

Mind the gap: Reducing the gap in life expectancy

The Report of the Director of Public Health for Enfield: 2014



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Welcome

I would like to welcome you to the Annual Public Health Report for 2014. This report focuses on the gap in life expectancy in Enfield, and what can be done to reduce this gap and support people to live longer, healthier lives.

Overall in Enfield, life expectancy is higher than the London average. However, there are large health inequalities, which ultimately lead to people in more deprived areas living shorter lives and being more affected by illness than those in the affluent parts of the borough. A woman living in Upper Edmonton has a life expectancy of 78.5 years, around 8 and a half years less than a woman in Grange ward. Similar differences can be seen in male life expectancy. I am very pleased to see that life expectancy figures have been improving, particularly improved in the more deprived wards such as Edmonton Green. There have also been improvements in some of the causes of ill health and mortality, including deaths from cardiovascular disease, increased numbers with controlled blood pressure and in the number of people who have given up smoking.

The Annual Public Health Report highlights the importance of evidence led interventions that can have an impact on improving health outcomes and life expectancy. The report includes examples of work across the borough which is contributing to a reduction in the gap in life expectancy. This ranges from innovative initiatives in healthcare settings and healthy schools initiatives, to community engagement events and activities. Ultimately, it is only by engaging fully with our partners and especially with the Enfield community that we can have an impact on reducing the gap in life expectancy. In looking forward, this report outlines much research and evidence of the most effective interventions that can further reduce the gap and increase life expectancy for all.

In tackling the wider determinants of health, it is important to focus on tackling poverty and worklessness which greatly contributes to poor health and health inequalities. In Enfield we have a particular issue with deprivation and child poverty, with more children living in child poverty in Enfield than any other London Borough. This remains a key challenge for us and we are totally committed to continuing to focus on tackling the wider determinants of health by working with our partners.

I would like to thank the Public Health team for their hard work in producing this report which will help to guide future work in reducing the gap in life expectancy and supporting people to live long and healthy lives.

Cllr. Rohini Simbodyal
Cabinet Member for Culture, Sport, Youth and Public Health



Foreword

The Director of Public Health has a statutory duty to produce an Annual Public Health Report. In contrast to the Joint Strategic Needs Assessment (JSNA), the Annual Public Health Report (APHR) enables a more focussed investigation into a particular topic.

My report this year focuses on reducing the gap in life expectancy, in particular what we can do to make the most rapid improvement. Interventions which make a difference in the medium and long term are also briefly discussed in this report. I intend future APHRs to focus on the medium and long term for example on employment or early years.

This particular report is aimed at a professional audience, particularly all of us with direct or indirect responsibility for making Enfield a healthier place to live. A briefer version will be produced for a broader audience.

Promising improvements

We are delighted to see how much improvement there has been since 2008. The three-year average rate in life expectancy at birth for both males and females has improved by 1.3 and 1.1 years, respectively. Recently released figures show encouraging improvements to life expectancy in the Edmonton area. Life expectancy at birth for both males and females in Edmonton Green has reached approximately 78 and 84 years, respectively. Upper Edmonton has also shown improvements in life expectancy at birth. This gives us confidence in our approach to tackling health inequalities and now enables us to broaden our focus to other areas especially the wards of Enfield Lock and Chase.

Since 2008, overall mortality and cardiovascular disease mortality rates have fallen. In 2010-2012, Enfield also had the lowest mortality rate for people under 75 when compared to our Public Health England Longer Lives peer group (a group of areas with comparable features). More than 3,500 extra people in Enfield have had their blood pressure detected and controlled since 2008/09. Hypertension is a known risk factor for premature death and disability. Smoking is also a known risk factor for ill health and it is a great achievement for Enfield, that almost 8,000 people have quit smoking since 2009/10.

We are delighted that the NHS Health Checks programme has improved steadily, with the number of checks increasing from 3,600 in the initial year (2010/11) to over 6,000 in 2013/14.

Empowering people living with long term conditions is vital and it is pleasing to see that diabetes self-education is now being rolled out.

I am pleased to see the broad range of partnerships we have developed to tackle health inequalities some of which are described in the final section of the report.

Partnership working

I am pleased to see that the local NHS is working closely with UCL Partners (UCLP), an academic health science network. The Managing Director of UCL Partners and a number of their colleagues came to visit the Health Improvement Partnership at Enfield's Dugdale Centre in January 2013. As a result of this a close relationship has been forged between the local NHS and UCLP, resulting in a number of programmes to improve quality and tackle the gap in life expectancy.

These include 'Hilo', the 'Atrial Fibrillation Pilot Project', aimed at preventing strokes, and the 'Secondary Prevention: Retrospective Case Records Review Pilot Project' to help understand the causes and prevention of cardiovascular admissions and mortality.

To tackle health inequalities in Enfield we have been working closely with local communities and providers but also with national charities such as Cancer Research UK and the British Heart Foundation.

We have also been working closely with the Department of Health's former head of health inequalities, Professor Chris Bentley, whose team achieved an enormous amount with their former target areas.

In July 2013, we held a major event at the Millfield Arts Centre in Edmonton where we brought together people from the local community, the NHS, Enfield Council, the voluntary sector and a range of other partners based both inside and outside Enfield, to discuss next steps for tackling health inequalities in Enfield and a Public Health programme of work around life expectancy was produced from this event.

Whilst there is much excellent practice in Enfield, elsewhere in London and rest of the country, we should always be prepared to look even further for best practice. In particular we have begun to consider the work undertaken in New York to tackle smoking and obesity and what might be applicable for Enfield.

Our Health and Wellbeing Board is vital for tackling health inequalities. The Board has made use of the Joint Strategic Needs Assessment to produce a strategy which has prioritised tackling the gap in life expectancy.

This report

The first section of this report describes the evidence base. When tackling health inequalities or indeed any other major challenge, it is important to review the evidence base, identify best practice locally and elsewhere, have strong leadership and engage communities and partners (both inside and outside Enfield).

The second section gives a description of the current picture in Enfield. Data and information are vital to quality improvement and tackling the gap in life expectancy, and the section on short term measures is data rich. I am delighted that so much data is collected at a sub-borough level to allow us to focus our short term interventions. Going forward we need to consider how we further strengthen our data systems to help tackle the medium and long term factors impacting on health inequalities.

The final part of the APHR has been handed over to colleagues and partners to describe what they are doing to tackle health inequalities in Enfield.

In summary, I am delighted at the progress that has been made over the past five years, and the quantitative improvements which have been evidenced. There is however still much to do. I feel confident that the right building blocks are in place to further reduce health inequalities in a sustainable manner.

We would like to thank members of the Health & Wellbeing Board and colleagues in the Council and Clinical Commissioning Group (CCG), particularly clinical colleagues, who reviewed drafts of the report to ensure accuracy.

Last, but not least, I would like to thank everyone in the public health team, colleagues, partners both for producing this report and for improving the health of people in Enfield; particularly the most vulnerable.

Dr. Shahed Ahmad
Director of Public Health



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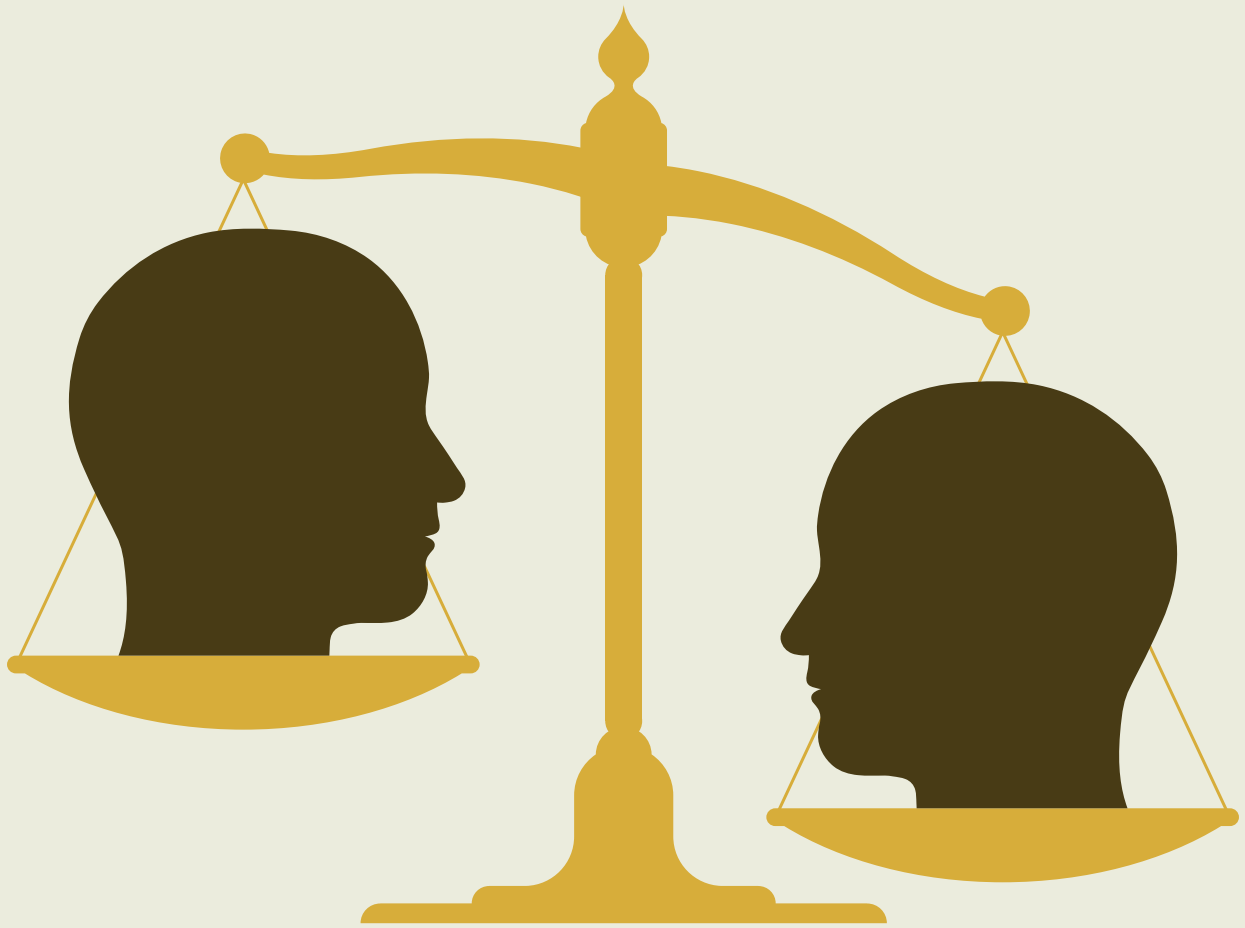
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Chapter 1.
Introduction



1.0 What are health inequalities?

1.1 The evidence

Health inequalities are the differences in health status or in the distribution of health determinants between different population groups (World Health Organisation, 2014). How well and how long one lives is strongly shaped by occupation, education and income. Differences in occupation, education and income in turn influence housing, social environment and access to services; these elements are all key drivers of inequalities in health outcome.

The Black Report demonstrated the correlation between poverty and health (Department of Health and Social Security, 1980). Living in areas of low income, poor employment and poor infrastructure increase the risk of ill health above and beyond factors at an individual level (EuroHealthNet, 2006). People with lower education, income or occupation tend to die at a younger age and have a higher prevalence of most types of health problems. These differences start at a young age and persist and widen at older ages (Eurohealth, 2009).

Since the mid-nineteenth century, death rates have fallen significantly and it is the chronic diseases of later life, like coronary heart disease and cancer which now dominate the mortality statistics. Despite these changes, the distribution of ill-health continues to follow the same patterns of disadvantage (Graham, 2009).

‘Such differences are avoidable and unjust. In a fair and prosperous society, everyone should have the same chance to lead a long and healthy life and enjoy the same opportunities for education, employment, recreation and fulfilment that good health brings’ (Department of Health, 2008, p.13).

The search for causes should extend beyond the individual to explore the underlying structures of inequality – ‘tackling inequalities generally is the best way of tackling health inequalities in particular’ (Secretary of State for Health, 1998). This is a key priority for Enfield – see Joint Health and Wellbeing Strategy for Enfield (London Borough of Enfield, 2014a).

1.2 Health inequalities in Enfield

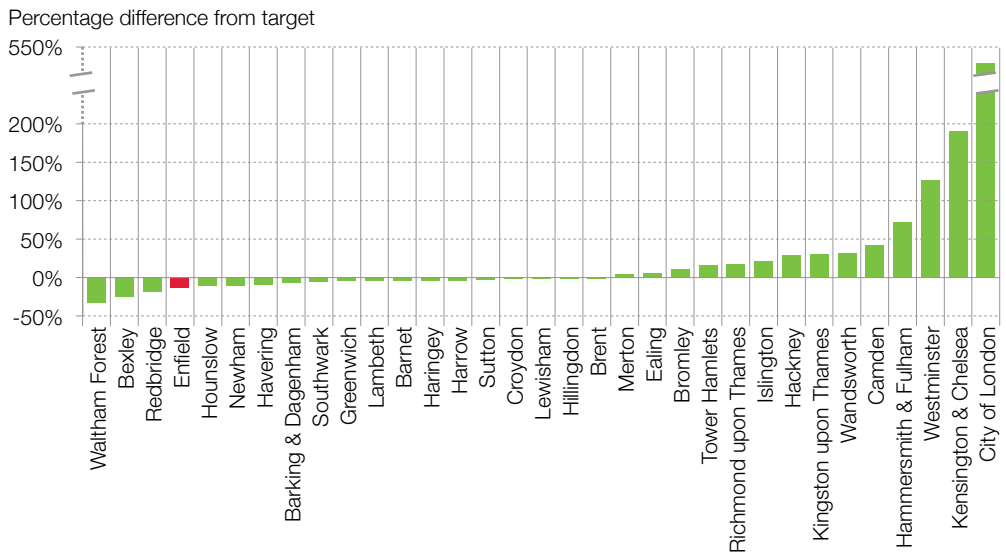
The London Borough of Enfield is a multi-ethnic borough with a population of 317,000 (ONS Mid-2012 population estimate) and growing. Almost 60% of the population are non-White. The proportion of under 15s (21.2%) is higher than both England (17.7%) and London (19%) averages.

In Enfield, 32.8% of children under 16 years live in poverty, ranking 6th worst in London and 10th worst nationally. Enfield has the highest number (23,210) of children living in poverty within London.

In 2014/15, Enfield’s public health allocation was £43 per person, lower than the London average of £68 per person, and below the England average of £67 per person. The allocation of budget per person in Enfield is not a local decision. In terms of distance from target budget, Enfield has the 4th highest gap amongst 32 London boroughs (Figure 1.1).



Figure 1.1: Public Health Allocation, Distance from target, 2014/15

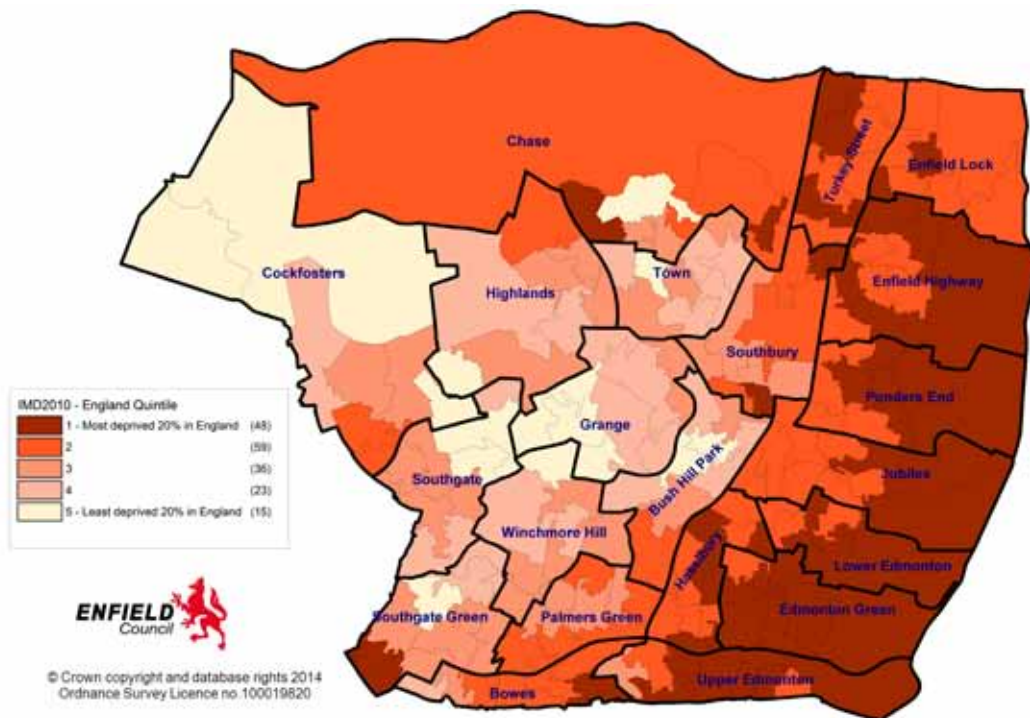


Source: PH exposition data, 2014/15

Enfield is a borough of high deprivation. It is the 14th most deprived of the 32 London boroughs and the 64th most deprived local authority district in England out of 326. The three Edmonton wards, in the South East, are all within the most deprived 10% of wards in England, whilst 12 of Enfield’s twenty-one wards are in the most deprived 25% of wards in England.

The Figure 1.2 below shows the location of areas of deprivation in Enfield, using national quintiles. The more deprived areas tend to be in the east of the borough, with the south-east of the borough being particularly deprived.

Figure 1.2: Deprivation in Enfield, 2010



Source: IMD, 2010

Higher socioeconomic deprivation overlaps with higher levels of poor health outcomes. Death rates and disease burden due to heart disease, stroke, cancer and diabetes are disproportionately high in areas of deprivation. The effects of health inequalities include differences in life expectancy and infant mortality.

Locally, the Joint Strategic Needs Assessment (London Borough of Enfield, 2014b) informs the Health and Wellbeing Board about the local needs. Enfield's vision of improving health and wellbeing in Enfield is set out in the current Joint Health and Wellbeing Strategy (London Borough of Enfield, 2014a).

The Enfield Joint Health and Well-being Strategy 2014-2019, five key priorities:

- Ensuring the best start in life
- Enabling people to be safe, independent and well and delivering high quality health and care services
- Creating stronger, healthier communities
- *Reducing health inequalities – narrowing the gap in life expectancy*
- Promoting healthy lifestyles and making healthy choices

1.3 Why is it important to reduce the gap in health inequalities?

The importance of reducing the gap in health inequalities has been given increased impetus in recent years. The Marmot Review (2010) showed us that health inequalities are still widespread in England. There is a pronounced socio-economic gradient in the prevalence of all major long-term conditions, in life expectancy and in healthy life expectancy.

There is a strong case for addressing health inequalities based on both moral and economic grounds. It is estimated that the annual cost of health inequalities is between £36 billion and £40 billion through lost taxes, welfare payments and costs to the NHS (Marmot Review). Indeed it is estimated that poor access to and effective use of healthcare contributes to, at least 15-20 percent of inequalities-related mortality (NHS England, 2013).

Inequalities contribute to financial pressure on health and social care. Sir Derek Wanless (2002) reported that with increasing costs in healthcare, increasing patient expectations on the quality of care, and greater demand due to the ageing and ailing population, healthcare could become unaffordable unless people became fully engaged in their own health.

Reducing health inequalities is a priority in England and for Enfield. Healthcare services can contribute through prevention of poor health for those most at risk and by promoting equality of access to and outcomes from service provision.

Tackling health inequalities is a priority for the NHS England and GP Clinical Commissioning Groups. The mandate to the NHS Commissioning Board (Department of Health, 2013), included tackling health inequalities;

“The NHS is a universal service for the people of England, and the NHS Commissioning Board (now called NHS England) is under specific legal duties in relation to tackling health inequalities and advancing equality. The Government will hold the Board to account for how well it discharges these duties” (Department of Health, 2013).

1.4 Causes of health inequality

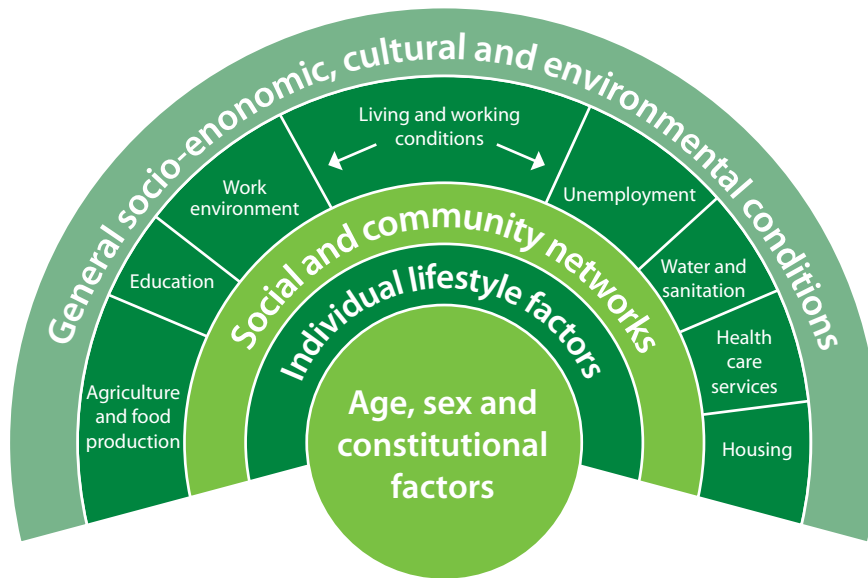
Health inequalities are a reflection of social (or wider) inequalities, which in turn are linked to inequalities in opportunities and aspirations. Health inequalities are influenced by several factors known as the determinants of health, all of which are interrelated. The determinants of health fall under several broad categories and are often represented using the Dahlgren and Whitehead (1991) model (Figure 1.3).

The determinants of health include:

1. Biological determinants such as age, gender, ethnicity.
2. Behavioural determinants such as smoking, diet, alcohol consumption, physical activity and other lifestyle behaviours.
3. Psychosocial determinants such as stress, isolation, social exclusion and lack of social support.
4. Socioeconomic determinants such as the physical and social environment, including housing, workplace, employment and wider environment, as well as access to income and services.

These factors can have a cumulative effect that can result in health inequalities.

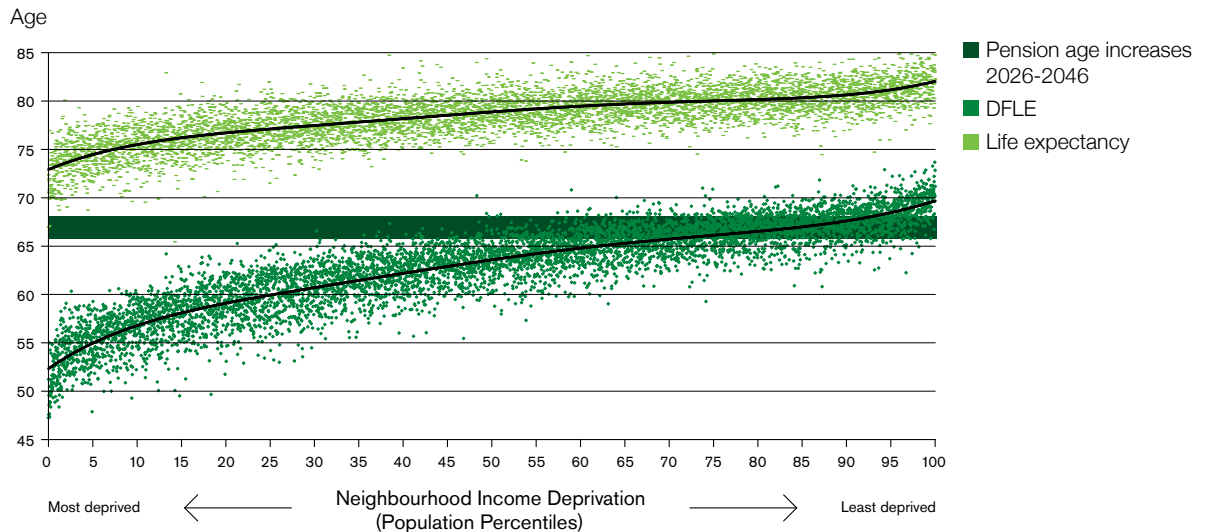
Figure 1.3: The determinants of health model



Source: Dahlgren G and Whitehead M. (1991). *Policies and Strategies to Promote Social Equity*. Stockholm: Health Institute of Future Studies.

Social inequalities are an important driver of health inequalities. While other factors such as biological or genetic predisposition or age influence the prevalence of ill health, there is a pattern of reduced life expectancy and higher levels of illness, which is linked to socio-economic status and the gradient between socio-economic groups (Department of Health, 2008).

Figure 1.4: Life expectancy and disability free life expectancy (DFLE) at birth, persons by neighbourhood income level, England 1999-2003



Source: The Marmot Review 2010, Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010. The Marmot Review HM Government 2010

Figure 1.4 illustrates the relationship between deprivation and life expectancy with disability free life expectancy. Narrowing the gap in life expectancy is a national concern, also in relation to planned increases in the pension entitlement age. Similarly, reducing the number of years people live with less than good health will reduce some pressures resulting from the costs of treating long term conditions and providing social care.

The importance of social determinants of health inequalities (such as poverty, housing, ethnicity, education, income, occupation and environment) is well established. Evidence from The Marmot Review (2010), Acheson (1998) and the Black Report (Department of Health and Social Security, 1980) clearly affirm that health inequalities are the result of complex interactions caused by a number of factors. Health inequalities will continue to be generated without action on these social determinants, which are widely known as the “causes of the causes of health inequalities” (The Marmot Report, 2010 p.39).

