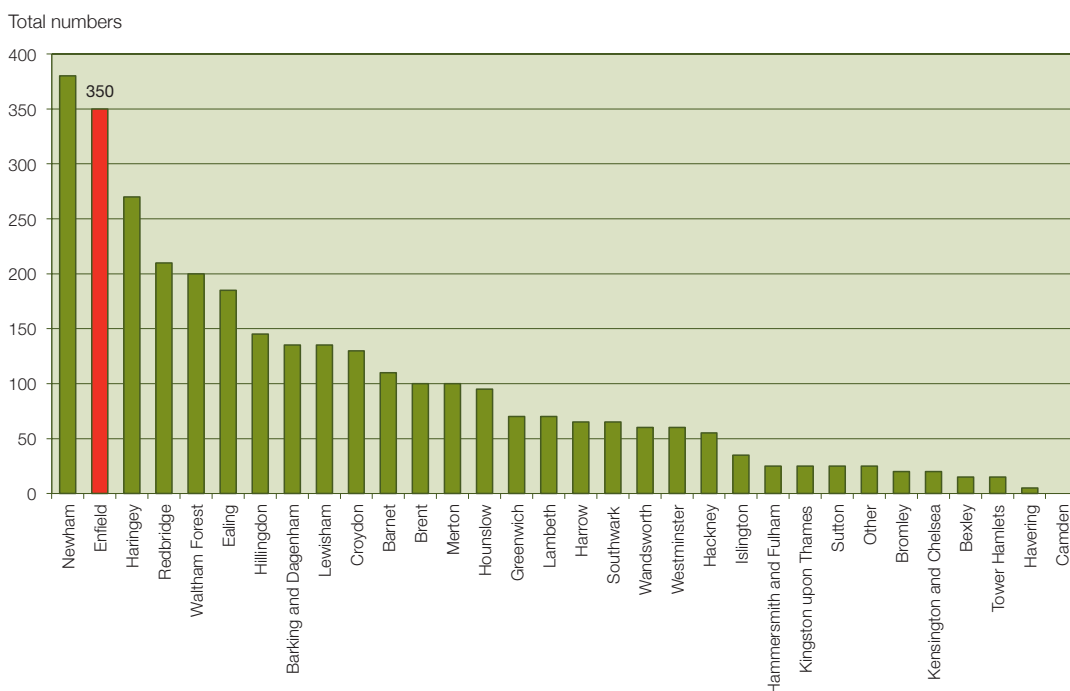
**Figure 3.19: Temporary accommodation**



Source: Department for Communities and Local Government

In addition to the high proportion (and absolute numbers) of Enfield residents in temporary accommodation, Asylum seekers present additional demands on local services. The latest data available (Figure 3.20) shows Enfield Borough supporting the second highest numbers of asylum seekers across all London boroughs.

**Figure 3.20: Asylum seekers (Quarter 1, 2011)**



Source: Home Office



Low incomes in Enfield may well contribute to tenants facing difficulties in sustaining secure housing. Enfield had the highest rate of landlord repossession orders in London. About 1,050 households or 2% of all households living in rented accommodation in Enfield had received a landlord repossession order in 2010<sup>71</sup>.

## Education and training

Educational attainment in Enfield is comparable to the England average but below that for London as a whole, as measured by Pupils Achieving 5+ A\*-C GCSEs or Equivalent, Including English and Mathematics. Educational attainment for children aged between 5 and 7 in Enfield is below national and London average levels (Achieving Level 2+ at Key Stage 1). Figure 3.21 below indicates the higher than national and London average figures for the percentage of half days missed due to unauthorised absence in all schools in Enfield.

**Figure 3.21: Education attainment**

Indicator	Enfield	London	England
Pupils achieving 5+ A* – C GCSEs or equivalent, including English and Mathematics	55.3%	58.2%	55.1%
Pupils achieving Level 2+ at Key Stage 1; in Reading	81.0%	84.0%	84.0%
Pupils achieving Level 2+ at Key Stage 1; in Writing	76.0%	80.0%	81.0%
Pupils achieving Level 2+ at Key Stage 1; in Mathematics	85.0%	89.0%	89.0%
Percentage pupil half day overall absence in all schools	5.82%	5.82%	6.04%
Percentage pupil half unauthorised absence in all schools	1.32%	1.15%	1.04%

Data for period September 2009 to August 2010, Department for Education Crown Copyright, accessed [www.neighbourhood.statistics.gov.uk](http://www.neighbourhood.statistics.gov.uk), April 2012

Data for Enfield Borough suggests the proportion of 16-18 year olds not in education, employment or training (NEETs) has fallen from 6.10% in 2009/10 to 4.20% in 2011/12<sup>72</sup>.

## Crime

Enfield has lower rates of notifiable crime than London or national averages. However burglary from dwellings and theft of motor vehicles is slightly above the London average. In Enfield most crime is committed by males (87%) with almost half of all crime suspects being aged 15-24. Just one in five offences committed in 2008/09 involved groups of offenders with the vast majority of crime being perpetrated by individuals (58%) or in twos (24%). Weapon enabled crime (for example, gun and knife crime) accounts for an insignificant proportion of total crime in Enfield.

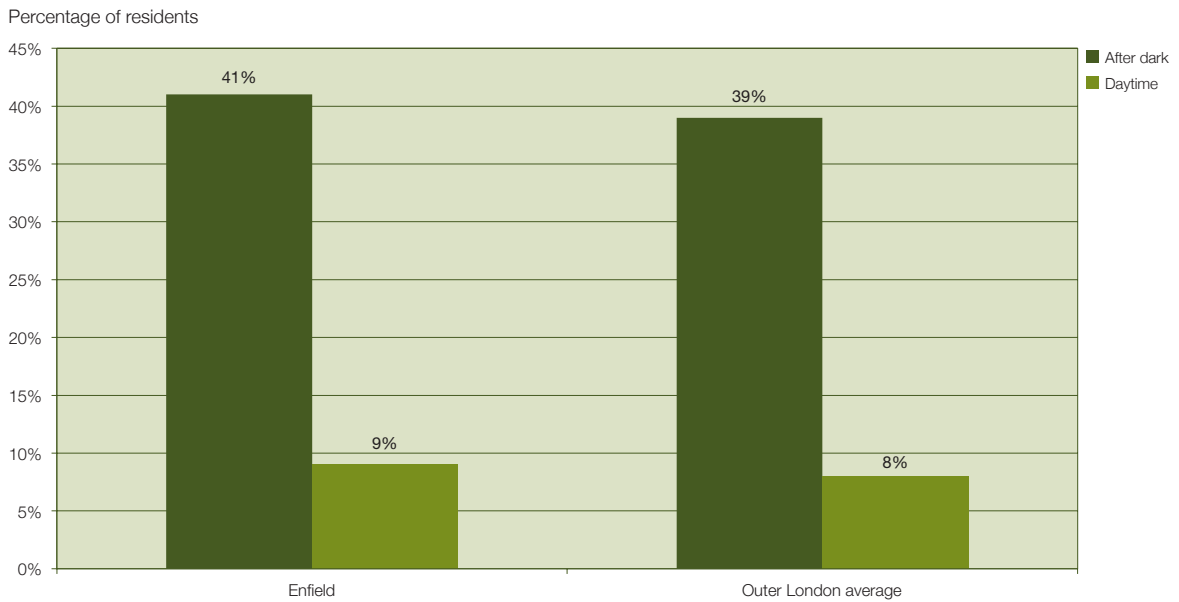


According to police data, victims of personal crime (such as domestic violence or wounding) are more likely to be female. The eastern part of Enfield, in particular Edmonton Green and Upper Edmonton wards, experience a disproportionate amount of all types of crime, disorder and anti-social behaviour. In the recent Place Survey the level of crime was top of the list of improvements that respondents wanted, in order to make Enfield a better place to live in.

Fear of crime was the most significant risk to good health and wellbeing identified by Enfield's Citizen's Panel; fear keeps people from going out, accessing services and maintaining social networks. People with a strong fear of crime are almost twice as likely to show symptoms of depression. The research also shows that fear of crime is associated with decreased physical functioning and lower quality of life<sup>73</sup>.

In the Enfield Place Survey 2008/09, people were asked about whether they felt safe or unsafe after dark, a summary of results are given below (Figure 3.22).

**Figure 3.22: Feeling unsafe (2008/09)**



Source: Enfield Place Survey 2008/09

### Physical environment

The physical living environment domain of the IMD measures the quality of individuals' immediate surroundings both within and outside the home. The indicators fall into two sub-domains: the 'indoors' living environment, which measures the quality of housing, and the 'outdoors' living environment which contains two measures relating to air quality and road traffic injuries. In 2007 Enfield was in the worse 20% of Local Authorities in England on for this domain; this was reinforced in the 2010 index.

The Residents survey in 2011 indicated that 15% of the borough's residents had been affected by noise from neighbours which shows a slight decrease compared to the 2007 survey.

### Conclusions: summary of the wider determinants of health in Enfield

Enfield residents experience higher levels of deprivation than London as a whole. 29% of Enfield children live in workless households, the 7th highest borough in London.

Enfield has the 10th highest proportion of working-age adults claiming an out-of-work benefit in 2010 across the London boroughs. Enfield is one of six London boroughs (along with Tower Hamlets, Redbridge, Brent, Haringey and Newham) with at least 20 times the national average rate of residents in temporary accommodation.

Partnership working must continue to address these wider determinants of health and wellbeing, and better targeting of health promotion to areas of greatest need is required to encourage healthy lifestyle choices.

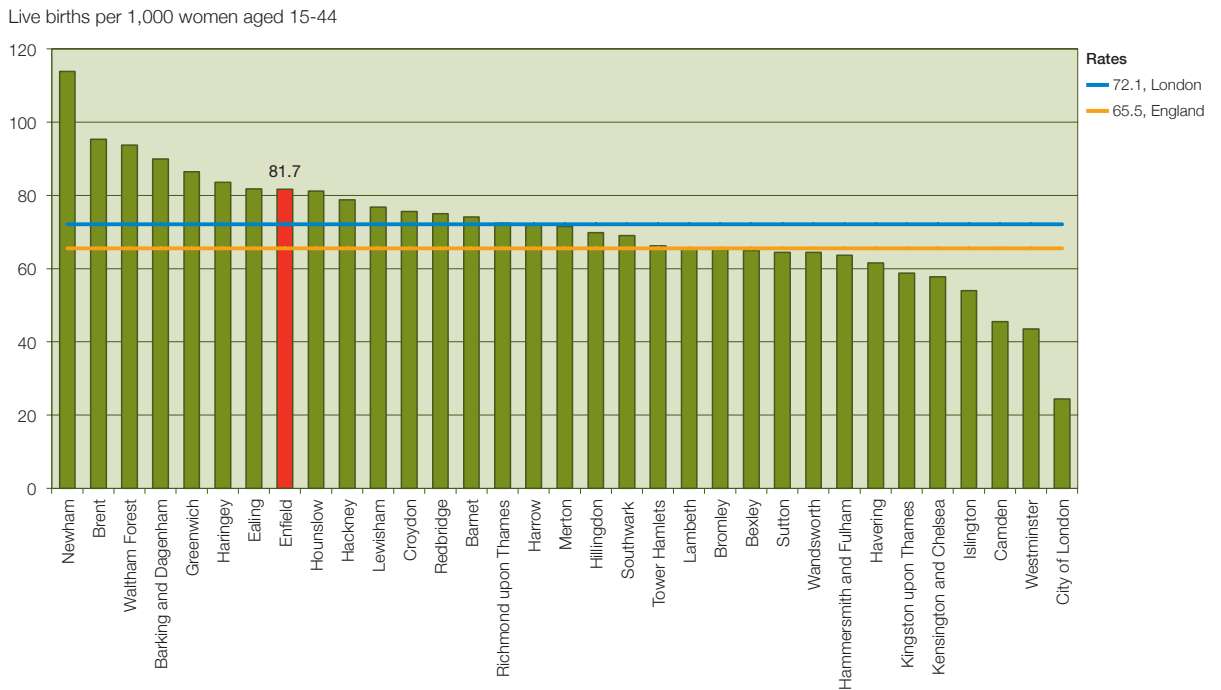
## Enfield Health Profile

This profile provides an overview of key life events of the population of Enfield. This section follows a life course approach: beginning with key birth related indicators we then consider some early years data; life expectancy and limiting long-term illness provide an overview of health and wellbeing experience. Mortality is one of the most important measures of health in any given population. We consider overall life expectancy and mortality rates before reviewing trends in some key causes of mortality.

### Fertility

The general fertility rate in Enfield is higher than the London and England averages. The rate of live births per 1,000 women aged 15-44 is the 8th highest across the London boroughs (Figure 3.23).

**Figure 3.23: Fertility rates (2010)**

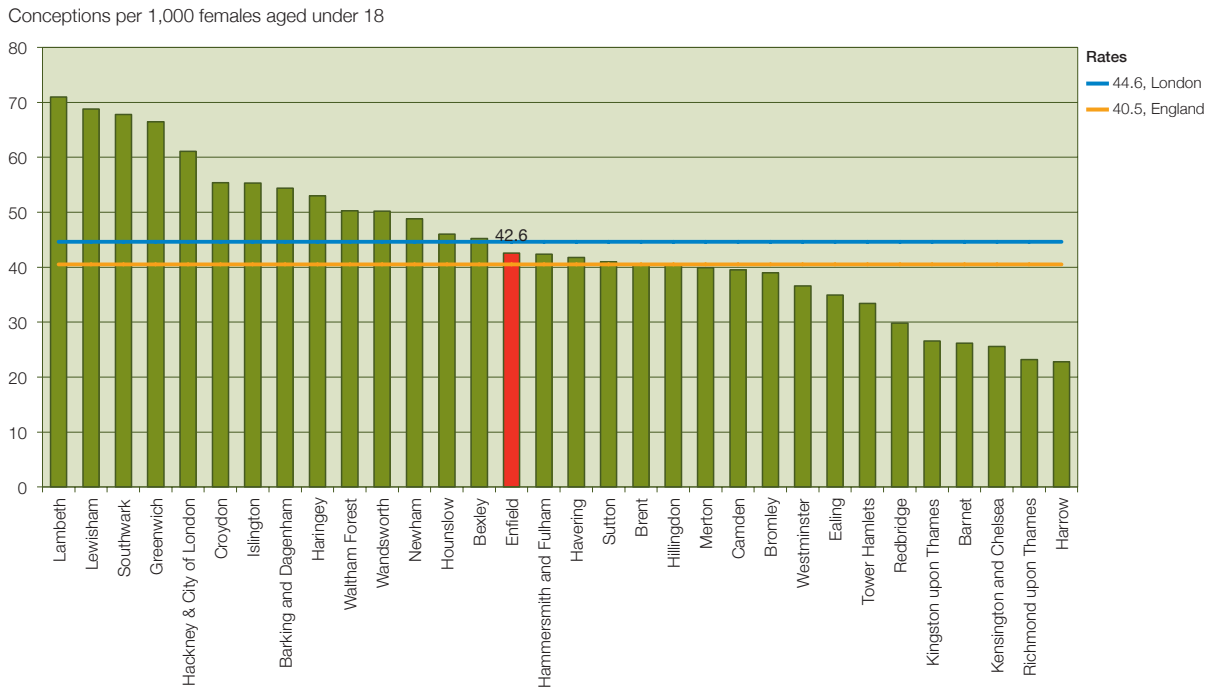


Source: Compendium of Population Health Indicators – NHS Information Centre

It is widely understood that teenage pregnancy and early motherhood can be associated with poor educational achievement, poor physical and mental health, social isolation, poverty and related factors. Socio-economic disadvantage can be both a cause and a consequence of teenage parenthood.

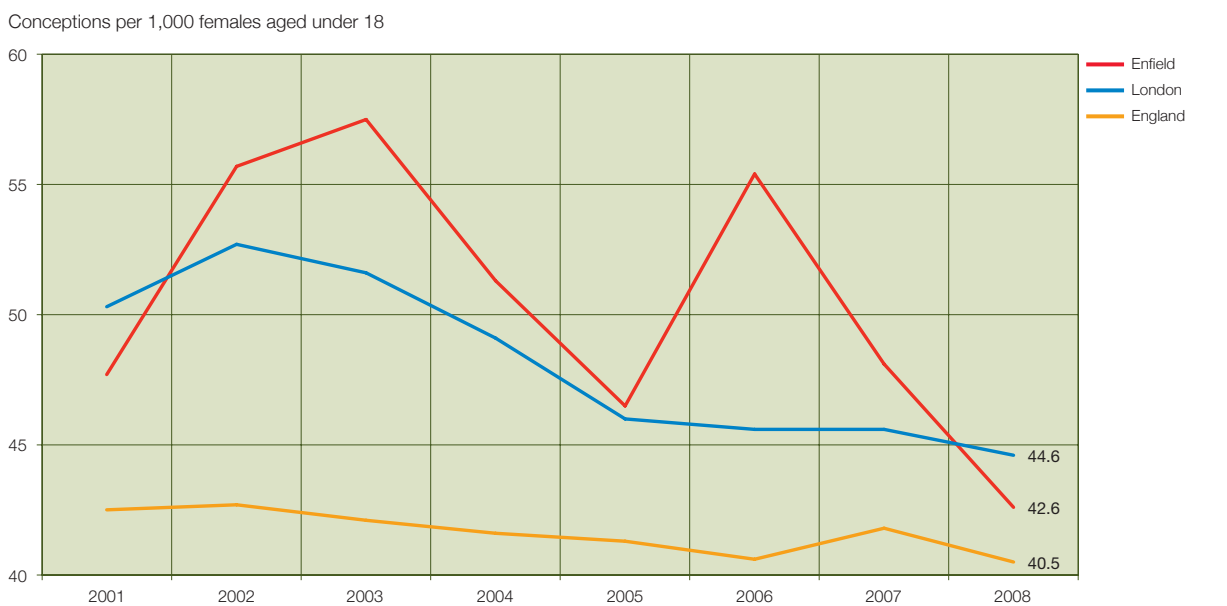
Recent figures show that the conception rate per 1,000 teenagers under 18 years in Enfield is now not significantly different to the England average and is lower than the London average (Figure 3.24). This is a considerable achievement for Enfield; Figure 3.25 highlights how the local Enfield rate has fallen steadily since 2006.

**Figure 3.24: Teenage conceptions across London (2008)**



Source: Office for National Statistics

**Figure 3.25: Teenage conception trends**

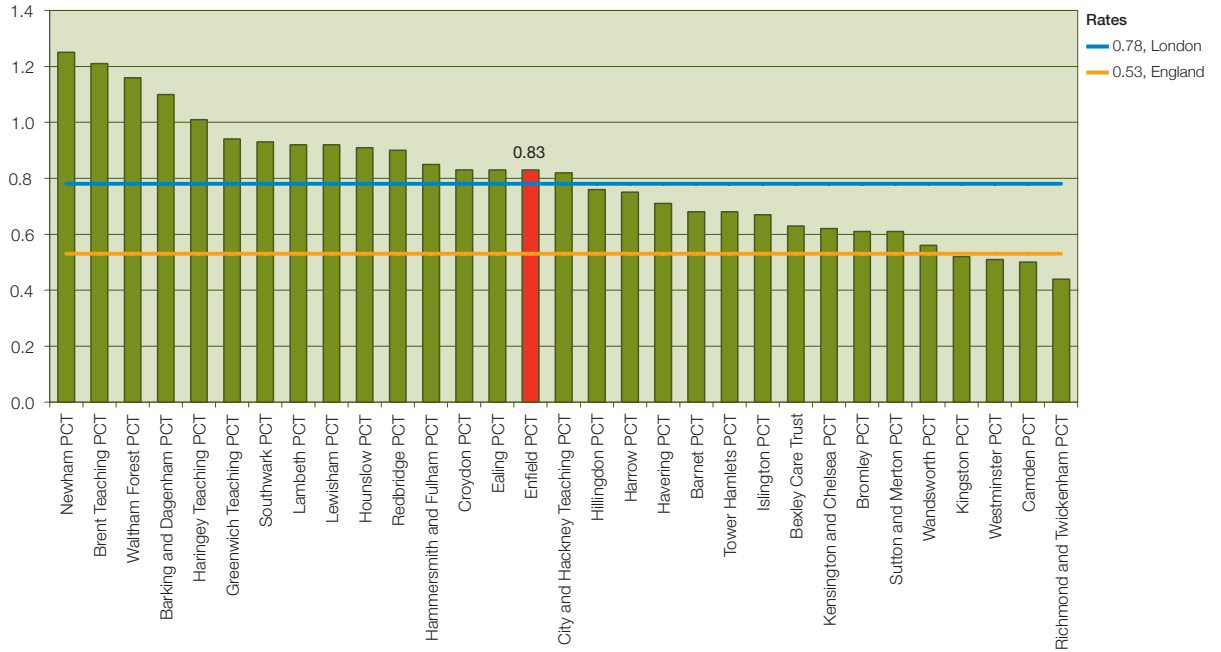


Source: Office for National Statistics

Abortion rates vary considerably across England and Wales. The rate for Enfield is considerably higher than the England average and broadly in line with the London average (Figure 3.26).

**Figure 3.26: Abortion rates (2010)**

Total period abortion rate per females aged 11-49 years

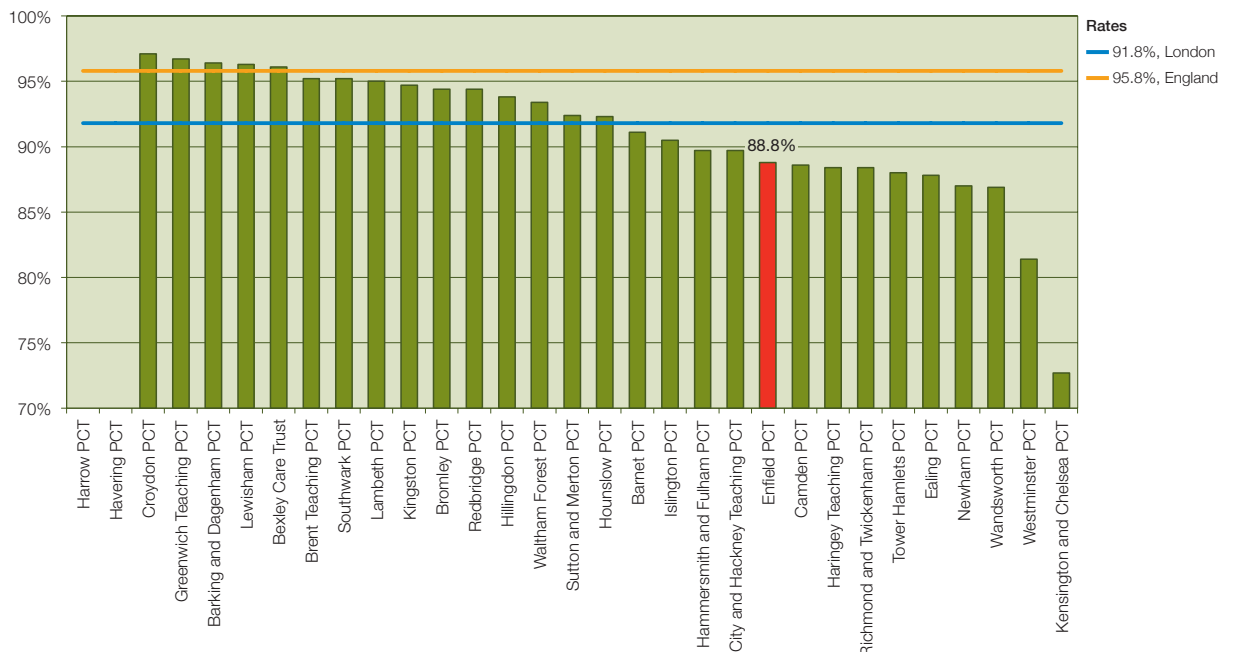


Source: Compendium of Population Health Indicators – NHS Information Centre

The percentage of abortions for Enfield women funded by the NHS is much lower than both the England and London averages; at 88.8% the percentage for Enfield women is the tenth lowest across the London boroughs (Figure 3.27).