1.5 Evidence Base for reducing Health Inequalities

Health Inequalities National Support Teams (HINST)

The Health Inequalities National Support Team (HINST) was a Department of Health team that provided tailored delivery support to health partnerships in England – Primary Care Trusts (PCTs)/NHS trusts and local authorities.

The HINST was established in 2007 to provide support to local areas focusing principally on the life expectancy element of the 2010 Public Service Agreement (PSA) target – to reduce by at least 10% the gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole. Local areas with the worst health and deprivation, known as spearhead areas were a fixed list of 70 local authorities in England, for three or more of the following five factors:

1. male life expectancy at birth;
2. female life expectancy at birth;
3. cancer mortality rate in under 75s;
4. cardiovascular disease (CVD) mortality rate in under 75s; and
5. deprivation (as measured using the Index of Multiple Deprivation (IMD), 2004).

The 70 spearhead areas mapped onto 62 Primary Care Trusts (PCTs) of which, 11 were in London. Spearhead areas had ‘stretch’ targets to improve population health outcomes more quickly than those with better health outcomes.

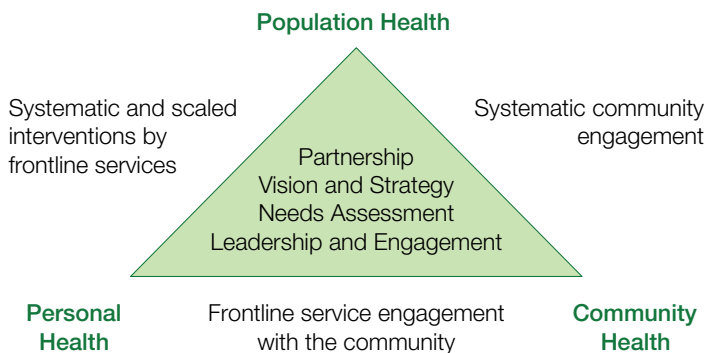
Whilst Enfield did not qualify as a spearhead area at the time, we face challenges at least as great as spearhead areas. Enfield can therefore benefit from the intervention strategies and learnings developed by HINST and systematically address the challenges.

The HINST used a diagnostic model to help local areas identify the key interventions to implement in order to succeed. The three categories of interventions are:

1. **Population health level** – direct input at population level through legislation, regulation, taxation, mass media (e.g. preventing smoking in enclosed public spaces).
2. **Personal health level** – applying effective personal health interventions (e.g. cholesterol management, affordable warmth) systematically, and at a scale such that improvements add up to population-level change.
3. **Community health level** – engaging, developing and empowering communities effectively and systematically enough that resulting health-improving and health-seeking behaviours lead to percentage change at population level.

Figure 1.5 illustrates the relationship between the three levels of intervention and the strategic interventions required.

Figure 1.5: HINST Health Inequalities – three levels of intervention

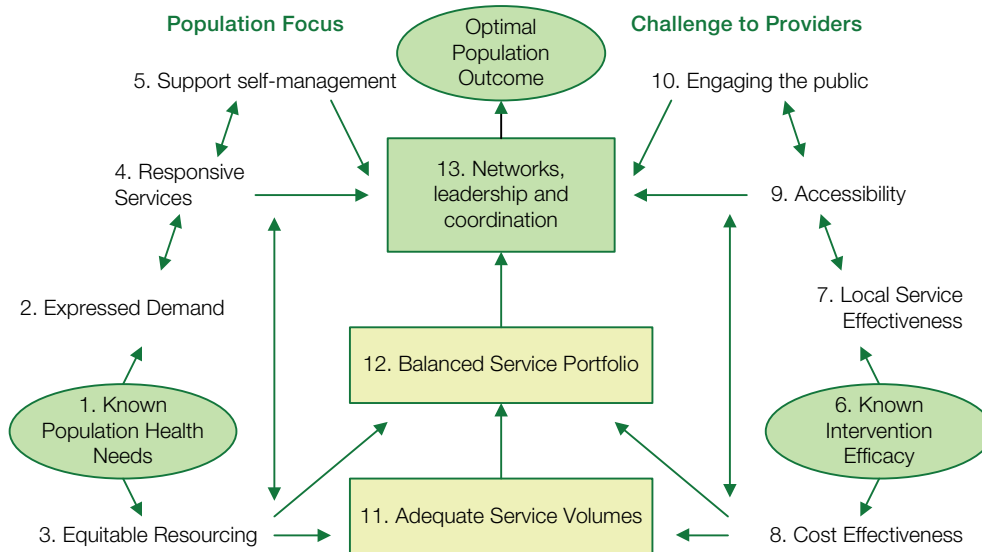


Source: Bentley C (2007). Systematically addressing health inequalities, Health Inequalities National Support Team.

The HINST provided support by selecting evidence based interventions that would achieve inequalities targets. This support was offered by (i) estimating reduction in number of deaths necessary to achieve target and (ii) by estimating scale of selected intervention required to achieve life expectancy targets by modelling potential number of deaths averted if the intervention was provided to all residents who would benefit. The team stated that services should be based where possible on strong evidence and that efficacy, based on experimental trials must translate into effective local intervention. This must be constantly checked through local audit and systems of governance.

The ‘Christmas Tree’ diagnostic model (Figure 1.6) systematically informs best practice and identifies those factors which will determine whether a given intervention will achieve its best possible outcomes in a given population. The model is underpinned by collaborative working and robust networks, with a strong focus on community involvement and engagement.

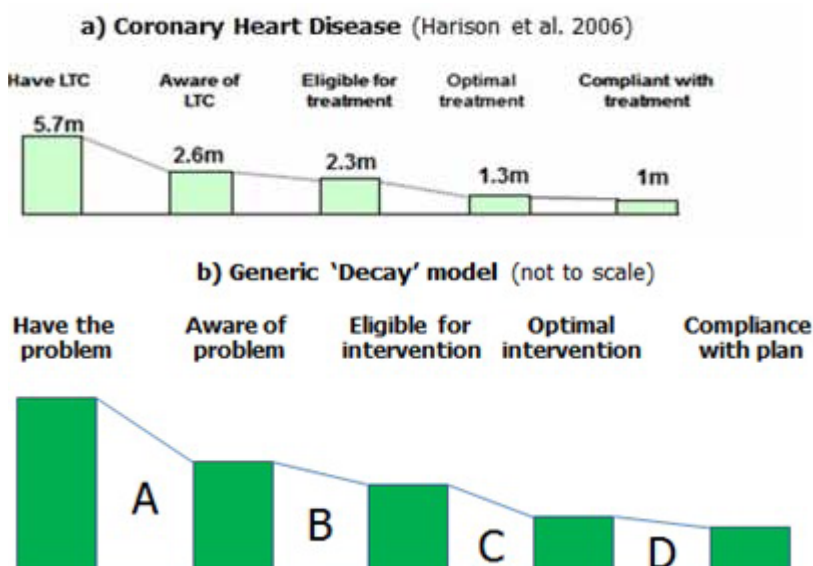
Figure 1.6: HINST “Christmas Tree” Diagnostic Model



Source: Bentley C. (2007). Systematically addressing health inequalities, Health Inequalities National Support Team.

A very important component of the Christmas tree model is to query how the population uses services, and is supported to do so. Using the example of the Long Term Condition (LTC) of heart disease, it was shown by a group in the UK, that while nearly 6 million people in the study population were known to have the condition, nearly 5 million fell by the wayside and only 1 million ended up properly taking the appropriate treatments (Harrison et al., 2006). This story is not unique to heart disease, but can be observed for other long term conditions, such as diabetes, and any other service-based issue e.g. affordable warmth, and reducing alcohol related harm.

Figure 1.7: Modelling the points of ‘decay’ in uptake of interventions



Source: Bentley C. (2007). Systematically addressing health inequalities, Health Inequalities National Support Team.

The generic model can be established, which identifies the different points at which society can intervene to prevent the ‘decay’ in successful uptake of interventions (see Figure 1.7). These, in summary, are:

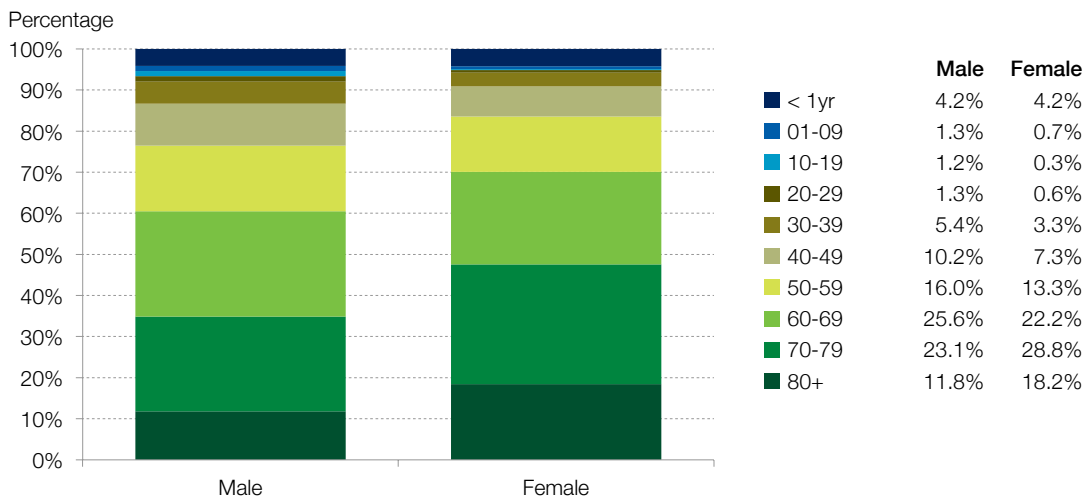
- A. Awareness and understanding in communities
- B. Presentation and Assessment through a range of entry points
- C. Quality of Service, delivering the right interventions in the right way
- D. Support for Self-Management, including peer support

In the past, services have been responsible for taking on all points in this sequence in isolation, and unsurprisingly have had limited success, particularly with those in deprived circumstances, and with the most problems.

Contribution of mortality gap for Over 50s to the overall LE gap

The HINST also provided evidence of the contribution of each age group to the gap in life expectancy gap, demonstrating the difference between the Spearhead area and England. Figure 1.8 below shows that more than three quarters (76.5%) of the male life expectancy gap between the Spearhead area and England are attributable to the difference in mortality amongst those aged 50 and over, i.e. age groups 50-59, 60-69, 70-79 and 80+. Similarly, more than 80% of the female life expectancy gap between the Spearhead area and England is attributable to the difference in mortality rate for those aged 50 and over.

Figure 1.8: Breakdown of the life expectancy gap between the Spearhead area and England, by age group, Males and Females, 2006-2008



Source: Health Inequalities Intervention Toolkit – Life Expectancy Spearhead Tool, Public Health England

HINST gestation intervention model

While many recommendations concentrate on interventions which could have an effect on life expectancy in the shorter term (i.e. 3 years), other interventions take longer and should continue alongside the interventions (such as work on obesity) which will have a longer term effect. HINST devised a gestational period intervention model to address the challenge of reducing inequalities. The rationale used in the model is based on visualising health inequalities interventions in three broad gestational timescales according to the speed of impact on health, based on desired outcomes. The model looks at the gestation period of interventions in the short, medium, and long term. The use of the model heavily depends on the outcomes that are being sought. It is important to note that the different gestation times for different interventions does not reflect the time it takes strategically to implement an intervention, but is focused more on the outcome of the intervention once it has been implemented.

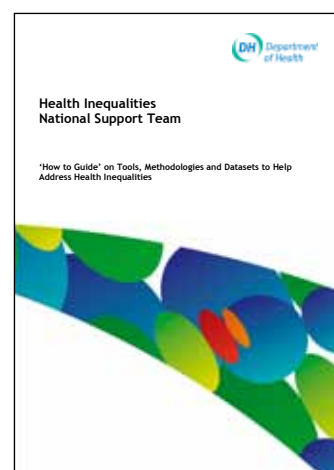
Action to reduce inequalities requires focus on causes such as, the wider determinants, the risk factors for disease (primary prevention and secondary prevention) and accessibility and responsiveness of the health services.

Interventions to achieve short term (less than five years) impacts can have a sizable impact on life expectancy. These include actions such as prevention of cardiovascular diseases, early identification of cancers and the management of long term conditions. However, these should be combined with other interventions that aim to realise an impact on outcomes in the medium term (0 to 10 years), such as lifestyle changes, and an impact on outcomes in the longer term (0 to over 10 years), such as education and employment.

The short, medium and long term have an impact at individual, community and population level. This means that the impact of interventions to reduce inequalities in the wider determinants for health will work on a continuum from short term, through medium term to long term, and in some cases the population level impact will be realised in the medium to long term.

Department of Health (DH), Health Inequalities National Support Team (HINST) state that focusing on the short-term interventions does not mean completely neglecting interventions with a medium or longer term gestation period. Several short-term interventions will also bring benefit in the medium term (e.g. tobacco control, physical exercise); and many of the developments needed to deliver the right levels of system and scale in the short term will be necessary to deliver long-term objectives (e.g. strengthening primary care delivery, systematic community engagement).

The Health Inequalities National Support Team produced a resource pack: *Redoubling the efforts to achieve the 2010 National Health Inequalities Life Expectancy Target* which provides useful guidance on their experience of working to reduce inequalities in the Spearhead areas. The documents, guides and tools highlight ways of improving outcomes, especially for patients and communities who often experience the poorest health and premature death. Evidence-based, high quality, innovative and early interventions make financial as well as clinical and social sense. Tackling inequalities effectively improves care and services for all patients and communities. The resource manuals have been built around good practice identified from the visits undertaken in spearhead areas that were expected to make an impact on mortality in a short timescale if delivered at a sufficient scale.



The materials are highly practical, many illustrated with tangible examples of improvements made in local areas, as well as providing a step-by-step checklist of how to take certain approaches and initiatives forward. Workbooks include cardiovascular disease, cancer, diabetes, infant mortality, seasonal excess deaths, tobacco control and alcohol harm reduction. The HINST supported Spearhead areas in systematically reviewing their practice against the standards in the workbooks.¹

The HINST also developed a set of priority actions to support areas implementing interventions to reduce the health inequalities of their populations. They considered these actions the essential components needed to impact on mortality and life expectancy (HINST).

Eight key priority actions were recommended:

- Priority Action 1 – **Strategy and governance**
- Priority Action 2 – **Setting appropriate outcome goals**
- Priority Action 3 – **Modelling the numbers**
- Priority Action 4 – **Driving up primary care quality and capacity**
- Priority Action 5 – **Proactive chronic disease management**
- Priority Action 6 – **Frontline service engagement**
- Priority Action 7 – **Community engagement**
- Priority Action 8 – **Delivery plans**

These priority actions could be used by partners in considering the approach to reducing inequalities in Enfield.

¹ HINST guides and workbooks available at: http://www.institute.nhs.uk/commissioning/general/health_inequalities_national_support_team_resources.html

For the purpose of this report, we propose to use the Department of Health Health Inequalities National Support Team gestation model (short, medium and long term) to address mortality and life expectancy. In this case interventions on early start, educational attainment, poverty and employment will have their impact on mortality in the long term, and will have an impact on wellbeing in the short term. For this reason, there is a continuum for interventions for which we expect an outcome at the population level.

Marmot Review

The most recent independent review of how health inequalities can be tackled was commissioned by the Secretary of State for Health for England in 2008, and chaired by Sir Michael Marmot. The remit of this review was to propose the most effective evidence-based strategies for reducing health inequalities in England. The Marmot Review (2010) on health inequalities “Fair Society, Healthy Lives” proposed some of the most potentially effective interventions, that might impact on the social determinants of health (see Box 1). For many, the review forms the context in which subsequent national and local policies to address health inequalities have been developed.

The central tenet of the Marmot Review is that avoidable health inequalities are unfair and putting them right is a matter of social justice. Health inequalities are not inevitable and can be significantly reduced. Inequalities present before birth set the scene for poorer health and other outcomes accumulating throughout the life course.

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 1: Marmot recommendations

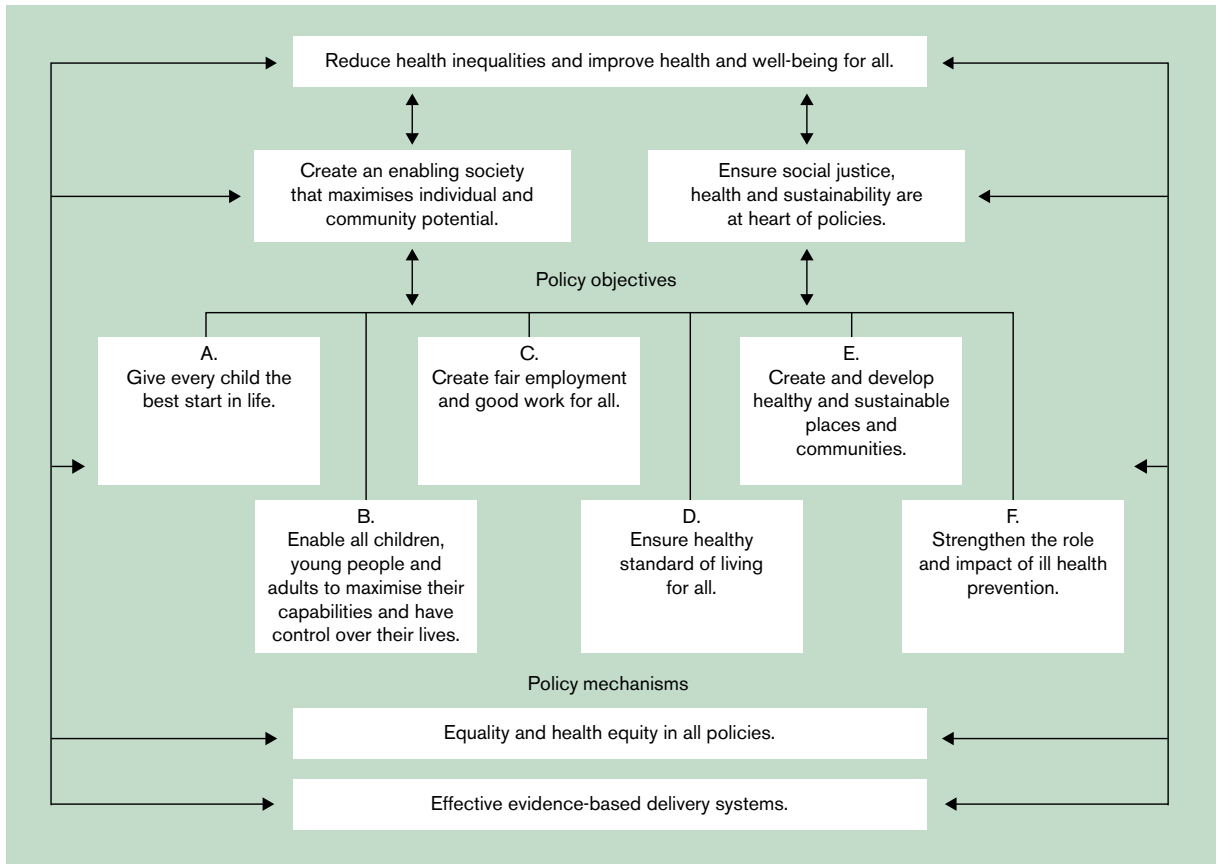
Fair Society, Healthy Lives recommended action on the six following policy objectives:

- 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.

Source: The Marmot Review 2010, *Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010*.

Both The Marmot Review (2010) and “Healthy Lives, Healthy People” White Paper adopt a life course framework for tackling the wider social determinants of health. This assumes that disadvantage starts before birth and grows through life. This is reflected in the set of policy recommendations developed by The Marmot Review, which start with the objective of giving all children the best start in life.

Figure 1.9: The policy objectives set out within the Marmot Review



Source: The Marmot Review 2010, Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010. The Marmot Review HM Government 2010

The Marmot Review declared that its central ambition was to create the conditions needed for people to take control over their own lives. The rationale was that if the conditions under which people are born, grow, live, work and age are favourable and more equitably distributed, then people will have and will feel they have more control over their own lives and this in turn will influence their health and health behaviours and those of their families.

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Chapter 2. **The Local Picture**



Key messages

- ▶ Enfield life expectancy at birth is **80.5 years** for males and **84.0 years** for females (above the London average).
- ▶ Enfield has **the lowest** rates of premature (under 75 years) mortality amongst 15 local authorities with similar socio-economic characteristics.
- ▶ There are differences in life expectancy between different areas of Enfield. In areas of higher deprivation, men live **8.7 years** less, and women live **8.6 years** less.
- ▶ Enfield has the **6th** highest child poverty rate and the **3rd** highest infant mortality rate in London.
- ▶ Enfield has largest number of children in poverty in London.

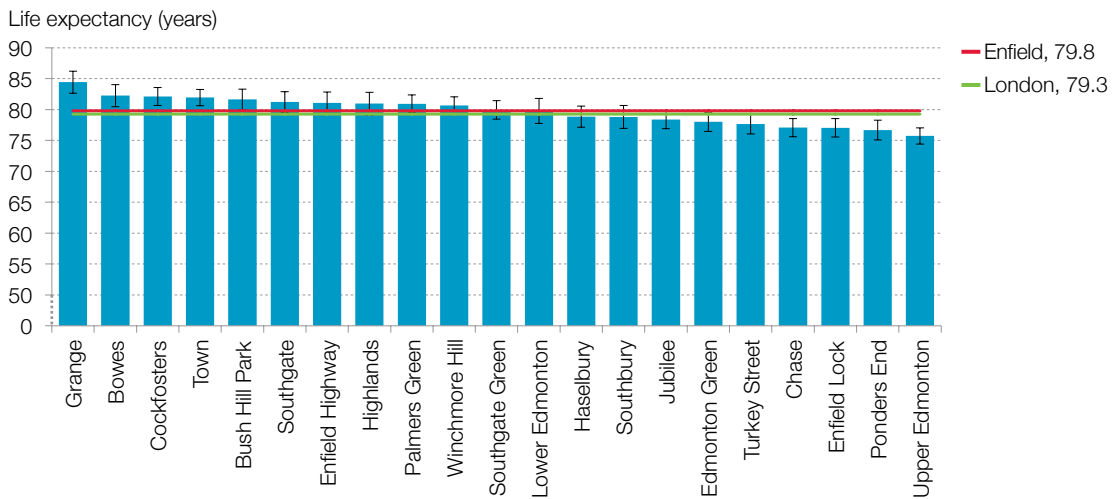
2.1 Life Expectancy in Enfield

Life expectancy can be defined as the average number of years a person would live, if he/she experienced a particular area's mortality rates throughout their life.² Life expectancy is used as an international measure of health status.

Life expectancy at birth for males living in Enfield is 80.5 years and for females is 84.0 years, above London and England averages (Life expectancy at birth for 2010-12, Office for National Statistics).

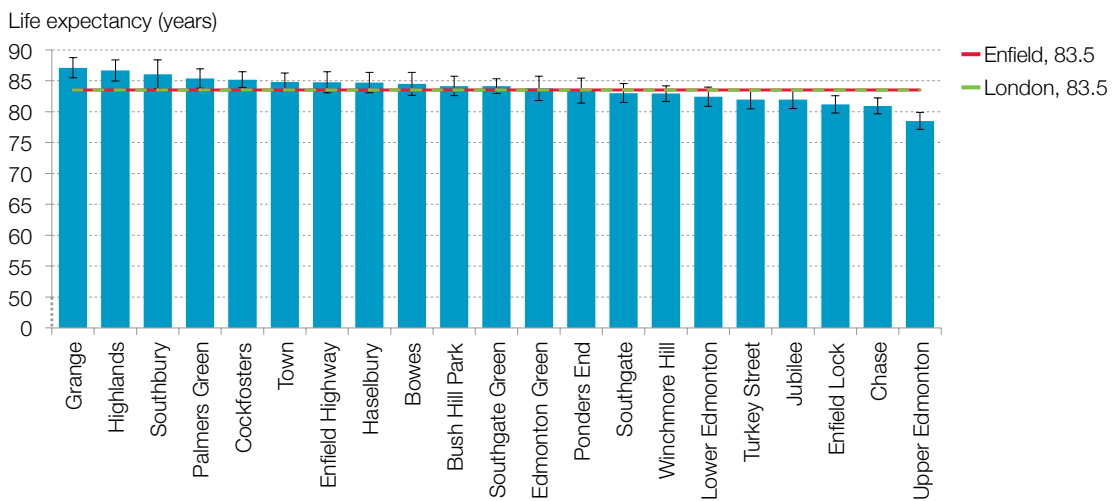
Although life expectancy at birth in Enfield is above the London and England averages, there is still wide variation in life expectancy within the borough (see Figures 2.1 and 2.2). Male life expectancy ranged from 75.7 years in Upper Edmonton ward to 84.4 years in Grange ward. Female life expectancy was also lowest in Upper Edmonton (78.5 years) and highest in Grange ward (87.1 years).

Figure 2.1: Male life expectancy at birth, Enfield wards, 2008-2012



Source: Greater London Authority using ONS mortality data and ONS mid-year population estimates

Figure 2.2: Female life expectancy at birth, Enfield wards, 2008-2012



Source: Greater London Authority using ONS mortality data and ONS mid-year population estimates

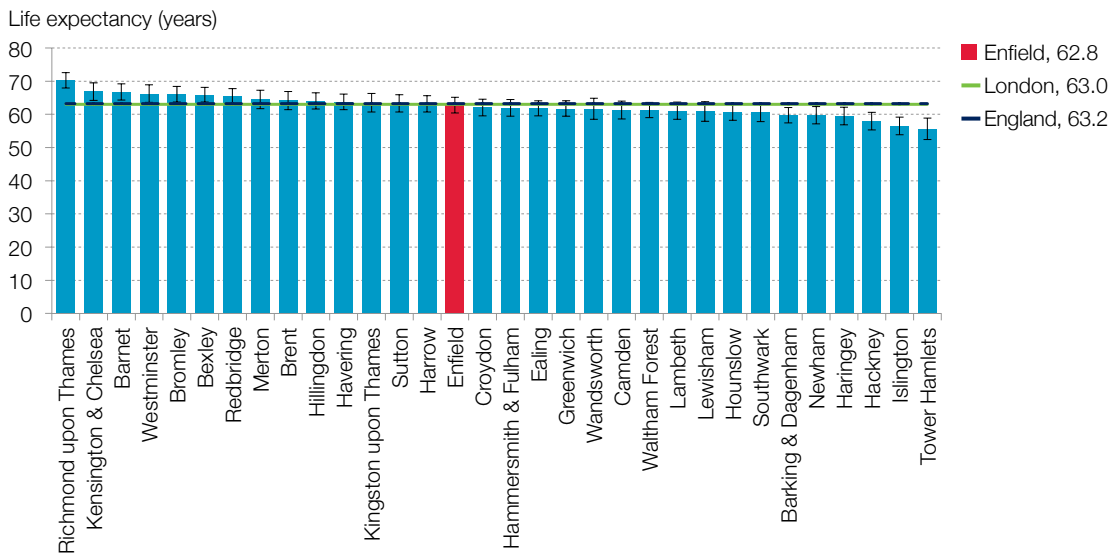
² Period expectation of life at a given age for an area in a given time period is an estimate of the average number of years a person of Life expectancy at birth for local areas in England and Wales, that age would survive if he or she experienced the particular area's age-specific mortality rates for that time period throughout the rest of his or her life. The figure reflects mortality among those living in the area in each time period, rather than mortality among those born in each area.

Healthy Life expectancy

Healthy life expectancy (HLE) estimates the average number of years a person would live in ‘Very good’ or ‘Good’ health if he or she experienced the mortality and health status of the specified population for that time period throughout their life (World Health Organisation, 2014).

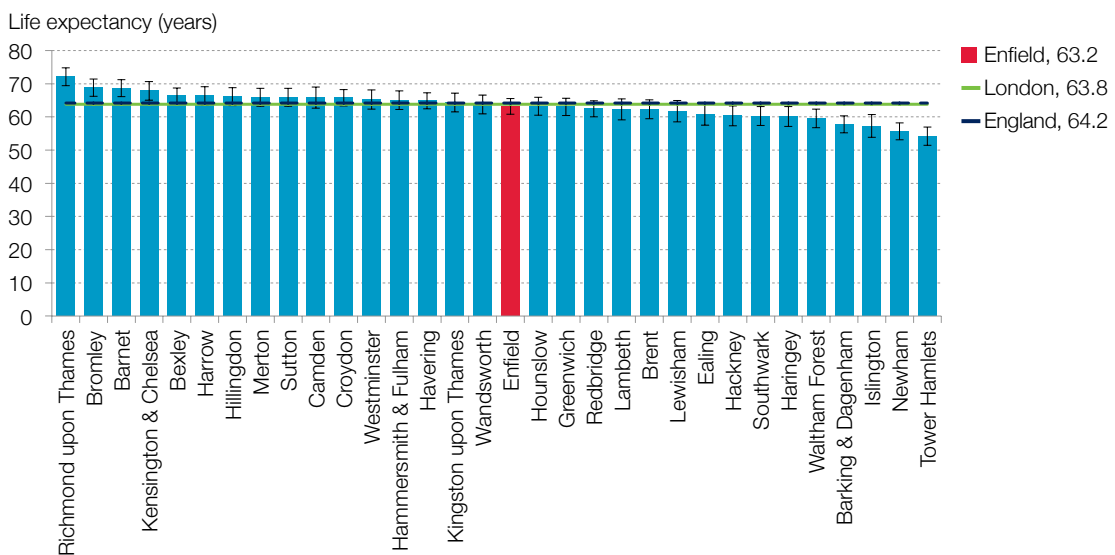
Despite higher life expectancy in Enfield overall compared to London and England, HLE for both males and females in the borough falls marginally below the London and England averages. This means that men and women in Enfield spend more years than average in ‘not good’ health (refer to Figures 2.3 and 2.4).

Figure 2.3: Healthy life expectancy at birth, Males, London boroughs, 2009-2011



Source: Office for National Statistics

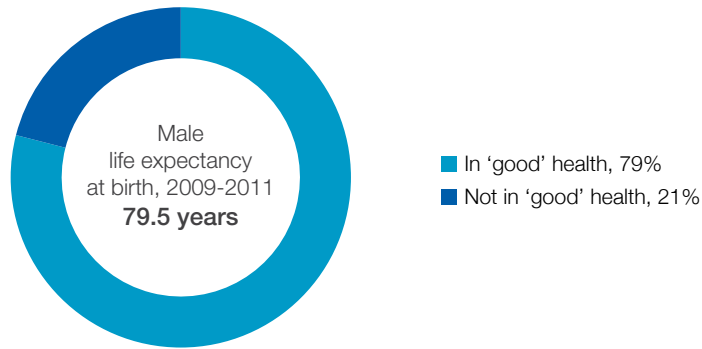
Figure 2.4: Healthy life expectancy at birth, Females, London boroughs, 2009-2011



Source: Office for National Statistics

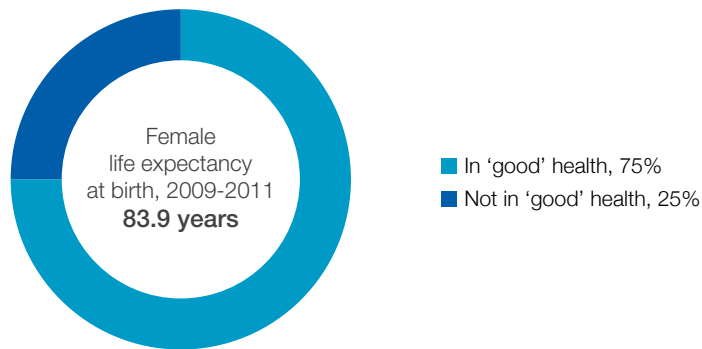
Men living in Enfield spend just over one fifth (21%) of their life not in 'good' health, whilst women living in Enfield spend a quarter of their life not in 'good' health (refer to Figures 2.5 and 2.6).

Figure 2.5: Proportion of life spent in 'good' health, Males, Enfield, 2009-2011



Source: Office for National Statistics

Figure 2.6: Proportion of life spent in 'good' health, Females, Enfield, 2009-2011

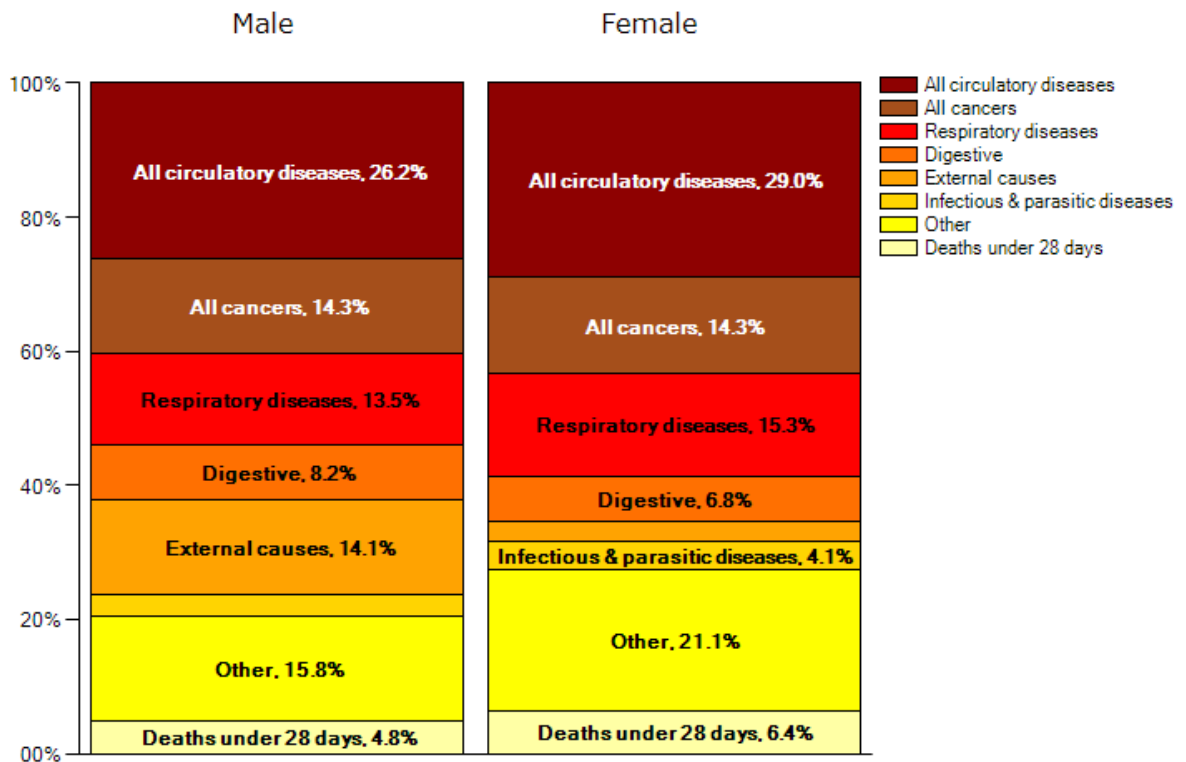


Source: Office for National Statistics

2.2 Inequalities in health outcomes and impact on life expectancy

Circulatory disease³, cancer and respiratory disease are not only the greatest causes of mortality in the borough but also contribute significantly to the gap in life-expectancy (Figure 2.7). For example, mortality from all circulatory diseases and cancers is the major contributor to the life expectancy gap for both males and females (26.2% and 29.0%, respectively). Deaths under 28 days also contribute to the gap in life expectancy.

Figure 2.7: Breakdown of life expectancy gap between the Most Deprived Quintile (MDQ) of Enfield LB and the least deprived quintile in the local authority average by cause of death, 2011

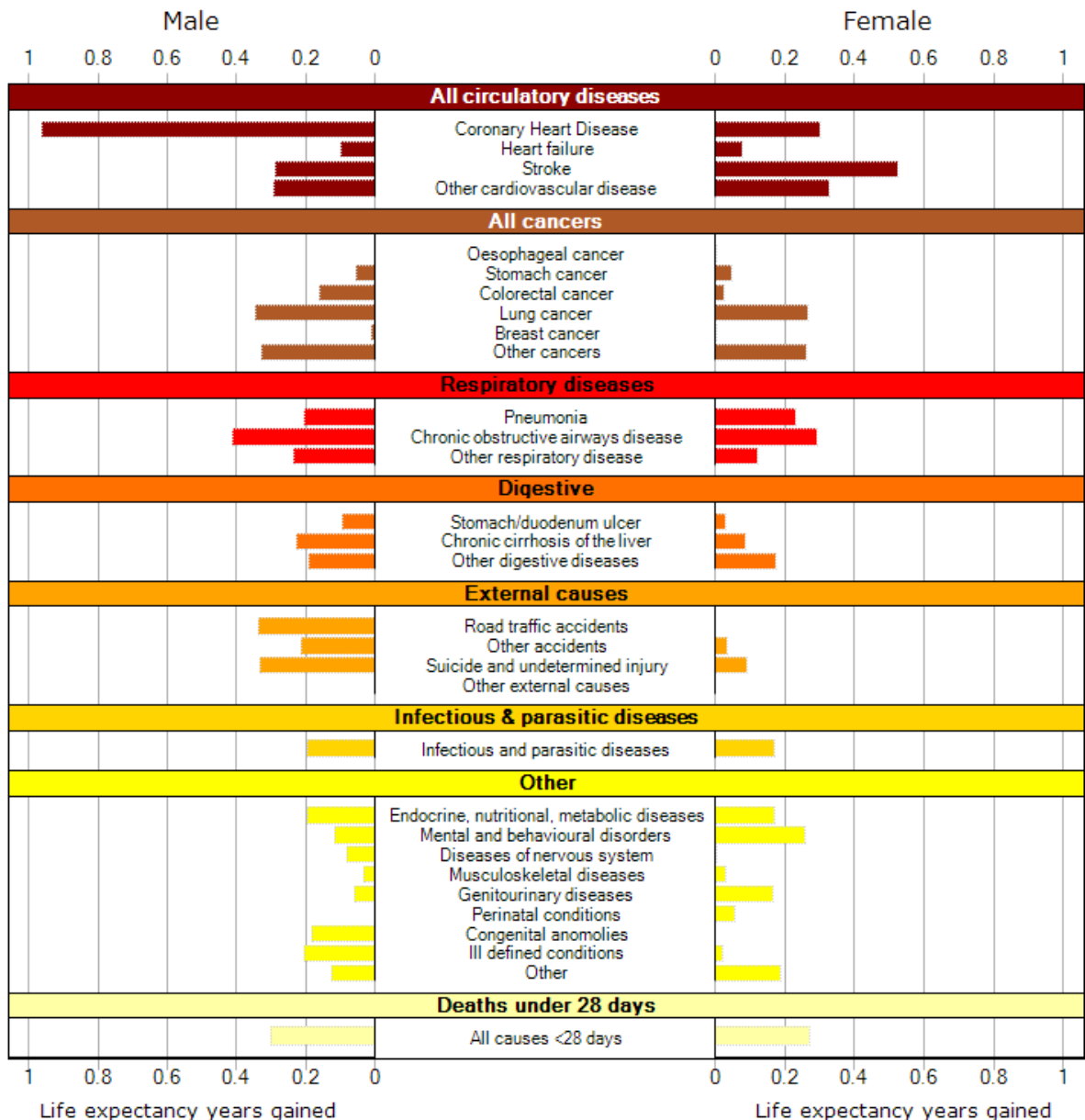


Source: London Health Observatory

³ Circulatory diseases include coronary heart disease (CHD) and stroke; Digestive diseases include alcohol-related conditions such as chronic liver diseases and cirrhosis; external causes include injury, poisoning and suicide.

Figure 2.8 illustrates the life expectancy years that potentially can be gained in the most disadvantaged quintile (20%) in Enfield for each cause of death, if the most deprived 20% in Enfield had the same mortality rate as least deprived quintile in Enfield. The figure helps to identify those diseases where there is excess mortality in the most disadvantaged quintile. In Enfield, a significant number of deaths could be prevented from Coronary heart disease in males, stroke in females and cancer in both genders. The figure displays the relative impact of key areas.

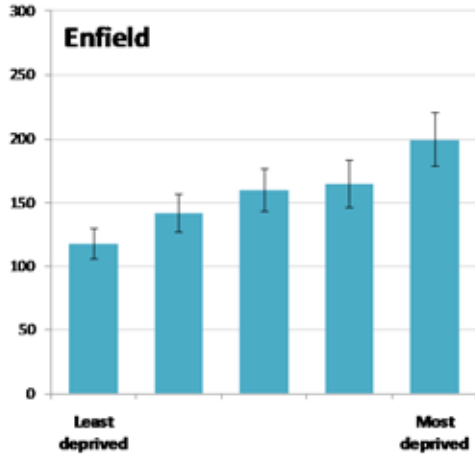
Figure 2.8: Years of life gained if people in the most deprived quintile of Enfield had the same mortality rate as the least deprived quintile, by cause of death



Source: London Health Observatory (LHO, 2008) The Health Inequalities Intervention Tool for all areas. Available at: http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx

Figure 2.9 clearly demonstrates the deprivation gradient for mortality from circulatory disease in Enfield, with the most deprived fifth of areas in Enfield having significantly higher rates of mortality compared to the least deprived areas of the borough.

Figure 2.9: Directly standardised mortality rate, circulatory disease, by relative deprivation quintile, Enfield, 2011
DSR per 100,000

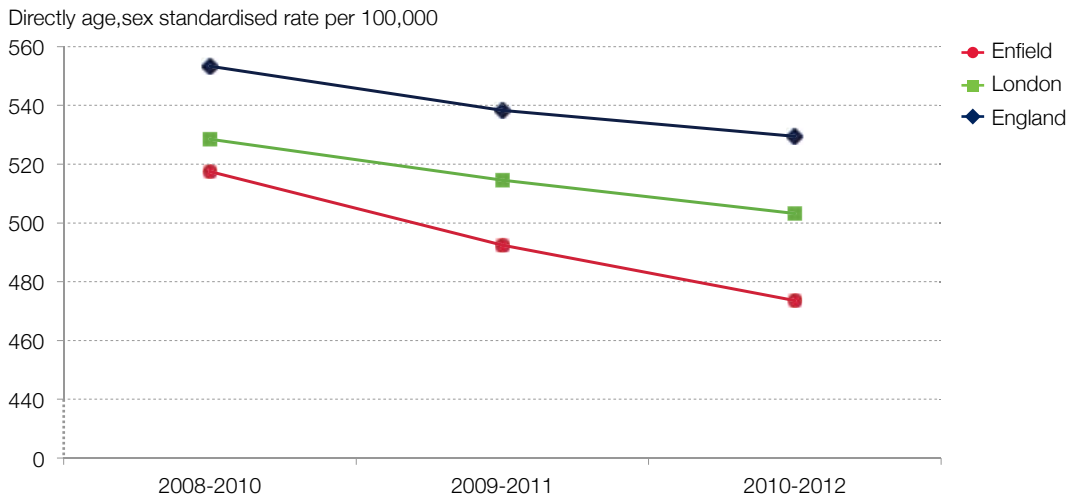


Source: Public Health Observatories based on ONS Annual Deaths Extract

2.3 What has been achieved so far?

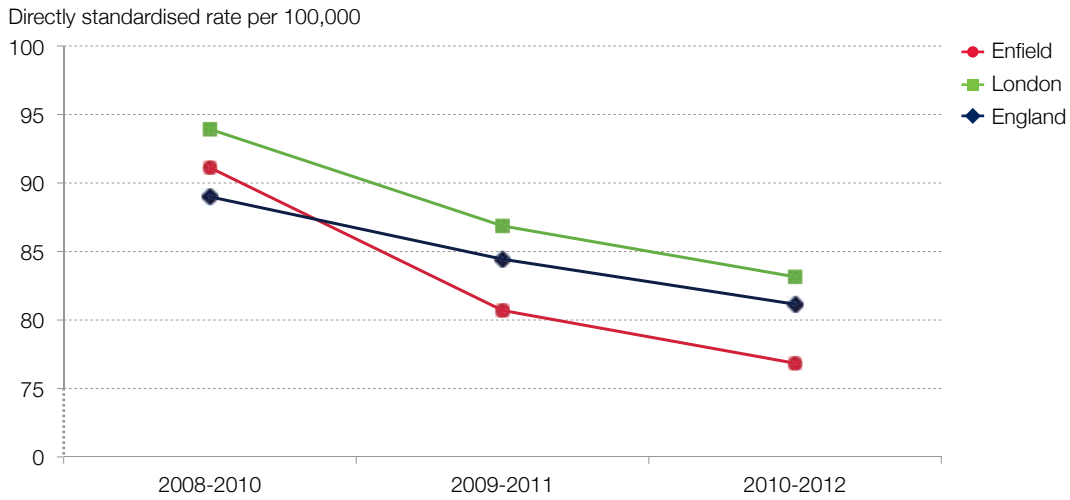
Since 2008, there have been significant reductions in overall mortality (Figure 2.10). Mortality from cardiovascular disease, the number one cause of death in Enfield, has fallen since 2008 to below the England average in 2012 (Figure 2.11). In addition, Enfield has attained the best position among its statistical neighbours in overall ‘premature’ deaths from cardiovascular disease (Figure 2.12).

Figure 2.10: All age all cause mortality (DSR per 100,000) in all persons in Enfield, 2008-2010 to 2010-2012



Source: Health and Social Care Information Centre

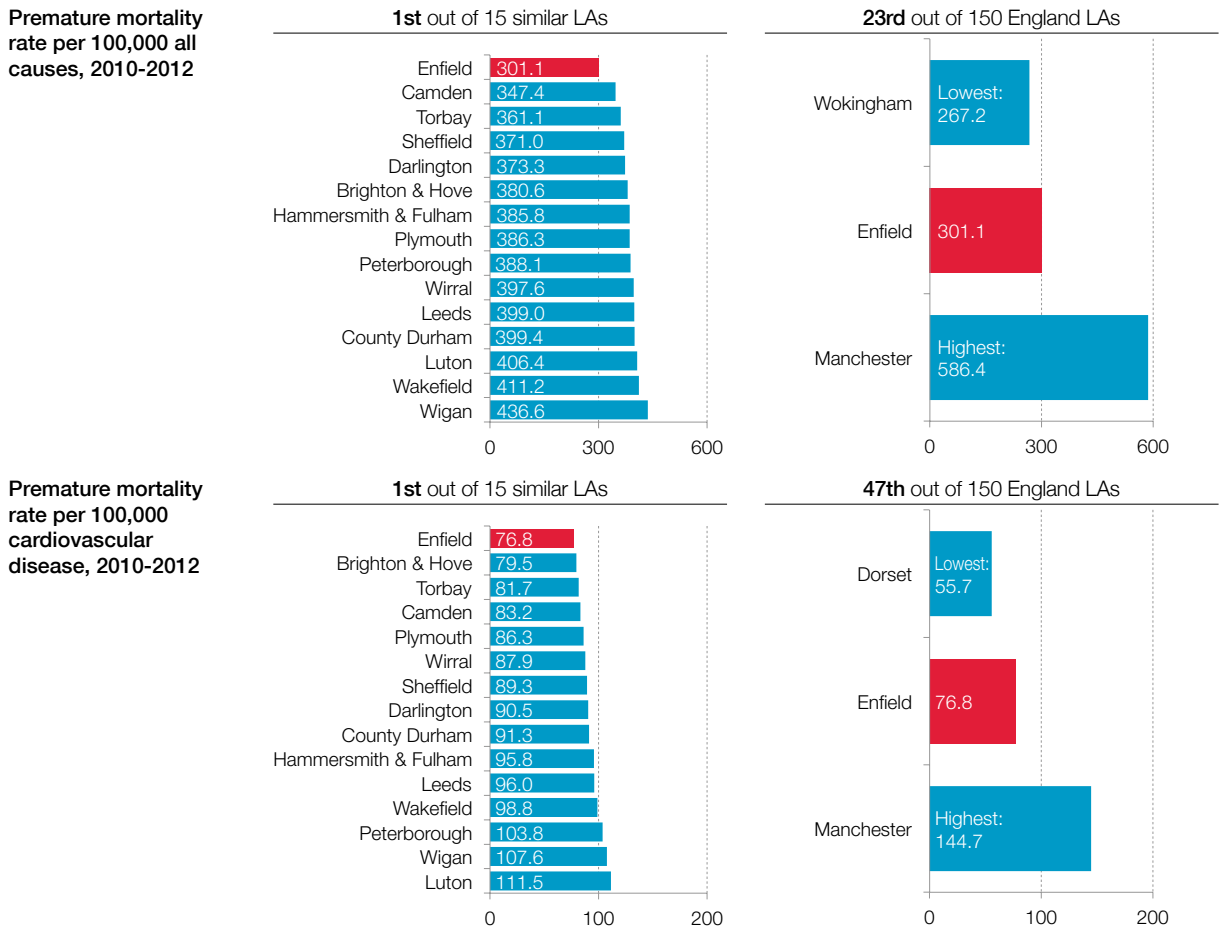
Figure 2.11: CVD mortality rate, directly age and sex-standardised rate per 100,000, Persons aged under 75 years, Enfield, London and England, 2008-2010 to 2010-2012



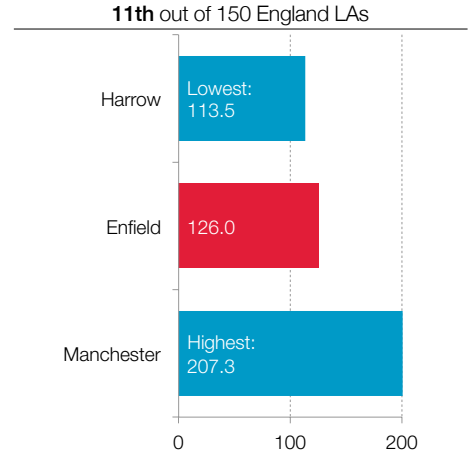
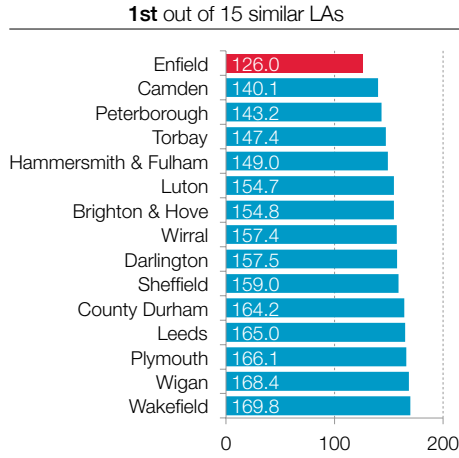
Source: Public Health Outcomes Framework, Public Health England

The ‘Longer Lives’ tool launched by Public Health England (PHE) compares rates of premature death (under 75 years) overall, and then the four most common causes of death (heart disease and stroke, cancer, lung disease, liver disease) in a given local authority, with all other areas in England. In the latest statistics, Enfield was well placed, being ranked 23rd out of all 150 local authorities, which was an improvement from the previous year, where Enfield was ranked 32nd. The comparison also focusses down to the 15 local authorities most similar in terms of socio economic characteristics. In the group in which Enfield is placed, we performed best in terms of premature deaths in these areas.