**Figure 3.27: NHS funded abortions (2010)**

Percentage of NHS funded abortions

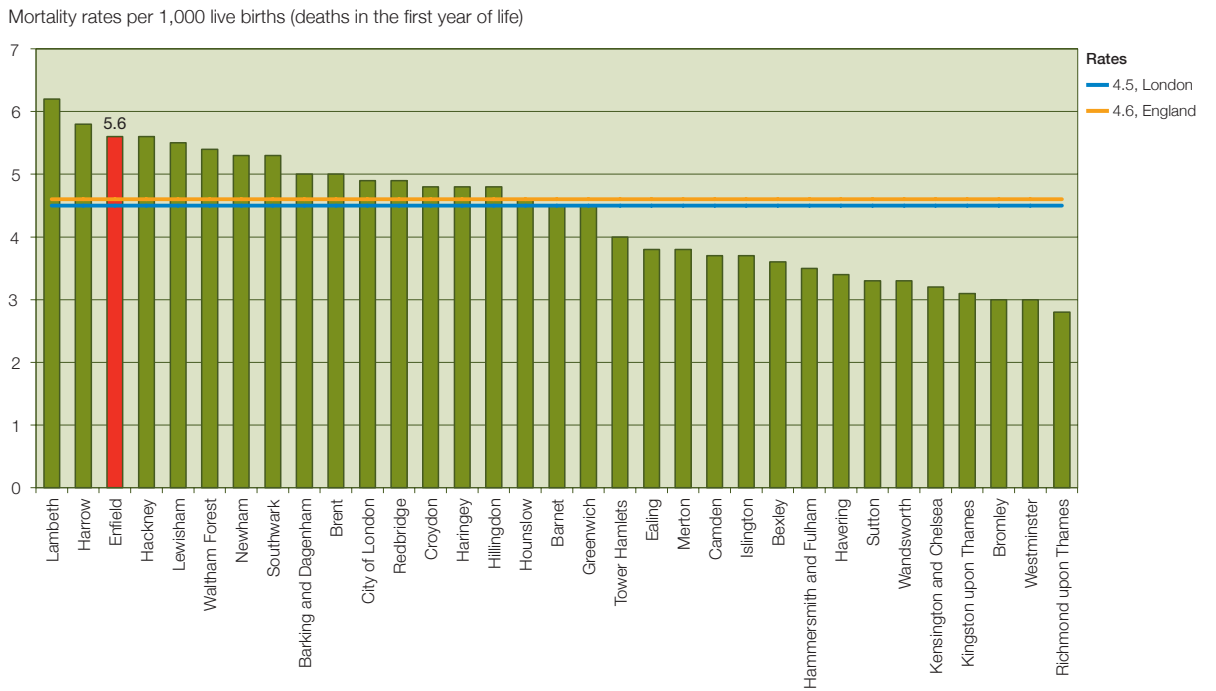


Source: Compendium of Population Health Indicators – NHS Information Centre

### Health and wellbeing in the early years

Infant mortality has traditionally been used as a major indicator of child health and, while infant mortality rates dropped sharply in the 1970s and 1980s, the rate of progress nationally since then has been much slower. During 2008-2010 the infant mortality rate in Enfield was 5.6 deaths in the first year of life per 1,000 live births; this is higher than the average rates for England and London with Enfield having the third highest rate across the London boroughs behind Harrow and Lambeth (Figure 3.28).

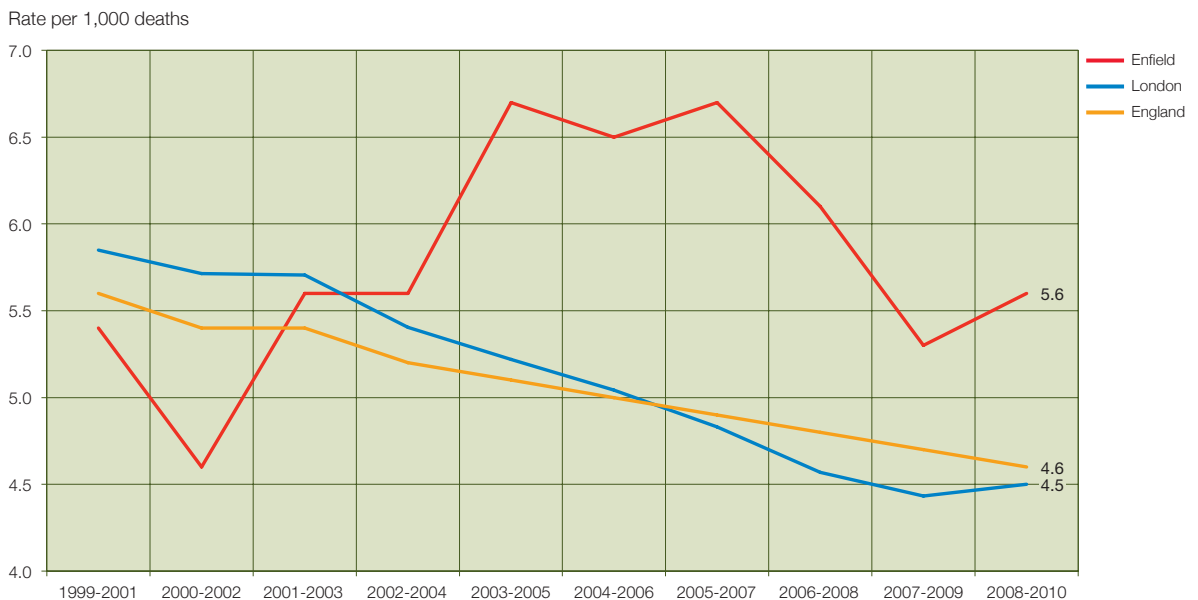
**Figure 3.28: Infant mortality (2008-2010)**



Source: Compendium of Population Health Indicators – NHS Information Centre

Over the last decade there has been a slight downward trend in this key indicator for England and London as a whole. The small numbers involved at Local Authority level mean small changes in the numbers of deaths can lead to dramatic fluctuations in rates; Figure 3.29 shows the variability in Enfield rates over time. The latest data available shows that although the Enfield rate (5.6/1,000) is higher than the national average (4.6/1,000) this is not a statistically significant difference<sup>74</sup>.

**Figure 3.29: Trends in infant mortality**



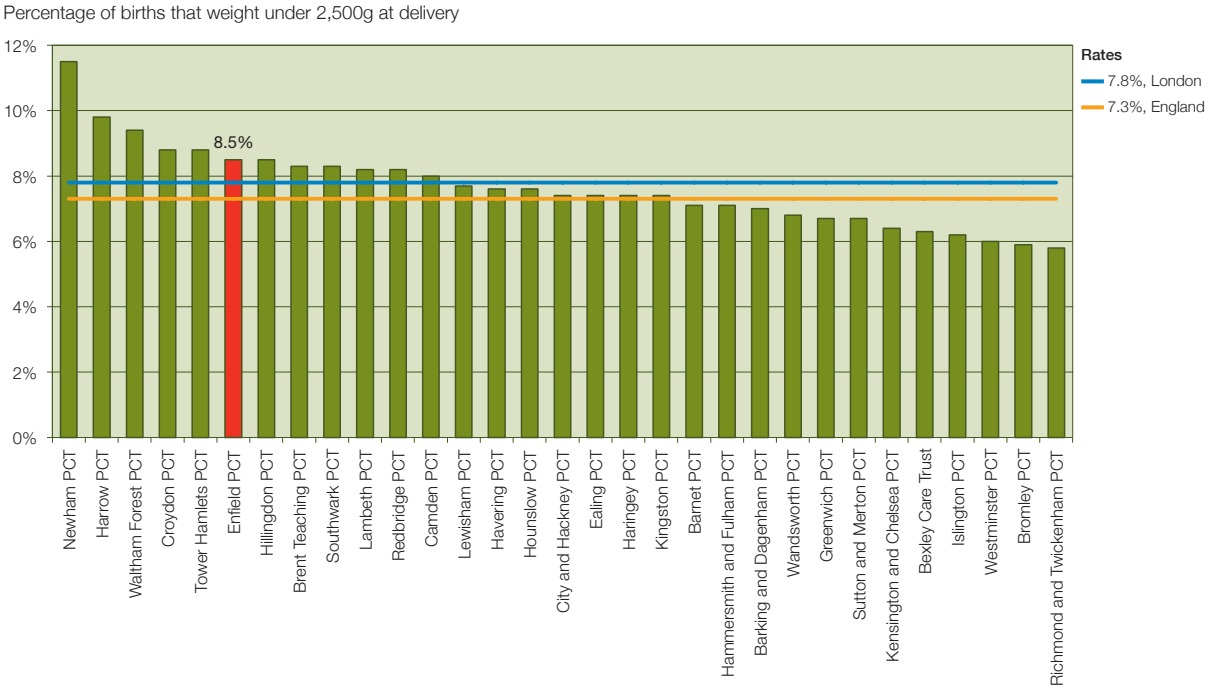
Source: Compendium of Population Health Indicators – NHS Information Centre

The rates of death and illness associated with low birth weight reflect both its immediate and its long-term health risks to the infant. It is closely correlated with poor health in the first four weeks of life, and with death before the age of two years; there are also associations with premature death from coronary artery disease<sup>75</sup>. Low birth weight is also associated with delayed physical and intellectual development in early childhood, and in adolescence<sup>76</sup>.



In Enfield, 8.5% of births weighed under 2,500g at delivery, the sixth highest in London and considerably higher than the London and England averages (Figure 3.30).

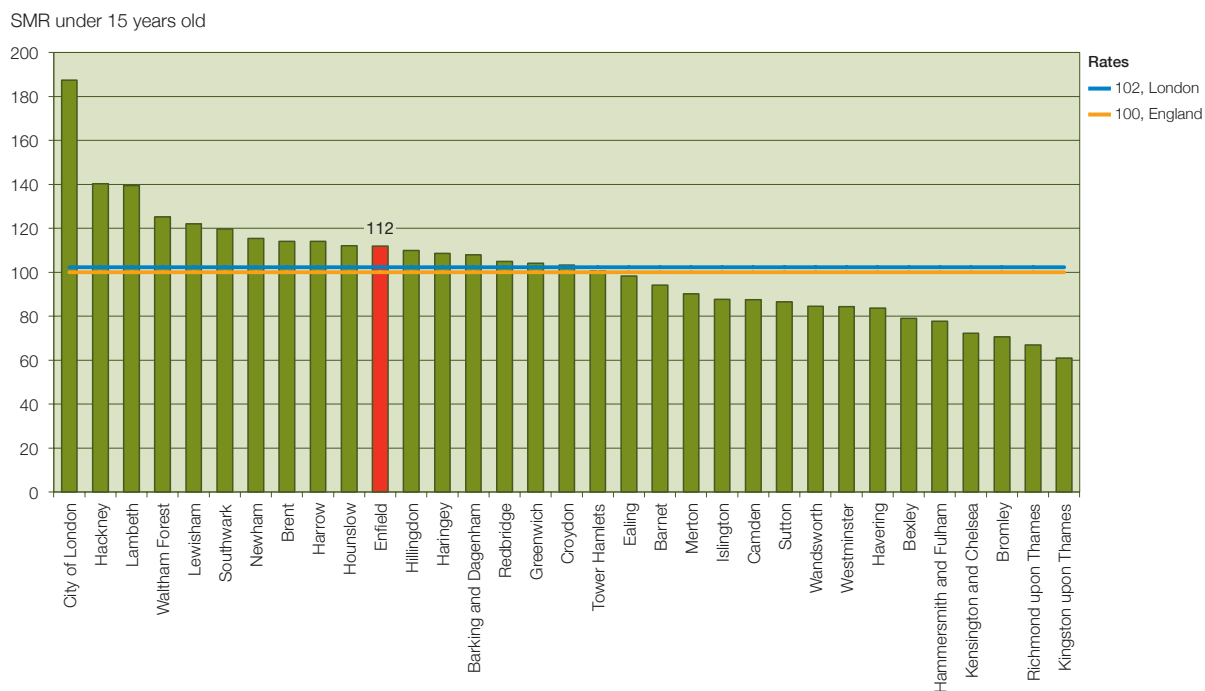
Figure 3.30: Low birth weight (2010)



Source: Compendium of Population Health Indicators – NHS Information Centre

Over the period 2002-2010, the directly standardised mortality rate per 100,000 children age 1-17 years for Enfield was lower than that for London as a whole and the England average, but not significantly so<sup>77</sup>. In Enfield, the mortality experience for children aged under 15 years old is the 11th highest in London (Figure 3.31).

**Figure 3.31: Childhood mortality (2008-2010)**



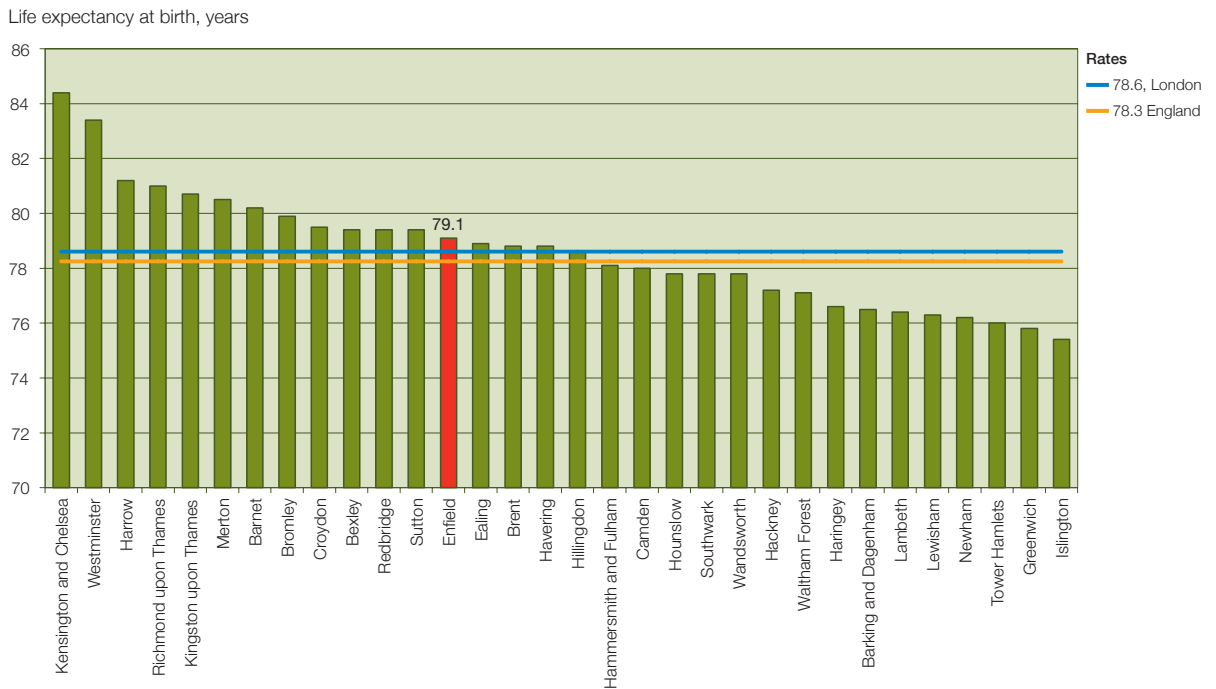
Source: Compendium of Population Health Indicators – NHS Information Centre



### Overall health and wellbeing experience

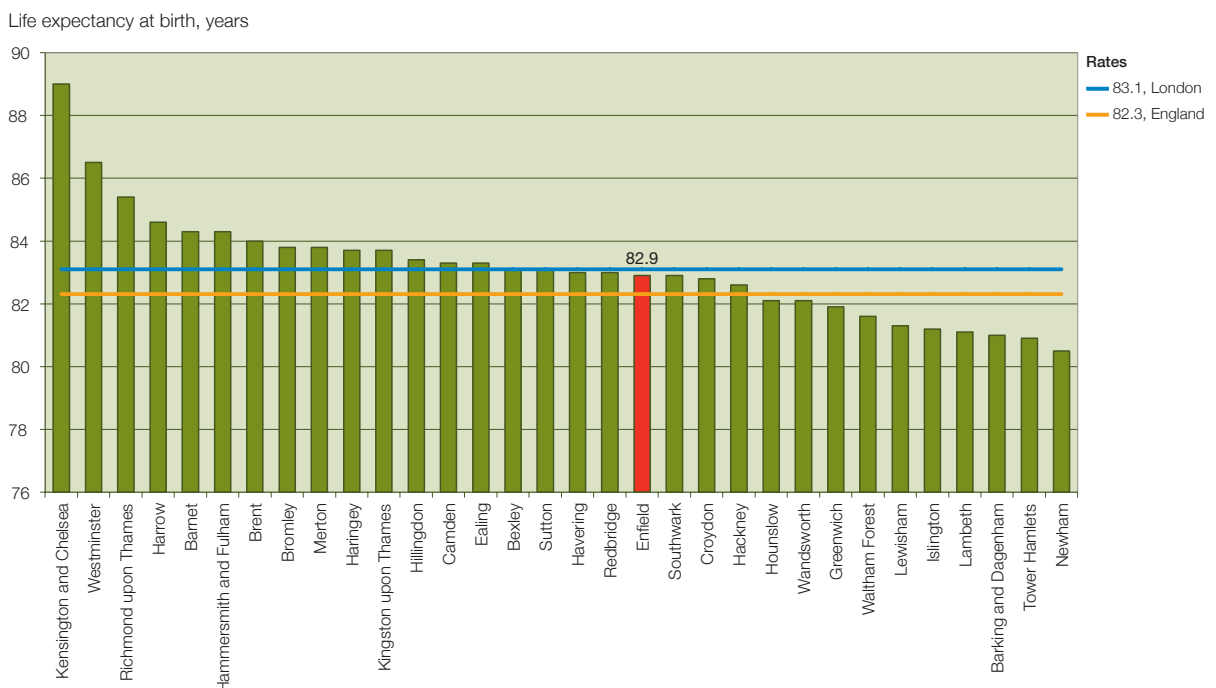
Overall life expectancy at birth gives an overall indication of the health status of a population. Male life expectancy at birth, at 79.1 years, is the 13th best across all London boroughs and higher than London and England averages (Figure 3.32). Life expectancy for females is typically greater than that for males. This is true in Enfield where life expectancy at birth for females is 82.9 years; higher than the England average of just over 82 years, but less than the London average of just over 83 years (Figure 3.33).

**Figure 3.32: Male life expectancy (2007-2009)**



Source: Compendium of Population Health Indicators – NHS Information Centre

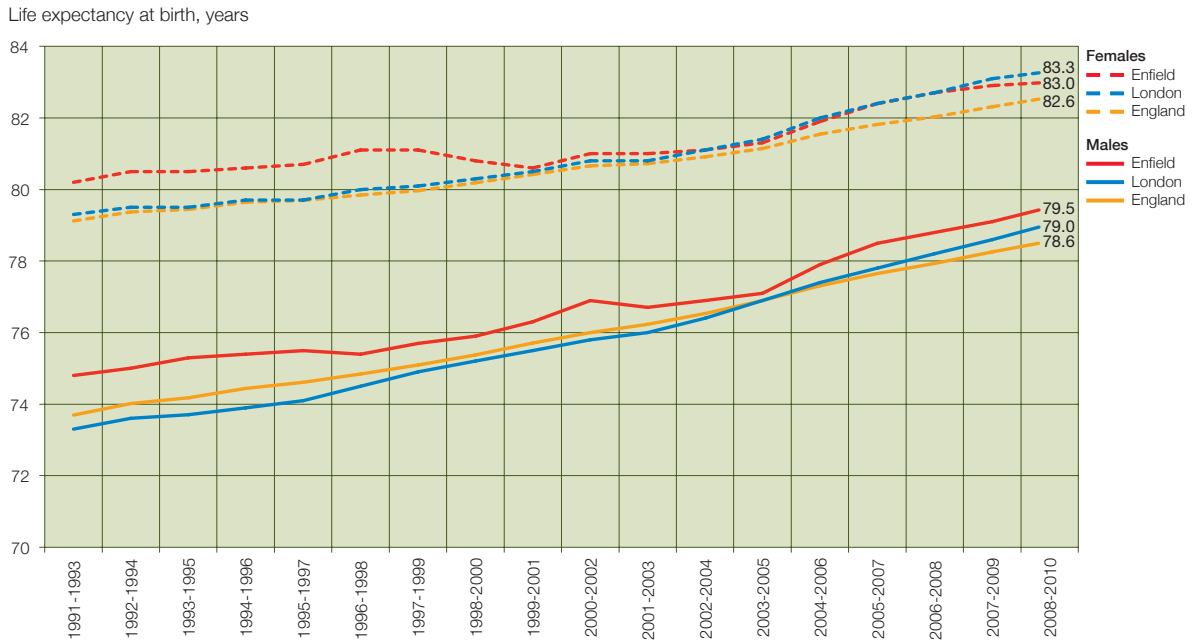
**Figure 3.33: Female life expectancy (2007-2009)**



Source: Compendium of Population Health Indicators – NHS Information Centre

Life expectancy has continued to rise over the last two decades, for England as a whole, London and Enfield (Figure 3.34).

**Figure 3.34: Trends in life expectancy**

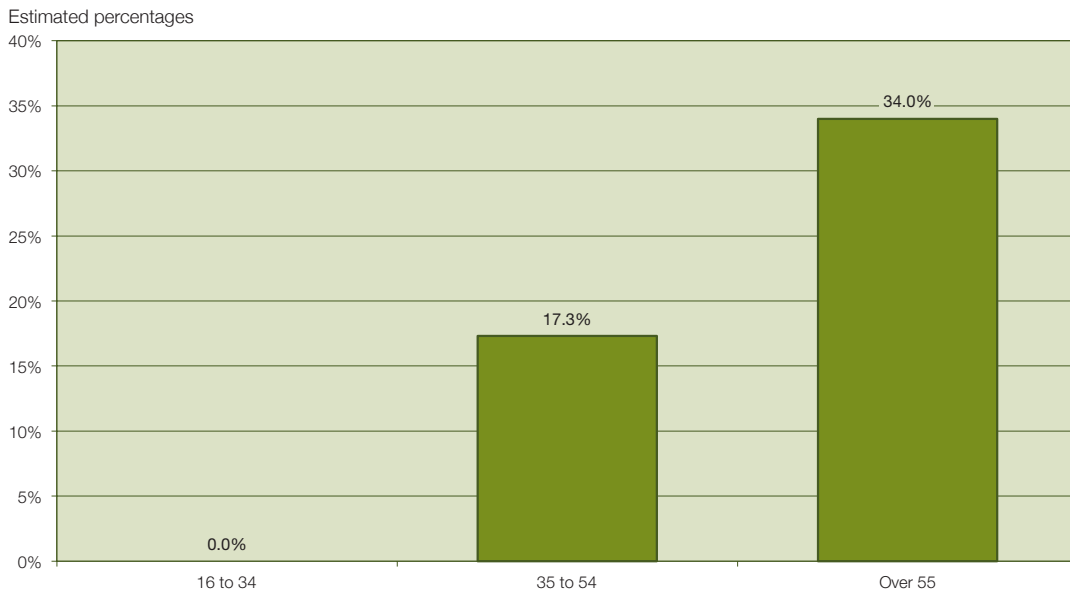


Source: Office for National Statistics

Although increasing life-expectancy is an achievement to be celebrated it also brings concerns of its own; namely how to ensure that increases in life-expectancy are at least matched by increases in healthy life expectancy. Overall, around 1 in 5 people report a disability or limiting long-term illness. It is estimated that one in three (34%) of adults in Enfield aged 55 and over has a limiting long-term illness (Figure 3.35). Limiting long-term conditions include physical and learning difficulties, as well as specific conditions such as dementia. There are estimated to be over 2,700 people in Enfield with dementia and this number is set to increase by more than 40% in the next 20 years<sup>78</sup>.

In terms of ethnicity, evidence indicates that Pakistani and Bangladeshi groups are more likely to report ‘poor’ health than average. These groups are more likely to experience poor mental health, more likely to report a disability or limiting long-term illness, and more likely to find it hard to access and communicate with their GPs than other groups. Among groups defined by religion, Muslim people tend to report worse health than average. It is unclear how far these worse-than-average outcomes are related to Pakistani, Bangladeshi and Muslim people’s relatively poor socio-economic position<sup>79</sup>.

**Figure 3.35: Limiting long-term illness (2006)**



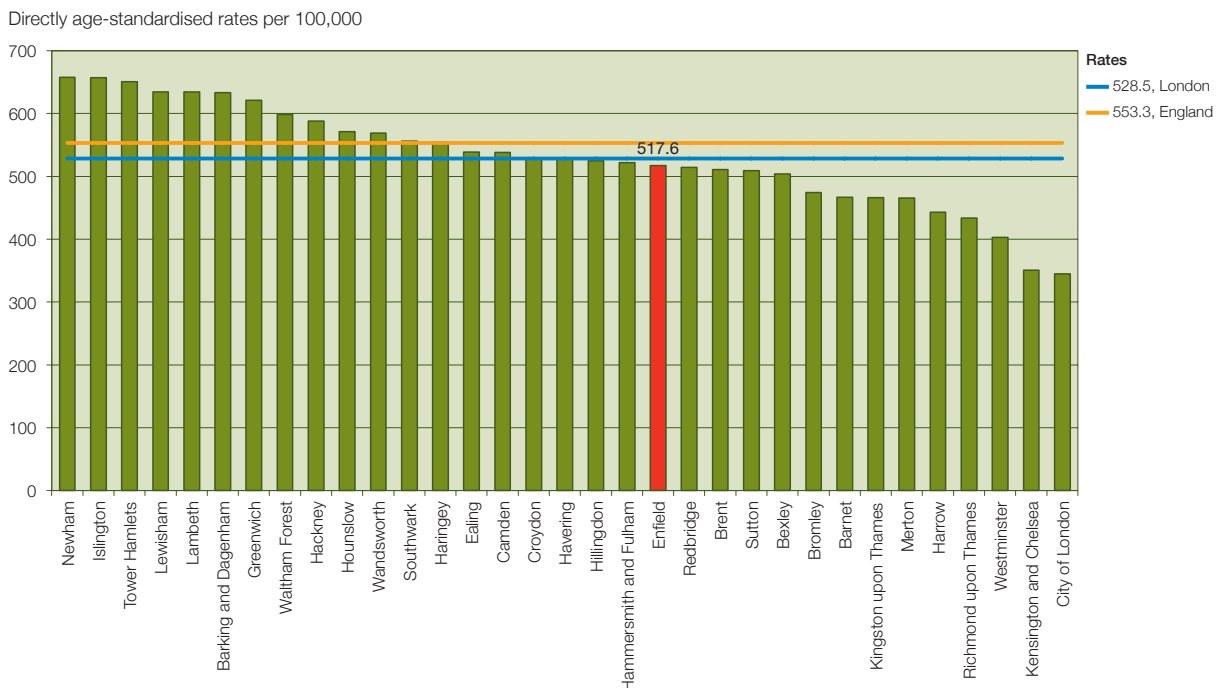
Source: London Health Observatory

### Mortality in Enfield

In this section we summarise key mortality related indicators for the population of Enfield. Mortality rates for a given population will depend to some extent on the ages of the people in that area. Age standardisation facilitates comparisons across geographical areas by controlling for differences in the age structure of local populations. Where possible we present figures using direct standardisation. Direct standardisation involves the calculation of the mortality rates that would have been observed had the age profile of the population of the borough been the same as that of a standard population (the European standard population).