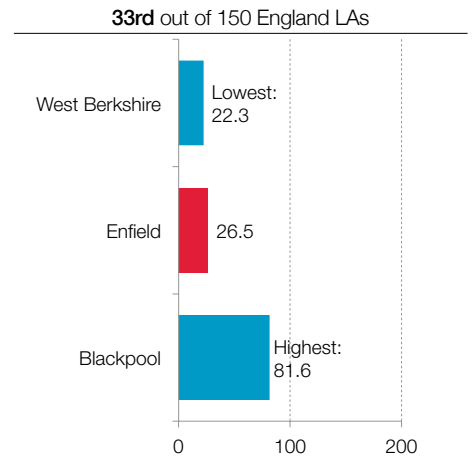
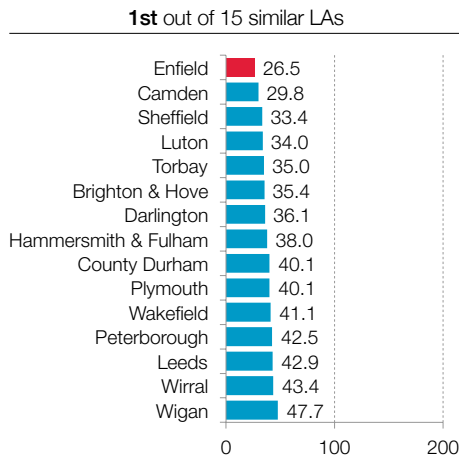
Figure 2.12: Longer Lives – Premature mortality in Enfield



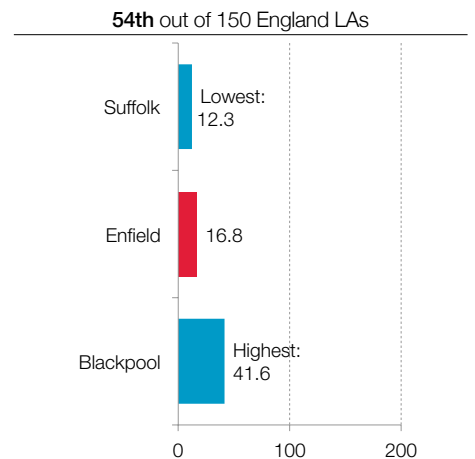
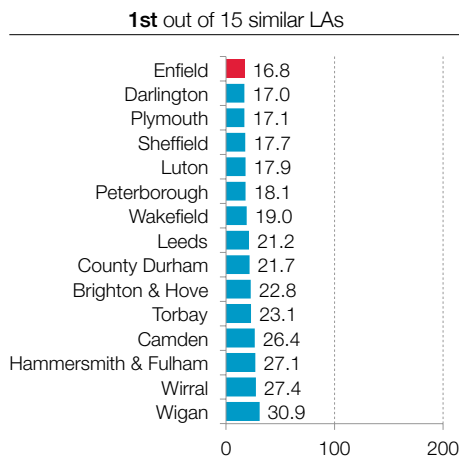
Premature mortality rate per 100,000 cancer, 2010-2012



Premature mortality rate per 100,000 lung disease, 2010-2012



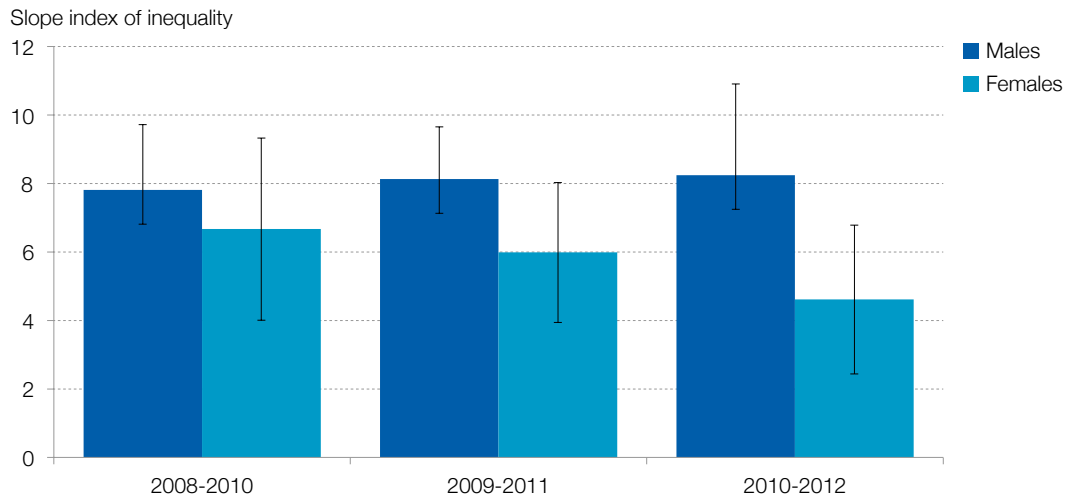
Premature mortality rate per 100,000 liver disease, 2010-2012



There have been significant improvements in male and female life expectancy within Enfield between 2008-2010 and 2010-2012. The Slope Index of Inequality (SII) has been used as a single score to represent the gap in years of life expectancy between the best-off and worst-off within a local authority, based on a statistical analysis of the relationship between life expectancy and deprivation scores across the whole authority (Baker et al. 2011).

Figure 2.13 shows the slope index of Inequality (SII) for males and females in Enfield. Between 2008-2010 and 2010-2012 the SII for females in the borough has decreased suggesting that the inequality gap has reduced. In contrast, there has been a marginal increase in SII for males in the borough over the same time period, however it is not statistically significant.

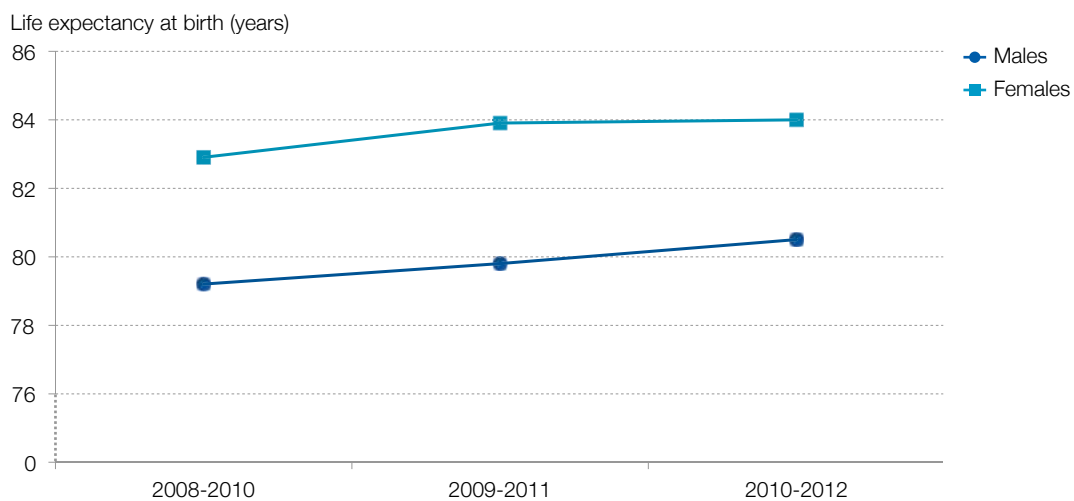
Figure 2.13: Slope Index of Inequality based on the local deprivation decile, Enfield, 2008-2010 to 2010-2012



Source: Public Health Outcomes Framework, Public Health England

Between 2008-2010 and 2010-2012, there was a statistically significant increase in life expectancy (at birth) for both males and females in Enfield. Over this entire period, male life expectancy in Enfield was significantly lower than female life expectancy. Figure 2.14 shows the increase in both male and female life expectancy at birth for Enfield between 2008-2010 and 2010-2012. During 2010-2012, male life expectancy in Enfield (80.5 years) was statistically significantly higher than both London (79.7 years) and England (79.2 years). In contrast, female life expectancy in Enfield (84.0 years) was not significantly different from London (83.8 years), but significantly higher than England (83.0 years), during the same period.

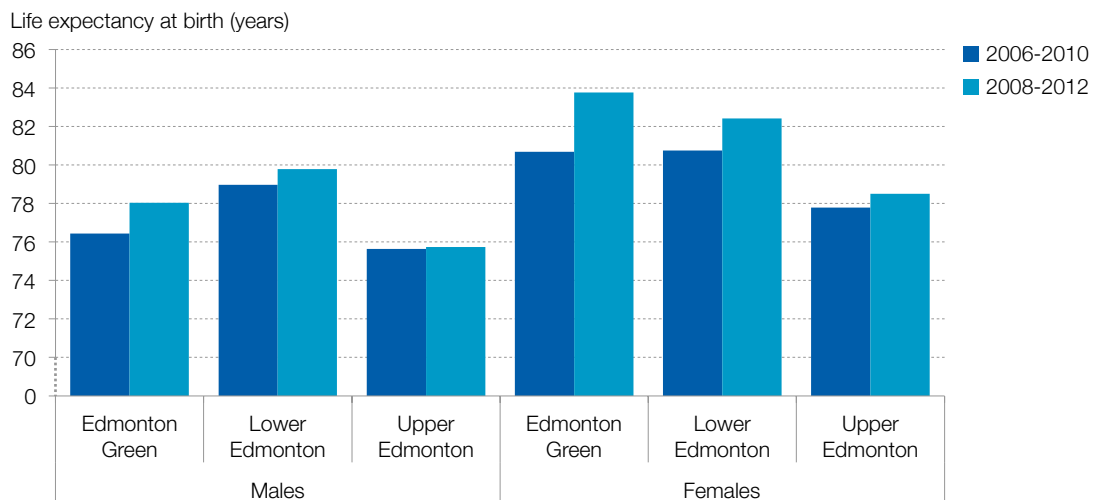
Figure 2.14: Life expectancy at birth for males and females in Enfield, 2008-2010 to 2010-2012 (3 years rolling averages)



Source: Office for National Statistics (ONS)

Figure 2.15 below shows that life expectancy at birth increased between 2006-2010 and 2008-2012, for both males and females in Edmonton Green, Lower Edmonton and Upper Edmonton. Whilst, none of these increases in life expectancy were statistically significant, for either males or females, in any of the three wards under consideration.

Figure 2.15: Life expectancy at birth by Enfield Local Authority wards and gender, 2006-2010 and 2008-2012 (5 year rolling averages)



Source: Greater London Authority using ONS mortality data and ONS mid-year population estimates

2.4 Putting evidence and policy into practice

Where should we target interventions?

There are several priority areas and critical health challenges in Enfield which include adults health, child health, mental health, fuel poverty and environment – these are described in detail in the JSNA (London Borough of Enfield, 2014a). In this report we are focusing on the gap in life expectancy within Enfield.

Enfield’s vision of reducing health inequalities gap is set out in the current “Joint Health and Wellbeing Strategy” (London Borough of Enfield, 2014b). For the purpose of this report we have used the framework developed by the Department of Health, Health Inequalities National Support Team (HINST), particularly following the guidance that inequalities can be tackled in three gestation times according to the speed of impact on health outcomes by the determinants (refer to Section 1.5). Targeted and universal interventions are presented in Chapter 6, ‘Our Partnerships’.

Interventions with outcomes in the short term

Interventions to achieve short term (less than five years) impacts can have a sizable effect on life expectancy. These include actions such as prevention of cardiovascular diseases, early identification of cancers, and management of long term conditions. Nationally, the Cardiovascular Disease Outcome Strategy (Department of Health, 2013) and Cancer strategy (Department of Health, Public Health England and NHS England, 2013) outline best practice guidance to improve outcomes and reduce inequalities.

Primary care management is crucial in reducing the gap in life expectancy, particularly in relation to hypertension and managing long term conditions such as CVD, Diabetes and COPD. In addition to national guidance and strategies (COPD and Diabetes), the National Support Team for health inequalities diagnostic model and priority actions based upon best practice are being utilised to implement chronic disease management. Improving prevention, risk management in primary care and enhancing case finding through the NHS Health Check programme is a key action in Enfield. The impact of interventions that can be made in those aged 50+ is significant, since this age group contribute most to life expectancy gap (see Section 1.5).

Other short term interventions include; tackling Enfield's high infant mortality rate, ensuring early diagnosis of HIV in the population and implementing population level interventions to protect vulnerable older people from preventable seasonal excess deaths.

Interventions with outcomes in the medium term

Lifestyle factors, such as smoking, physical activity, nutrition, alcohol all play a part in reducing the gap in life expectancy. It is expected that the impact of interventions that address lifestyle factors will be realised in the medium term (0-10 years). Tackling child poverty is a medium to long term impact intervention. Currently Enfield ranks 6th worst in London for childhood poverty, with the actual number of children being highest in London. Medium term interventions are discussed in Chapter 4.

Interventions with outcomes in the long term

The impact of interventions that address the wider determinants of health such as deprivation, income, employment, housing, education, environment and crime will be realised in the longer term. In this report, we define long term interventions as changes which will take over 10 years to produce changes in health and reduce the gap in life expectancy. These are discussed in Chapter 5.

The remainder of the report discusses the above areas for intervention in further detail. The following chapters have been structured to reflect the gestation period for each intervention.



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Chapter 3. Interventions with outcomes in the short term

The main contributing diseases to the life expectancy gap in Enfield are cardiovascular diseases and cancer. These conditions can cause disability to the patient and have financial consequences. However, many cases can be avoided by prevention and early effective treatment.

The interventions that can reduce the gap in life expectancy in the shortest amount of time are those that target the main causes of premature death in the borough, such as cancer, cardiovascular disease, respiratory problems, diabetes and HIV.

Primary care professionals e.g. GP and practice nurses that are the first to see a patient, often GPs, can have a big impact in the short term, with recent reports identifying the potential for GPs to address health inequalities and the health and wellbeing of the population as a whole (Thorlby, 2013; Goodwin et al., 2011).

In Enfield, it is estimated that approximately 26,000 patients with hypertension and 4,000 patients with coronary heart disease, remain unknown to primary care (Figure 3.1).

In this report, we focus on short term interventions as those which can have an impact in five years or less. The 'short term' refers to the gestation period between intervention and desired outcome. It does not reflect the time taken to make the strategic change to support the intervention. The emphasis is on long term conditions (early identification and management), protecting vulnerable older people from preventable seasonal excess deaths, tackling infant mortality and the role of primary care.



3.1 Primary Care Management

Key messages

- **41,041** people are diagnosed with hypertension.
- **9,476** of these patients have their blood pressure not controlled or not monitored.
- Further **26,000** people are estimated to be living with hypertension without diagnosis.
- Finding people with undiagnosed long term conditions is crucial. A further **50,385 cases** of long term conditions are estimated to be undiagnosed for conditions such as diabetes and COPD.
- Most of the GP practices in Enfield offer Health Checks. They are also available through a community programme.
- Co-production of health through joint management of health by GPs, other healthcare providers and patient self-management is essential.

Why is primary care management important in reducing the gap in life expectancy?

Historically, GPs have undertaken a central role in health improvement as well as in reducing the gaps in health inequalities. In this respect, GPs do not work alone, but make their unique contribution in collaboration with clinical commissioners, public health professionals and the community (Thorlby 2013).

“Population health” has always been an important part of primary care, although to a varying extent across the country. The population health approach is concerned with the health and well-being of local communities and populations, whilst still addressing the needs of individuals and families. This approach is interested in the distribution of health within the entire population (including those who do not attend GP practices) and focusses on proactive, preventative programmes covering the whole population (Durham County Council, 2013, p38).

In general, GP practices in more deprived areas face increasing pressure from the rising number of people with long term conditions (LTCs) There is increasing evidence demonstrating the importance of primary care as the most efficient way of delivering, cost-effective, evidence-based programmes which address the leading risk factors for ill health, whilst enhancing the management of LTCs through lifestyle interventions (Boyce et al., 2010).



3.1.1 Long Term Conditions management in primary care

Overview

Around 15 million people in England have a long term condition (LTC) i.e. a condition that cannot be cured at present, but can be controlled by medication and/or other treatments/therapies. People with LTCs account for 50% of all GP appointments, 70% of all inpatient bed days and 70% of the total health and care spend in England annually. The scale of the challenge presented by long term conditions in the UK is huge, with the number of patients with multiple LTCs (three or more) set to increase from 1.9 million in 2008 to 2.9 million in 2018. Within this scenario, the most prevalent LTCs covered by the Quality and Outcomes Framework (QOF)⁴ are hypertension, cardiovascular disease, respiratory conditions and depression, whilst those rising most quickly are diabetes, cancers and chronic kidney disease (Department of Health, 2012, p3-6).

Against this background, it is very important that LTCs, such as hypertension, coronary heart disease and diabetes, are systematically well managed through appropriate treatment and interventions, aimed at slowing the progression of the disease and improving health outcomes. Some long term conditions have very few visible symptoms and many people are unaware of their condition. Early identification will help slow or prevent disease progression.

Figure 3.1 shows a chart depicting the recorded and modelled estimated prevalence and numbers of undiagnosed cases for common LTCs in Enfield, for 2012/13. The bubbles allow visual comparisons to be made between values in the chart; bigger bubbles correspond to higher prevalence/numbers. Modelling took into account age, gender, deprivation and smoking status of the population. Based on this model, the estimated number of undiagnosed cases for these common LTCs (hypertension, diabetes, coronary heart disease, chronic kidney disease, COPD and stroke/TIA) in Enfield could be over 50,000.

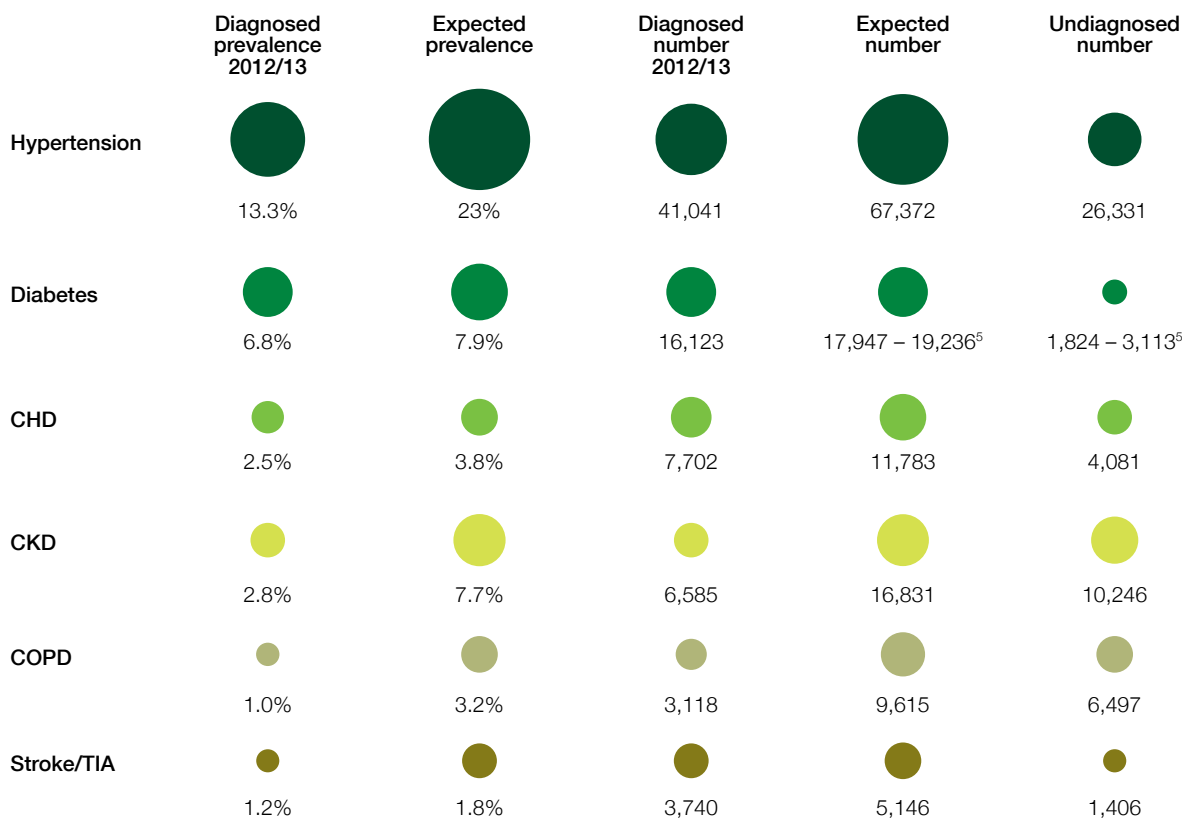
⁴ The quality and outcome framework (QOF) is a nationally agreed financial incentive scheme for general practice for achieving a defined set of targets. Part of the thinking behind QOF was to reduce the variation in the quality of care in general practice and therefore reduce inequalities in access to health care.

For patients who have been diagnosed with long term conditions self-management is equally as important as care from GPs and other healthcare providers (Department of Health, 2005). Self-management commonly involves understanding and following medical regimens, and making challenging changes in lifestyle, such as weight loss or increasing physical activity. Self-management involves three different kinds of tasks:

1. care of the body and management of the condition,
2. adapting everyday activities and roles to the condition and
3. dealing with the emotions arising from having the condition.

Figure 3.1 illustrates the gap in diagnosed and undiagnosed patients for hypertension, diabetes, coronary heart disease (CHD), chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD) and Stroke/TIA. The undiagnosed number of patients is given by the difference between diagnosed and expected prevalence.

Figure 3.1: Recorded and modelled estimated prevalence and numbers of undiagnosed cases for common LTCs in Enfield, 2012/13



Abbreviations: CHD – Coronary Heart Disease; CKD – Chronic Kidney Disease; COPD – Chronic Obstructive Pulmonary Disease; TIA – Transient Ischaemic Attack

Sources: **Diagnosed prevalence/number:** QOF 2012/13, HSCIC. **Expected prevalence/number:** <Hypertension, CHD, COPD, Stroke/TIA> National Practice Profile, PHE. <Diabetes> Diabetes prevalence model for England CCGs, National Diabetes Information Service, PHE. <CKD> CKD prevalence model 2007, PHE. **Undiagnosed number:** Undiagnosed numbers for each condition were derived by extracting the “diagnosed number” from the “expected number”.

⁵ Modelled estimated number of diabetes patients is available for both Enfield CCG residence population and CCG registered population. It ranges between 17,947 and 19,223. Based on these figures, the number of possibly undiagnosed diabetes patients is estimated to be between 1,824 and 3,110 in Enfield.

3.1.2 Preventing and managing long term conditions

In this section, we look at some of the Quality and Outcomes Framework (QOF) indicators, to understand the variation within Enfield. The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. QOF is a voluntary process for all surgeries in England and was introduced as part of the GP contract in 2004. QOF awards surgeries achievement points for:

- managing some of the most common chronic diseases e.g. hypertension, asthma, diabetes
- how well the practice is organised
- how patients view their experience at the surgery

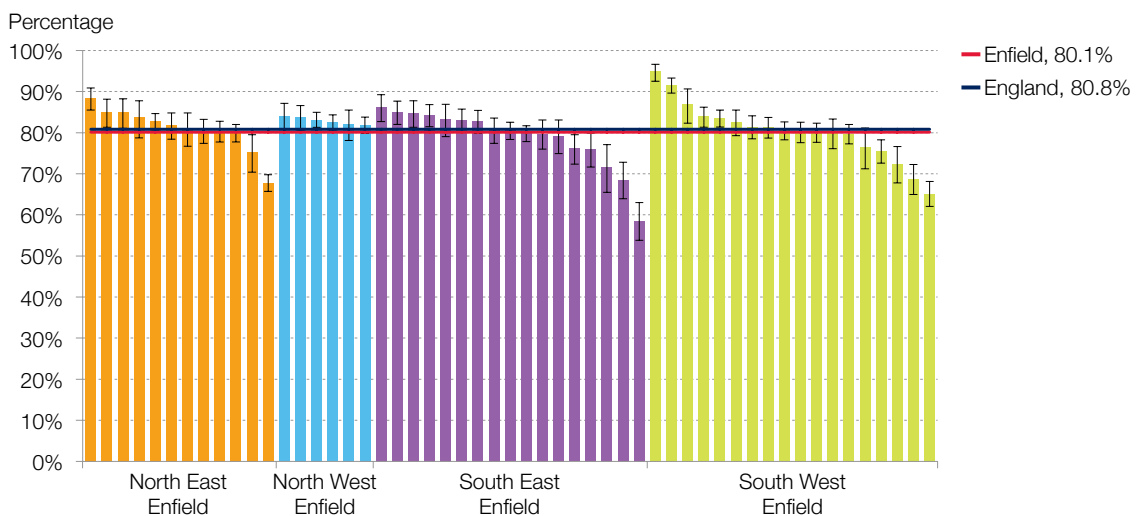
Blood pressure

High blood pressure is also known as the “silent killer” (NHS Choices, 2014a). If left untreated, high blood pressure increases the risk of heart attack or stroke. For those with conditions such as diabetes, having high blood pressure also increases the risk of complications including diabetic retinopathy (damage to the eye) and diabetic nephropathy (kidney damage). Controlling blood pressure is therefore crucial in managing long term conditions and improving health outcomes.

The only way of knowing there is a problem with an individual’s blood pressure is to have their blood pressure measured. Excluding exceptions, 80.1% (31,565 out of 39,411) of patients with hypertension had their blood pressure under control in 2012/13 in Enfield. This level of blood pressure control in patients with hypertension is similar to the London average of 79.8%, and just below the England average of 80.8%.

Many GP practices within Enfield show above average control of blood pressure in patients with hypertension (Figure 3.2). However, there are several GP practices where the percentage of patients with hypertension whose blood pressure was controlled is below the national average. Wide variation is observed amongst GP practices, ranging from 58.5% to 95.0%, which is most notable in the South East Enfield and South West Enfield localities. Identifying and understanding this variation amongst GP practices within Enfield is in one way of addressing health inequalities.