The overall, directly age standardised mortality rate for Enfield during 2008-2010 (517.5 per 100,000 population) was lower (better) than the average for London as a whole (528.5) and the England average (553.3) and considerably lower than the comparator outer London areas of Croydon, Greenwich and Waltham Forest (Figure 3.36).

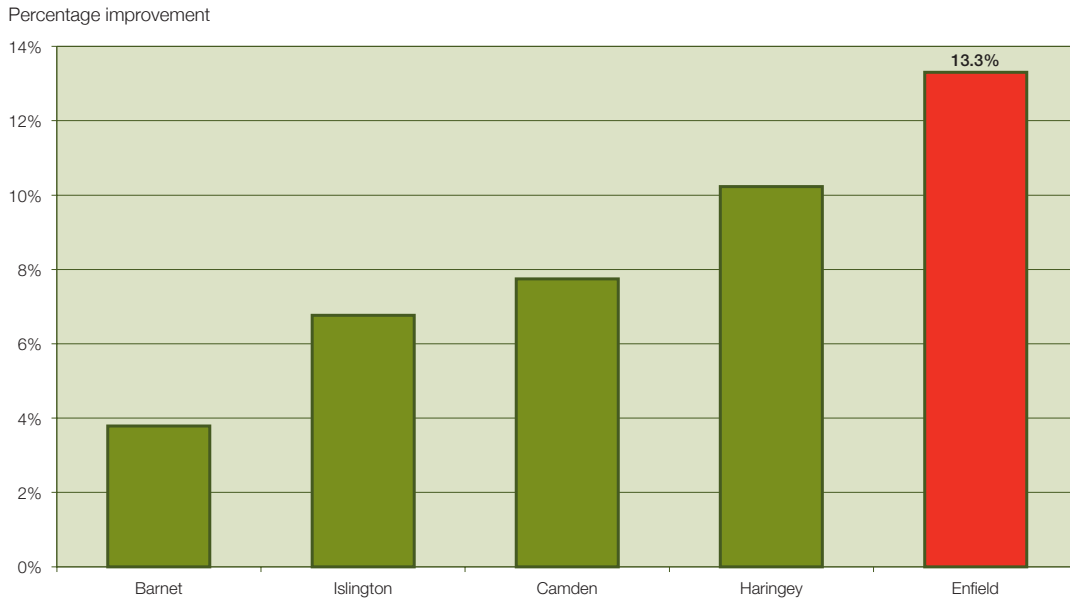
**Figure 3.36: All Age All Cause Mortality by borough (2008-2010)**



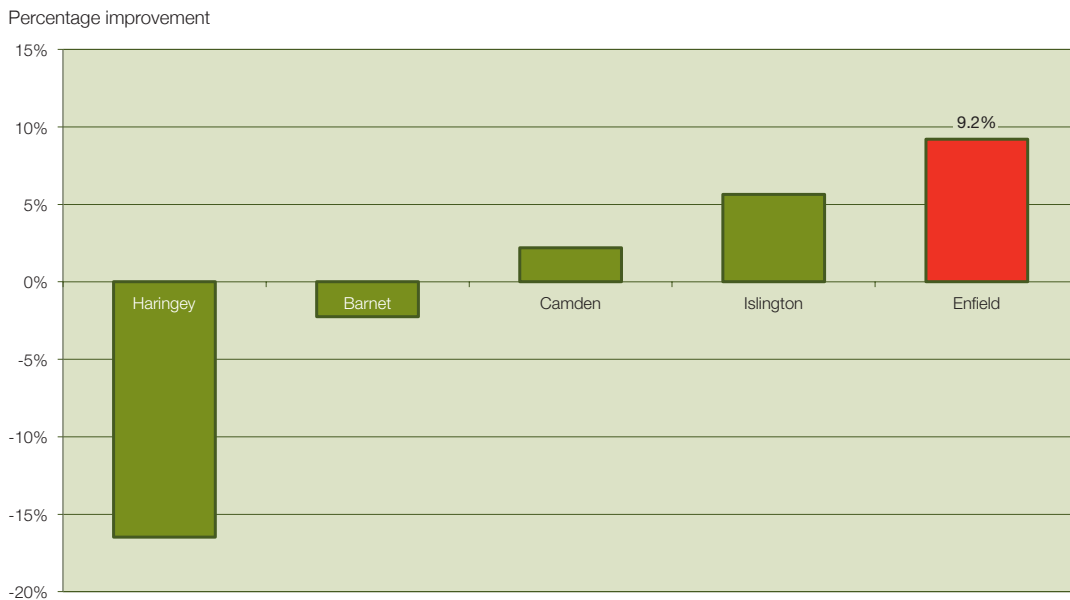
Source: Compendium of Population Health Indicators – NHS Information Centre

It is pleasing to see that the All Age All Cause Mortality Rate improvement in Enfield has been the best in the NHS North Central Cluster London for the period 2008-2010 (males: Figure 3.37, females: Figure 3.38). There is a very good evidence base about how to improve this indicator. In the short-term it is primarily about a focus on circulatory diseases and cancer. The most important short-term interventions are those to help people control high blood pressure and high cholesterol levels and to reduce smoking levels in the population. Since 2009 Enfield has had a strong focus on these elements and the results are welcome.

**Figure 3.37: Improvement in All Age All Cause Mortality for males (2008-2010)**



**Figure 3.38: Improvement in All Age All Cause Mortality for females (2008-2010)**

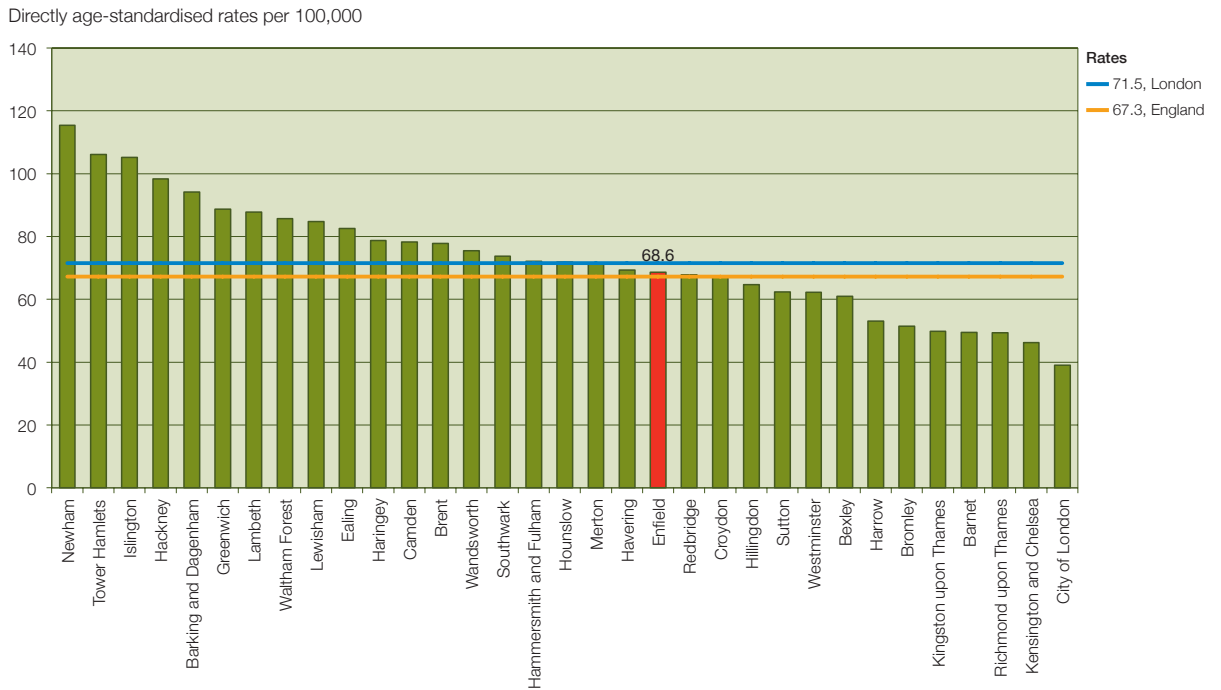


The largest numbers of deaths in 2010 were due to circulatory (cardiovascular) diseases, cancers and respiratory diseases. Circulatory diseases, which include deaths from ischaemic heart disease and strokes, accounted for 32% of all deaths, while cancers and respiratory diseases (including deaths from pneumonia) accounted for 29% and 14% of all deaths respectively. Over the course of the 20th century, there have been fairly steady decreases in mortality rates for these three broad disease groups in England and Wales. The reasons for this include improvements in the treatment of these illnesses. Government backed initiatives to improve people’s health through better diet and lifestyle, for example, the Department of Health’s White Paper entitled ‘Choosing Health: making healthy choices easier’ published in 2004 could also have contributed to improvements in mortality rates<sup>80</sup>.

Cardiovascular disease – also known as heart and circulatory disease – is the biggest killer in the UK. In 2009, around one third of all deaths in the UK were due to CVD. Of these, over 82,000 deaths were caused by coronary heart disease, and about 49,000 were caused by stroke<sup>81</sup>.

Mortality from all circulatory disease in those aged under 75 years was slightly (but not significantly) higher in Enfield than the England average (Directly age-standardised rate per 100,000 of 68.6 for Enfield compared with 67.3 for England) and considerably less than the average for all London boroughs (71.5) (Figure 3.39).

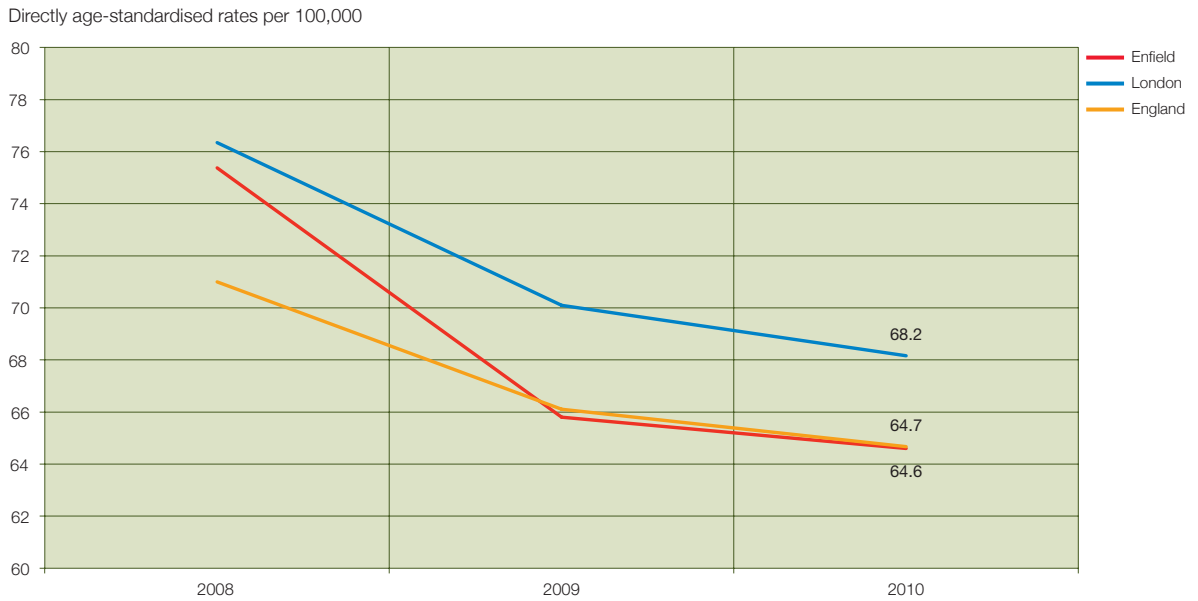
**Figure 3.39: Mortality from circulatory disease (2008-2010)**



Source: Compendium of Population Health Indicators – NHS Information Centre

The mortality rate in Enfield from circulatory diseases has fallen 2008-2010 (Figure 3.40). Key to this were improvements in the control of high cholesterol levels and high blood pressure in primary care and the work to reduce smoking levels (led by the newly established tobacco control alliance).

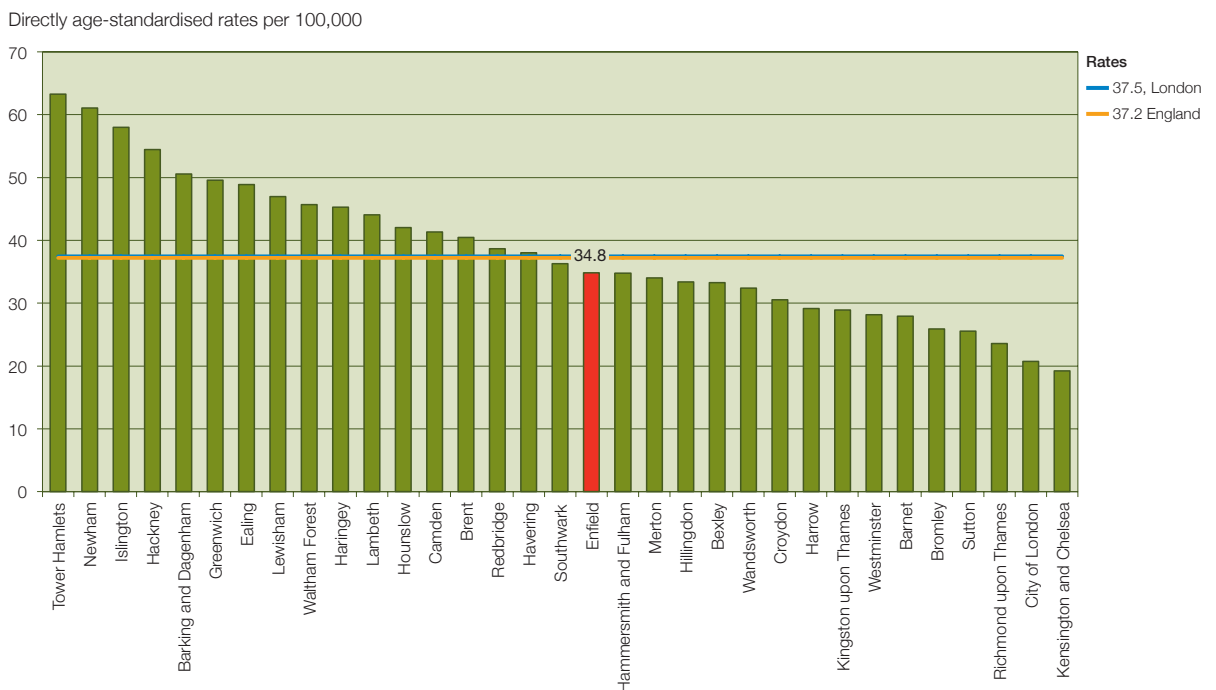
**Figure 3.40: Reduction in mortality from circulatory diseases**



Source: Compendium of Population Health Indicators – NHS Information Centre

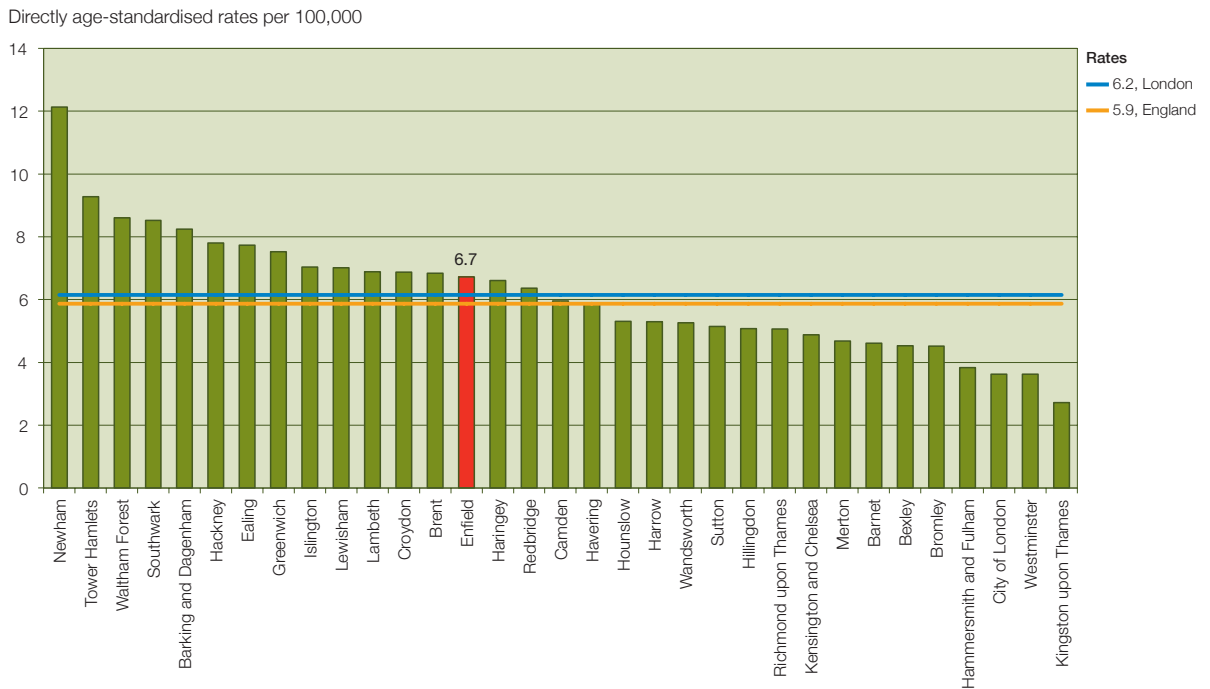
Whilst the overall mortality rate for cardiovascular diseases in Enfield compares favourably with London rates, this masks differences at disease level. The mortality rate for CHD (Figure 3.41) shows Enfield to be below England and London averages. However, whilst strokes account for less deaths the mortality rate from stroke for under 65s in Enfield (Directly age-standardised rate of 6.7 per 100,000) is considerably higher than the rates for London as a whole (5.9 per 100,000) and the England average (6.2 per 100,000) (Figure 3.42).

**Figure 3.41: Mortality rate from coronary heart disease (2008-2010)**



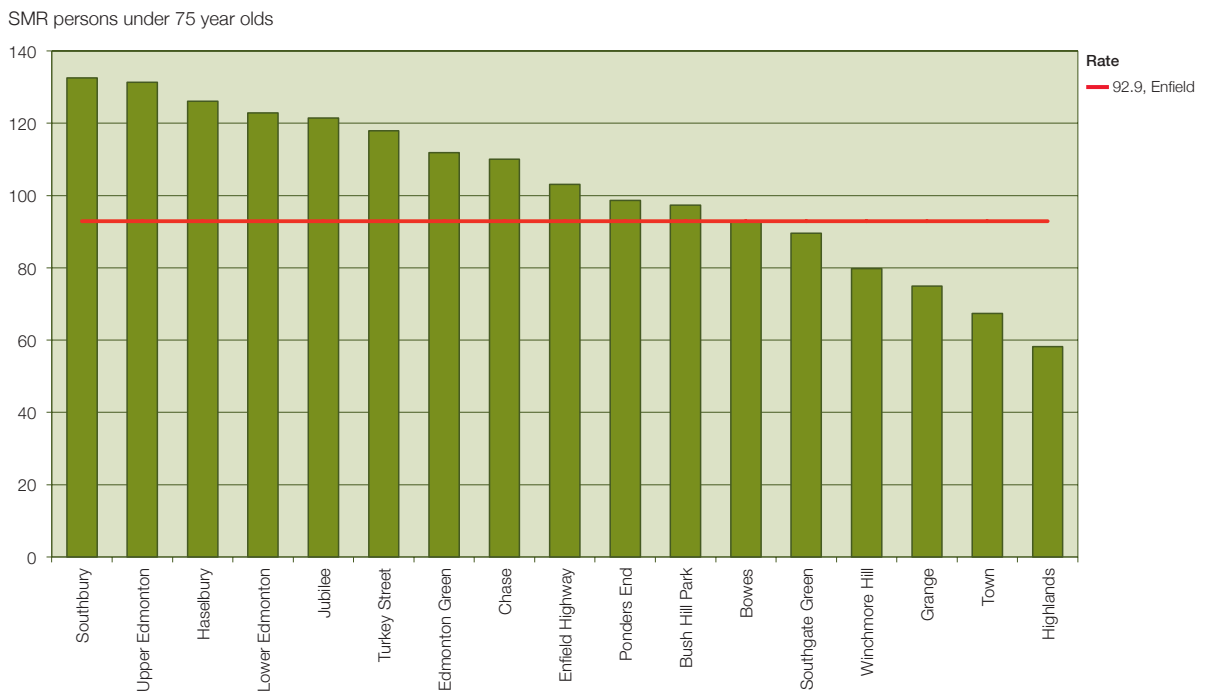
Source: Compendium of Population Health Indicators – NHS Information Centre

**Figure 3.42: Mortality rate from stroke (2008-2010)**



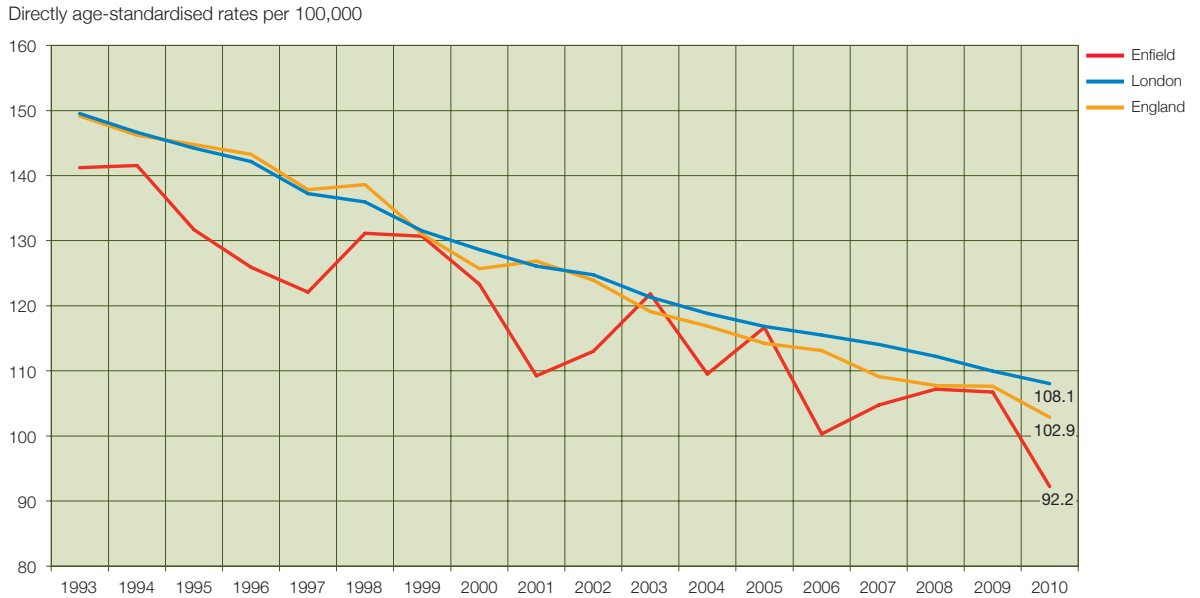
Enfield has a high level of health inequalities. Within Enfield, CHD standardised mortality ratios (SMRs) vary considerably at ward level with higher SMRs in the more deprived wards in the east of the borough (Figure 3.43). It should be noted that Cockfosters, Enfield Lock, Palmers Green and Southgate wards have values under 20 and therefore SMRs have not been calculated. The mortality rate in 2008-2010 for persons who live in the most deprived areas of Enfield was 234.3 per 100,000. This is 1.4 times greater than the overall mortality rate for Enfield and 1.7 times greater than the mortality rate for persons who live in the least deprived areas of Enfield<sup>182</sup>.

**Figure 3.43: Mortality ratios from coronary heart disease by Enfield ward (2004-2008)**



Trends in cancer mortality rates show an overall decrease in Enfield over the last two decades (Figure 3.44) in line with national and London as a whole. Early (under 75 years) deaths from all cancers is better (lower) in Enfield than London as a whole and the England average (though not significantly so) (APHO profile). This positive story hides issues however at ward level and for outcomes with specific cancers.

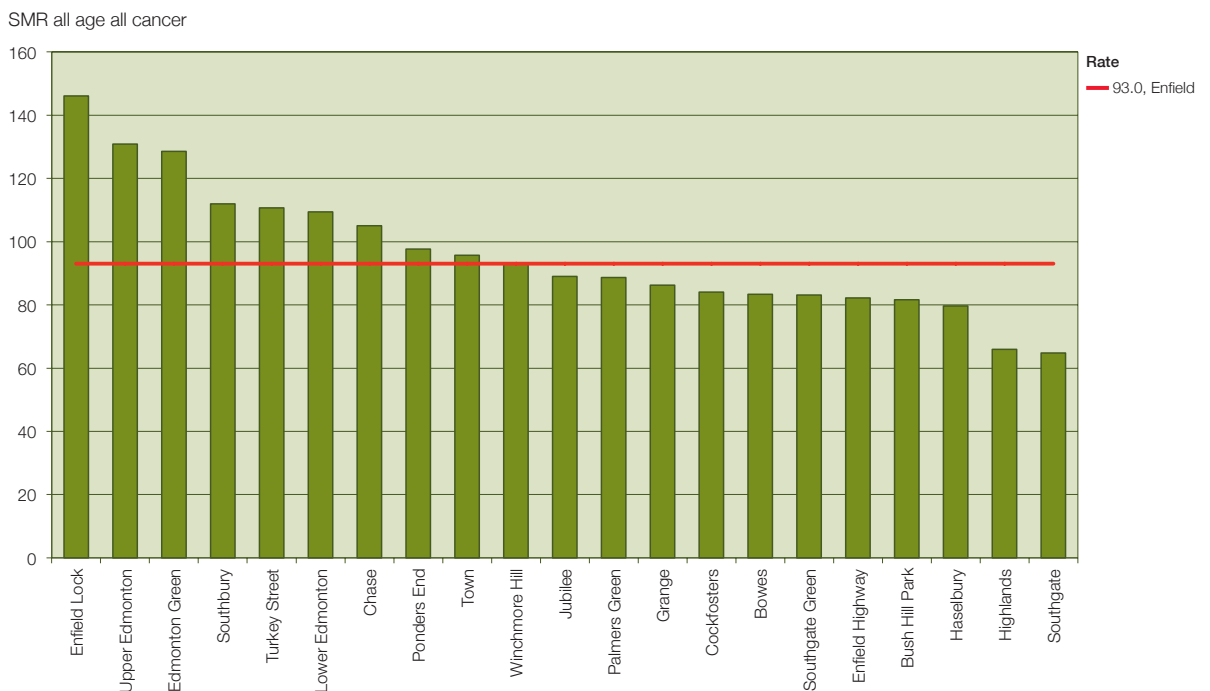
**Figure 3.44: Cancer mortality**



Source: Compendium of Population Health Indicators – NHS Information Centre

At ward level, the SMR for all cancers shows considerable variation and suggests much higher rates in the more deprived wards in the east of the borough (Figure 3.45). This link between deprivation and poor health outcomes is not particular to Enfield and suggests the need for targeting of treatment and preventative initiatives.

**Figure 3.45: Cancer mortality by ward (2004-2008)**



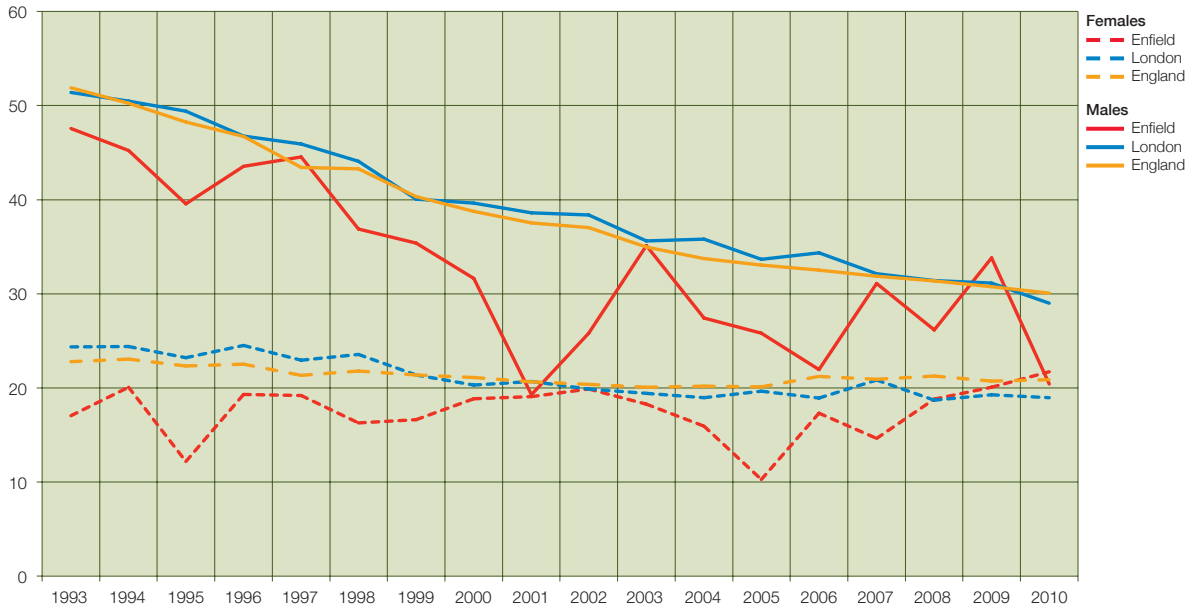
Source: London Health Observatory



In keeping with national and London averages, the overall trend in mortality from lung cancer in Enfield is downward. The trend is more clearly seen in males (Figure 3.46). National and London average female lung cancer mortality shows a slight decline over the period 1993 to 2010; for Enfield women there is no clear decrease over the period.

**Figure 3.46: Trends in lung cancer deaths**

Directly age-standardised rates per 100,000

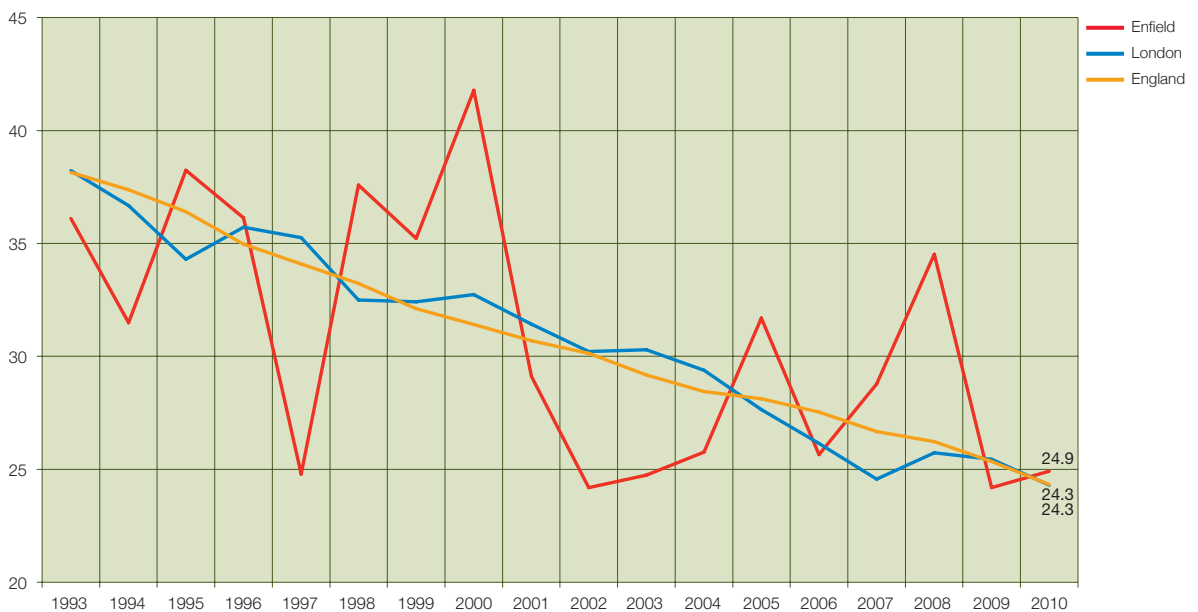


Source: Compendium of Population Health Indicators – NHS Information Centre

The latest data (2010) for Breast cancer deaths for females in Enfield shows a directly standardised rate of 24.9 per 100,000 females, this being slightly higher than the rate for London as a whole and the England average (both 24.3 per 100,000) (Figure 3.47). The rate for Enfield shows considerable fluctuation over the period 1993-2010.

**Figure 3.47: Trends in breast cancer mortality**

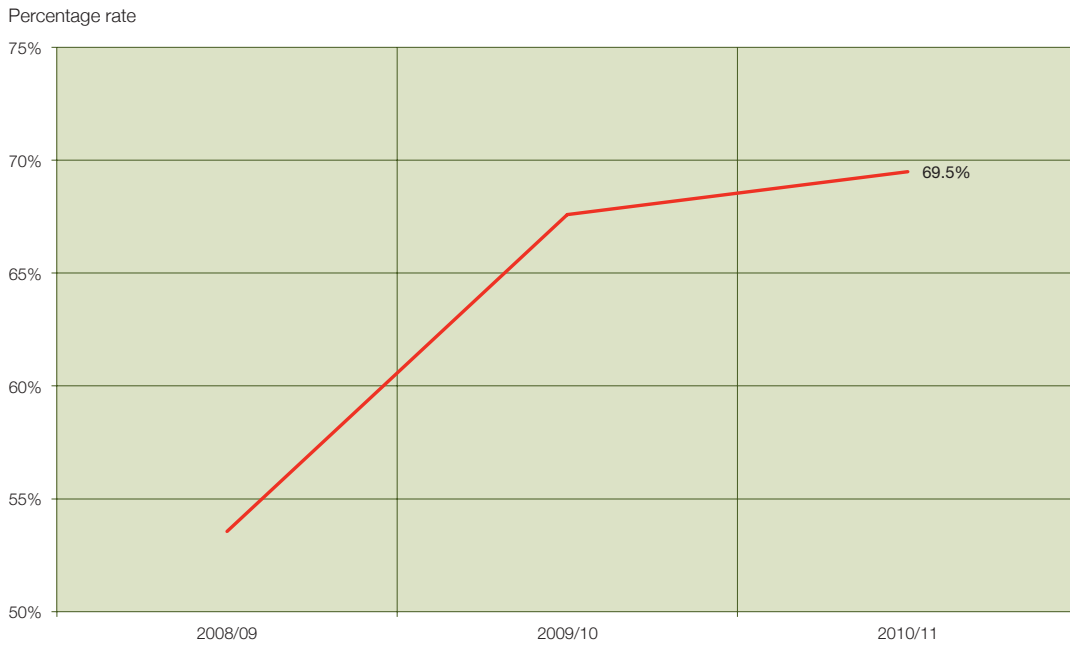
Directly age-standardised rates per 100,000



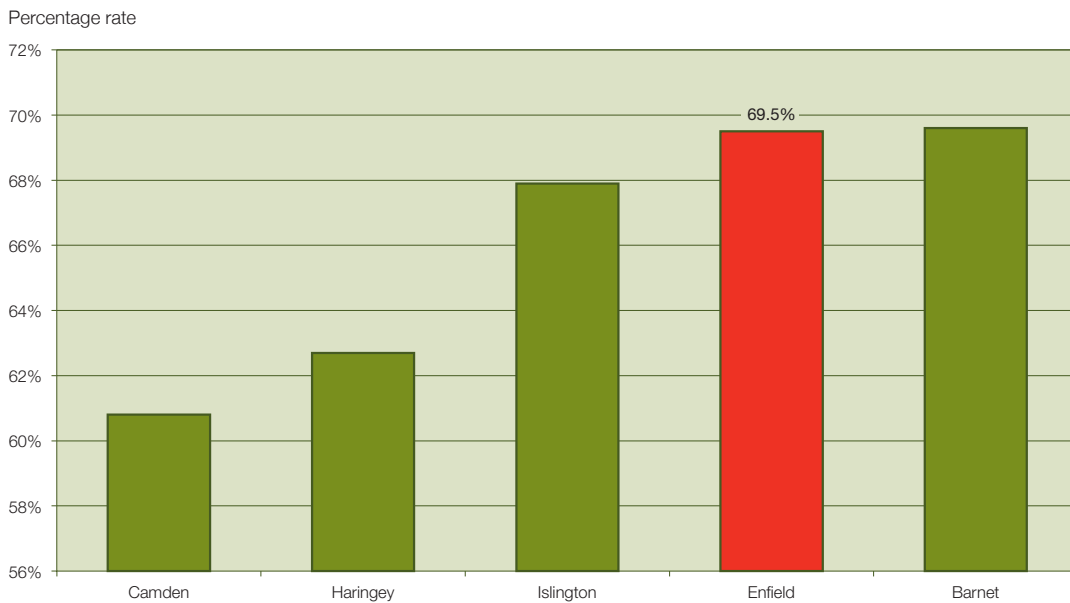
Source: Compendium of Population Health Indicators – NHS Information Centre

As with many other cancers, early diagnosis and subsequent early treatment impacts survival rates. Breast screening is promoted vigorously within Enfield which has resulted in improvements in rates since 2008 (Figure 3.48 and Figure 3.49).

**Figure 3.48: Trend in breast screening coverage**

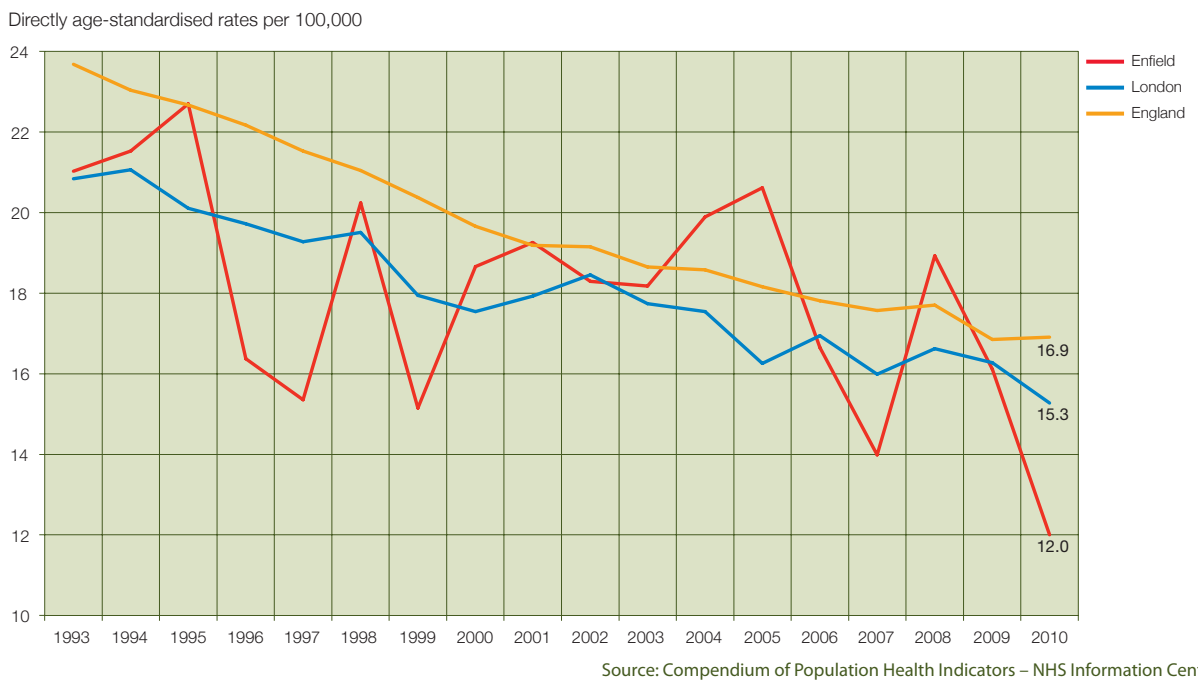


**Figure 3.49: Breast screening coverage comparisons (Quarter 3, 2010/11)**



In line with national and London averages, the overall trend in mortality from colorectal cancer in Enfield is downward (Figure 3.50). Bowel cancer is one of the most curable cancers and early diagnosis has a significant impact on survival. Almost half of bowel cancer cases are diagnosed at a later stage (stages 3 and 4). In Enfield in the years 2006 to 2008 there were around 124 new cases of bowel cancer diagnosed and around 26 people under the age of 75 died each year from bowel cancer; Enfield's survival rates are lower than in neighbouring boroughs. The NHS Bowel Cancer Screening programme aims to identify people at an early stage thereby improving survival from bowel cancer. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%. Enfield achieves the highest screening rates in the cluster; Quarter 2 figures for 2011/12 were 42% for Enfield compared with Barnet 39%, Camden 34%, Haringey 38% and Islington 35%.

**Figure 3.50: Trends in colorectal cancer deaths**

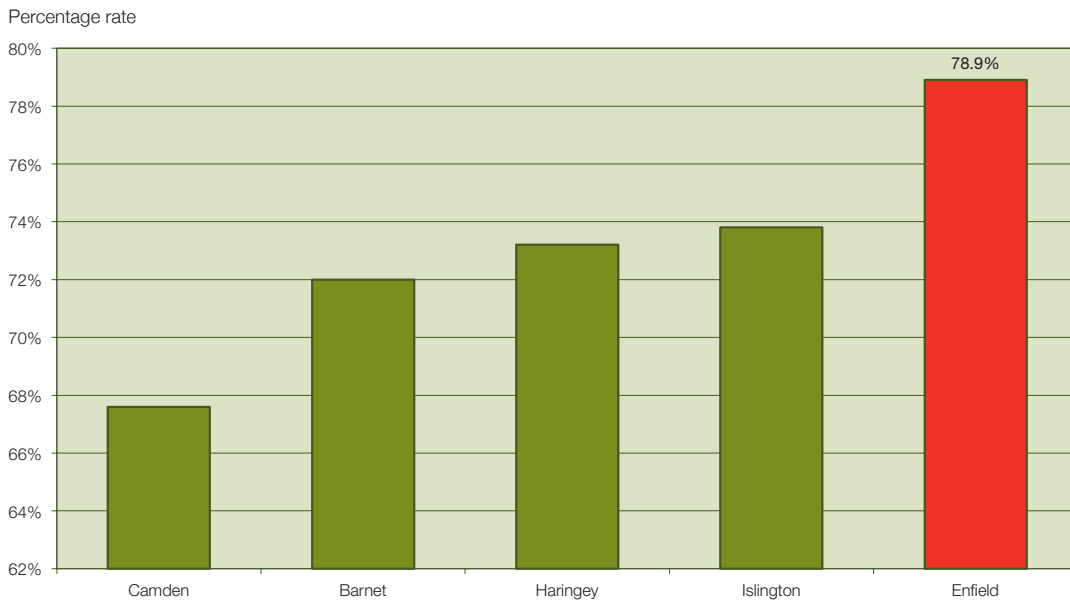


Enfield has had success in driving up cervical screening rates (Figure 3.51 and Figure 3.52).

**Figure 3.51: Increasing cervical screening**

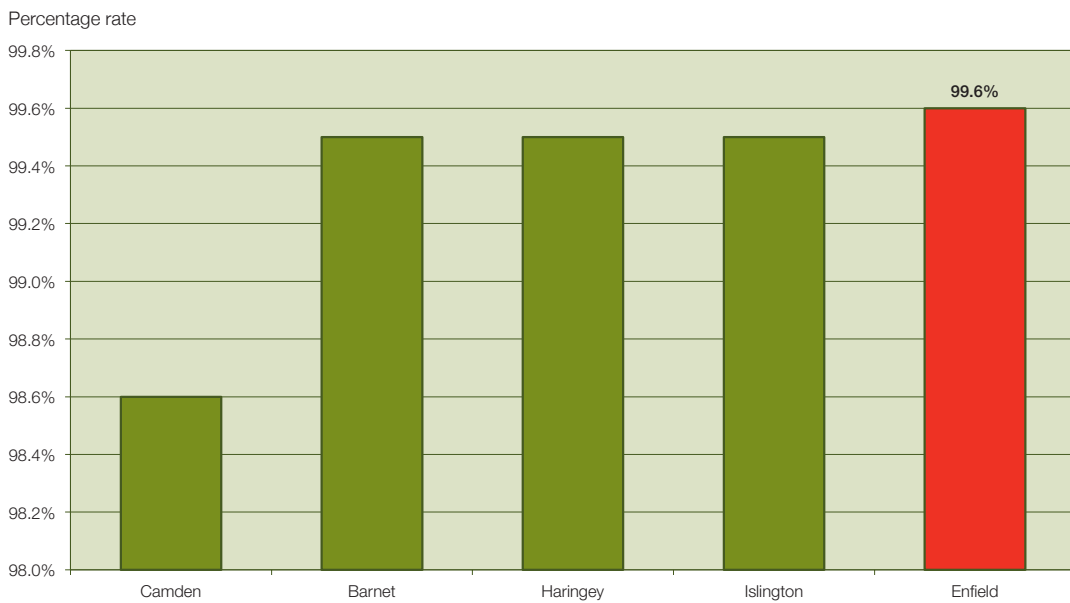


**Figure 3.52: Cervical screening comparisons (2010/11)**



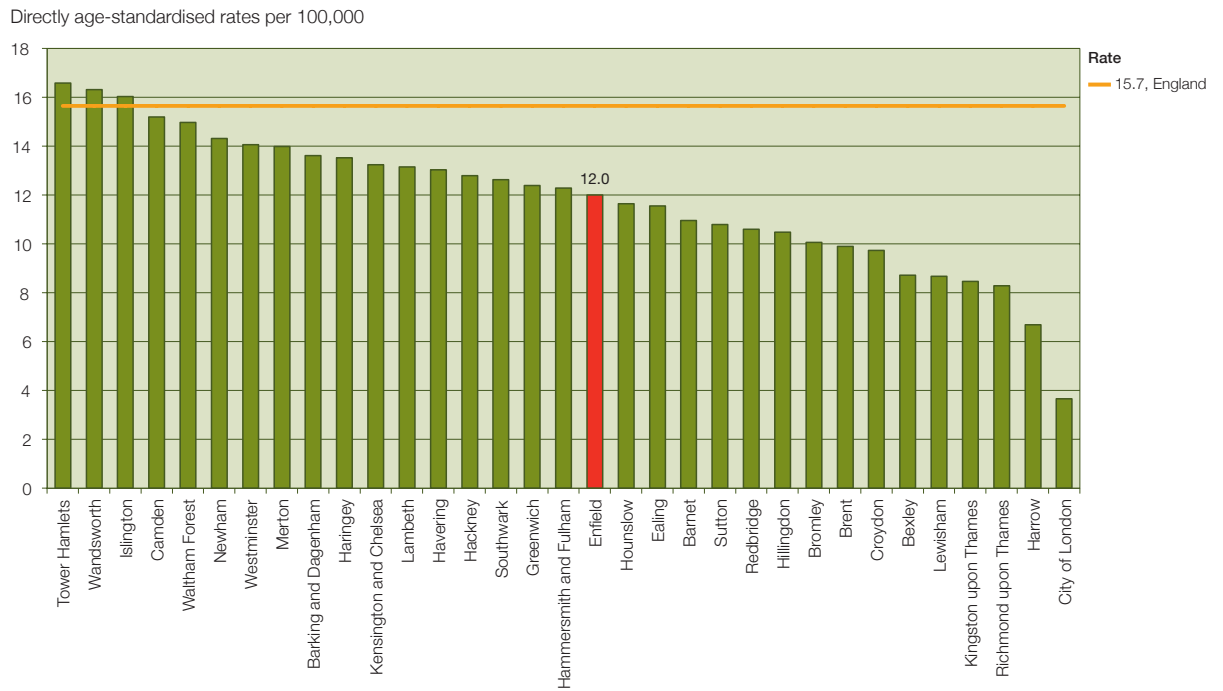
Through close working with primary care and laboratory colleagues Enfield has ensured that the turnaround time for reporting results is the best within the North Central London sector (Figure 3.53).