Figure 3.2: Percentage of patients with hypertension whose blood pressure is controlled (150/90 mmHg or less), Enfield practices, 2012/13

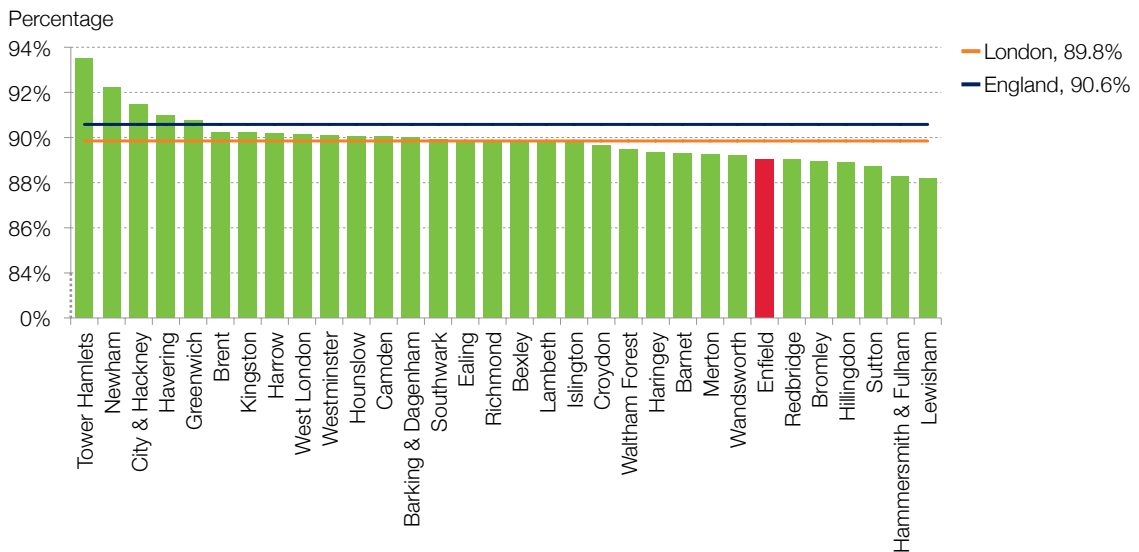


Source: Quality and Outcomes Framework (QOF), Health and Social Care Information Centre

In addition to managing blood pressure in patients diagnosed with hypertension, it is crucial to manage blood pressure in patients with long term conditions. Again primary care is well placed to address any inequalities that may arise in managing long term conditions and associated risk factors.

Managing blood pressure is important for patients living with coronary heart disease (CHD) to prevent further events and deterioration. Excluding exception, 89.0% of eligible patients with CHD (6,709 out of 7535) had their blood pressure under control in 2012/13. This was comparable to the London figure (89.8%) and slightly lower than the England average of 90.6%. Tower Hamlets, Newham and City and Hackney are in the top three in London for controlling blood pressure in patients with CHD (Figure 3.3).

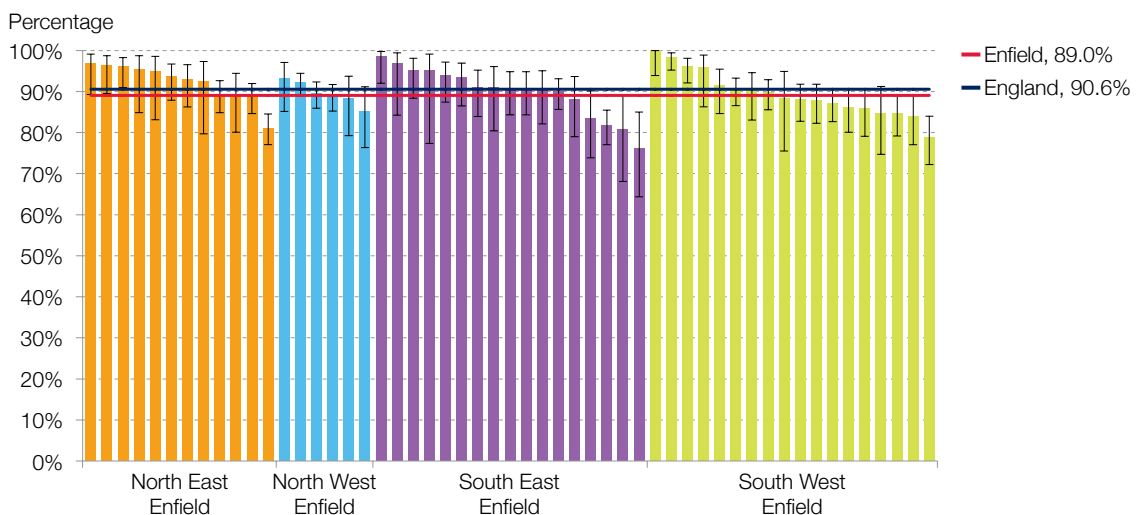
Figure 3.3: Percentage of patients with CHD whose blood pressure is controlled (150/90 mmHg or less) London CCGs, 2012/13



Source: Quality and Outcomes Framework (QOF), Health and Social Care Information Centre

A large number of GP practices within Enfield show above average control of blood pressure in patient with CHD. However, there are a number of GP practices where the percentage of patients with CHD whose blood pressure was controlled is below the national average. Wider variation is observed amongst practices in the South West Enfield locality in 2012/13 (Figure 3.4). Reducing this variation will also contribute to reducing health inequalities.

Figure 3.4: Percentage of patients with CHD whose blood pressure is controlled (150/90 mmHg or less), Enfield practices, 2012/13



Source: Quality and Outcomes Framework (QOF), Health and Social Care Information Centre

Quality and Outcomes Framework (QOF), indicators provide a useful perspective in understanding relationships between CHD and blood pressure. Moreover, added insight can be gained by looking at life expectancy by GP practice to provide support where necessary. With this in mind, the top ten practices with lowest male and female life expectancy in Enfield have been presented in Tables 1 and 2.

Tables 1 and 2 show the QOF performance of ten GP practices in Enfield where male life expectancy⁶ and female life expectancy are lowest, together with QOF indicators for Coronary Heart Disease (CHD06 and CHD08), exception rate (see box below), NHS Health Check⁷ information and the number of patients estimated to have hypertension for each practice⁸.

The QOF includes 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. Patient exception reporting applies to those indicators in the clinical domain of the QOF where level of achievement is determined by the percentage of patients receiving the designated level of care.

Table 1: QOF achievement and exception rates for coronary heart disease (CHD) indicators in the ten Enfield practices with the lowest male life expectancy at birth

GP practice	Estimated Life Expectancy in years (male)	NHS Health Check Q2 2012/13-Q3 2013/14	CHD Recorded prevalence	CHD06 ⁹ Achievement	CHD06 Exception Rate	CHD08 ¹⁰ Achievement	CHD08 Exception Rate	No. patients who possibly have uncontrolled hypertension
A	75.8	32	2.5%	83.5%	7.1%	86.7%	11.8%	482
B	76.2	13	0.6%	95.2%	8.7%	81.0%	8.7%	394
C	76.3	0	2.6%	91.1%	3.8%	78.8%	5.7%	505
D	76.9	89	1.6%	90.9%	3.5%	85.4%	15.8%	545
E	77.1	227	2.7%	90.8%	1.6%	82.2%	3.3%	576
F	77.1	293	1.8%	90.4%	0.0%	74.7%	4.8%	612
G	77.1	93	2.1%	96.0%	1.6%	76.2%	3.9%	567
H	77.2	0	0.7%	96.9%	3.0%	72.7%	0.0%	596
I	77.3	254	2.3%	90.0%	0.8%	76.1%	5.6%	1377
J	77.3	0	2.2%	88.2%	0.0%	64.5%	0.0%	489

Note: The designations "A" to "J" for the GP practices in Table 1 do not refer to the same practices as in Table 2 (i.e. Practice "A" in Table 1 is not the same as Practice "A" in Table 2.)

Source: Quality and Outcomes Framework (QOF) 2012/13 data

Within the GP practices in Enfield with the lowest male life expectancy at birth, the QOF prevalence for coronary heart disease (CHD) ranged from 0.6%-2.7%; achievement on CHD06 varied from 83.5%-96.6% and achievement of CHD08 ranged from 64.5% to 86.7%. The possible number of patients (male and female) with uncontrolled hypertension within these practices varied from 394-1,377 (Table 1). By looking at this information together GP practices and partners can begin to target interventions to address any variation.

6 Practice level life expectancy was initially calculated by the Public Health Observatory for Middle Super Output Area (MSOA) as part of the 'Small Area Indicators'. A weighted average was computed, based on the 2011 Attribution Data Set (ADS) of GP registered population, to estimate the GP practice values.

7 The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, is invited (once every five years) to have a check to assess their risk of disease and is given support and advice to help them reduce or manage that risk.

8 Modelled estimated prevalence of hypertension was developed by Public Health Observatory (currently a part of Public Health England) taking into account of age, sex, ethnicity and deprivation of the practice population. By applying the modelled estimated prevalence to the practice list size (QOF 2012/13), we were able to calculate the number of patients estimated to have hypertension for each practice. The number of patients who possibly have uncontrolled hypertension was then derived by extracting the number of patients with recorded hypertension whose blood pressure is under control (last measured blood pressure 150/90 mmHg or less) from the number of patients estimated to have hypertension.

9 CHD06: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less.

10 CHD08: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 15 months) is 5 mmol/l or less.

Table 2: QOF achievement and exception rates for coronary heart disease (CHD) indicators in the 10 Enfield practices with the lowest female life expectancy at birth

GP practice	Estimated Life Expectancy in years (female)	NHS Health Check Q2 2012/13-Q3 2013/14	CHD Recorded prevalence	CHD06 ¹¹ Achievement	CHD06 Exception Rate	CHD08 ¹² Achievement	CHD08 Exception Rate	No. patients who possibly have uncontrolled hypertension
A	79.6	293	1.8%	90.4%	0.0%	74.7%	4.8%	612
B	79.6	13	0.6%	95.2%	8.7%	81.0%	8.7%	394
C	80.2	32	2.5%	83.5%	7.1%	86.7%	11.8%	482
D	80.5	0	2.6%	91.1%	3.8%	78.8%	5.7%	505
E	80.6	224	1.4%	98.5%	10.7%	85.9%	14.7%	572
F	81.3	227	2.7%	90.8%	1.6%	82.2%	3.3%	576
G	81.4	261	2.2%	89.3%	4.3%	72.5%	10.2%	1462
H	81.4	59	1.1%	92.3%	11.4%	81.1%	15.9%	278
I	81.4	0	0.7%	96.9%	3.0%	72.7%	0.0%	596
J	81.5	89	1.6%	90.9%	3.5%	85.4%	15.8%	545

Source: Quality and Outcomes Framework (QOF) 2012/13 data

Table 2 shows the performance of the ten GP practices in Enfield where female life expectancy at birth is lowest. Within the GP practices in Enfield with the lowest female life expectancy, the QOF prevalence for coronary heart disease (CHD) ranged from 0.6%-2.7%; achievement of CHD06 varied from 83.5% to 98.5% and achievement of CHD08 ranged from 72.5% to 86.7%. The possible number of patients (male and female) with uncontrolled hypertension within these practices varied from 278 to 1462. Again, looking at this information together provides intelligence for GP practices and partners to target interventions and address variation.

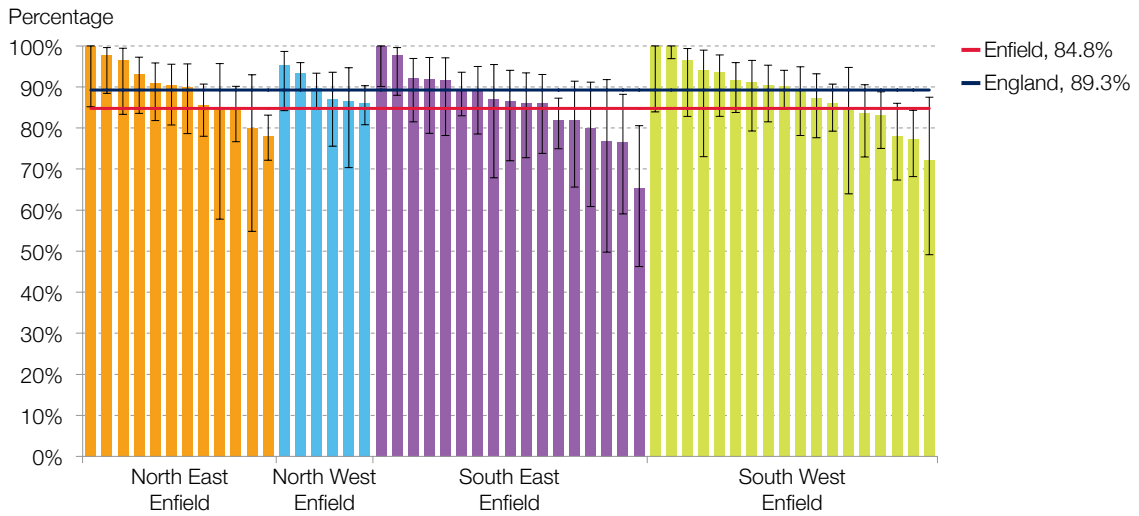
Patients with a history of stroke or Transient Ischaemic Attack (TIA) also require management of their blood pressure. In Enfield, 87.7% of patients with the history of stroke or TIA had their blood pressure controlled in 2012/13. This was comparable to the London average of 88.4% and the England average of 89.3%. At the time, there were 570 patients with the history of stroke or TIA whose blood pressure was not controlled or not monitored.

There is evidence of wide variation amongst GP practices in the control of blood pressure in patients with a history of stroke/TIA, ranging from 65.4% to 100% in 2012/13 (Figure 3.5). Whilst many GP practices are managing blood pressure in patients with a history of stroke/TIA (above average), there are a number of GP practices where the control of blood pressure in patients with a history of stroke/TIA is considerably below average.

¹¹ CHD06: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less.

¹² CHD08: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 15 months) is 5 mmol/l or less.

Figure 3.5: Percentage of patients with history of Stroke/TIA whose blood pressure is controlled (150/90 mmHg or less), Enfield practices, 2012/13

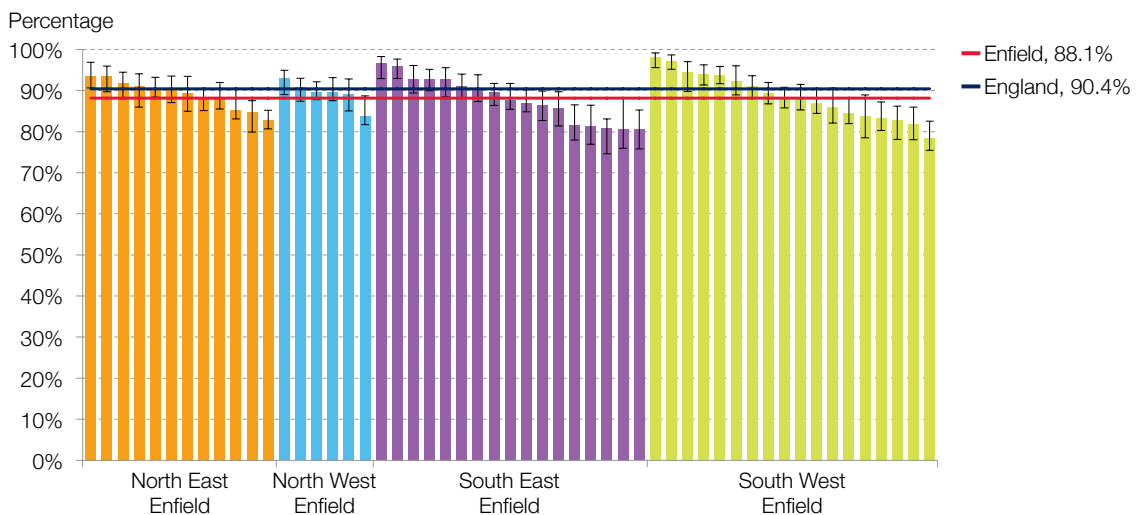


Source: Quality and Outcomes Framework (QOF), Health and Social Care Information Centre

Diabetes is another long term condition which critically requires management of blood pressure. In Enfield, 88.1% of patients with diabetes had their blood pressure controlled in 2012/13. This was comparable to the London average (89.6%) but slightly lower than the England average of 90.4%. This means that there were 2,351 patients with diabetes in Enfield whose blood pressure was not controlled or monitored.

At GP practice level, the percentage of patients with a history of diabetes, whose blood pressure was controlled, ranged between 78.5% and 98.0% (Figure 3.6). Practices in the South East and South West show greatest variation. Understanding the causes of this variation at practice level provides an opportunity to support practices where necessary.

Figure 3.6: Percentage of patients with diabetes, whose blood pressure is controlled (150/90 mmHg or less), Enfield practices, 2012/13



Source: Quality and Outcomes Framework (QOF), Health and Social Care Information Centre

Tables 3 and 4 show the top ten practices with lowest male and female life expectancy in Enfield, together with prevalence of diabetes and QOF diabetes indicators (DM26 and DM28).

Table 3 shows the performance of the ten GP practices in Enfield with lowest male life expectancy at birth, and associated QOF indicators DM 26 and DM 28. Within the GP practices in Enfield with the lowest male life expectancy, the QOF prevalence for diabetes ranged from 5.5%-9.3%; achievement of DM26 varied from 56.8% to 73.2% and achievement of DM28 ranged from 72.6% to 91.1%. There is also a wide range of exception reporting, from 0.0% to 23.3%. Looking at all this information together provides an opportunity to address those areas where improvements can be made by individual GP practices.

Table 3: QOF achievement and exception rates for diabetes indicators in the 10 Enfield practices with the lowest male life expectancy at birth

GP practice	Estimated Life Expectancy in years (male)	NHS Health Check Q2 2012/13-Q3 2013/14	Diabetes Recorded prevalence (17+)	DM26 ¹³ Achievement	DM26 Exception Rate	DM28 ¹⁴ Achievement	DM28 Exception Rate	No. patients who possibly have uncontrolled hypertension
A	75.8	32	9.3%	56.8%	8.7%	76.2%	5.8%	482
B	76.2	13	6.4%	70.7%	5.7%	86.3%	3.4%	394
C	76.3	0	7.5%	61.5%	12.3%	80.2%	10.0%	505
D	76.9	89	6.8%	57.3%	5.5%	77.1%	3.3%	545
E	77.1	227	9.0%	66.6%	7.1%	80.1%	5.5%	576
F	77.1	293	7.8%	70.6%	4.0%	83.6%	2.5%	612
G	77.1	93	7.4%	73.2%	23.3%	91.1%	20.9%	567
H	77.2	0	5.5%	58.1%	10.1%	72.6%	7.9%	596
I	77.3	254	8.5%	60.4%	6.9%	80.0%	4.1%	1377
J	77.3	0	7.4%	58.5%	0.0%	73.6%	0.0%	489

Note: The designations "A" to "J" for the GP practices in Table 3 do not refer to the same practices as in Table 4 (i.e. Practice "A" in Table 3 is not the same as Practice "A" in Table 4.)

Source: Quality and Outcomes Framework (QOF) 2012/13 data

Table 4 shows the performance of the ten GP practices in Enfield with lowest female life expectancy at birth, together with diabetes prevalence and associated QOF indicators DM 26 and DM 28. Within the GP practices in Enfield with the lowest female life expectancy, the QOF prevalence for diabetes ranged between 4.9% and 9.3%; achievement of DM26 varied from 56.8% to 88.8% and achievement of DM28 ranged from 72.6% to 95.5%. Again, there is a wide range of exception reporting, from 2.5% to 37.6%. The possible number of patients with uncontrolled hypertension within these practices varied from 278 to 1462. The information shown in Table 4 demonstrates variation and also areas for improvement which may contribute to reducing the gap in life expectancy.

Table 4: QOF achievement and exception rates for diabetes indicators in the 10 Enfield practices with the lowest female life expectancy at birth

GP practice	Estimated Life Expectancy in years (female)	NHS Health Check Q2 2012/13-Q3 2013/14	Diabetes Recorded prevalence (17+)	DM26 ¹⁵ Achievement	DM26 Exception Rate	DM28 ¹⁶ Achievement	DM28 Exception Rate	No. patients who possibly have uncontrolled hypertension
A	79.6	293	7.8%	70.6%	4.0%	83.6%	2.5%	612
B	79.6	13	6.4%	70.7%	5.7%	86.3%	3.4%	394
C	80.2	32	9.3%	56.8%	8.7%	76.2%	5.8%	482
D	80.5	0	7.5%	61.5%	12.3%	80.2%	10.0%	505
E	80.6	224	7.1%	88.8%	37.6%	95.5%	25.5%	572
F	81.3	227	9.0%	66.6%	7.1%	80.1%	5.5%	576
G	81.4	261	7.2%	64.9%	8.3%	78.5%	4.5%	1462
H	81.4	59	4.9%	64.6%	11.7%	78.3%	10.2%	278
I	81.4	0	5.5%	58.1%	10.1%	72.6%	7.9%	596
J	81.5	89	6.8%	57.3%	5.5%	77.1%	3.3%	545

Source: Quality and Outcomes Framework (QOF) 2012/13 data

¹³ DM26: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol in the preceding 15 months.

¹⁴ DM28: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months.

¹⁵ DM26: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol in the preceding 15 months.

¹⁶ DM28: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 15 months.

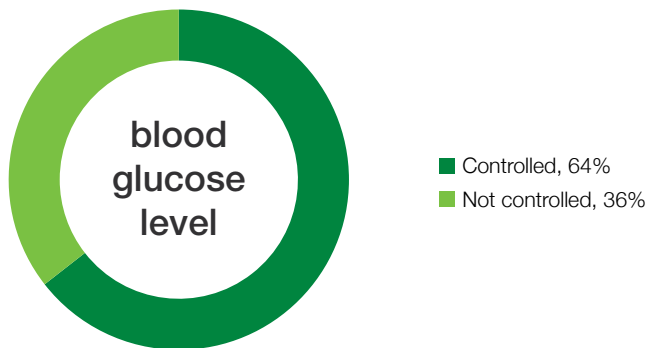
Controlling blood glucose level amongst patients with diabetes

Primary care is also responsible for supporting the patient’s self-management of blood glucose level in individuals with diabetes. The most common measure of long-term diabetes control is the HbA1c test. In Enfield, 64% of eligible patients with diabetes (9,537 patients) had blood glucose level controlled (HbA1c is 59mmol/l (7.5%) or less) in 2012/13. This was similar to the London average of 64.3% and just below the England average of 66.5%. At the time, there were 6,586 patients with diabetes whose blood glucose level was not controlled or monitored.

However, as with managing blood pressure, it is the wide variation in performance between GP practices that is of particular concern.

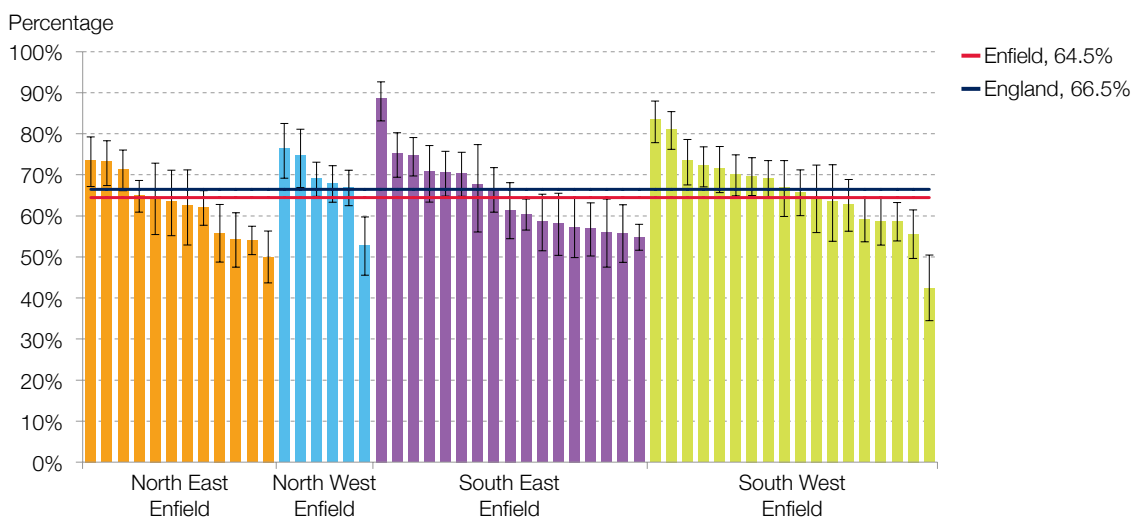
Figure 3.7 depicts the numbers of diabetes patients whose blood glucose level was controlled in Enfield during 2012/13 (n=9537) compared to the number for whom it was uncontrolled (n=5259).

Figure 3.7: Blood glucose level control in Enfield, 2012/13



Source: Quality and Outcomes Framework (QOF), Health and Social Care Information Centre

Figure 3.8: Percentage of patients with diabetes whose last measured blood glucose is 59 mmol/l (7.5%) or less, Enfield practices, 2012/13



Source: Quality and Outcomes Framework (QOF), Health and Social Care Information Centre

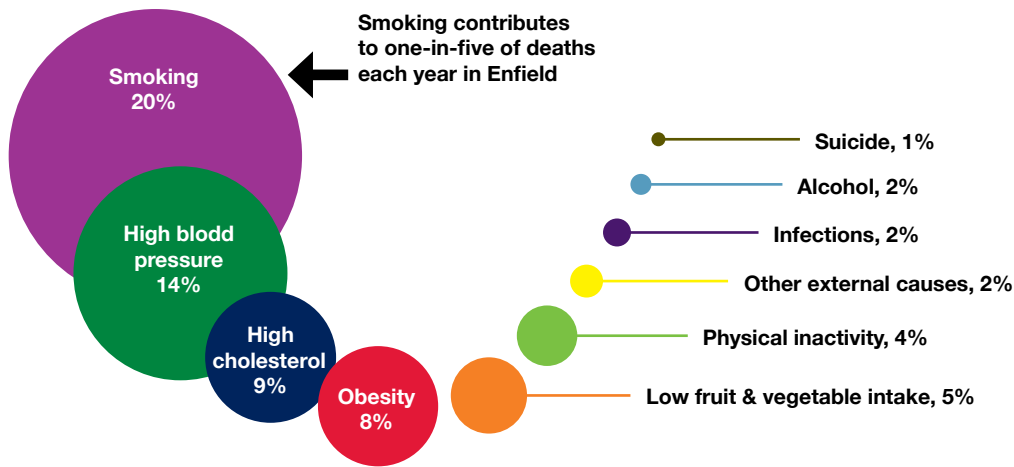
There is considerable variation between practices in the control of blood glucose level in patients with diabetes. At GP practice level, the percentage of patients with diabetes whose blood glucose level is controlled varied from 42.3% to 88.8% (Figure 3.8). So, whilst the Enfield average is comparable to London and national, at GP practice level there is evidence of some practices with below average control of blood glucose level in patients with diabetes, thus offering another opportunity to impact on reducing inequalities in health.