**Figure 3.53: Cervical screening lab results turnaround time (October 2011)**



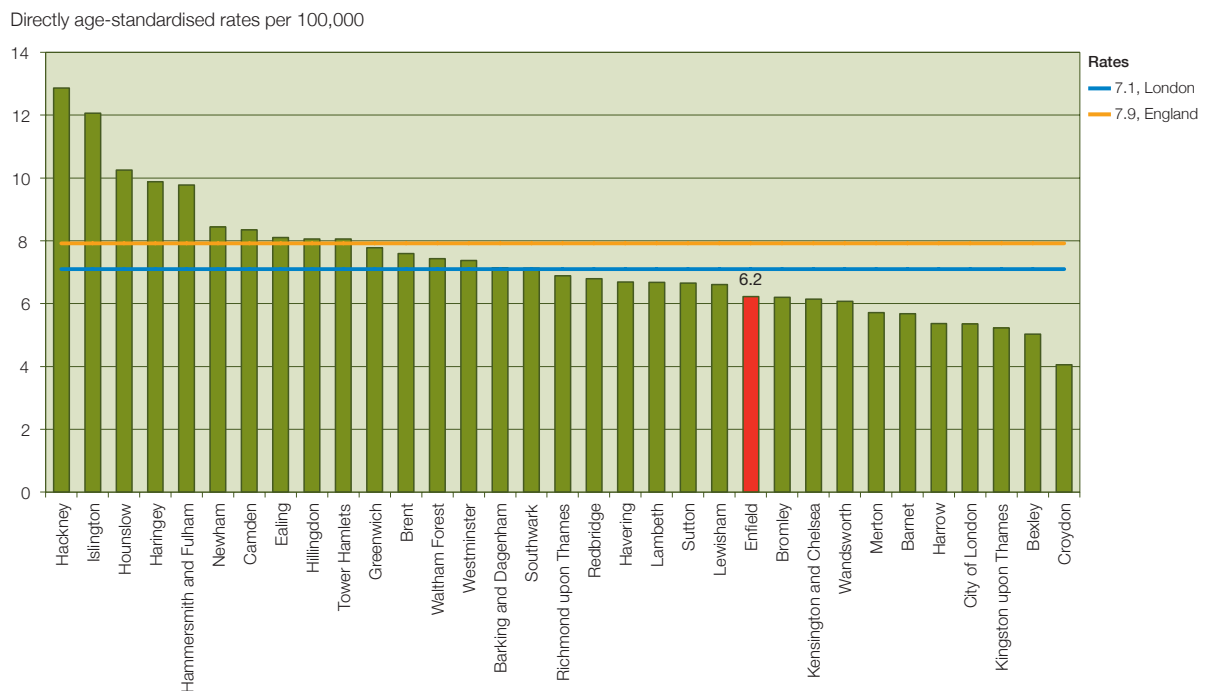
The rate of road injuries and deaths per 100,000 population (2007-2009) for Enfield is significantly better than the England average and higher than the figure for London as a whole<sup>83</sup>. The overall death rate from all accidents for Enfield is lower than comparator outer London suburbs of Waltham Forest and Greenwich, but higher than that of Croydon (Figure 3.54). A similar pattern emerges for mortality from suicide and injury (Figure 3.55).

**Figure 3.54: Deaths from accidents (2007-2009)**



Source: Compendium of Population Health Indicators – NHS Information Centre

**Figure 3.55: Deaths from suicide and undetermined injuries (2008-2010)**



Source: Compendium of Population Health Indicators – NHS Information Centre

## Protecting the health of the population of Enfield

Health protection is a key component of the work of a public health department. Enfield public health department works closely with colleagues at the health protection agency to protect and improve the health of Enfield residents.

The Health Protection Agency (HPA) works closely with local health service providers to protect the local population from threats to their health from infectious diseases and environmental hazards. In order to carry out these functions, staff from the HPA's local Health Protection Unit (the North East and North Central HPU) attend all relevant meetings with local health units and inform the Public Health department of any serious notifiable diseases and outbreaks within the local community and acute trusts. The HPU provides advice and assistance where necessary. The most important function is the containment of notifiable infectious diseases.

In Enfield, following TB the most commonly notified disease in 2011 was mumps, followed by measles, though it should be noted that only 19 mumps and 13 measles cases were laboratory confirmed.

Infection	2009	2010	2011
Acute Hepatitis A	*	5	*
Acute Hepatitis B	5	*	5
E.coli infection, VTEC O157	7	*	*
Legionellosis	*	*	*
Listeriosis	*	*	*
Measles	39	19	38
Meningococcal infection	7	7	8
Mumps	69	57	52
Paratyphoid	5	*	*
Pertussis (Whooping Cough)	6	*	15
Rubella	8	5	9
Shigellosis	5	*	5
Typhoid fever	*	7	*
<b>Total</b>	<b>173</b>	<b>131</b>	<b>154</b>

\* Figures suppressed due to small numbers

As all boroughs have different sized populations it is interesting to compare the rate of disease per 100,000 population. The following table shows that Enfield has lower rates of measles and mumps than most of its neighbours, but a higher rate of Pertussis (this disease is discussed in more detail below).

Infection	Barnet	Camden	Enfield	Haringey	Islington
Acute Hepatitis A	1.44	1.27	1.02	2.22	0.52
Acute hepatitis B	0.57	1.70	1.70	1.33	1.03
E.coli infection, VTEC O157	0.00	0.42	0.00	0.89	1.03
Legionellosis	0.29	1.27	1.36	0.89	0.52
Listeriosis	0.29	0.00	0.00	0.00	0.52
Measles	20.68	23.79	12.89	22.67	23.70
Meningococcal infection	2.30	3.40	2.71	2.22	2.06
Mumps	16.94	25.91	17.63	23.11	23.70
Paratyphoid fever	2.30	0.42	0.34	2.22	0.00
Pertussis (Whooping Cough)	2.01	2.97	5.09	4.44	4.12
Rubella	2.30	0.85	3.05	1.78	0.00
Shigellosis (Bacillary Dysentery)	1.72	5.95	1.70	1.78	6.18
Typhoid fever	0.29	1.27	0.68	1.78	0.00

The majority of notifiable diseases occurred within the age group 20-29 years (39 cases), followed by 1-4 year olds (31 cases) and then under 1s (17). There were slightly more notifications in females (83) than males (71). In the 20-29 year old group, the most commonly notified disease was mumps (24 cases), followed by measles (5). In the 0-4 year olds the highest number of notifications was for measles (21) followed by pertussis (11).

Four common notifiable infectious diseases have been highlighted below to illustrate the importance of recognition and prevention of these diseases.

**Measles** is one of the statutorily notifiable infectious diseases. It most commonly affects 1 to 4 year olds, though measles can be caught at any age. It is an acute viral infection, highly contagious, spreading by direct contact with an infected person or through the air when he or she coughs or sneezes. It is a vaccine preventable disease, through the MMR vaccine (Measles, Mumps and Rubella). The first dose is given at 12 to 15 months and the second at 3½ to 5 years.

The illness is characterised by a rash, starting with irritability, a runny nose, conjunctivitis (red eyes), a hacking cough and an increasing fever that comes and goes. The fever peaks at around 40.6°C (105°F). These symptoms may last up to 8 days. The rash starts from day 4 and lasts 4-7 days. It usually starts on the forehead and spreads downwards over the face, neck and body. Complications from the disease are more severe and more likely in infants under 12 months, in children who are poorly nourished, those with weakened immune systems and children with vitamin A deficiency.

One million children die from measles world-wide each year. Even in the UK, complications are quite common. They include a severe cough and breathing difficulties (croup), ear infections, viral and bacterial lung infections (pneumonia), and eye infections (conjunctivitis). The most serious problems involve the nervous system. Inflammation of the brain (acute encephalitis) can occur 2-6 days after the rash has appeared. Less than 1 in 1,000 measles cases is affected in this way, but 25% of those are left with brain damage. Measles infection during pregnancy can result in the loss or early birth of the baby.

There were 38 cases of measles reported in Enfield in 2011, compared to 19 in 2010. This is lower in comparison to neighbouring boroughs but is still an increase on the previous year. The most effective way to prevent the spread of measles is vaccination.

According to World Health Organisation, (WHO), an immunisation rate of 95% or more would provide “herd immunity” i.e. where unvaccinated people are protected by having a high proportion of the population vaccinated, thereby preventing onward transmission.

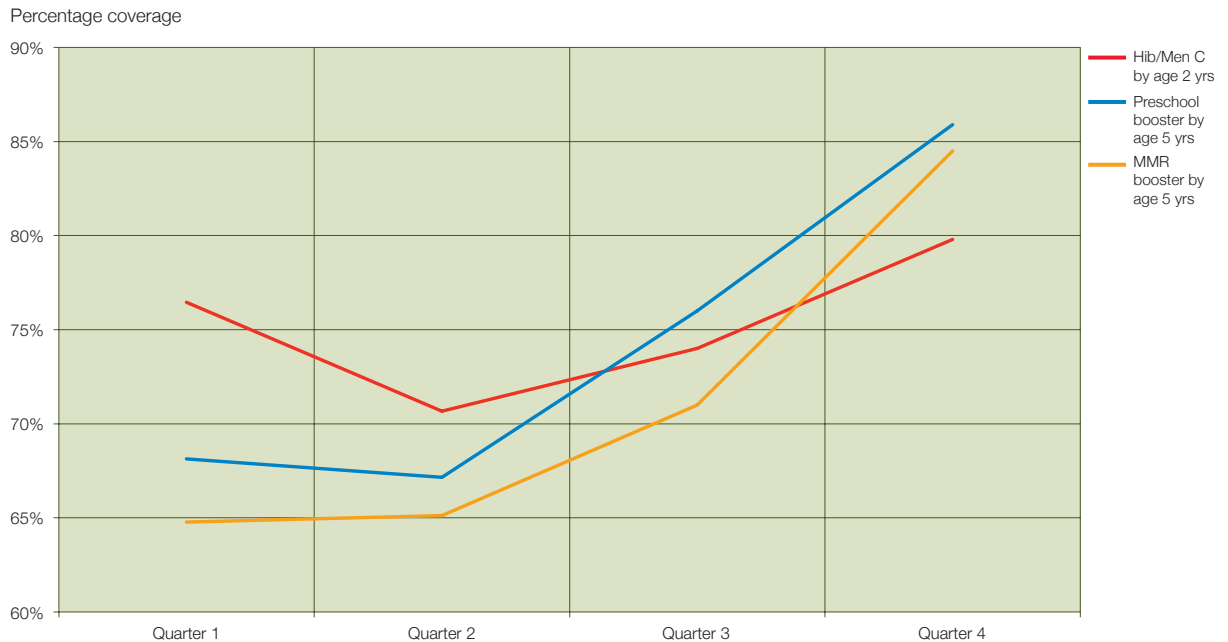
**Pertussis**, also known as whooping cough, is a bacterial respiratory infection which starts with an irritating cough, cold and a fever. Over the next week the cough gradually changes to one which comes in prolonged bouts persisting over several weeks, maybe longer. The coughing episodes may be followed by a “whoop” as the person becomes able to breathe again and may also be followed by bouts of vomiting. Adults have a milder illness that lasts two to three weeks. Infants under 6 months are most at risk of complications.

In Enfield there were 15 cases of pertussis reported in 2011 compared to less than 5 in 2010. This reflects an increase in cases in North London and across England and Wales in 2011, which noted a doubling in the number of cases reported in 2011 compared to 2010. Pertussis usually affects babies and young children, however many of the recent cases are in teenagers and adults between 15-40 years of age.

It's important that, to prevent future outbreaks of the infection, all children have the pertussis vaccine as part of their routine vaccination programme starting at 2 months of age.

During the last two quarters of 2011/12 Enfield has seen significant improvements in childhood immunisation rates (Figure 3.56). One of the key reasons behind this is that Enfield has a Children's Trust which has a very strong focus on immunisations which has resulted in immunisation not being just a health service priority but also a partnership priority.

**Figure 3.56: Immunisation improvement (2011/12)**



**Tuberculosis** is another notifiable infectious disease, which commonly is an infection of the lungs, but can also affect any part of the body. It is caused by bacteria called 'Mycobacterium tuberculosis' which can survive in the body for many years in an inactive or dormant state when symptoms are not shown by the person affected. However, when the bacteria become active, they multiply and cause the symptoms referred to as active tuberculosis. The most common symptoms are persistent cough that does not get better with usual antibiotics; loss of weight, fever, heavy night sweats, tiredness and, less commonly, coughing up blood and in some cases swollen glands.

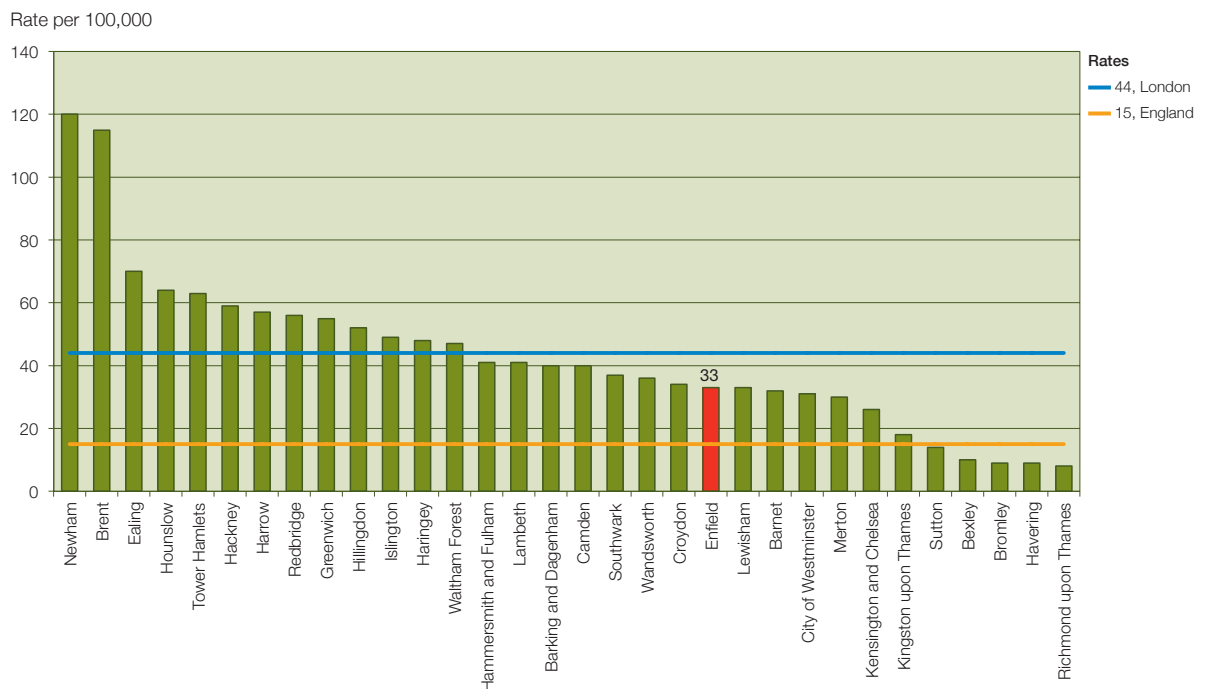
During the last century, with better housing, nutrition and effective treatment, TB became uncommon in the UK. However, over the past 25 years or so, the number has been growing slowly.

TB is not an easy infection to catch. Of those closely exposed to a case of infective TB, only about 30% of healthy individuals get infected and of those only 5%-10% will go on to develop active TB (usually in the first 5 years following infection). It is rare for children with TB to pass the infection to others and children usually get TB from adults with active respiratory TB. Those with TB can become non-infectious soon after beginning treatment (usually 2 weeks) if they take the proper treatment as it is prescribed.



The incidence of tuberculosis in Enfield is in the lower third of boroughs across London (Figure 3.57).

**Figure 3.57: Tuberculosis (TB) incidence (2007-2009)**



Source: Association of Public Health Observatories

The number of cases of TB notified in Enfield has shown a gradual decrease over the past few years, 121 in 2009, 101 in 2010 and 81 in 2011. Of the 5 North Central boroughs, Enfield has the lowest rate per 100,000 population, which is encouraging.

Local Authority	Number of cases			Rates per 100,000 population		
	2009	2010	2011	2009	2010	2011
Barnet	114	118	104	32.74	33.89	29.87
Camden	112	78	77	47.58	33.14	32.71
Enfield	121	101	81	41.03	34.25	27.47
Haringey	140	111	143	62.22	49.33	63.56
Islington	101	71	91	52.04	36.58	46.88
<b>Total</b>	<b>588</b>	<b>479</b>	<b>496</b>			

The most effective way to prevent the spread of TB is by diagnosing people as soon as possible and ensuring they have a full course of correct treatment.

**Gastro-intestinal infections** can be caused by eating food contaminated with food-poisoning bacteria such as salmonella or campylobacter or viruses such as norovirus. Symptoms include diarrhoea, stomach cramps and sometimes vomiting and fever. Most people recover without treatment, but some may need hospital care because of dehydration.

In Enfield last year there were 133 cases of campylobacter reported and 38 cases of salmonella. These are higher levels compared to surrounding boroughs.

All cases of salmonella and campylobacter are investigated by environmental health officers along with the HPA to look for the source of infection so that we can help to prevent other people from becoming unwell and also to look for any patterns or trends which show possible connections between the people who are affected. One such investigation looked into the possible causes of a particular type of salmonella food poisoning in six people living in Enfield. All the patients were contacted and undertook questionnaires to investigate the characteristics of their illness and to look for possible food sources. The investigation concluded that, although all the patients lived in, or close to Enfield, and had become unwell within a few weeks of each other, there were no identifiable links between the cases and no direct food sources could be identified as causing the illness.

Norovirus is a viral infection, commonly known as winter vomiting disease, which causes similar symptoms to food poisoning. It is highly contagious. There were 10 reported community outbreaks of norovirus in Enfield in 2011, in hospitals, schools and care homes.

The key to preventing the spread of harmful food-poisoning bacteria and viruses is by washing your hands frequently with soap and warm water along with keeping all your work surfaces and utensils clean, and keeping away from nursery, school or work until 48 hours after the symptoms have stopped.

### **Additional areas of health protection with local Public Health involvement**

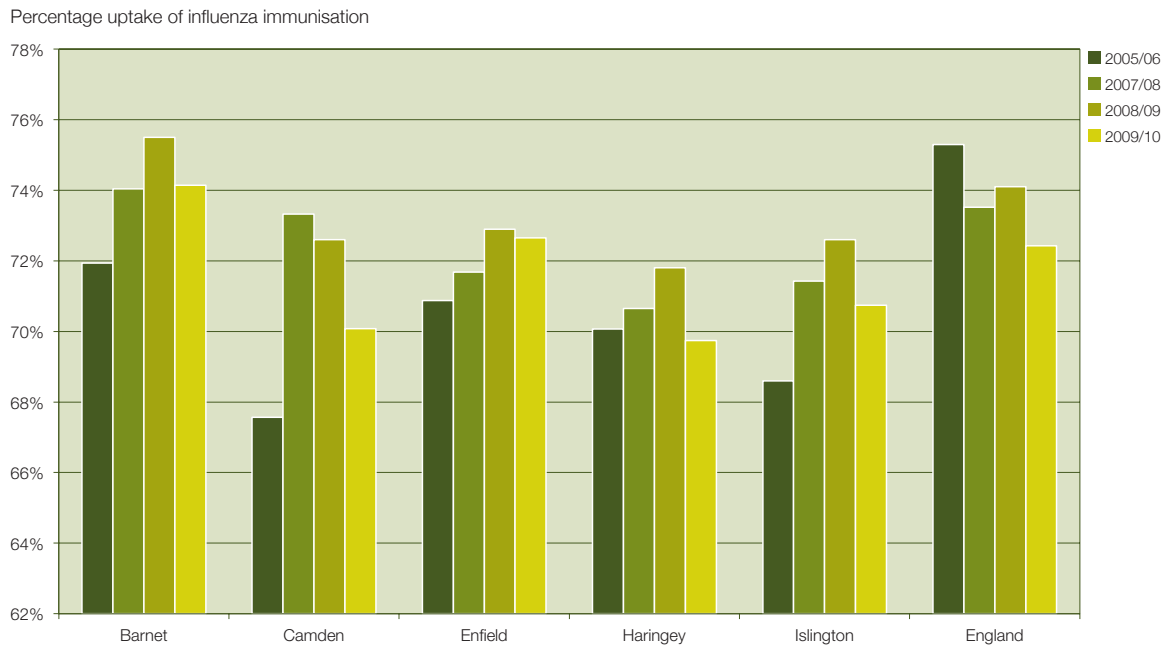
The diseases mentioned above are “notifiable” which means that a clinician has a statutory duty to notify the Health Protection Agency when a case is diagnosed or strongly suspected. Additional infectious diseases exist but do not need to be notified; examples of two of these are highlighted below.

#### **Influenza**

Influenza is a viral infection that usually lasts for about a week, and is characterised by sudden onset of high fever, aching muscles, headache and severe tiredness, non-productive cough, sore throat and runny nose. The virus is easily transmitted from person to person and therefore tends to spread rapidly in seasonal epidemics. Most infected people recover within a couple of weeks without requiring medical treatment. However, in some vulnerable groups (such as the elderly and those with additional medical conditions) infection can lead to severe complications and sometimes death.

Immunisation against influenza is therefore important to protect the health of those groups of people who are most at risk of complications due to their age or medical condition. The uptake of influenza immunisation in Enfield has been broadly comparable with the other PCTs in the North Central London ‘cluster’; over the winter 2011/12 Enfield achieved top of cluster. Over the four years shown the Enfield uptake has increased to close the gap on the national rate (Figure 3.58).

**Figure 3.58: Flu immunisation (2005/06 to 2009/10)**



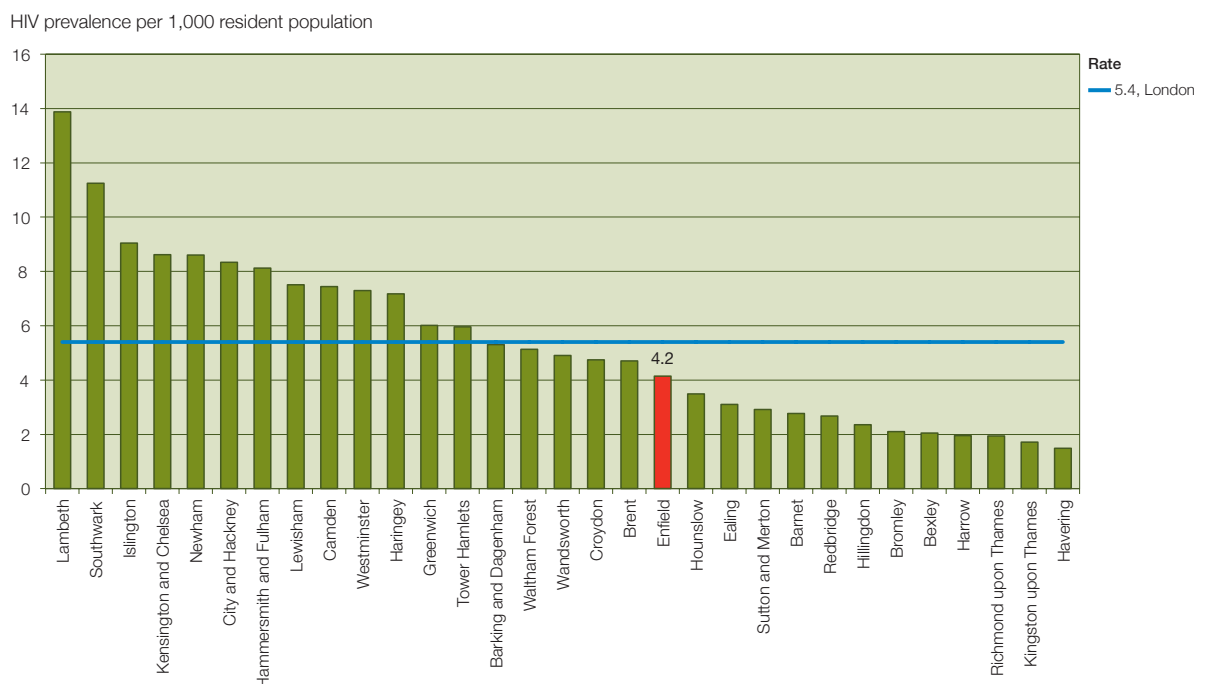
Source: Compendium of Population Health Indicators – NHS Information Centre

**HIV**

The Human Immunodeficiency Virus (HIV) is a virus which attacks the body’s immune system. If a person is infected with HIV they may not have any symptoms initially. Over a quarter of people in the UK with HIV don’t know that they are infected. People who are unaware that they have HIV are more likely to spread it to others. Early diagnosis ensures that effective treatment can be started which keeps the virus under control and allows the immune system to remain healthy. The later treatment is started the less effective it is. It is therefore important to protect a person’s sexual health through using condoms and encourage testing for people at risk to identify infections as soon as possible.

The prevalence of diagnosed HIV in Enfield was 4.2 per 1,000 population aged 15-59 years in 2010. This is below the London average of 5.4 per 1,000 population aged 15-59 years (Figure 3.59).