3.1.3 Multiple risks

There is evidence that healthy behaviours (not smoking, not being physically active, consuming alcohol in moderation, eating 5 pieces of fruit or vegetable a day) have a cumulative positive effect on health being associated with a four-fold reduction in the risk of mortality in people aged 45-79 (Buck & Frosini, 2012).

In Enfield, one in five people die from smoking each year; high blood pressure contributes to 14% of all deaths; high cholesterol to 9%; obesity contributes to 8%; low fruit and vegetable intake to 5% and 4% of all deaths are associated with physical inactivity (Figure 3.9). There are substantial gains in life expectancy to be made in addressing these unhealthy behaviours. Collaboration between primary care and public health is focusing on health improvements and lifestyle interventions using national and international best practice examples.

Figure 3.9: Contribution of lifestyle to health



Source: Enfield Performance Report, 2013

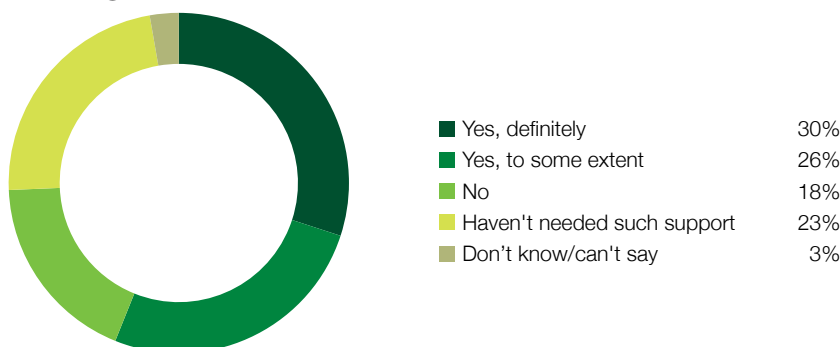
3.1.4 Patient experience and access to GP services

The GP Patient Survey has been designed to give patients the opportunity to comment on their experience of their GP practice. The survey asks patients about a range of issues related to their local GP surgery and other local NHS services. This includes questions about how easy or difficult it is for patients to make an appointment at their surgery, satisfaction with opening hours, and the quality of care received from their GP and practice nurses, amongst other things.

Support with managing long term conditions

In Enfield, 56% of respondents felt that they had enough support from local services or organisations to help manage their long term condition (LTC) in the last six months (Figure 3.10). This compared with 64% of respondents in England overall, who felt that they had enough support in managing their LTC (The GP Patient Survey, 2014).

Figure 3.10: Percentage of patients in Enfield CCG who felt they had enough support from local services to manage their long term condition, December 2013

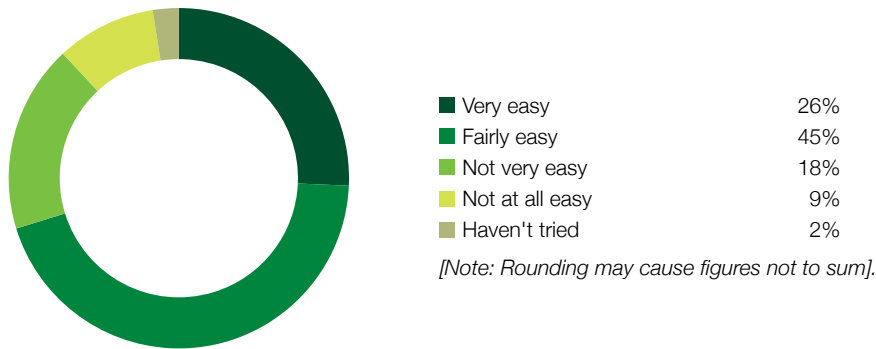


Source: The GP Patient Survey

Access to GP services

In terms of accessing GP services, 71% of patients in Enfield CCG found it easy to get through to someone at the GP surgery on the telephone (Figure 3.11), compared to 74% in England as a whole (data based on December 2013 figures from The GP Patient Survey).

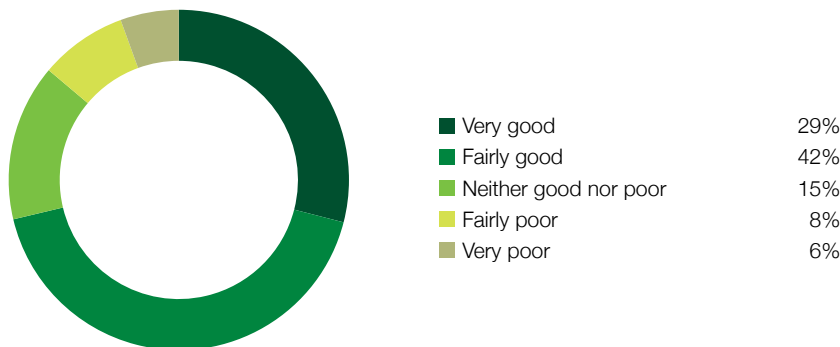
Figure 3.11: Percentage of patients in Enfield CCG who reported that it was easy to get through to their GP surgery by telephone, December 2013



Source: The GP Patient Survey

71% of Enfield patients rated their overall experience of making an appointment with their GP as “good” compared to 75% in England overall (Figure 3.12).

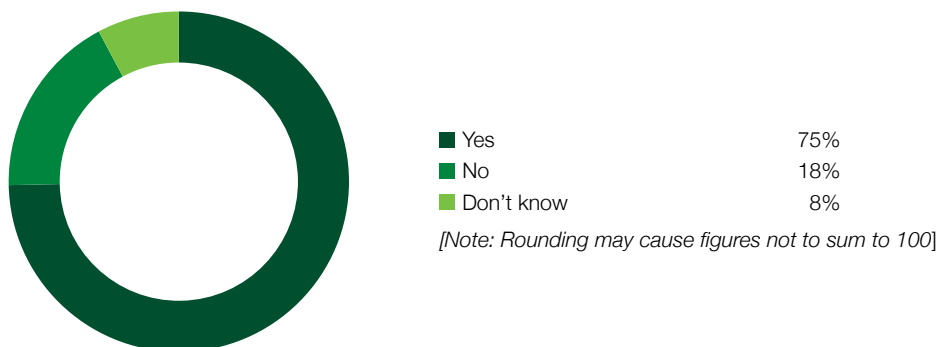
Figure 3.12: Percentage of patients in Enfield CCG who described their overall experience of making an appointment as “good”, December 2013



Source: The GP Patient Survey

75% of patients in Enfield agreed that their GP surgery was open at convenient times (Figure 3.13), similar to the England average of 76% (The GP Patient Survey, 2014).

Figure 3.13: Percentage of patients in Enfield CCG who felt their GP surgery was open at convenient times, December 2013

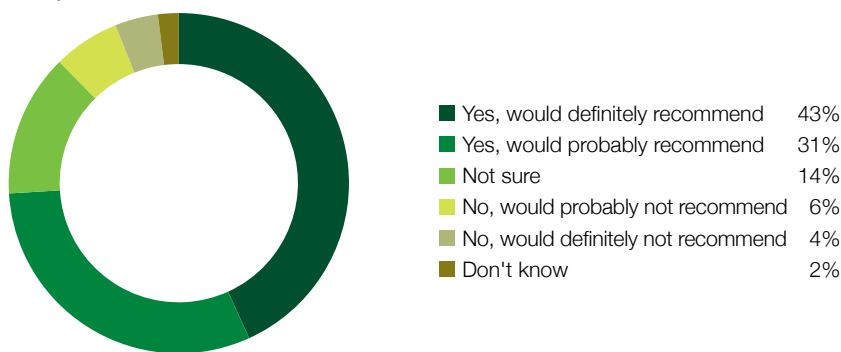


Source: The GP Patient Survey

Overall experience

Almost three quarters of patients in Enfield CCG (74%) would recommend their GP surgery to someone who had just moved to the local area, compared with 79% of patients in England as a whole (Figure 3.14 below).

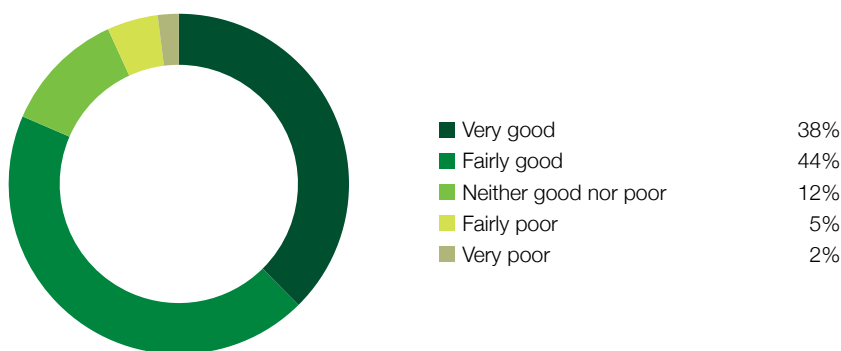
Figure 3.14: Percentage of patients in Enfield CCG who felt they would recommend their GP surgery to someone who had just moved into the area, December 2013



Source: The GP Patient Survey

Similarly, 82% of respondents in Enfield CCG rated their overall experience of their GP surgery as “good” compared with 86% in England as a whole (refer to Figure 3.15 below).

Figure 3.15: Percentage of patients in Enfield CCG who rated their overall experience of their GP surgery as “good,” December 2013



Source: The GP Patient Survey

Enhancing and Improving Access has been a key element of the CCG's Transformation Programme and as such aims to deliver sustainable improvement to long term patient experience and satisfaction of GP services. Since early 2012, the CCG has worked with its GP practices:

- To help clear the backlog of patients waiting for appointments;
- To complete a capacity and demand exercise to identify gaps in provision;
- To ensure that GPs completed telephone triaging training in order that patients requesting an appointment were booked to see the most appropriate member of the practice team to meet their needs;
- To ensure that Medical Receptionists completed telephone training in order to deal more efficiently and effectively with high volumes of calls;
- To provide a dedicated 'phone line for use by the Primary Care Navigator at Urgent care Centre to ensure that patients whose needs would be most appropriately addressed by their practice were booked to be seen there, rather than at A&E;
- To allow practices to review their current service delivery and make the necessary changes to meet the needs of their patient populations, e.g. the facility to book appointments and order repeat prescriptions on-line for those patients who would prefer not to attend or call the practice to do so.

The CCG also established a Minor Ailment Scheme with 52 local Community Pharmacies in February 2013 which provides direct access for patients, entitled to free prescriptions, suffering from one of a pre-approved list of twenty minor ailments, e.g. hay fever, sore throat. The Minor Ailment Scheme utilises pharmacy expertise and capacity to improve access for patients via a 'Minor Ailment Scheme passport' up to a maximum of ten occasions.

These two initiatives delivered an additional 50,000 patient appointments in 2013/14.



3.2 Cardiovascular Disease (CVD)

Key messages

- On average **around 150 people** aged under 75 years die from cardiovascular disease (CVD) each year in Enfield.
- Almost **two thirds** of those deaths are considered preventable through prevention and management of existing conditions.
- CVD accounts for almost **1 in 4** premature deaths (under 75 years) in Enfield.
- Around **7,700 people** are living with coronary heart disease (CHD) in Enfield.
- There are around **3,700 people** who have previous history of stroke or Transient Ischaemic attack (TIA).
- Most of the GP practices in Enfield offer Health Checks. These are also available through community programmes.

Cardiovascular disease (CVD) is a general term that describes diseases of the heart and circulatory system, including coronary heart disease (CHD), stroke or transient ischaemic attack (TIA) and heart failure.

The national cardiovascular disease outcome strategy (Department of Health, 2013a) outlines best practice guidance to improve cardiovascular disease outcomes in line with the NHS, Public Health and Adult Social Care Outcomes Frameworks. The strategy also contributes to reducing health inequalities by reducing mortality, improving quality of life and experience of care.

Improving prevention, risk management in primary care and enhancing case finding through the NHS Health Check programme is a key action in the strategy. The strategy draws actions together into priorities which include management of atrial fibrillation, heart failure, obesity, diabetes and chronic kidney disease. The management of hypertension and conditions which contribute to cardiovascular problems (especially atrial fibrillation and diabetes) is central to the strategy.

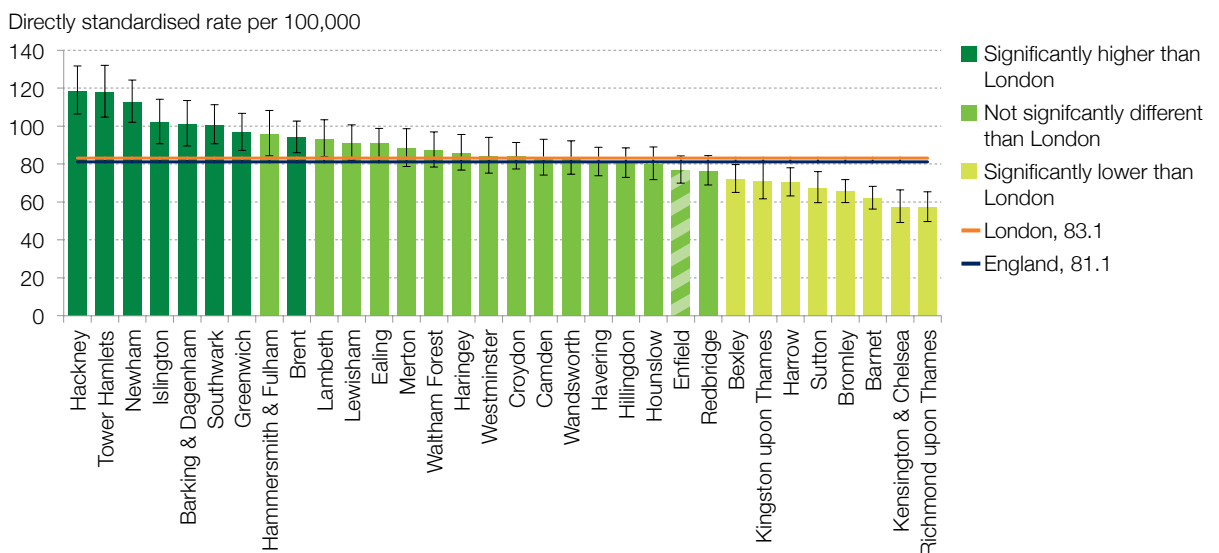
Best practice elsewhere in the country also informs our intervention strategies (Fell, 2014; Harrison et al. 2006).

3.2.1 The local picture

Cardiovascular diseases are one of the main contributing diseases to the life expectancy gap in Enfield and represent one of the largest causes of death and disability in England (Department of Health Cardiovascular Disease Team, 2013). These conditions cause disability to the patient and have financial consequences. However, most cases can be avoided by prevention and early effective treatment.

Cardiovascular disease (CVD) accounts for one in four premature deaths (under 75 years) in Enfield and is the second biggest killer amongst people aged under 75 years. On average, CVD causes roughly 150 deaths each year amongst people aged under 75 years in Enfield, of which about two-thirds are considered preventable by effective treatment and improvements in lifestyles.¹⁷

Figure 3.16: Directly age, sex standardised rate for cardiovascular disease, persons aged under 75 years, London boroughs, 2010-2012 (pooled)



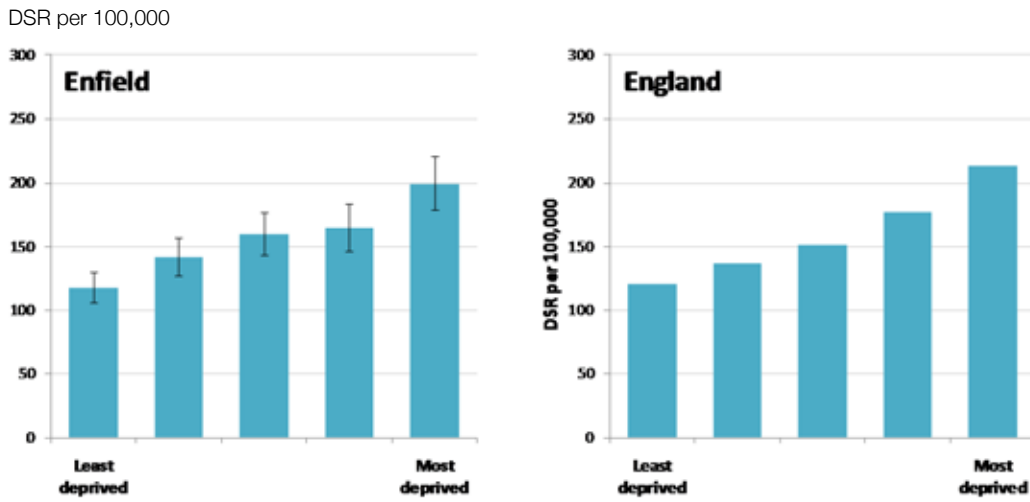
Note: Hammersmith and Fulham have wide confidence intervals which overlap with London, which means not significantly different from London

Source: Public Health Outcomes Framework (PHOF), Public Health England

¹⁷ ONS defines “preventable deaths” as “A death is preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense”. The cause of preventable CVD deaths includes Ischaemic heart disease, DVT with pulmonary embolism, Aortic aneurysm and dissection to 0-74 year olds.

Enfield’s premature mortality rate from CVD (under 75 years) is the 10th lowest amongst 32 London boroughs (Figure 3.16) and the lowest amongst 15 local authorities with similar socio-economic characteristics.¹⁸ However, Enfield shows a deprivation gradient for deaths from circulatory disease in people of all ages (Figure 3.17). This means that the people living in the 20% most deprived areas of Enfield have a 1.7 times higher mortality rate (all ages) compared to people living in the 20% least deprived areas of Enfield. Addressing this deprivation gradient will have a direct impact on reducing the gap in life expectancy between the most deprived and least deprived areas in Enfield.

Figure 3.17: Directly standardised mortality rate for all persons for all circulatory disease, by relative deprivation quintile for Enfield and London, 2011



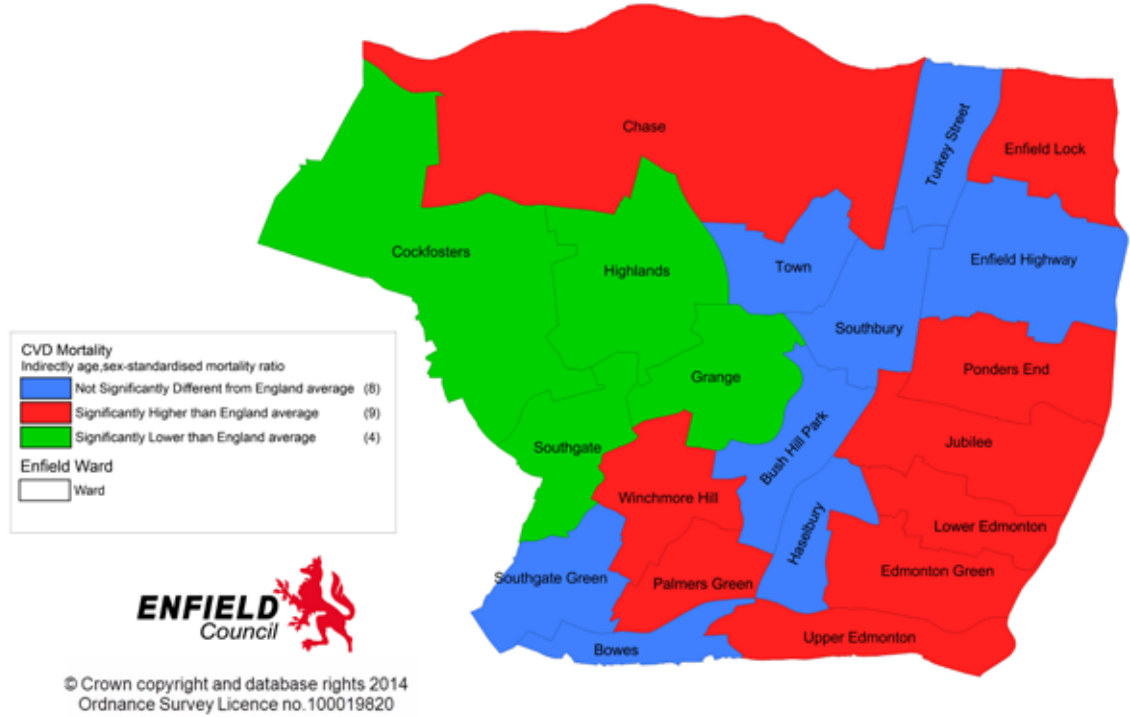
Source: Public Health Observatories Annual Deaths Extract, Office for National Statistics



18 Source: Longer Lives, PHE. Enfield is amongst the “more deprived” local authorities based on the index of multiple deprivation 2010. Other local authorities in this group include: Brighton and Hove, Camden, County Durham, Darlington, Hammersmith and Fulham, Leeds, Luton, Peterborough, Plymouth, Sheffield, Torbay, Wakefield, Wigan, and Wirral

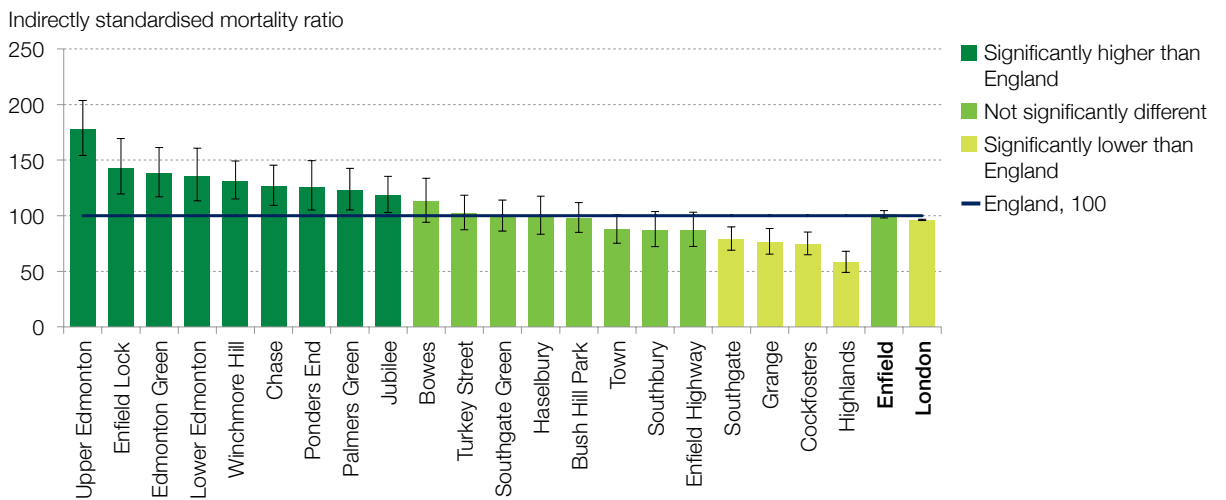
The wards with higher premature mortality rates (under 75 years) than expected based on the England average include Jubilee, Palmers Green, Ponders End, Chase, Winchmore Hill, Lower Edmonton, Edmonton Green, Enfield Lock and Upper Edmonton (Figures 3.18 and 3.19).

Figure 3.18: CVD mortality – indirectly age and sex standardised ratio for persons aged under 75 years in Enfield wards, 2006-2010 (pooled)



Source: London Health Programme, Public Health England

Figure 3.19: CVD mortality – Indirectly age and sex standardised ratio for persons aged under 75 years in Enfield wards, 2006-2010 (pooled)



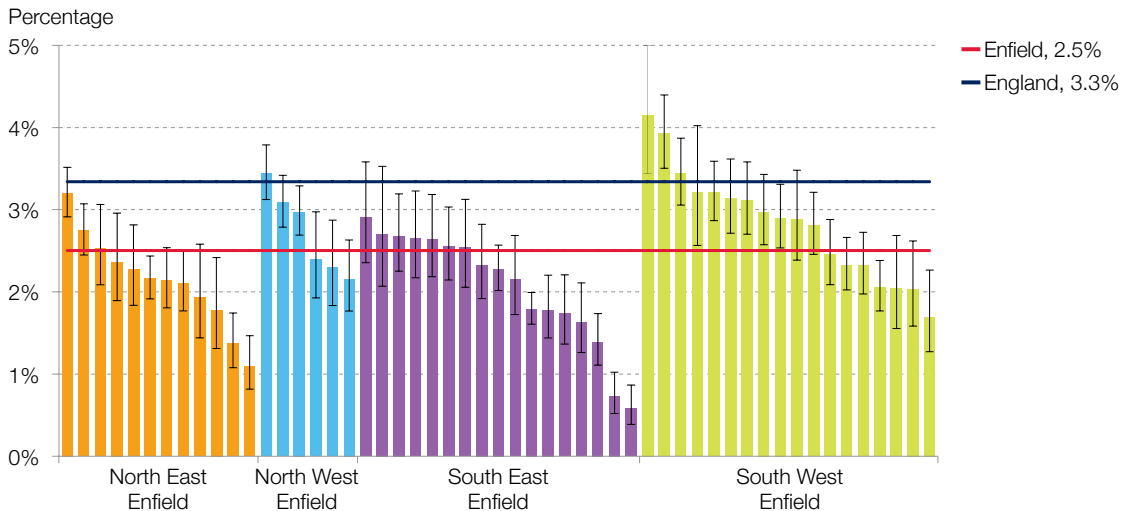
Note: Indirectly standardised ratio compare rates with the standard area, in this case England. This does not allow between areas comparison i.e. ranking.