**Figure 3.59: HIV prevalence by borough (2010)**

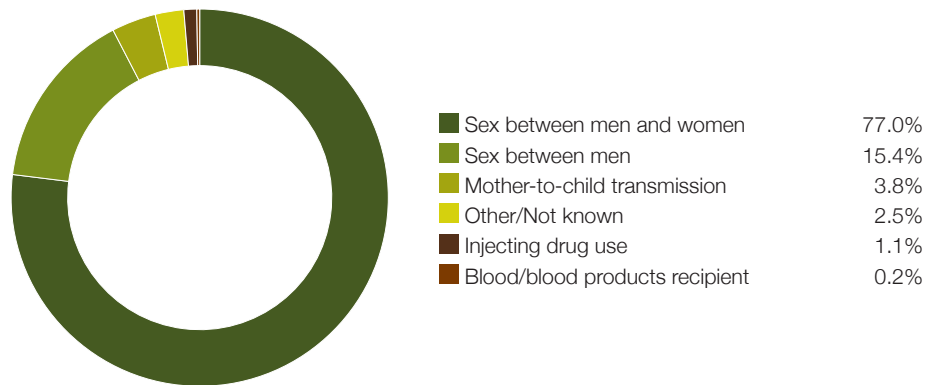


Source: Health Protection Agency

Within Enfield a large proportion of people are diagnosed late with HIV. In 2009 33% of people were diagnosed at a late stage in Enfield; across the North Central London cluster the range was from 23% in Islington to 36% in Haringey. Improving access to testing and encouraging people to seek testing will drive these figures down.

Sex between men and women was the most probable route of HIV infection in Enfield (Figure 3.60).

**Figure 3.60: HIV infections by probable route of exposure (2010)**



Source: Health Protection Agency, August 2011

## The key health challenges for the population of Enfield

Here we highlight areas from the health profile that suggest health challenges for partners in Enfield:

- Between 2008-2010, the infant mortality rate in Enfield was the third highest rate in London.
- Although immunisation rates are increasing in Enfield they are still below the national average and the level needed to prevent outbreaks of disease.
- Childhood obesity rates in Enfield are amongst the highest in the country.
- Cardiovascular diseases and cancers are Enfield's biggest killers.
- The mortality rate from stroke for under 65s in Enfield is considerably higher than the rates for London and England.
- Enfield's 1 and 5 year survival rates for colorectal cancer are lower than neighbouring boroughs.
- It is estimated that one in three adults in Enfield aged 55 and over has a limiting long-term illness; the numbers of people living with dementia in Enfield are rising and this trend is predicted to continue.
- Uptake of HIV testing should be encouraged so that people are diagnosed earlier in their infection; this improves their health and protects others in the community. (2010 figures show that 55% of people were diagnosed late in Enfield (i.e.: with a CD4 count of less than 350); this compares to 49% overall in London and 52% in England).
- There is a large gap in life expectancy within Enfield. This gap is greater for women than for men.
- The more deprived parts of Enfield tend to experience worse health than the rest of the borough.

# Chapter 4

## Working Together to Improve Health and Tackle Health Inequalities

Tackling health inequalities requires close partnership working. In the spirit of partnership working, this section is a selection of independent reports produced by our partners

# Chapter 4 (a)

## Primary Care Improvement Plan

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### Introduction

Working through NHS North Central London, Enfield's Primary Care Improvement plan will utilise almost £11 million over three years to improve; the access and range of primary care services for patients, patient satisfaction with services and health outcomes for people living in the Borough of Enfield.

Whilst the public health profile in terms of life expectancy is broadly similar to the UK national average, there are wide differences between specific communities and cultures within Enfield.

Whilst health outcomes have improved dramatically over recent years, with men in Enfield now living slightly longer than the London average (79.5 years compared to 79.0), women are still below the London average (83 years compared to 83.3). Additionally, there are increasing numbers of people with chronic long-term conditions that require greater levels of treatment and intervention in order to remain living independently.

Data from Department of Health National Survey ([www.gp-patient.co.uk/info](http://www.gp-patient.co.uk/info)) covering 5,104 Enfield patients showed that 74% of patients were satisfied with their overall experience of making an appointment with their GP, compared to 76% across London and 79% nationally. Their experiences within primary care are also lower than national levels (88% nationally reported good levels of overall experience compared to 86% across London and 84% in Enfield).

General Practice level data shows that whilst some practices achieve, and indeed, exceed targets set for specific levels of achievement such as cervical screening and immunisation, others, for a variety of reasons, fall behind that delivery. The improvement plan will ensure that all patients have equitable access to high quality healthcare regardless of where they live in the Borough of Enfield.

Significant improvements have been made in recent years towards cervical cytology screening, childhood immunisations and reduction in teenage pregnancies. The improvement plan will specifically address areas where further gains for the benefit of patients can be made. A sub-committee of the Health and Wellbeing Board will examine a range of health issues to identify treatments and interventions that will narrow the gap in health inequalities across the Borough of Enfield and to improve access for patients which will lead to better health outcomes for the population of Enfield. This may include: improving diabetes management and cholesterol control, which from the national Quality Outcomes Framework, reports poorer levels than average of management of these conditions in the South East area of Enfield; improving diagnosis and treatment of diseases such as chronic obstructive pulmonary disease (COPD) as we are aware that we have lower reported levels than average which suggests that we have an undiagnosed and untreated population. Practices that are performing well against certain targets will be asked to share their learning and experiences with practices that require assistance to make improvements.



## Engagement

Working closely with the public, patients and healthcare professionals has ensured the improvement plans fit with the broader aims of the local authority, health care providers including hospitals and the voluntary organisations, as well as meeting the expectations of the public. There will be slightly different improvement plans to take account of the differing needs of patients across the Borough of Enfield. Local healthcare professionals and the public will continue to develop the improvement plans and ensure delivery of plans remains focused on local patient needs. Active encouragement is being given to establishing robust GP Patient Participation Groups. Smaller practices may combine their efforts for efficiency gains. These groups will challenge the improvement plans and will be able to support implementation to ensure that we deliver a improvement plans of activities that narrows the gap in health inequalities and improves the experiences for patients utilising primary care services.

## Benefits

The project team recognise the need to provide real benefits for patients within primary care. Whilst the first year of the programme aims to provide the infrastructure for carrying out the changes required to make the improvements, there will also be a range of services and additional capacity that supports patients in a variety of ways.

## Networks

The improvement plan takes the concept of clustering GPs and GP practices into networks, thus preserving the close relationship smaller practices have with their patients, and with other GPs and healthcare professionals and volunteers to provide more cohesive locally delivered services.

Local clinical leaders drawn from the GP community will act as catalysts for changing care pathways, introducing new ways of delivering healthcare and will self-monitor across the network to ensure levels of performance are raised across the network as a whole. The aim is to ensure that all patients, irrespective of their registered practice, will have access to all services provided within the primary care setting. This may mean that practices will work together to ensure consistent delivery across the network. Travelling distances will be minimal and joined up information systems will ensure accurate records are updated in real time.

## Minor Ailments Scheme

The improvement plan is examining in detail the aspects of a minor ailments scheme for pharmacies. Potentially this could reduce demand on practices by allowing pharmacists with suitable training to offer advice and over the counter medication for a range of minor ailments. The project team will be evaluating other schemes to ensure lessons are learnt ahead of any scheme being approved and implemented.

## Productivity

The NHS Institute Productive Primary Care model will be utilised alongside the Primary Care Foundation Improving Access and Delivering Urgent Care programme with a range of practices. Both schemes aim to improve efficiency within practices of between 5%-20% by using better designs of flow for patients, triage and skilled treatments and interventions aimed at eliminating repeat problems. A dedicated former practice manager will be working alongside practices in making simple but proven changes to the day-to-day work.

## Training

We are working with NHS North Central London to introduce a unique scheme with University College Hospital London to provide four new GPs into the area, creating an additional 17,500 GP appointments per year. The training of GPs within practices will be highlighted and will provide a significant element towards succession planning for the future, and also supports GP education and training in managing more complex cases in primary care.

Nurses in primary care play an essential role in both well-person checks on the older population as well as disease specific checks for diabetes, COPD and coronary heart disease. We are running specific training sessions for nurses in prescribing, disease management and case finding for frequent users of hospital. This will enable practices to take direct charge of patients that can be managed safely in primary care, knowing that their equipment and skill set is up-to-date. We will also build in specific advice and support from hospital based consultants to provide teaching and case feedback to healthcare professionals ensuring better referrals when required are made.

Information Systems: Information sharing across GP computer systems using a web-based service will allow real-time data sharing and updating by a range of primary care staff delivering services in different settings. A summary care record will also be uploaded to the NHS central information system enabling essential data such as allergies or underlying conditions to be seen by care teams across the UK in accident and emergency departments, ensuring safe and effective care at all times.

We are also working closely with our local hospitals to introduce electronic discharge letters following a hospital admission. This means practices will receive information quickly following an admission and discharge from hospital, thus allowing the GP to arrange follow up with patients and ensure health outcomes are improved through accurate information being available to the GP practice which will allow the GP to pro-actively manage patients who have been discharged from hospital.

## Text messaging

Whilst text messaging might not be new for some practices, we are rolling out the service to both large and small surgeries. The new service will enable two-way texting. Patients will be reminded about appointments, and if they no longer require the appointment, they can reply and thus free up the appointment slot for another patient to improve access for patients. Health information such as flu vaccination reminders, or campaign messages such as Stop Smoking days can be targeted at specific groups of patients based on the GP information systems.

## Premises

During 2012/2013 each practice will have to register with the Care Quality Commission as a provider of primary healthcare services. Whilst the registration process itself is straightforward, it should be recognised that many practices may not yet be compliant with the robust standards the CQC impose on services applying for registration. The programme is carrying out an audit of all practices during the late summer of 2012 and practices have been invited to apply for small improvement grants to carry out minor remedial works. This should help us to improve clinical space availability, access and infection control issues.

In addition, and separate from the improvement plans, but being supported through consultation, the local NHS are supporting at least four schemes that will provide new premises builds or significant refurbishments that will help bring together services, increase capacity and provide modern facilities for the care and treatment of patients.

## Partners

The voluntary sector organisations have expressed a real desire to work in partnership with GPs, proving services such as counselling, and signposting patients to appropriate services will be explored. Several partners have expressed a commitment for working across organisations with a single assessment and one-stop shop approaches for both older people and those with high levels of need in the community.

## Summary

The plans will see improvements in the access and range of primary care services for patients, patient satisfaction with services and health outcomes for people living in the Borough of Enfield.



## Children's Trust Board

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### What is it?

The Enfield Children's Trust has the lead on a number of key indicators that are wider determinants of health (these are discussed below), however, in addition to these it is important to note that the partnership also significantly contributes to tackling areas of child health inequalities including raising take-up of immunisations, reducing infant mortality, reduction of obesity at reception and Year 6, reduction of teenage conceptions and improving emotional wellbeing (addressed elsewhere in this report).



The Children's Trust recognise that there are a number of wider determinants that are already part of the recently published Enfield Children and Young People's Plan 2011-2015 and feature under domain 1 of the new Public Health Outcomes Framework. These include: strategies to reduce the number of children in poverty; ensuring the children have school readiness; pupil absence is reduced; ensure there is a reduction in first time entrants to the youth justice system and that there is a reduction in the number of 16-18 year olds not in education, employment or training (NEET).

In 2011 the Children's Trust re-configured its structure moving away from a locality based partnership approach which was previously delivered through Children's Area Partnerships, to a more streamlined and efficient model, in line with capacity constraints effecting all partners and focusing engagement on senior decision makers.

### How will it improve health?

Tackling poverty at all levels will positively impact on the health of our families from conception to the grave. Ensuring families are sufficiently engaged with health and wider partnership services will enhance our ability to intervene earlier and tackle issues such as poor nutrition, dental caries, immunisations and obesity. We need to work with families to address the inequalities that lead to poor outcomes and reduced life expectancy.

For the other wider determinants the health impacts can seem less obvious however issues often initially present themselves through poor mental health including low self esteem, self image, low motivation, lack of aspiration and stress. The lack of positive early engagement with services can delay early identification of increased risky behaviours such as substance misuse, self harm or vulnerability to sexual exploitation or unprotected sexual activity.

## What have we achieved?

During 2011/12 there has been significant development of two key strategic areas of poverty and school readiness. Extensive consultation across the Local Authority and its partnerships have refocused services and developed progressive strategies and action plans aimed at effecting measurable change.

### 1. Children in Poverty

Poverty in Enfield remains a significant challenge, impacted on by issues of inward migration of families with more complex needs and the general wider economic environment.

Enfield has seen a decline in the percentage of child poverty for the third year in a row (34.8%). However this is still above our target of 32.2%. It is important to note however that although the proportionate percentage has decreased the actual numbers of children in poverty has increased due to general population expansion. For this same period the London (19.2%) and England (27.6%) averages have seen an increase.

Enfield is committed to tackling the issues of inequality caused by poverty and is in the process of developing a strategy and action plan to address some of our most challenging issues.

The Drive Towards Prosperity: Enfield's Child and Family Poverty Strategy has 7 key aims these are:

- Aim 1: Developing employment, education, training and skills
- Aim 2: Maximising income and supporting financial resilience
- Aim 3: Supporting families to achieve their aspirations
- Aim 4: Improving children and young people's experiences
- Aim 5: Narrowing the gap – reducing health inequalities
- Aim 6: Encouraging the development of sustainable housing
- Aim 7: Reducing and preventing crime

The 7 Aims of the Strategy also act as Enfield's Life Chance Indicators and the measures set against these aims will monitor how effective Enfield is at reducing the number of children, and their families, who live in poverty.

### 2. School Readiness

The Children's Trust has formally adopted a new Prevention and Early Intervention Strategy; this clearly defines what we mean by early intervention, it explains the context of our work, key intentions, aims, principles, risks and measures. Our strategic approach is to ensure that children are equipped to engage with school and achieve their potential.

This "School Readiness" strand is particularly, but not exclusively, focused on the clear commitment to early years services as a prime prevention mechanism enabling problems to be tackled at the very earliest opportunity in a child's life. It recognises that interventions must be holistic in nature and mindful of the full family and community context in order to maximise the potential for change and the adoption of a resilience culture.

A key feature of our approach to school readiness is incorporated in local redesign and transformation of commissioning and targeting of Children Centre provision.

The new "Core Purpose" for Children's Centres has 4 key strands that characterise the role centres play in ensuring all children and their families have the best chance of developing skills that prepare them for school life:

- Providing access to universal early years services in the local area including high quality and affordable early years education and childcare
- Providing targeted evidence based early interventions for families in greatest need, in the context of integrated services
- Acting as a hub for the local community, building social capital and cohesion
- Sharing expertise with other early year's settings to improve quality.



### 3. Other wider determinants

In addition to the strategy areas above there has also been good progress in the areas of pupil absence, first time entrants to Youth Justice and 16-18 year old NEET. Below is an over-view of performance in these areas for the past year.

#### **Pupil Absence**

We have seen a consistent downward trend in persistent absence since 2006/07 when the secondary absence rate stood at 5.7%, the latest published figures for 2010/11 for Enfield are 4.1%, 0.1% above the national average of 4%.

#### **First Time Entrants To The Youth Justice System**

For the first 11 months of 2011/12 our total was 252 First Time Entrants. The figure for 2010/11 was 386. We are currently performing well against our target of 390.

#### **16-18 Year Olds Not in Education, Employment or Training**

Overall there is a downward trend. The 2011/12 November to January three month average and final reported figure is 4.2%. This years percentage shows an improvement from 2010/11 (5.8%) and 2009/10 (6.1%) and importantly is below the LA NEET target of 6%.

# Enfield Health and Wellbeing Board

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The Health and Social Care Act 2012 states that every local authority must establish a Health and Wellbeing Board for its area. It also assigns specific new functions to the Health and Wellbeing Board, including leading on the development of the Joint Strategic Needs Assessment (JSNA) to provide a strong information and intelligence system. They will also lead on the development of a Joint Health and Wellbeing Strategy (JHWS). Boards should be in place from April 2013, with shadow boards in place from April 2012.

## Purpose

The purpose of the Board is to improve the health and wellbeing for the residents of Enfield and reduce current inequalities in outcomes. The Board will hold partner agencies to account for delivering improvements to the provision of health, adult and children's social care and housing services.

Three delivery groups composed of partner agencies will be used to ensure that partnership working is operationally effective and delivering work as assigned by the Health and Wellbeing Board, including:

- Health Improvement Partnership Board
- Joint Commissioning Partnership
- Improving GP Quality and Access.

## Vision

Our vision is for a healthier Enfield, where everyone is able to benefit from improvements in health and wellbeing. We want to reduce health inequalities in Enfield and for its people to have a healthier, happier and longer life. We want Enfield to be a healthy and happy place to live, work, raise a family and retire in.

## Health and Wellbeing Strategy

The themes of the current Strategy are:

1. **Healthy Start** – addressing the issues of child health and wellbeing within the borough, including: Child Poverty, Infant Mortality, Childhood Obesity, Immunisation and Maternity Services.
2. **Narrowing the Gap** – focusing on health inequalities, including life expectancy, cardiovascular disease, cancer rates, respiratory disease, diabetes, aging, long-term conditions, learning and physical disabilities.
3. **Healthy Lives** – this chapter will look at the impact of adult obesity, sport and physical activity, sexual health, substance misuse, smoking cessation and tobacco control and the role of health trainers.
4. **Healthy Places** – will review the borough as a place and how this impacts resident's health and wellbeing, through deprivation, inequalities and migration, regeneration, deprivation within north London, housing and homelessness, crime and feeling safe.
5. **Partnerships and Capacity** – chapter five discusses the next steps for the JSNA into volume three, looks at new national legislation and its impact on the way health and wellbeing services will be commissioned going forward, including the personalisation agenda. It will also overview areas such as, safeguarding, mental health, focus groups and engagement used for this volume and proposed to volume three.

## JSNA Priorities

**Poverty:** Poverty and unemployment were identified as significant risks to good health and wellbeing in consultations with the public. Average income in Enfield is in the worst 10% of local authorities in England, going from 54th worst in 2004 (out of 354, with 1st being the lowest) to 25th worst 2007. This is reflected in some other indices of deprivation i.e. Enfield's unemployment rate (6.7% March 2009) is above the London and national averages, and Enfield has the 4th largest number of households in temporary accommodation in England.

**Health Inequalities:** Inequality in health outcomes mirrors the patterns of deprivation seen within the borough. The differences are so significant that it is judged essential to have this as a priority – albeit one that is reflected across all other areas. Life expectancy at birth in Enfield over the past 15 years has been higher than London or national averages for both males and females. However there is a significant life expectancy gap between deprived and more affluent wards within the borough, and there is evidence that this gap is widening for both men and women.

**Obesity:** Obesity was identified as a significant risk to good health and wellbeing in consultations with the public and consumes very significant amounts of NHS spend. Enfield has the 3rd highest prevalence of obese people in London (27% Enfield, 18% London – Health Survey For England 2007 London Boost). Obesity levels among Enfield's young people are a particular concern with 37.6% of Enfield's young people in year 6 and 24.8% in reception year being overweight or obese.

**Infant Mortality:** Enfield has the highest infant mortality rate in London, and is significantly higher than national rates. Infant mortality is regarded as a good indicator of the overall health of a society and is to be seen as the 'tip of the iceberg', signalling more widespread problems for some groups, families and individuals.

**Long-term Conditions:** It is estimated that there could be over 32,000 people in Enfield with long-term conditions aged 45-64 by 2012. It will be important to consider this population for health checks and screening for risk to enable early intervention and prevention, and to plan for the growth in demand for services.

**Mental Health:** There is a widely held belief amongst professionals that there are poor health outcomes for people with mild/moderate mental illness, dementia, young people in transition from Child and Adolescent Mental Health Services and for people from some black and minority ethnic groups. There is also evidence of high demand on GP services from people suffering from lower level mental health conditions.

**Healthy Lifestyle:** In addition to factors listed above, it is a priority because:

- Higher than London average binge drinking over 55 (13.9%)
- Teenage conceptions are higher than the London average – 48.1 per 1,000 (2007)
- 55% of all adults living in Enfield are not participating regularly in any moderate intensity sport and physical activity, which is above the London average.

Alcohol consumption was identified as a significant risk to good health and wellbeing in consultations with the public.

**Feeling Safe:** Fear of crime was the most significant risk to good health and wellbeing identified by the Citizen's Panel. In the recent Place Survey the level of crime was top of the list of improvements that respondents wanted, in order to make Enfield a better place to live in. Fear of crime plays a part in keeping people from going out, accessing services and maintaining social networks – all vital to wellbeing.

**Access to Health and Wellbeing Information:** Local consultations demonstrate a belief that there are poor health outcomes for some black and minority ethnic groups and particularly vulnerable groups, resulting from difficulties in accessing appropriate information about health and wellbeing.

# Stroke

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Implementation of the Enfield Stroke Strategy Action Plan (Incorporating the findings from the Care Quality Commission special review of stroke services 2011).

## What is it?

The Enfield Stroke Strategy sets out how health and social care commissioners will work together to improve the range and quality of local stroke services; address health inequalities related to stroke; improve awareness of stroke and Transient Ischaemic Attack (TIA) symptoms; and reduce the prevalence of stroke.

Following publication of the strategy in 2011, an action plan was developed to implement the strategy's recommendations. The action plan also incorporates the findings from the CQC special review of stroke services (2011). The action plan consists of fifteen objectives ranging from managing transfer home from the in-patient setting to improving outcomes one year post stroke.

## How will it improve health?

The aim of the action plan is to implement a seamless stroke care pathway. Historically the various elements of the stroke pathway tended to work in silos and in some areas were under developed and under resourced e.g. community services. Care pathways promote organised and efficient patient care based on the evidence based practice.

## What we have achieved?

The action plan consists of fifteen objectives and specific actions from all objectives have been completed to date. These include:

- Running monthly drop-ins at the Ruth Winston Centre and Edmonton library to increase awareness of stroke in the local community
- Cascading of aphasia awareness training to approximately 70 staff members.

Several services also commenced between July/August 2011, including:

- Enfield stroke community rehabilitation team (incorporating early supported discharge)
- Stroke navigator providing support and navigation to stroke survivors and carers across the stroke pathway
- Social support co-ordinator facilitating stroke survivors to regain meaningful life roles through social support
- Life roles facilitator facilitating stroke survivors to re-integrate back into the community through taking up volunteering opportunities. This role also undertakes six month reviews for all stroke survivors.

We also now have clear data collection processes in place so that we can monitor the impact of the pathway on a regular basis.

## What we are planning to achieve?

We are planning to improve the range and quality of adult health and social care services for people who have suffered a stroke and their carers; address health inequalities related to stroke; improve awareness of stroke symptoms; and reduce the prevalence of stroke in Enfield.

# Housing and Public Health

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Private Sector Housing Renewal Grants are used to improve the condition of private sector housing in the borough for those who face a physical difficulty, during 2011/12 the Council enabled the completion of 261 grants.

The majority of these grants were used to improve accessibility within the home, enabling people to remain living independently in their own homes. 192 households were enabled in this way.

The balance of the grants were used to improve basic standards in the home, remove hazards that could have harmed the occupier and undertake small works that improved the safety and security of the home.

94% of customers who received a service from the Grants Team thought that the work undertaken had improved their experience of living at home.

Enforcement action is sometimes required when a landlord fails to keep a property in reasonable condition. 688 requests for assistance with disrepair within the home were resolved for tenants living in the borough.

Prevention of homelessness is the core business of the Community Housing Service.

During the year, the service worked with 229 households to help them stay in their existing home and prevent their housing arrangement from breaking down.

576 households were helped to move to another home and in doing so avoided becoming statutorily homeless. A further 129 households were prevented from losing their homes as a direct result of an intervention from Enfield Homes Welfare Benefit Advisors.

However, statutory homelessness remains a challenge in Enfield with 1,956 households living in temporary accommodation at the end of March 2012. Although this number remains high, the downward trend in numbers continues with a reduction of 148 households in temporary accommodation from the start of the year.

The Community Housing Service has an excellent relationship with partner agencies to assist rough sleepers, as a result of this rough sleeping is not a feature of the homelessness challenges in Enfield. The last official estimates identified 3 persons sleeping outside in autumn 2011.

As soon as rough sleepers are brought to the attention of the Housing Service, a referral is made to specialist agencies, such as London Street Rescue, who will work with the person to bring an end to the rough sleeping.

Social housing remains in short supply in Enfield. Only 884 households in total, moved into new social rented homes during 2011/12.

Most of the homes that became available had only one bedroom. Of the total number of homes let, 274 were 2 bedroom homes and only 183 were 3 bedroom homes. The particular shortage of 3 bedroom family sized homes, means that 1,975 households currently registered with the Council for 3 bedroom family sized homes will have little chance of achieving a social rented home in the foreseeable future.

# Everybody Active in Enfield: Sport and Physical Activity

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## What is it?

The Enfield Council's Everybody Active Team, aims to promote sport and physical activity for health, social and emotional benefits by providing a wide range of programmes across the borough for all ages and abilities. The Everybody Active Strategy is about making sport and physical activity an important and valued part of everyday life, facilitating activities in schools, at the workplace and within the community.

We are committed to providing a range of activities for our residents and continually seek external funding to develop and expand the range further. Our current programmes consist of:

(this is not an exhaustive list):

- Activities at our youth clubs and leisure centres
- An extensive Walks programme including buggy walks and Nordic walking
- An outreach estates programme in the east of the borough
- Coach and instructor development
- Club Development and promotional days
- Competitive pathways and events
- Step Success wellness programme
- Dance classes such as Ballet, Jazz, Zumba and Street Dance
- Disability Sport
- Family sport sessions
- Fun Run and Fun Walk (3k and 10k walk, jog or run)
- Healthy Lifestyles – Adult programme
- Healthy Weight projects
- Holiday and term programmes for young people
- Volunteer Development
- Women and Girls programme





## How will this improve health?

### Obesity

The Everybody Activity Strategy addresses obesity in both adults and young people and the importance of physical activity in reducing the levels of obesity by increasing energy expenditure of individuals, help in controlling weight and lowering the risk of becoming obese.

### Long-term conditions

Regular physical activity, active play and sports can be a practical means to achieving numerous gains, either directly or indirectly through its positive impact on health and other major risks, in particular high blood pressure, high cholesterol, obesity, tobacco use and stress. It reduces the risk of dying prematurely. Low-medium risk patients can use exercise as an alternative for medication. We will tailor a programme or signpost them to activities that will best suit their requirements.

### Mental health

Participation in sport and physical activity promotes psychological wellbeing, reduces stress, anxiety and depression. It also helps prevent or control risky behaviours, especially among children and young people, like tobacco, alcohol or other substance use, unhealthy diet or violence.

## What we have achieved?

Figure 4.1: Numbers attending Sports Development Courses

Financial year	Young people	Adults	Totals
2009/10	27,307	22,014	49,321
2010/11	47,475	24,277	74,097

In the last 2 years we have seen an increase of 22,776 in attendances (46% increase). Some highlights include:

- An 87% uptake on summer courses for young people
- Over 70 referrals to exercise from GPs and Health trainers
- 9th Place in London Youth Games competition
- Over 500 walkers for the Enfield Night Hike 15k walk in partnership with The Nightingale Cancer Support Centre and Barnet and Chase Farm Hospitals NHS Trust
- Over 900 walkers, joggers and runners for the Mayor's Charity Fun Run
- Over 2,000 on our Inclusive and Active programme for Disabled young people
- Over 10,000 attendances for our Street Active programme targeting under 24 year olds in the east of the borough.

## What we are planning to achieve?

- Greater focus on Sports activities for teenagers across the borough as a result of the Enfield Survey Results.
- Pilot 'Active and Ease' Project in Partnership with LB Haringey targeting Sedentary Adults.
- Delivery of Sports Makers volunteering programme, encouraging engagement in sports for Enfield residents in a variety of roles.

For further information please contact us on:

Our general line: 020 8379 3762

Visit our website to what we offer: [www.enfield.gov.uk/sport](http://www.enfield.gov.uk/sport)

Or email us on: [sport@enfield.gov.uk](mailto:sport@enfield.gov.uk)



# Olympics

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On the 6th July 2005, London won the right to host the London 2012 Olympic Games and Paralympic Games. At the opening ceremony on Friday 27 July 2012, London will welcome approximately 17,000 competitors and officials to compete over a 17 day period in the largest sporting event in the world. There will be 20,000 accredited media, 6,000 reporters and photographers and 14,000 broadcasters covering the event. The Paralympic Games will follow on from the Olympic Games, starting on 29 August through to Sunday 9 September, with a further 4,500 athletes and 2,300 officials taking part in 20 sports.

The 2012 Games will embrace the Olympic philosophy to celebrate sport, culture and education to create unique opportunities and inspire a lasting legacy for London and the rest of the UK.

Enfield's vision for the Games is to ensure that the London 2012 Olympic Games and Paralympic Games are remembered not just for providing the best ever sporting and cultural festival, but also for bringing the best legacy meeting local expectations. In addition, the borough aims to use the Games delivery process to improve performance.

Olympic values are excellence, friendship and respect. Paralympic values include determination, inspiration, courage and equality of opportunity.

These principles resonate strongly with the Council's mission to promote the social, economic and environmental wellbeing of its communities and help residents improve their neighbourhoods, setting high standards for quality and value for money and listening to its partners and citizens in delivering local democracy. It aims to work with its partners to plan, shape and deliver services which meet real local needs in the most efficient way, reducing inequalities and protecting and enhancing quality of life in the borough.

Enfield plans to maximise the opportunities presented by the Olympic and Paralympic Games in 2012 to ensure Enfield's residents and businesses benefit from the legacy of the 2012 games.

Enfield aims to:

1. Maximise volunteering and training opportunities for residents
2. Engage more young people in active sport by working with schools and colleges
3. Build on, and expand, opportunities to participate in sports and cultural activities for all of our communities
4. Maximising regeneration and employment opportunities especially in the cultural, leisure and sporting industries
5. Develop the Council's structures and community sector capacity to deliver a legacy from the 2012 Games.

Residents will benefit from the strategy because it pulls together a number of themes that will deliver community and Council objectives. It will help deliver educational and place shaping objectives by engaging with young people and by delivering economic development, tourism, health improvement and volunteer opportunities. It provides regeneration opportunities, employment and training opportunities and will provide a focus for cultural activities in the borough. The borough will also benefit from inward investment opportunities.



Desiree Henry from Edmonton got the call from LOCOG just a week before the Olympics opening ceremony. She had been chosen by Daley Thompson to take part in lighting the London 2012 cauldron along with six other young people.

Desiree trains at Enfield and Haringey Athletics Club and holds the fastest time in the country in her age group with a personal best time of 23.93 seconds. Last year she won the English Schools 200m and was part of the winning relay team. Later this year she will be competing in European Championships in France.

## Safer Stronger Communities Board

Andrea Clemons

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The Safer and Stronger Communities Board (SSCB) has a statutory duty to assess crime and community safety and substance misuse each year and to produce a partnership plan which sets out how improvements will be achieved.

The Community Safety Partnership Plan for 2012/13 will focus on:

- Tackling gangs and serious youth violence
- Tackling violence against women and girls (VAWG)
- Reducing serious acquisitive crime (e.g. domestic burglary and robbery)
- Improving Community engagement
- Reducing anti-social behaviour
- Ensuring community safety during the Olympics.

Crimes of violence in particular have a significant impact on the health and wellbeing, not only of the victims of crime, but also the wider community.

Enfield is one of 30 areas nationally (16 in London) who will receive additional funding from the Home Office to tackle gangs and serious youth violence.

Enfield SSCB has recently been reviewed by central Government agencies and received a very positive report. The Enfield SSCB is recognised as a strong, established partnership both nationally and internationally, however there are areas which could be strengthened, especially in relation to the cross partnership work linking with Health and Wellbeing.

- The Health and Wellbeing Board has an opportunity to strengthen links with the Safer Stronger Communities Board.
- Need to improve data sharing with Health services and A&E departments in particular (learn lessons from the Cardiff model).
- Need to establish specific programmes for sexual offences and trauma focussed work for victims, including front line staff.

The VAWG activity is linking with health professionals to maximise opportunities to intervene early to prevent repeat incidents of domestic violence, or sexual offences.

DV in particular is acknowledged to be an area which is significantly under-reported to the police, although victims may have the opportunity to discuss with their GPs or with other health service providers.

Greater interaction will enable us to shape services, improve health and wellbeing and reduce costs.

In addition to the impact of violent crime on health and wellbeing, the fear of crime is reflected as the number one concern in the Joint Strategic Needs Assessment and although the risk may be overestimated by some individuals, fear of crime can have a debilitating effect on some of the most vulnerable in society, causing isolation and increasing the long-term risks to health.

We aim to increase the level of engagement particularly with those who are unknown to services to ensure that they have access to help where it is needed and reassurances about the level of risk, where this is at odds with perceptions.

# Noise

Ned Johnson

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Noise is a pollutant which affects or will affect a significant percentage of the population of Great Britain at some point in their lives. Noise is generally defined as unwanted sound and can arise from any number of sources and have a variety of effects. Noise in itself has a very subjective element to it, as noise for one person can be another person's pleasure, making it rather hard to characterise at times. Loudness of sound alone cannot decide noise, as certain sources may seem very loud but are often seen as an acceptable part of everyday life, such as road-traffic or the ringing of church bells; however, other sources, such as loud music, or industrial noise are not. What is clear that noise can have a negative effect on the quality of life of those who are exposed to this pollutant.

Statutory Nuisance is enshrined in law under Part III of the Environmental Protection Act 1990. Where noise is deemed to be a Statutory Nuisance we will serve a Noise Abatement Notice on the person responsible for the noise. This Notice is a legal requirement not to cause noise nuisance again; a breach of such a Notice is a criminal offence which carries a maximum fine of £5,000 for residential premises and £20,000 for commercial premises upon summary conviction in a Magistrates Court. An alternative to prosecution for breach for Notice is the service of a Fixed Penalty Notice (FPN) which is a civil discharge of the offence committed by breaching the notice. FPNs for residential premises are £100 and £400 for commercial premises.

In 2011 we received 2,483 residential noise complaints and 421 complaints regarding commercial premises giving a total of 2,904 noise complaints.

The Council has officers available during the working day to address both residential and commercial noise complaints; during weekend nights we run an Out of Hours Noise Service.

The Out of Hours Noise Service currently runs every Friday and Saturday night between the hours of 21:00 – 03:00. The service predominantly deals with noise complaints arising from both commercial and domestic premises. The teams will also undertake observation tasks, set by day time staff, to provide intelligence regarding on going investigations. This service regularly handles over 1,500 complaints per year demonstrating a very clear need for night-time enforcement.

Residents surveys in 2011 indicated that 15% of the borough's residents had been affected by noise from neighbours which shows a slight decrease compared to the 2007 survey.

Where complaints concern licensed premises and those complaints relate to the licensing objectives (which are: crime and disorder; public nuisance; public safety; and the protection of children from harm) any responsible authority (including the Police, Environmental Health) and any interested party (including local residents and businesses) may ask the Council, as Licensing Authority, to review the Premises Licence. In considering any review application, the Council's Licensing Sub-Committee may choose to:

- revoke the licence;
- suspend the licence for up to three months;
- remove the Designated Premises Supervisor (DPS) from the licence;
- exclude a licensable activity from the licence; and
- modify the conditions of the licence.

Breach of conditions or the terms of the licence (i.e. hours, activities) can also lead to a review.

## Achievements

- Seven licensing reviews were carried out last year of which over 50% were for noise associated with the premise. These resulted in modified conditions and reduction of hours.
- 127 representations made by Regulatory Services.
- Three premises were also prosecuted for noise offences.
- 230 visits were made to premises Out of Hours (night time visits) to assess or deal with noise.
- Dealt with over 400 commercial complaints.
- Dealt with 2,596 domestic complaints.

# Air Pollution

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The Air Quality Regulations 2000 and Amendment Regulations 2002 set out objective levels for six air pollutants of concern to health. The objectives are set at levels below which even the most sensitive individual would not feel adverse effects upon their health. All local authorities are required to periodically review and assess air pollution levels for the six pollutants in their geographic areas. These pollutants are:

- Nitrogen dioxide
- PM<sub>10</sub>
- Sulphur dioxide
- Carbon monoxide
- Lead
- 1,3-butadiene.



Enfield Council have undertaken the review and assessment process in line with Department for Environment, Food and Rural Affairs (DEFRA) requirements and concluded that the objective levels are being exceeded for nitrogen dioxide and PM<sub>10</sub> and that there was relevant public exposure at multiple locations throughout the borough along all the major routes and some local roads due to road traffic. Industrial emissions have been demonstrated to have a very small impact in comparison to road traffic.

The process of review and assessment is undertaken using both computer dispersion modelling data, real-time air quality monitoring data and nitrogen dioxide diffusion tubes.

We monitor for nitrogen dioxide, PM<sub>10</sub> and sulphur dioxide with real-time analysers across 4 sites located at various points in the borough. There are 9 sites monitored with nitrogen dioxide diffusion tube sites. Diffusion tubes are for indicative monitoring and are changed on a monthly basis; real-time analysers are very accurate and run 24 hours a day. The data generated by the real-time stations is ratified by the Environmental Research Group and is available on the London Air Quality Network site.

[www.londonair.org.uk/londonAir/default.aspx](http://www.londonair.org.uk/londonAir/default.aspx)

The monitoring data for 2011 underlined that there continues to be exceedences of the annual mean objective for nitrogen dioxide at roadside sites. None of the real-time monitoring sites exceeded the objectives for PM<sub>10</sub>. The diffusion tube data for 2011 showed that the annual mean objective for nitrogen dioxide was exceeded at two roadside locations, the rest were below the objective level.

As a consequence of predicted exceedences of the air quality objectives the whole of the London Borough of Enfield was declared an Air Quality Management Area (AQMA) for nitrogen dioxide and PM<sub>10</sub> in 2001. Following this declaration we produced an Air Quality Action Plan which set-out how the Council will work towards meeting the air quality objectives for the two pollutants of concern. The Action Plan was released in March 2003 and a new version is currently being written and will be ready for consultation in September 2012.

Enfield Council is a partner in airTEXT which is a free text alert service available to all residents who wish to sign-up. When you sign up to receive pollution alerts from airTEXT, you select a zone that you'd like to receive the alerts for. Twice every day at about 7am and 7pm, computers at the company which runs the forecasting make a prediction of the air pollution on every street in London for the rest of that day or all of the next day.

When air pollution levels are predicted to reach moderate or higher levels over more than one tenth of your zone, we will send you an SMS message, a voice mail or an email, to warn you that pollution may be elevated.

<http://www.airtext.info/index.php>

# Tobacco Control

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## What is it?

Tobacco control is classified as any initiative which aims to reduce the demand for tobacco products. Enforcement is an example of a key intervention that contributes to tobacco control and Trading Standards Services are responsible for the following:

- Regulation of the age of sale
- Regulation of tobacco trading and counterfeit/non-duty paid tobacco products
- Regulation of the point of sale for tobacco
- Regulation of advertising and sponsorship.

Trading Standards working with other enforcement agencies such as HMRC endeavour to tackle the prevalence of smoking and tobacco use in conjunction and co-operation with the various partner agencies whose remit also covers wider issues of tobacco control.

## How will it improve health?

Smoking costs the NHS £2.7 billion per year nationally. In 2006-2008 smoking was estimated to cause approximately 177.64 deaths per 100,000 in people aged 35+. (Source: Local Tobacco Control Profile for Enfield). Smoking prevalence is highest in our poorest communities predominantly in the east of the borough. In Enfield it has been estimated that smoking related illnesses cost £4 million a year just in the Acute Sector.

## What have we achieved?

Trading Standards officers are committed to regulating tobacco control through tackling illegal and underage availability. This includes:

- **Reducing Supply and Availability** – targeting underage sales
- **Regulating Tobacco Trading** – targeting counterfeit/illicit products
- **Reducing Tobacco Promotion** – enforcement of advertising and sponsorship restrictions
- **Regulating Tobacco** – packaging and labelling requirements (including smokeless products).

This is achieved through advice, enforcement and engagement in both local and national initiatives, including:

- Providing support/educating retailers and representative organisations, through joint or corporate training events, to enable them to trade within the law
- Test purchasing
- Educational campaign on the increase in age restriction for tobacco
- Promotion of No ID No Sale
- Promotion of Challenge 21/Challenge 25 policies
- Press releases and radio interviews
- Routine inspections (statutory notice/advertising ban compliance)
- Developing partnerships.

During the period 2010/11 Trading Standards took part in the Regional Trading Standards Tobacco Control project for the UK. This work was funded by the Department of Health and included the following:

- Detection and disruption of sales of illegal and counterfeit tobacco products
- Reducing the number of illegal sales to underage people in retail premises and via vending machines (which ceased in October 2011)
- Monitoring the display of tobacco products at point of sale
- Monitoring the supply of niche tobacco products; removing product from supply that fails to comply with existing legislation.

This year we had eleven joint visits with Her Majesty's Revenues and Customs (HMRC):

- 10,000 cigarettes seized;
- 50 bottles of vodka;
- 3 bottles of champagne;
- less than 1 kilo of hand rolled tobacco.



## What are we planning to achieve?

In line with; 'Healthy lives, healthy people: a tobacco control plan for England' we have formed a Tobacco Control Alliance with Haringey. In addition to the current program of work we will concentrate on the following, to reduce the uptake of tobacco use:

- To educate and enforce the display of tobacco products which requires tobacco products to be removed from display:
  - On 6 April 2012 for large shops
  - On 6 April 2015 for all other shops
- To educate and enforce the advertising and display of products and pricing
- The Government will consult on options to reduce the promotional impact of tobacco packaging, including plain packaging, and an assessment of the impact of these options, before the end of 2011
- To consult on the introduction of plain packaging for all tobacco products
- To proactively support the initiative of the Tobacco Control Alliance and implementation of the action plan to reduce smoking prevalence from its current 21.8% to around 18%.

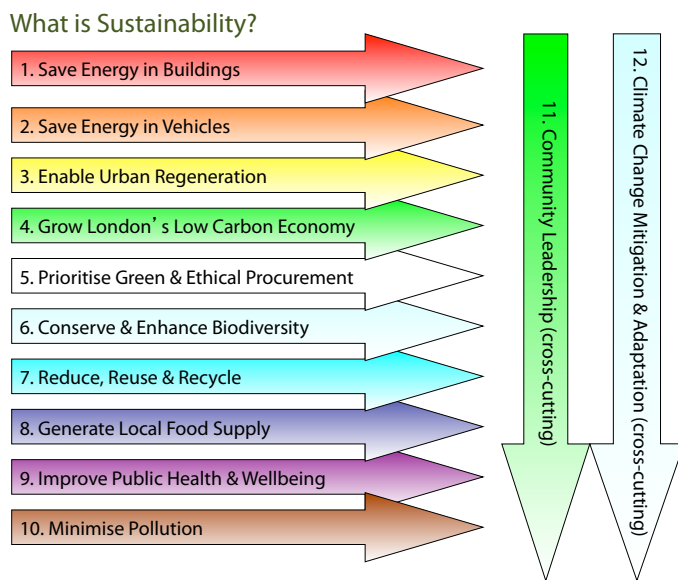
# Enfield’s Sustainability Programme

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## What is Sustainability?

We are all familiar with the word ‘sustainability’ but what does this actually mean? Many people think of recycling, renewable energy and climate change. As is shown below, delivering sustainability is much more than this. Enfield 2020 is the name for Enfield’s new Sustainability Programme and Action Plan. Collectively delivering the 12 strategic priorities within Enfield 2020 will improve public health, save money on energy bills, create local jobs and protect our local environment.

**Figure 4.3: Enfield 2020**



With national government's presumption in favour of sustainable development, the recession, significant health inequalities in Enfield, the disturbances of 2011, local authority budget cuts, spiralling energy bills and the threat of climate change, improving sustainability is top of Enfield’s agenda.

## How will it contribute to health improvement?

Enfield 2020 brings together the large number of sustainability projects that the authority is already delivering under the 12 strategic priorities. This includes the Upper Lee Valley Heat Network, seeking to invest £3.4 million to improve the energy performance of 32 of Enfield’s public buildings and installing a further 6 electric vehicle recharging points in the borough.

Going forward, Enfield 2020 will also be used to strategically commission a number of new sustainability projects to maximise value for money by developing projects to address multiple strategic priorities. For example, the continued development of Enfield’s network of walking and cycling greenways will reduce obesity, improve local air quality by minimising pollution, save energy in vehicles and enable urban regeneration.

This approach to sustainability maximises the economic, environmental and social benefits for Enfield. This will be seen by residents through improved health and wellbeing, economic development, urban regeneration and an increased sense of community, where people are encouraged to change their lifestyle to deliver a range of benefits.





### What has Enfield achieved so far?

To date Enfield's work on public health has focused on a combination of Primary Care Trust and Environmental Health interventions.

### What are we planning to achieve?

Enfield 2020 creates the opportunity for the Health and Wellbeing Board to commission new sustainability projects to address multiple strategic priorities. This will deliver a number of benefits:

1. Improve public health and wellbeing
2. Deliver a number of ancillary sustainability benefits
3. Maximise the effectiveness of public health funding by leveraging additional match funding and contributions in kind into Enfield
4. Integrate the authority's new public health responsibilities within the Council, making it the Council's 'day job'.

## Using Green Spaces for Exercise

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Via the HEALTHY WALKS programme that is already in place the parks service contributes to many health issues based on levels of activity that assist with many Health outputs surrounding obesity and cardio-vascular ailments. This is done in partnership with the Sports team and packs of information are passed to the GP network to enable referrals into the organised walks project.

Open spaces also provide space for sports and play activity that is not organised and the range of facilities for children's play has improved considerably over recent years.

In addition the council provides a considerable offer for allotment spaces which allow not only the growing of food (Healthy Lifestyles) but also provides a healthy outdoor activity.

In the draft Development Management Document the councils position on open space provision shows a commitment to continuing to provide high quality open space for the future.



## Reducing Casualties on the Road

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We will continue to introduce improvements to reduce road casualties, using both engineering solutions and education. We are currently implementing the councils manifesto pledge to introduce 20 mph zones in residential roads around every school in the borough. Currently 24 have been completed or are on site, with a further 7 being designed for implementation in 2012/13.

We are finalising designs to improve the 15 worst junctions in the borough for accidents involving people who are killed or seriously injured.

The Road Safety Education Team will continue to co-ordinate Safe Drive Stay Alive (SDSA) in the borough, which has now been delivered to over 4,000 young people.

The Road Rangers scheme has now been rolled out to 26 primary schools with several more requesting to join the scheme.

We have a very successful Theatre in Education project where secondary school students compete to write and perform a short play on road safety. The winning entry then gets the opportunity to perform to primary school children across the borough and have their work turned into a film by a professional production company.

Our Bikeability cycle training is now seeing over 1,000 children per year take the course. This not only makes them safer cyclists but it also promotes a healthy lifestyle, promotes green travel and could lead to reduced congestion.

Enfield has a relatively poor record for accidents involving powered two wheelers (motorbikes and scooters) and so we are targeting motorbike safety with specific campaigns. Bikesafe is a nationally recognised course, run in London by the Metropolitan Police and we have taken the opportunity to promote this with a display in the town centre and providing staff with free places on a course. We have commissioned two commercials promoting motorbike safety and carried out an advertising campaign on billboards borough wide.

Along with these specific projects, we continue to carry out the following seasonal safety campaigns:

- Summer Drink Drive
- Christmas Drink Drive
- Be Safe Be Seen
- In Car Safety
- Speeding
- Drug Driving.



# Infectious Disease (Animal Diseases)

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## What is it?

At a local level the fundamental aim of an animal disease contingency plan is to ensure that the local authority can provide a rapid and appropriate response in an emergency disease situation.

The outbreaks of Foot and Mouth Disease in 2001 and 2007, as well as Avian Influenza and Bluetongue outbreaks during 2007 in Great Britain clearly exemplified the massive impact that a notifiable animal disease outbreak can have upon the farming industry, tourism, local communities and the economy.

The Civil Contingencies Act 2004 reflects the role of local authorities in providing civil protection at a local level and places a statutory duty on the Authority to maintain emergency plans for events or situations likely to cause serious damage to human welfare and the environment. The animal welfare function and enforcement of controlled areas is the responsibility of Planning and Environmental Protection.

## How will it improve health?

The Animal Health Act 1981 (as amended by the 2002 Act) places statutory duties on local authorities in relation to animal disease outbreaks. This role is focused on preventing the spread of the notifiable animal disease, and thus limiting the effect of the disease on human and animal activities.

## What have we achieved?

Regulatory Services has animal disease contingency plans in place as required under the Civil Contingencies Act 2004, and has responsibilities under the Animal Health Act 1981 and the EC Communities Act 1972.

These plans are regularly reviewed to ensure that the Authority can provide a rapid and effective response from the outset of a suspect notifiable animal disease case. The plan sets out a clear range of specific functions that must be performed by the authority in the event of a notifiable animal disease outbreak.

## What are we planning to achieve?

In the event of an outbreak the animal health and welfare enforcement function must perform a number of key requirements throughout the management and control stage of the outbreak.

This will be concentrated in a number of key areas:

- Enforcing restrictions and movement controls
- Working with Animal Health, including identifying livestock holdings as well as tracing and issuing movement licences
- Ensuring Cleansing and Disinfection conditions are complied with
- Communication with the farming community.

The authority through its program of animal licensing and role of the animal welfare officer together with its inspection of farms in the borough seeks to ensure the highest possible standards are maintained in Enfield, thus preventing the possibility of an outbreak. To ensure we meet these standards the authority uses the services of the City of London veterinary services for inspections of farms and livestock.

# Infectious Disease

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## What is it?

The Law requires reporting of infectious diseases to the local authorities, these are known as notifiable diseases and will be investigated by either the Local Authority (LA) or the Health Protection Agency (HPA).

Cases can be notified in a number of ways including information from a person suffering from an illness, a GP, the Consultant in Communicable Disease Control (CCDC) or the Health Protection Agency (HPA) laboratory. Notifiable diseases include Food Poisonings, Cryptosporidiosis, Giardiasis, Dysentery, Legionnaires' Disease, Typhoid Fever and Viral Hepatitis.

## How will it improve health?

The purpose of investigating an infectious disease is to identify the source and to prevent further spread of the disease.

During the investigation the case will be asked to provide information on their occupation, foods they have eaten out or at home, any travel or functions attended and details of any close contacts. The case will be advised of good personal hygiene practice and will be sent information on the infectious disease and how to prevent further illness.