Source: London Health Programme, Public Health England

3.2.2 Coronary Heart Disease

Coronary heart disease (CHD) includes heart attacks and heart failure. CHD makes up the biggest proportion of early deaths (under 75 years) from CVD in Enfield. Currently 7,702 people in Enfield are living with diagnosed CHD (2012/13), which equates to 2.5% of the GP registered population. This prevalence is above the London average of 2.1% and below the England average of 3.3%. Modelled estimates suggest that the actual population prevalence is 3.8%, which implies that there are over 4,000 people in Enfield with undiagnosed CHD.

Figure 3.20: Recorded prevalence of coronary heart disease, Enfield practice, 2012/13



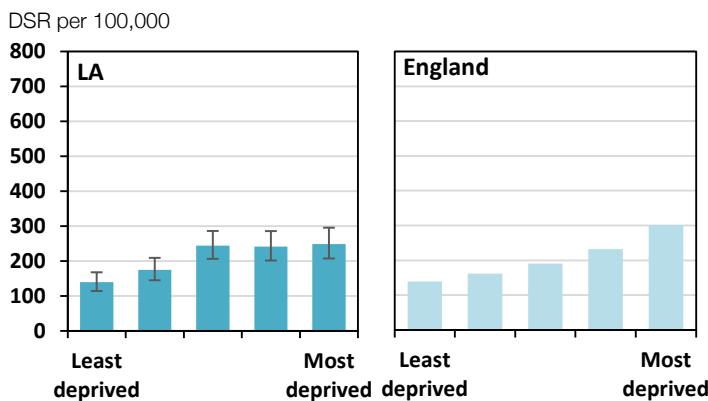
Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

The prevalence of CHD varies widely within Enfield, ranging from 0.6% to 4.2% of the GP registered population (Figure 3.20). It is important to note that prevalence is not standardised by age, which means that GP practices serving a higher proportion of older people are likely to have a higher prevalence of CHD. Nevertheless, this is an indication of the current, known burden of the disease.

Emergency admissions

Emergency admission for CHD can be an indication of how the condition is being managed and in some cases identifies previously unknown patients with the disease. Similar to England, there is evidence of a deprivation gradient in emergency admissions for CHD in Enfield (Figure 3.21). CHD emergency admissions for people living in the 20% most deprived areas of Enfield was 1.8 times greater than CHD emergency admissions for people living in the 20% least deprived areas of Enfield, in 2011/12. This highlights inequality in CHD by deprivation. In England, CHD emergency admissions for people living in the 20% most deprived areas was 2.2 times greater than admissions for people living in the 20% least deprived areas.

Figure 3.21: CHD emergency admission by deprivation quintile, directly age and sex standardised rate (DSR) per 100,000, 2011/12



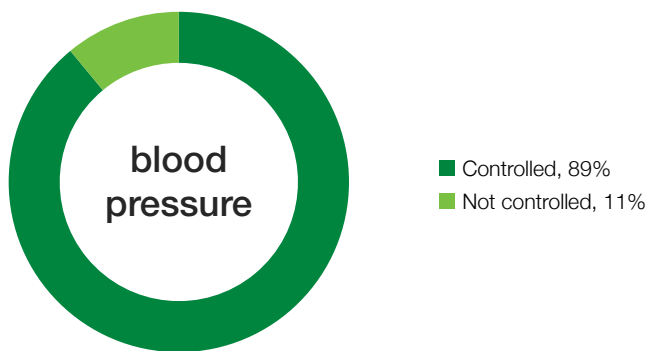
Source: Cardiovascular disease Local Authority health profile, South East Public Health Observatory (current Public Health England)

Risk factors for CHD

There are a number of risk factors for CHD including smoking, lack of physical activity, excessive alcohol consumption, obesity, raised blood pressure, raised serum cholesterol levels and diabetes mellitus. Managing risks to prevent further problems are crucial for CHD patients, particularly high blood pressure and high blood cholesterol levels. The following series of charts below demonstrate the management of CHD risk factors.

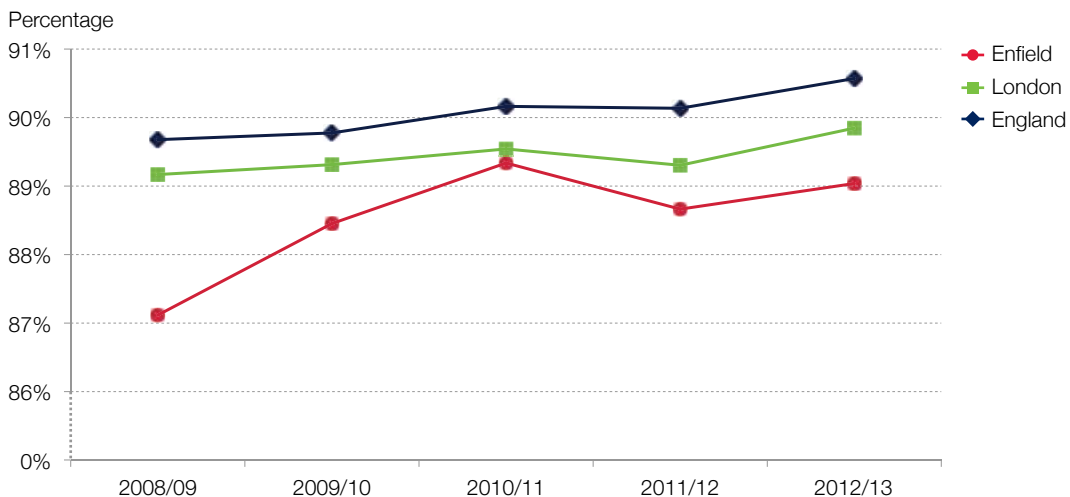
In Enfield, 89% of patients with CHD have their blood pressure under control i.e. less than 150/90 mmHg (Figure 3.22). This is similar to London (90%) and England (91%). There has been considerable improvement in the percentage of patients with CHD whose blood pressure is under control since 2008/09, with the gap narrowing between Enfield and England over time (Figure 3.23).

Figure 3.22: Blood pressure control amongst patients with coronary heart disease, 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

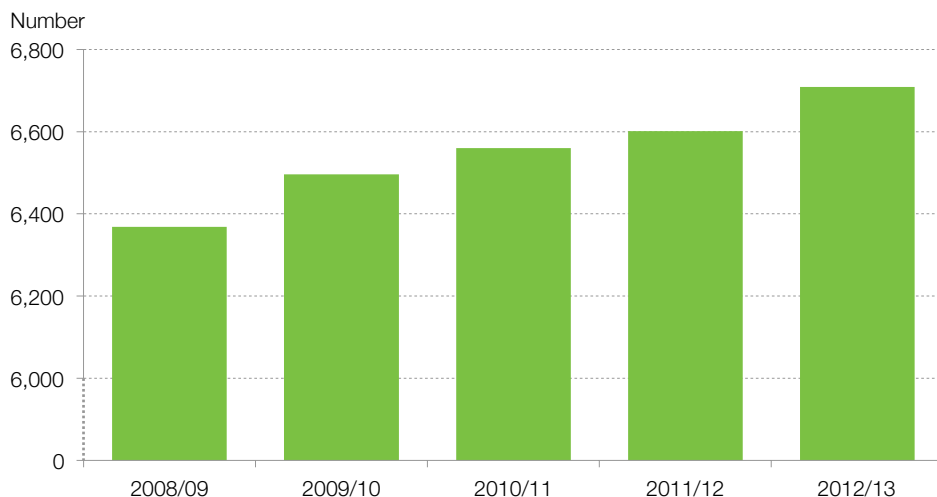
Figure 3.23: Percentage of patients with CHD whose last measured blood pressure was 150/90 mmHg or less, 2008/09 – 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

In more practical terms, the number of patients with CHD whose blood pressure is under control has improved since 2008/09 (Figure 3.24).

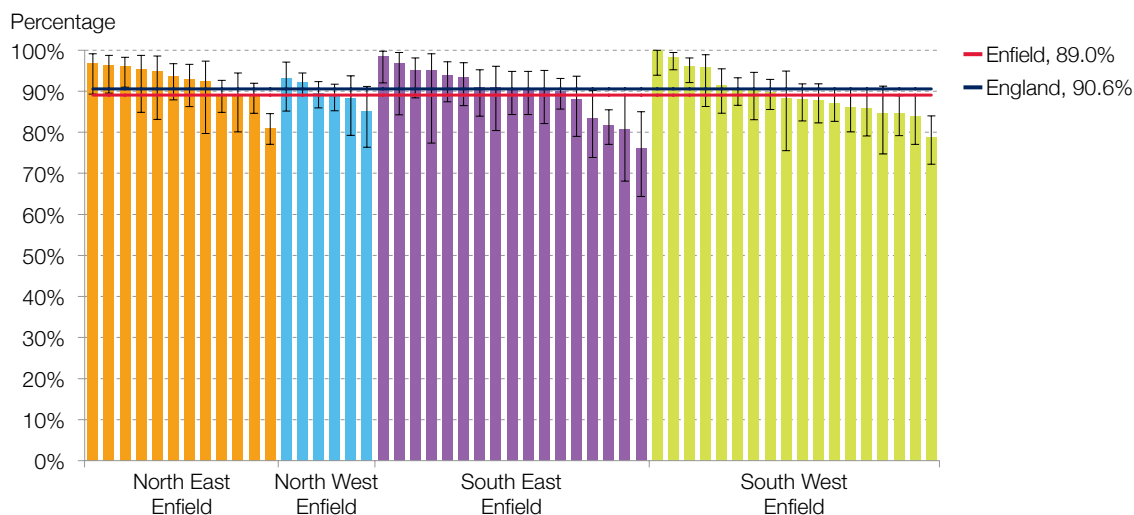
Figure 3.24: Number of patients with CHD whose blood pressure is under control, 2008/09 – 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

The improvement in controlling blood pressure in patients with CHD is a great achievement and testament to primary care intervention. However, there remains wide variation in the percentage of patients with CHD who have blood pressure under control, between GP practices within Enfield ranging from 76% to 100% (Figure 3.25).

Figure 3.25: Percentage of patients with CHD whose last measured blood pressure was 150/90 mmHg or less (CHD06), Enfield practices, 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

The percentage of patients with CHD who have blood cholesterol levels under control is somewhat lower than the percentage of CHD patients with controlled blood pressure.

In Enfield, 78% of CHD patients had their blood cholesterol levels under control (total cholesterol 5mmol/l or less), same as London (78%) and similar to England (80%). In Enfield, just over one fifth of eligible CHD patients do not have their cholesterol level monitored or controlled (Figure 3.26).

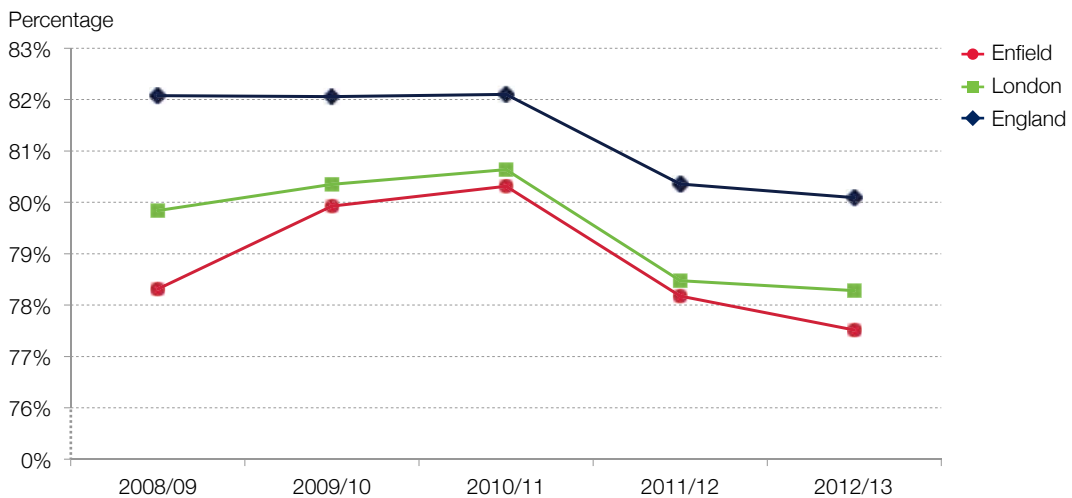
Figure 3.26: Total cholesterol control amongst patients with coronary heart disease, 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

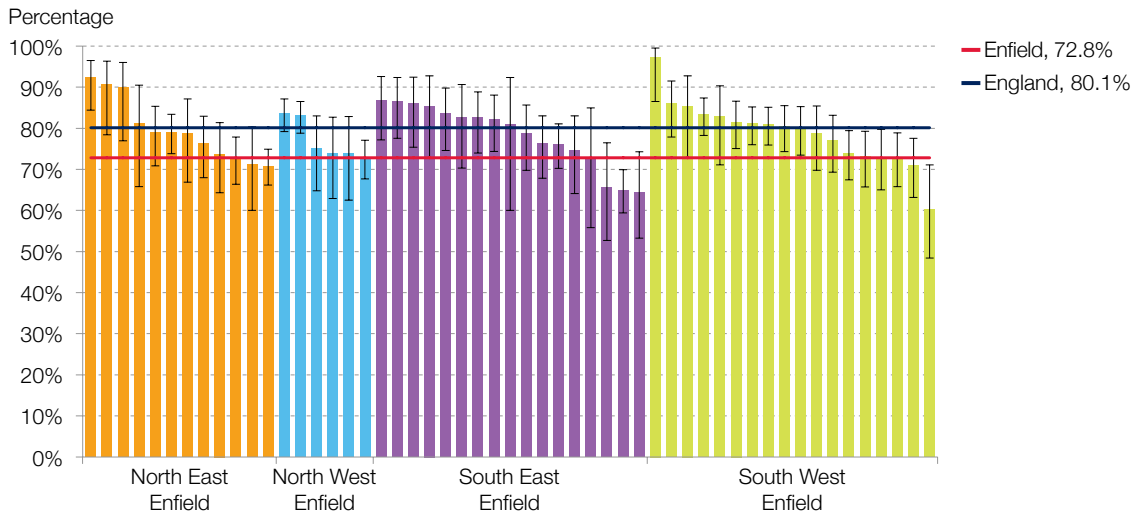
In Enfield, the proportion of CHD patients whose blood cholesterol level is under control has been falling since 2010/11 (Figure 3.27). A similar picture is seen in London and England. Since management of blood cholesterol in patients with CHD is a crucial, further investigation may be beneficial to understand how to target improvements. In the first instance observing variation at GP practice level provides useful insight (Figure 3.28).

Figure 3.27: Percentage of patients with CHD whose blood cholesterol is under control, 2008/09 – 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

Figure 3.28: Percentage of patients with CHD whose last measured total cholesterol was 5 mmol/l or less, Enfield practices, 2012/13



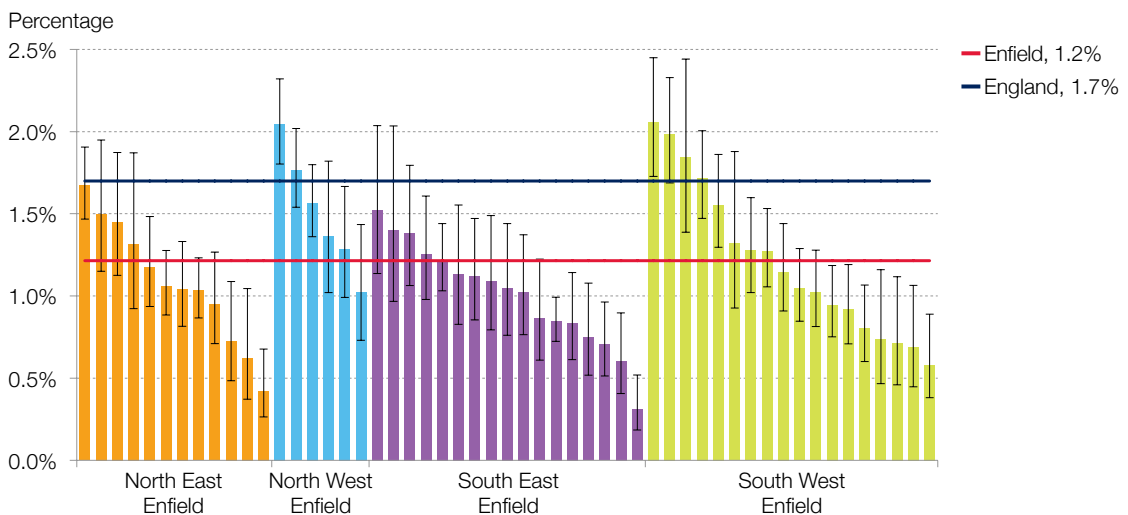
Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

There is considerable variation between GP practices in the percentage of CHD patients with controlled cholesterol level, ranging from 60.3% to 97.4% (Figure 3.28).

3.2.3 Stroke/Transient Ischaemic Attack (TIA)

In Enfield, 3,740 people are living with a history of stroke or transient ischaemic attack (TIA). This equates to 1.2% of patients registered with a GP, which is above the London average (1.0%) but below the England average (1.7%). Within Enfield GP practices the percentage of patients with a history of stroke or TIA varied considerably between 0.3% and 2.1% (Figure 3.29).

Figure 3.29: Percentage of patients with history of Stroke or TIA, Enfield practices, 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

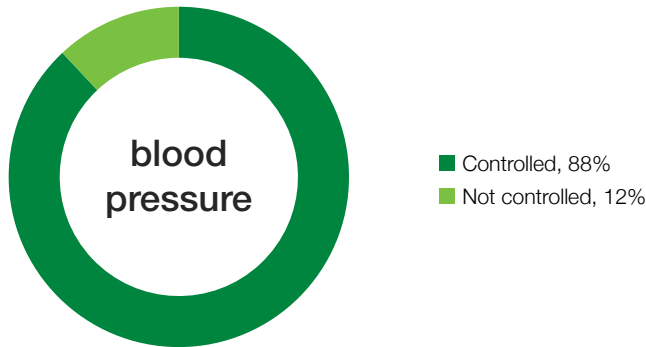
Similar to CHD, the emergency admission rate for stroke, for people living in the 20% most deprived areas of Enfield was 1.4 times greater than stroke emergency admission rates for people living in the 20% least deprived areas of Enfield. Nationally, emergency admissions for stroke in the 20% most deprived areas was 1.8 times greater than emergency admissions in the 20% least deprived areas (2011/12).

Risk factors for stroke/TIA

High blood pressure and high level of cholesterol are two of the main risk factors for stroke and TIA. To prevent further episodes of stroke or TIA, managing the level of blood pressure and blood cholesterol is crucial.

Amongst Enfield’s eligible patients with previous stroke or TIA, 88% had their blood pressure controlled at 150/90 mmHg or less (Figure 3.30), equal to London (88%) and England (89%).

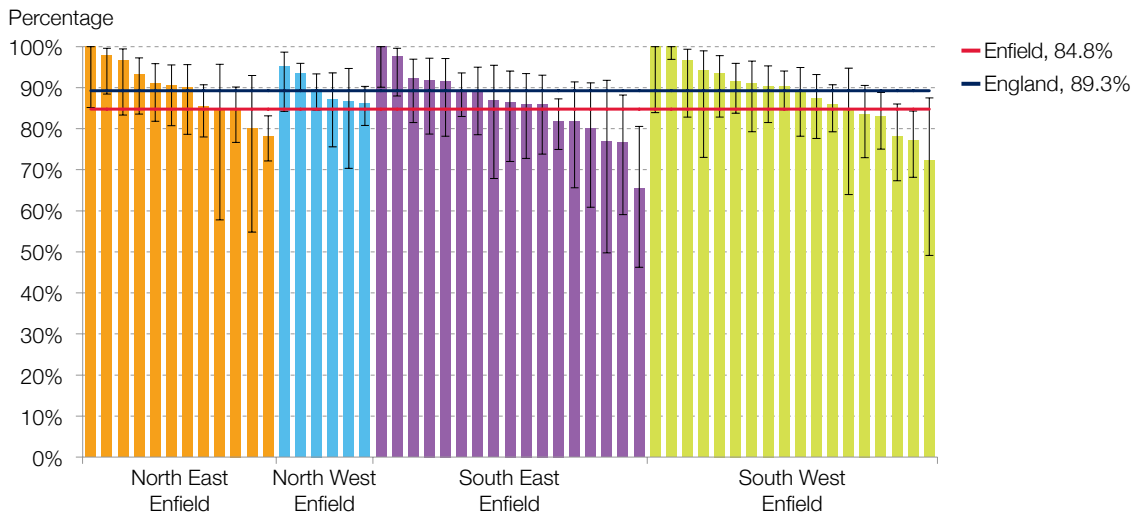
Figure 3.30: Blood pressure control amongst patients with previous stroke or TIA, 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

Again, there is variation at practice level where the percentage of patients with previous stroke or TIA whose blood pressure is under control varies widely between 65% and 100% (Figure 3.31).

Figure 3.31: Percentage of patients with previous stroke or TIA whose last measured blood pressure was 150/90 or less, Enfield practices, 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

In Enfield, three quarters of eligible patients with previous history of stroke or TIA (74%) had their blood cholesterol below the threshold (Figure 3.32).

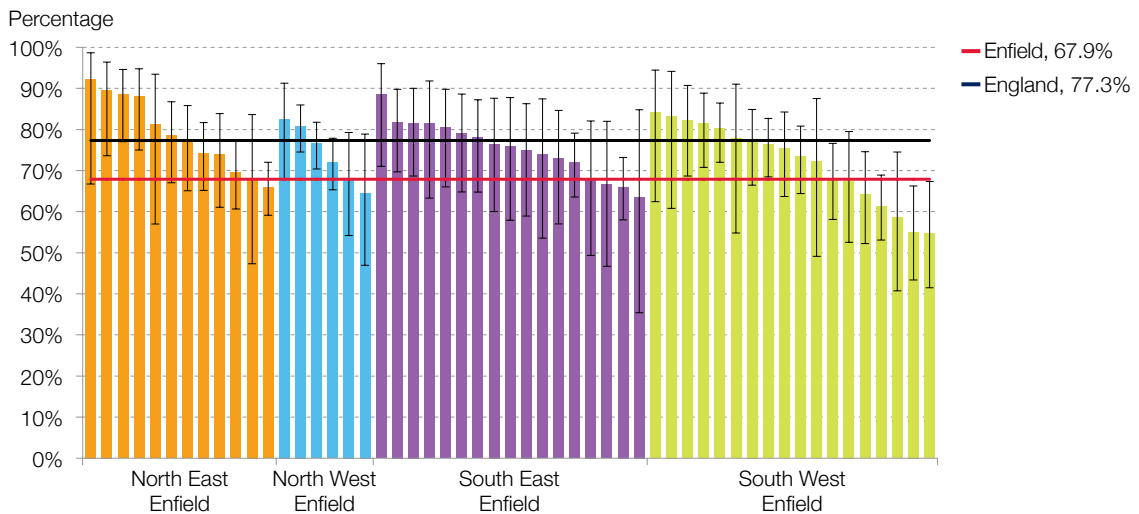
Figure 3.32: Total cholesterol control amongst patients with previous stroke or TIA, 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

Again there is an opportunity to address the wide variation between GP practices within Enfield in the control of cholesterol levels in patients with previous history of stroke or TIA; ranging from 54.7% to 92.3% (Figure 3.33).

Figure 3.33: Percentage of patients with previous stroke or TIA whose last measured total cholesterol was 5mmol/l or less, Enfield practices, 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

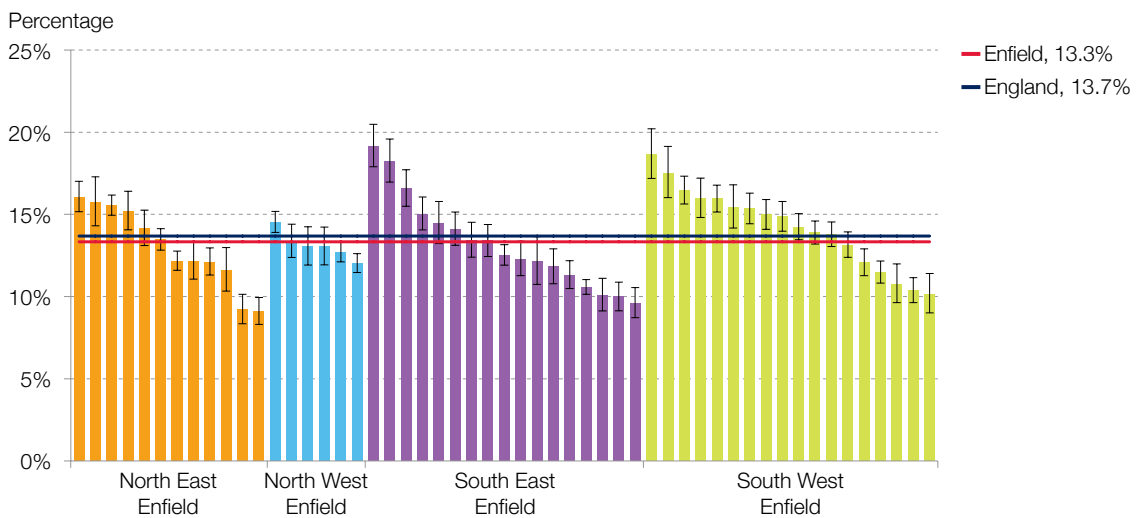


3.2.4 Hypertension

If left untreated, hypertension increases the risk of cardiovascular diseases. There are currently 41,041 patients living with diagnosed hypertension in Enfield. This represents 13.3% of the Enfield registered population, which is above London (11.0%) and marginally below England (13.7%). Modelled estimates suggest that there may be a further 26,000 people in Enfield living with hypertension without diagnosis.