There are guidelines produced jointly by the LA and HPA for each of the notifiable diseases. These are followed to ensure that a person suffering from an infectious disease who may be in a risk group, such as a food handler, young child or care worker are excluded from work or school/nursery for a safe period or until they are free from infection to prevent the spread of the infection.

There may be occasions with food poisonings where a food source may be implicated such as a restaurant or event. This matter will then be investigated by the Local Authority where the premises or event is situated.

We will carry out food hygiene inspections and work with businesses to offer advice and provide information to improve food hygiene. We will also offer advice to prevent the spread of infection for premises such as a nursery or care home. We also run courses for business to train food handlers in food hygiene.

## What have we achieved?

- We have investigated all reported cases of infectious diseases that we have been able to make contact with. We have investigated small outbreaks and worked with business to improve food hygiene within the premises.
- We work closely with other agencies such as the HPA and laboratories and have identified clusters of food poisoning locally which have required further investigation.
- We have carried out a series of training sessions with our poor food businesses to improve hygiene standards and reduce the risk of food poisonings as well as inspecting all our high risk food premises.
- We have carried out regular food hygiene courses throughout the year to train food handlers.
- We have promoted safe food preparation at home by having a stand in the civic centre canteen during food safety week.

## What are we planning to achieve?

- To investigate all cases of infectious disease in partnership with the HPA that is reported to us.
- To run further food hygiene courses throughout the year to train food handlers.
- To inspect all our high risk food premises this year and continue to run the project targeting our poor food businesses.
- To work with the HPA to prepare a joint outbreak control plan in case of a large outbreak of food poisoning at any time and particularly during the Olympics.

# Diet and Food Control

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## What is it?

Enfield has the third highest prevalence of obese people in London<sup>84</sup>. Obesity levels among Enfield's young people are a particular concern with 41.6% of Enfield's young people in year 6 and 28.2% in reception year being overweight or obese.

Diseases related to overweight and obesity were estimated to cost the NHS in Enfield £75 million annually in 2008 and it is expected this will rise to £84 million by 2015.

Obesity is also one of the contributory factors in the health inequalities in Enfield. There is a significant gap in life expectancy for men and women

between the deprived and more affluent wards (8.8 years for men and 10 years for women). Obesity is associated with cardiovascular disease and cancers which are the biggest cause of death in Enfield and the biggest contributor towards the life expectancy gap.

As around 48% of Londoners eat a takeaway at least once a week, and 1% of men in both the 25-34 and 45-54 groups eating out twice a day, the food consumed out of the home can play a part in Londoners health<sup>85</sup>.

Research has shown that 80% of pupils purchase food/drink from takeaways near school<sup>86</sup>. Three out of ten purchases were from takeaways and typically included food items such as chips, chicken or pizza. The research also noted that school pupils respond to special offers.



## How will it improve health?

Considering the large percentage of people using takeaways and their age range, a pilot project was run last year to encourage businesses to offer a healthier food choice. This was to assess the effectiveness and impact of this type of intervention on the health of Enfield residents by working with a small number (10) of fast food outlets.

Our aim was to also promote and publicise those businesses that made improvements to provide healthier choices for consumers. The longer term impacts of the project were:

- Improved health of residents by ensuring provision of healthy food options available for sale
- At least maintenance (given economic climate) or increased trade for the participating businesses, and for the healthy options in particular.

## What are we planning to achieve?

Continuing with the current program of intervention to increase the number of participants in the scheme and with the implementation of the restriction of fast food takeaways within 400 metres of secondary schools.

# Chapter 4 (b)

## Infant Mortality

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### What is it?

“Infant mortality is a sensitive measure of the overall health of a population. It reflects the apparent association between the causes of infant mortality and other factors that are likely to influence the health status of whole populations, such as their economic development, general living conditions, social wellbeing, rates of illness and the quality of the environment.”<sup>87</sup>

While the infant mortality rate for England is at an all-time low, rates in Enfield are significantly higher than those for England and London.



### What we have achieved

- A comprehensive strategy and action plan (2010-2013) was produced through the work of the multi-disciplinary infant mortality working group.
- Data from ONS (Office for National Statistics) and CDOP (Child Death Overview Panel) was reviewed and identified two areas to concentrate on; reducing SUDI (Sudden unexpected deaths in infancy) and encouraging early access to maternity.
- Safer Sleeping messages are promoted through training of practitioners and providing information to the public.
- Early access to maternity has been promoted via primary care and pharmacists as well as directly to the public through the ASAP (As soon as you're pregnant) campaign.
- Audit of late maternity bookers to identify target groups and reasons for late booking.
- Production and dissemination of “credit card” with key messages; highlighted by DH as good practice.
- 12 volunteers recruited from parent champions (Parent Engagement Panel) and trained to become breast feeding helpers to support women in the community.
- Healthy Start vitamins now being given out by NMUH midwives and piloted through a group of Children's centres to expand access.
- Training provided to housing staff to raise awareness of overcrowding and safer sleeping; messages disseminated via Enfield Homes.

### What we are planning to achieve

- Safer Sleeping update for professionals (May 2012).
- Community development work to promote early access to maternity messages.
- Working with the safeguarding board to provide training for community groups to promote early access to maternity services.
- Promotion of smoking cessation via baby clinics during 2012 to encourage new parents to quit.

# Immunisation

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## What is it?

Immunisations are one of the most effective public health interventions of all time. It is important to have high levels of coverage to maintain herd immunity. In the UK, these diseases are kept at bay by high immunisation rates. Around the world, millions of people a year die from infectious diseases with more than five million of these being children under the age of five. Many of these deaths could be prevented by immunisation. As more people travel abroad and more people come to visit this country, there is a risk that they will bring these diseases into the UK. The diseases may spread to people who haven't been immunised so a baby is at greater risk if he or she has not been immunised. Immunisation doesn't just protect your child; it also helps to protect your family and the whole community, especially those children who, for medical reasons, cannot be immunised.

## How will it improve health?

Although immunisation rates are improving they are not as high as they need to be in Enfield and cases of measles have been emerging.

Enfield's population is increasing in diversity and there is a need to address inequalities in health. The NICE guidance (2009) 'Reducing differences in the uptake of immunisations' aims to help increase immunisation uptake among children and young people in settings where immunisation coverage is low. It has been shown, particularly in the latest report on health inequalities by Marmot, that achieving a healthy start to life improves not only health throughout life, but also social and economic opportunities and wellbeing.

## What we have achieved

Following the recent formation of the Clinical Commissioning Groups immunisation has been highlighted as a priority in Enfield. Work is being done with GP practices to improve data flows and call/re-call systems. Practices have been sent a best practice guide and defaulters policy to help them target those children who do not regularly attend for vaccination. Practice visits have been aimed at streamlining GP IT systems to ensure they are all using correct codes and submitting the correct information on time.

Outreach clinics have been successfully held in schools to catch children who have missed MMR or pre-school boosters. These sessions also provide an opportunity for parents to ask questions and find out information about immunisation. An immunisation day was held at Edmonton Children's Centre in July and immunisation sessions have also been held for Foster Carers and the Young People's Project. NHS Enfield continually promotes the immunisations available through work with early year's practitioners, schools and children's centres as well as providing articles to local newspapers and adverts in the community. Numerous community and voluntary groups now circulate immunisation information on a regular basis. Regular training is provided jointly with North Central London to primary care professionals to ensure they have the most up to date knowledge on immunisation.

## What we are planning to achieve

- Improved immunisation rates in Enfield.
- Improved data collection from practices via an automated upload tool.
- Improved immunisation uptake from vulnerable and hard to reach communities.



# Breastfeeding

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Breastfeeding saves lives and protects the health of mothers and babies both in the short and long term. Breastfeeding services are a cost-effective intervention, contributing to savings from reduced hospital admissions for gastrointestinal and respiratory infections.

In recent years, several large, good-quality studies and reviews have demonstrated that not breastfeeding can pose a range of significant health risks for both child and mother. These include short-term outcomes such as gastroenteritis and respiratory disease, requiring hospitalisation, and in the longer term evidence suggests that infants who are not breastfed tend to have higher levels of blood pressure and blood cholesterol in adulthood and may also be at a greater risk of type 2 diabetes. For mothers, breastfeeding is associated with a reduction in the risk of breast and ovarian cancers. A recent study also suggests a positive association between breastfeeding and parenting capability, particularly among single and low-income mothers.

Breast milk is the best form of nutrition for infants, and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life. Thereafter, breastfeeding should continue for as long as the mother and baby wish, while gradually introducing the baby to a more varied diet.

Prevalence of breastfeeding at 6-8 weeks is a key indicator of child health and wellbeing. The Government aims to increase breastfeeding rates so that they are as high as possible.

## How does this improve health?

More mothers are breastfeeding but continuation rates in the UK remain among the lowest worldwide. This is mirrored in Enfield where breastfeeding initiation is high but prevalence of breastfeeding drops off rapidly. Anecdotal evidence suggests that white UK women from low socioeconomic groups have low breastfeeding rates.

Normalising breast feeding by providing opportunities for women to breast feed in the community is expected to aid continuation rates. In addition providing peer support for mothers will also benefit maintenance of breastfeeding.

## Achievements

- Breastfeeding helpers were recruited from parent champions (Parent Engagement Panel) to be trained by the Breastfeeding Network (BfN) as volunteers to support mums in their local communities to breastfeed. After completing their training in December 2011 they have now been deployed to various centres in Enfield.
- A Community breastfeeding policy was developed and agreed with provider services.
- The Enfield Breastfeeding Welcome Scheme was developed and resources produced including stickers to be displayed on premises and certificates of membership. Businesses in Enfield approached to support the Breastfeeding welcome project.
- Health Promotion and Social Marketing of breastfeeding using different approaches such as resource development, targeted distribution and advertising in print and audio-visual media.
- Collaborative working with the local authority, voluntary sector and other health colleagues.
- Advertising breastfeeding issues opportunistically at different events and venues.
- Training provision on breastfeeding for the healthy under-fives group.

## Enfield Health Trainers Service

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Health Trainers are members of the community who have been recruited and trained as NHS accredited Health Trainers. They provide free one-to-one motivational advice and support to those who want to make a lifestyle change.

They help individuals to:

- give up smoking
- lose weight
- increase physical activity
- eat more healthily.

Health Trainers use procedures supported by health psychologists to help you make a lifestyle change and they are trained extensively to deliver these sessions.

The aim of this service is to improve the health of the local community through providing personalised support.



### How does it work?

Individuals are referred through their GP and other health professionals, self-referrals are also accepted. Health Trainers will see them for six sessions, which can take place weekly, fortnightly or monthly depending on need.

The first session is allocated for 1 hour, where a short health needs assessment will be done including setting a health goal. This is then followed up by 5 half hour sessions for review of the goal that has been set.

Health Trainers are trained to:

- help set a realistic goal
- help develop a personal health plan
- support individuals to achieve goal set with practical advice.

There are a number of tools they use to give you the support required. All sessions are confidential.

### Where are Health Trainers based?

Health Trainers are based in several locations across the borough including:

- Forest Road Primary Care Centre
- Evergreen Primary Care Centre
- Eagle House Surgery
- Freezywater Primary Care Centre
- Enfield Carers Centre
- Enfield Island Village
- DMC Enfield Lock
- Tottenham Hotspur Foundation (satellite centre).

## How will it improve health?

Eating healthily, increasing physical activity and stopping smoking are key factors to improving health. The Health Trainer Service is a key initiative through which to address health inequalities and supports the primary and secondary prevention of a range of long-term conditions including diabetes, obesity and Cardiovascular Disease.

Health Trainers are uniquely placed in the community to provide behaviour change support to those living in areas of high deprivation. In addition to this, their role encompasses signposting to local services such as, employment and mental health support. This is a significant part of their role and can have a major impact on an individual's economic, educational or social status as many of the barriers to behaviour change are linked to social issues.

## What have we achieved?

- Recruited and trained a diverse team of Health Trainers.
- Attracted a wide range of funding.
- Over 2,000 referrals to the service over the last 4 years.
- On average three quarters of people referred achieved behaviour change.
- Majority of those referred are from areas of high deprivation.
- Rated amongst top 10 in England (2010) for achieving behaviour change.
- First London Health Trainer site to be teamed up with a Premier League football club.
- Health Trainers have been featured on BBC Radio 4, Primary Care Live TV and in the local press.

## What are we planning to achieve?

Future plans are to expand the service, improve effectiveness and help to reduce health inequalities by reaching the most vulnerable in the community.

# NHS Healthchecks

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## What is it?

An NHS Health Check aims to lower the risk of heart disease, stroke, diabetes and kidney disease. It's for adults in England aged between 40 and 74 who haven't already been diagnosed with any of those four diseases. People who are eligible for an NHS Health Check are invited for a check once every five years. At the check, the risk of heart disease, stroke, kidney disease and diabetes is assessed, and the patient is offered personalised advice and support to help lower that risk.

## How will it improve health?

Vascular disease currently affects the lives of over 4 million people in England. It causes 36% of deaths (170,000 a year in England) and is responsible for a fifth of all hospital admissions. It is the largest single cause of long-term ill health and disability, impairing the quality of life for many people. The burden of these conditions falls disproportionately on people living in deprived circumstances and on particular ethnic groups, such as South Asians. Vascular disease accounts for the largest part of the health inequalities in our society.

## What have we achieved?

NHS Enfield introduced the NHS Healthchecks programme in the south-east of the borough in 2010/11 as a means of reducing health inequalities. 3,600 healthchecks were undertaken in 2010/11. The programme was continued in 2011/12 and expanded into the North-east of the borough. There are now some 30 practices providing healthchecks throughout the east of the borough.

In quarter 1, 2012/13, 1,161 healthchecks were delivered and 2,415 offered. The year's target is 5,500 delivered and 15,900 offered. Delivery is targeted to the east of the borough in order to help to reduce the large health inequalities in the borough.

## What are we planning to achieve?

In 2012/13 NHS Enfield is planning to offer 15,900 healthchecks and to deliver 5,500. This will be through primary care and through community providers. It is expected that community providers will be used to target 'hard to reach' communities e.g. those people who do not traditionally access primary care and/or the NHS. The eventual aim is to offer healthchecks throughout Enfield.

In Enfield we are moving towards a mixed model of healthcheck provision including community delivery of healthchecks. This will target people who may not be registered with a GP practice and/or do not respond to invitations to attend general practice. Once people have had a healthcheck they will be given appropriate advice/treatment and will be entered onto GP systems. In this way, more and more, people should enter a systematic screening programme.



# Stop Smoking Services

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## What is it?

Enfield Stop Smoking Services are a free to use, very successful stop smoking service that is available to everyone who wants to stop smoking. It has a network of 1:1 stop smoking advisors across the borough as well as a programme of group clinics.

## How will it improve health?

Smoking is the greatest cause of death, disability and health inequalities in the borough. Smoking causes almost 90% of deaths from lung cancer, around 80% of deaths from bronchitis and emphysema, and around 17% of deaths from heart disease. It is responsible for approximately 20% of all deaths in the borough as well as a significant proportion of illness and disease. About one third of all cancer deaths can be attributed to smoking. These include cancer of the lung, mouth, lip, throat, bladder, kidney, stomach, liver and cervix.

Smokers are not the only people affected by smoking; exposure to other people's tobacco smoke is also a cause of ill-health. Second hand smoke has been shown to cause lung cancer and heart disease in adult nonsmokers, increased sensitivity and reduced lung function in people with asthma, irritation of the eye, nose and throat, reduced lung function in adults with no chronic chest problems.

Secondhand smoke exposure also harms babies and children, with an increased risk of respiratory infections, increased severity of asthma symptoms, more frequent occurrence of chronic coughs, phlegm and wheezing, and increased risk of cot death and glue ear. It is estimated that globally 600,000 deaths a year are caused by secondhand smoke.

## What have we achieved?

In the past 4 years the Enfield Stop Smoking Service has helped over 5,000 people to stop smoking. This has been through advertising and promoting the service throughout the borough, marketing the service to the different communities in Enfield, co-ordinating stop-smoking services with primary and secondary care and targeting services to those most in need.

Enfield also has a very strong Tobacco Control Alliance that aims to reduce:

- the number of people who start smoking in the borough
- increase the number of areas that are smoke-free and
- reduce smoking prevalence in the borough.

## What are we planning to achieve?

This year (2012/13) we are planning to help 1,569 people to stop smoking. This is a significant increase on last year and an extra 100 quitters more than the 1,469 target that was achieved in 2010/11.



# HIV

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The Public Health Outcomes Framework suggests that PCTs should be working towards a reduction in the proportion of people diagnosed with HIV at a late stage of infection. The HPA and NHS London are expecting each PCT to reduce their late diagnosed patients through testing those at highest risk. Presently, for Enfield this is likely to be heterosexual Black Africans.

The number of people living with HIV is increasing in Enfield. Both the local authority and NHS have important roles in supporting people living with HIV, encouraging people to test for HIV, normalising HIV testing, providing education about HIV and how to prevent it and reducing late diagnosis of HIV.

The latest Survey of Prevalent HIV Infections Diagnosed (SOPHID) (2010) data has found that there are now 816 people living with diagnosed HIV in Enfield, an 8.6% increase from 2009 (751) and 34% increase from 2006 (611). This is a prevalence of approximately 5 per 1,000.

Black African women are the largest diagnosed group accounting for 43% (351), black African men are next 22% (165) followed by white men 17% (135). In terms of gender 56% of diagnosed HIV cases are in women. The most common probable route of infection is heterosexual sex (77%), followed by sex between men.

Between 2005 and 2010 the number of people living with HIV in Enfield has increased by 52%, compared to 48% nationally. It is estimated that one third of people who have HIV do not know they have it.

## How does increasing access to HIV testing improve health?

Increasing access to HIV testing will help to reduce the number people being diagnosed with late stage HIV late diagnosis. Evidence shows that those people, who do not realise they have HIV are most likely to spread it to others. NHS London estimates that late diagnosis will cause increased morbidity (with up to 15 times more costs arising from increased in-patient stays) and mortality (and 1 in 4 deaths in first year of diagnosis). People who are diagnosed earlier are 3-4 times more likely to practise safer sex and prevent onward transmission.

There are significant gains that can be obtained from increasing the uptake of testing as whilst there are excellent treatment options now available, these are most effective if the infection is diagnosed early. Late diagnosis of HIV infection is associated with increased morbidity and mortality, increased costs to healthcare services and a reduced response to anti-retroviral treatment.

Current UK guidelines aim to 'normalise' and increase HIV testing in all healthcare settings to reduce the levels of undiagnosed HIV infection. In areas where more than 2 in 1,000 people in the general population have diagnosed HIV, the guidelines recommend that an HIV test is considered for everyone at GP registration and hospital admission.

## What has been achieved?

A sexual health needs assessment was carried out to look at the sexual health needs of Enfield, as a result of this HIV and the lack of availability of HIV testing was highlighted as a major issue. Subsequently Public Health developed a business case that examined and recommended a number of HIV testing initiatives. Health and Social Care have agreed to fund SHIP, a sexual health education programme for GPs.

## What we are planning to achieve in 2012/13

- Training of GPs to increase HIV testing in primary care.
- Testing in acute settings.

# NHS Cancer Screening Programmes

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## What is it?

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. These individuals can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.

The Department of Health's Improving Outcomes: A Strategy for Cancer published January 2011, recognised that cancer screening was an important way to detect cancer early.

The NHS Cancer Screening programme covers Breast, Bowel and Cervical Screening.



## How do the screening programmes improve health?

Cancer treatment is generally more effective when the disease is found early. The impact of the NHS Cancer screening programmes are demonstrated as follows.

### Breast cancer screening

In 2010, evidence from trends in population based mortality rates show that in the UK, breast cancers are diagnosed earlier and treated more effectively than they were in the 1980s, and breast cancer mortality in middle age is falling.

In Enfield, in 2010, 12,500 women were invited for breast screening and around 70% of these women attended screening. We encourage **all** eligible women to take up the offer of a free mammogram.

### Bowel cancer screening

About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying from it each year. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%.

In Enfield, in 2010, 11,026 people were invited to have bowel cancer screening and 217 of those who returned the test kit were referred for further tests; of these 11 were diagnosed with bowel cancer. Participation in the bowel screening programme is generally poor, only about 45% of people complete and return the kit.

## Cervical cancer screening

Cervical cancer is one of the few cancers that are preventable – pre-cancerous cell changes can be detected by screening before they have a chance to develop into a cancer; this makes cervical screening very worthwhile.

The effectiveness of the programme is judged by coverage. This is the percentage of women in the target age group (25 to 64) who have been screened in the last five years. If overall coverage of 80% can be achieved, the evidence suggests that a reduction in death rates of around 95% is possible in the long-term.

In Enfield, in 2010, 38,000 women were invited for screening and 7 screen detected cancers were found. Currently coverage is 78.9%.

## Reducing the risk of developing cancer

We know that the risk of developing cancer depends on a combination of our genes, our environment and aspects of our lives, many of which we can control.

Experts estimate that more than four in 10 cancer cases could be prevented by lifestyle changes, such as:

- Not smoking
- Keeping a healthy body weight
- Cutting back on alcohol
- Eating a healthy, balanced diet
- Keeping active
- Staying safe in the sun.

## What we want to achieve

We would like the population of Enfield to know what they can do to reduce the risk of developing cancer and encourage everyone who is eligible to take up the offer of free cancer screening.



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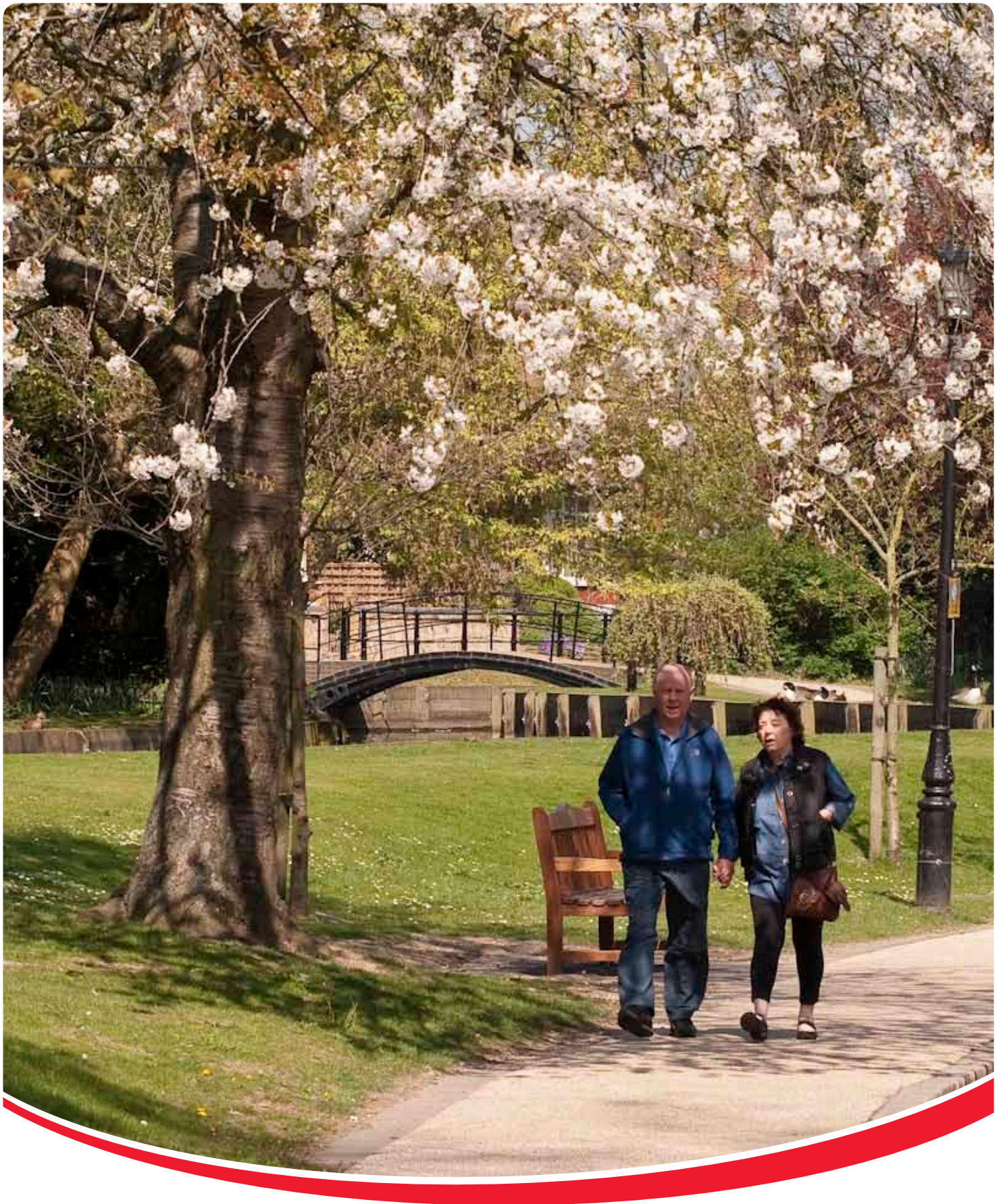
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