Within Enfield, the recorded prevalence of hypertension varies widely between GP practices ranging from 9.1% to 19.2%. The greatest variation is observed in GP practices belonging to the South East Enfield locality (Figure 3.34).

Figure 3.34: Recorded prevalence of hypertension, Enfield GP practices, 2012/13

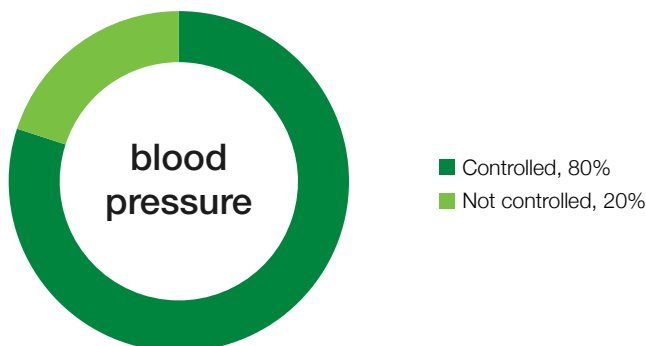


Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

Managing hypertension is crucial in reducing the risk of cardiovascular diseases. For those who have other existing conditions, such as diabetes, CHD and history of stroke/TIA, maintaining good level of blood pressure is essential to prevent further episodes and complications.

Taking exceptions into consideration, 80% of eligible patients in Enfield with diagnosed hypertension (31,565 patients) had controlled blood pressure. One fifth of eligible patients (7,846 patients) did not have their blood pressure controlled (Figure 3.35).

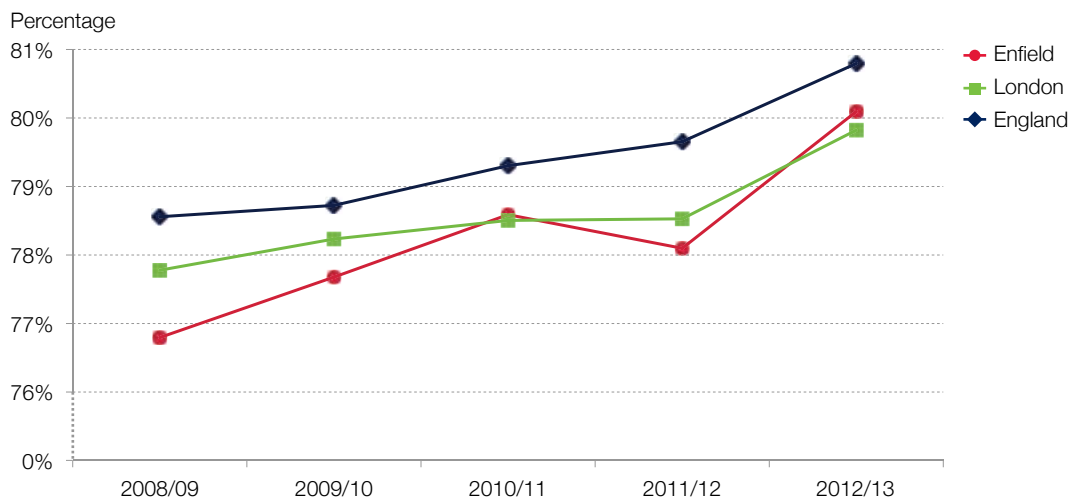
Figure 3.35: Blood pressure control amongst patients with diagnosis of hypertension, 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

Since 2008/09, there has been considerable improvement in the percentage of patients with hypertension whose blood pressure was controlled (Figure 3.36), in line with London and national improvements.

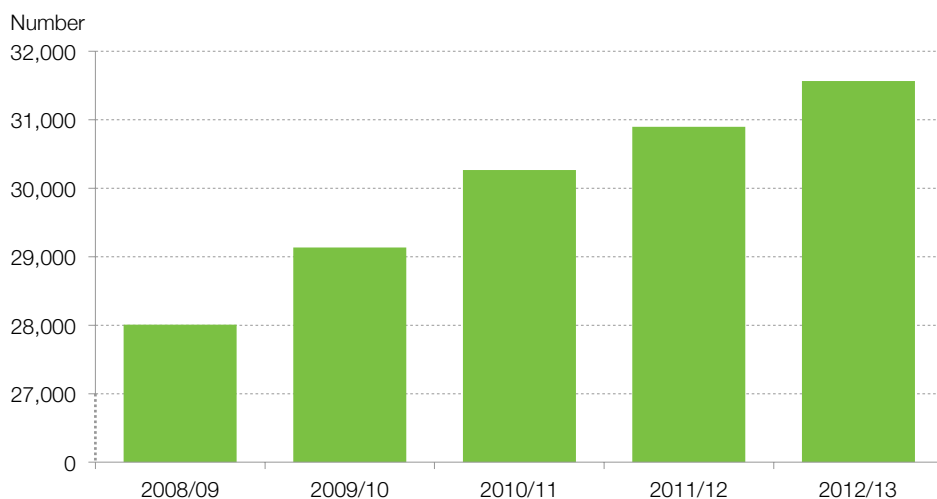
Figure 3.36: Percentage of patients with hypertension whose blood pressure was controlled, 2008/09 – 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

In more practical terms, the number of patients with hypertension who had controlled blood pressure has increased from 28,000 in 2008/09 to 31,600 in 2012/13; an increase of 3,600 patients with controlled blood pressure (Figure 3.37).

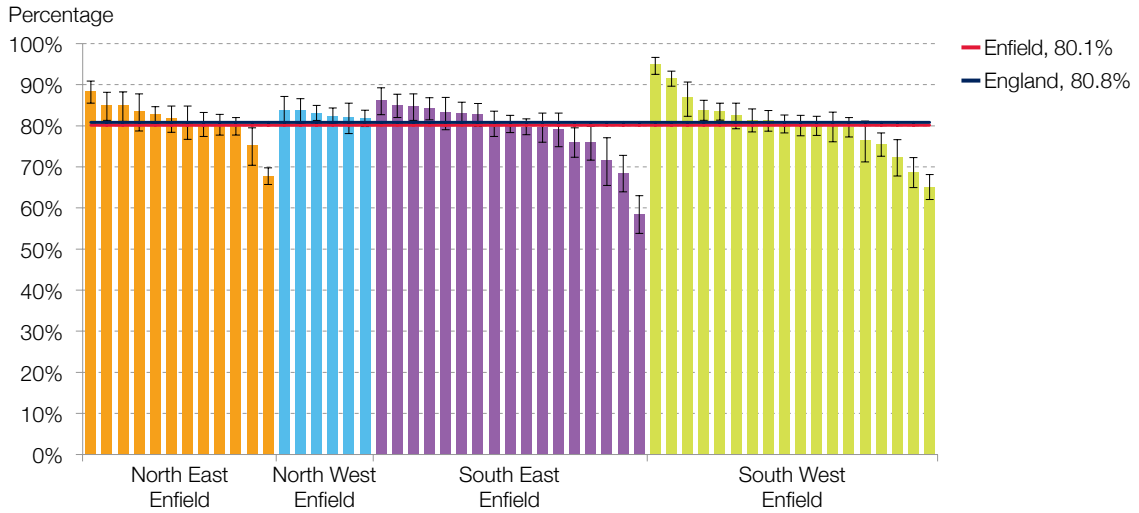
Figure 3.37: Number of patients with hypertension whose last measured blood pressure was 150/90 mmHg or less in Enfield, 2008/09-2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

Whilst there have been improvements in blood pressure control for patients with hypertension in Enfield, there remains wide variation amongst GP practices, ranging from 58.5% to 95.0% (Figure 3.38).

Figure 3.38: Percentage of patients with hypertension whose last measured blood pressure was 150/90 mmHg or less, Enfield GP practice, 2012/13



Source: Quality Outcomes Framework (QOF), Health and Social Care Information Centre

3.2.5 Lifestyle and environmental factors

There are several risk factors for cardiovascular disease (CVD). Most of these risk factors are interlinked, which means people who have one of these risk factors are likely to have others as well.

- High blood pressure
- Smoking
- High blood cholesterol
- Diabetes
- Poor diet
- Lack of physical activity
- Being overweight or obese
- Excessive alcohol consumption
- Stress

Reducing these risk factors is essential in managing and preventing the future development of cardiovascular disease. Integrated work between primary care, public health and partners are addressing these risk factors and tackling the challenge of finding the ‘missing thousands’ who remain unknown to health and social care.

GPs and health professionals from 25 targeted practices attended a hypertension training event on 17th July 2014.

The NHS Health Checks¹⁹

The NHS Health Checks programme aims to lower the risk of heart disease, stroke, diabetes and kidney disease. It is aimed at adults in England aged between 40 and 74 years who have not already been diagnosed with vascular disease, diabetes, or chronic kidney disease. People who are eligible for an NHS Health Check are invited once every five years. The risk of vascular disease is assessed, and the patient is offered treatment and/or personalised advice and support to help lower these risks.

¹⁹ Further information on NHS HealthChecks can be found at: <http://www.nhs.uk/Conditions/nhs-health-check/Pages/NHS-Health-Check.aspx>



3.3 Cancer

Key messages

- Cancer is a term covering a broad range of diseases of different organs in the body which differ in type and effect.
- **4,654** people (1.5% of registered population) are diagnosed with a type of cancer in Enfield.
- More than **1,000** new cases of cancer are reported every year in Enfield.
- Cancer is the **second biggest** cause of mortality in people of all ages within Enfield.
- Roughly **250** people under 75 years die from cancer each year in Enfield.
- More than **two in five cancer cases** could be prevented by lifestyle changes, such as, not smoking.
- There is a clear difference in number of **deaths** occurring in the most deprived areas of Enfield compared with the least deprived areas.

3.3.1 Why is cancer important in reducing the gap in life expectancy?

Every two minutes someone in the UK is diagnosed with cancer and one in three people in the UK will develop some form of cancer during their lifetime (Sasieni, P.D. et al. 2001). Breast, lung, bowel and prostate cancers together account for over half of all new cancers each year in the UK. Although cancer can develop at any age, it is most common in older people (Boyle, P. et al. 2003).

As with many health conditions, there are a range of inequalities in the outcomes and experience of cancer patients. These can occur at every stage of the patient pathway, including in awareness, incidence, access to treatment and care, patient experience, survival and mortality. In general, incidence and mortality rates from cancer are higher in disadvantaged groups and areas, leading to worse outcomes.

National Cancer Equality Initiative (NCEI) was established in 2008 to undertake a range of activities, including recommendations national and local actions to reduce inequalities in cancer care; data collection, analysis and publication; targeted interventions; training, development and research; evaluation and monitoring; and embedding equality (NCEI, 2010).

The National Cancer strategy promotes prevention, early awareness and diagnosis (Department of Health, Public Health England and NHS England, 2013).

There are recommendations throughout the care pathway which are also reflected in the National Support Team for health inequalities cancer guidance. The delivery of interventions is aimed at reducing mortality from cancer and increasing cancer survival. One year survival rates are a good indication of the impact of short term interventions which should reflect awareness and early diagnosis. 5 year survival rates reflect longer term impact of interventions.

It is estimated that more than two in five cancer cases could be prevented by lifestyle changes, such as not smoking, reducing intake of alcohol, maintaining a healthy body weight, and avoiding excessive sun exposure (Boyle, P. et al. 2003).

Moreover, when cancer is diagnosed at an early stage, treatment options and chances of a full recovery are greater. For example, over 93% of bowel cancer patients diagnosed with the earliest stage of disease survive at least five years compared with less than 7% of those diagnosed with the most advanced stage disease. The same pattern is true for lung cancer, breast cancer, and for many cancers, common or rare (Durham County Council, 2013).

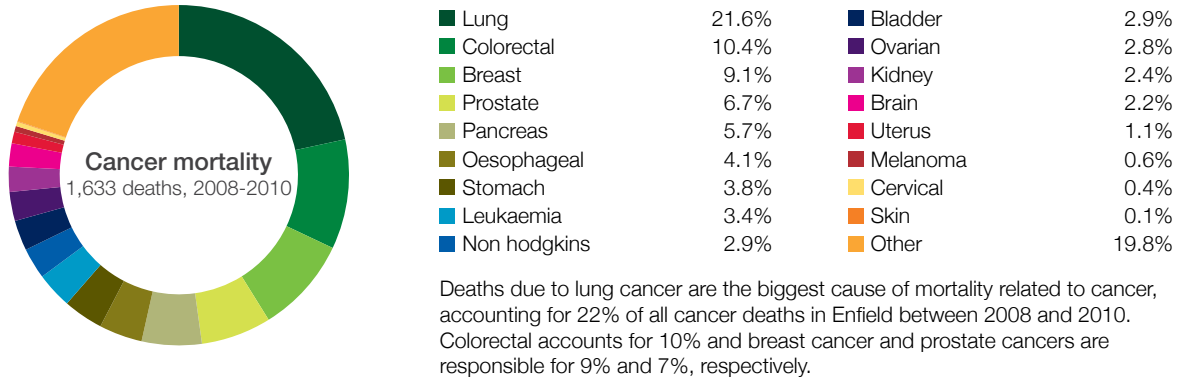
The total cost of cancer nationally is estimated at £15.8 billion per year, £7.6 billion coming from the economic cost of early deaths, £5.6 billion from the healthcare cost and £2.6 billion from unpaid care. Programme budgeting information suggests that Enfield (PCT) spent a total of £33.27 million on the treatment of cancers and tumours in 2011/12.



3.3.2 Mortality

Cancer is the second biggest cause of mortality in people of all ages within Enfield (Figure 3.39). It is responsible for 540 deaths in people of all ages, per year (2008-10) and accounts for 27% of all deaths each year in Enfield.

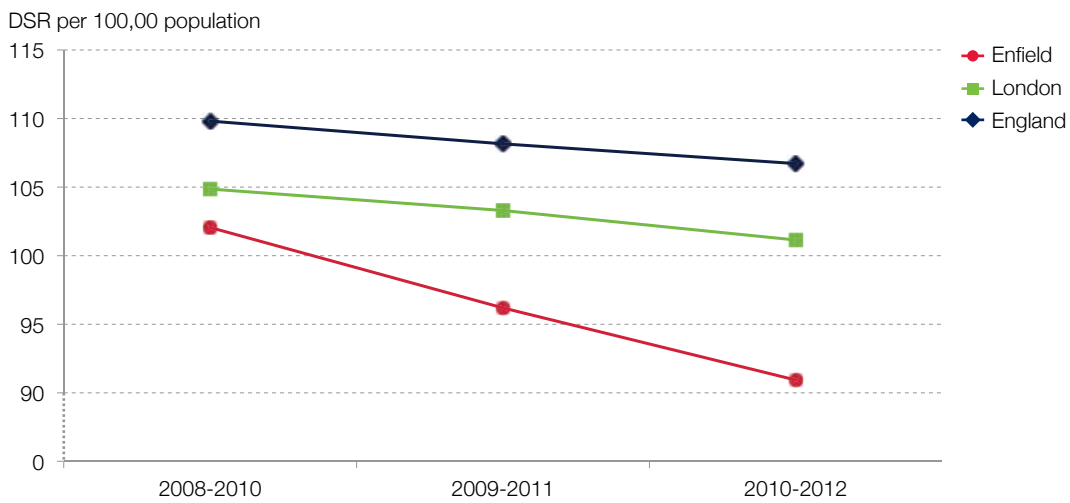
Figure 3.39: Proportion of cancer deaths by specific site, Enfield, 2008-2010



Source: Health and Social Care Information Centre Indicators portal

Recent data show premature mortality (under 75 years) due to cancer is falling in Enfield, London and England (Figure 3.40). In Enfield the rate has reduced from 139 per 100,000 population in 2008-2010, to 126 per 100,000 population in 2010-2012, a reduction of 10%.

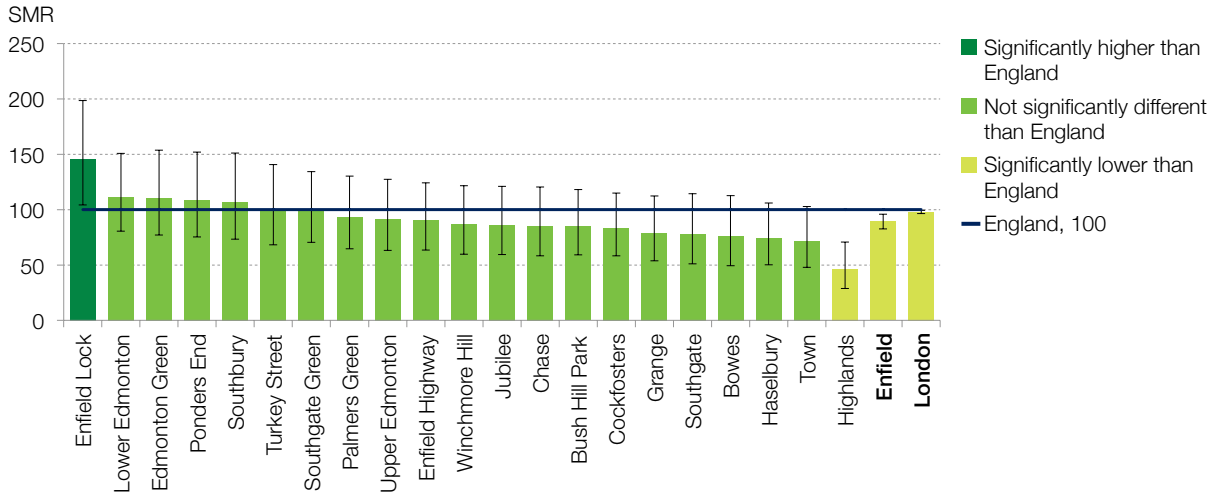
Figure 3.40: Directly standardised mortality rate for all persons under 75 years, for all cancers



Source: HSCIC Indicator Portal

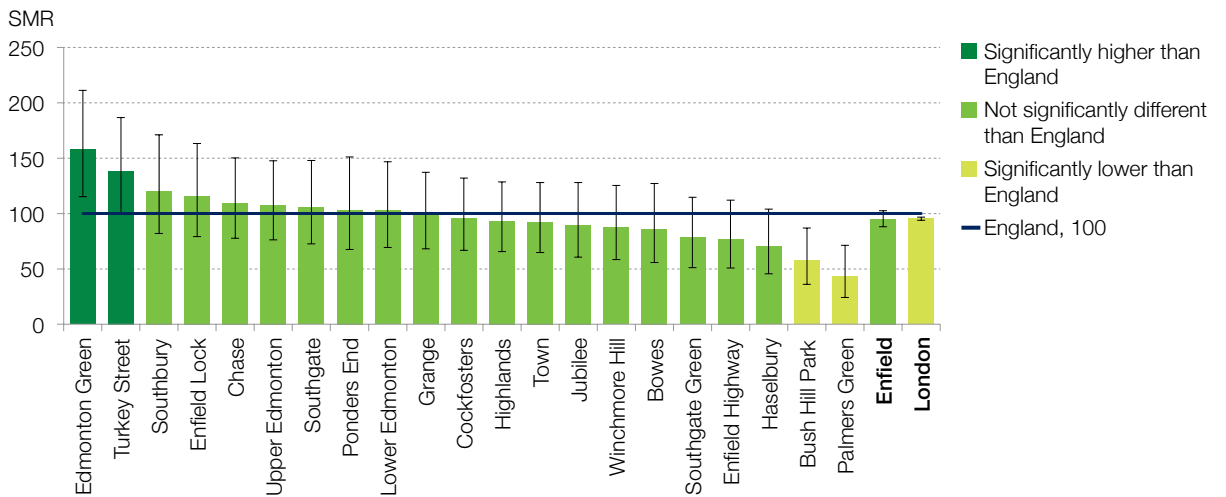
Although premature mortality in Enfield is falling steadily (Figure 3.40), there is a variation within the borough. Premature mortality (under 75 year olds) due to all cancers is much higher in the ward of Enfield Lock compared with the England average for males (Figure 3.41). Premature mortality (under 75 year olds) for females is significantly higher than the England average in the wards of Edmonton Green and Turkey Street (Figure 3.42). In contrast, Highlands ward showed mortality rates in males to be significantly lower than England, while in females both Bush Hill Park and Palmers Green had rates significantly lower than England.

Figure 3.41: Mortality (indirectly standardised ratio: SMR) due to all cancers in males, under 75 years, wards, 2006-2010



Source: HSCIC Indicator Portal

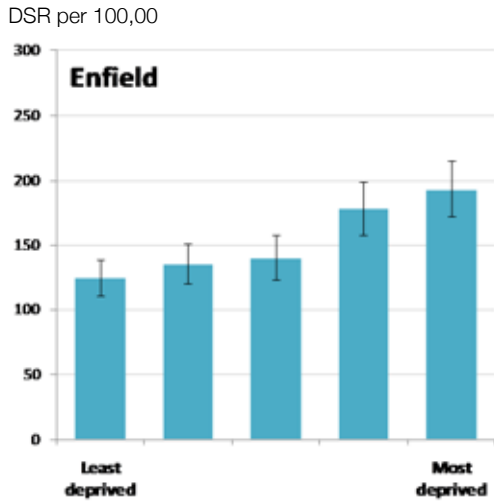
Figure 3.42: Mortality (indirectly standardised ratio: SMR) due to all cancers in females, under 75 years, wards, 2006-2010



Source: HSCIC Indicator Portal

Premature mortality (under 75 years) from cancer in Enfield is similar to London and England. However, there is a clear difference in number of deaths occurring in the most deprived areas of Enfield compared with the least deprived areas. People living in the 20% most deprived areas of Enfield have significantly higher rates of mortality compared to the 60% living in the least deprived areas (Figure 3.43).

Figure 3.43: Directly standardised mortality rate for all persons, for all cancers, by relative deprivation quintile for Enfield, 2011



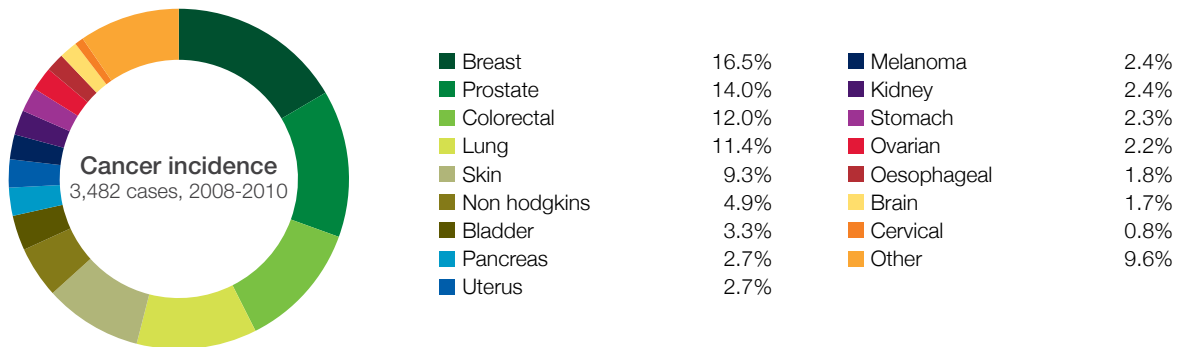
Source: Public Health Observatories Annual Deaths Extract, Office for National Statistics

3.3.3 Incidence

Incidence refers to the number of new cases diagnosed in a period. In Enfield:

- **190** people are diagnosed with breast cancer
- **160** men are diagnosed with prostate cancer
- **140** people are diagnosed with Colorectal cancer
- **130** people are diagnosed with Lung cancer

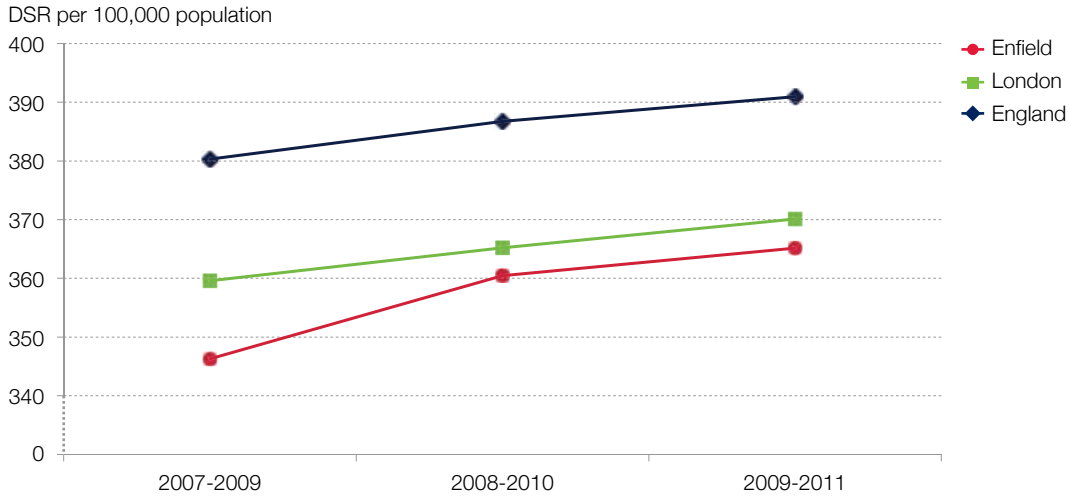
Figure 3.44: Proportion of cancer incidence by specific site, Enfield, 2008-2010



Source: HSCIC Indicator Portal

Cancer incidence (Figure 3.44) has been increasing in Enfield, London and England (Figure 3.45). In Enfield the incidence rate has increased from 358 per 100,000 population in 2008-2010, to 365 per 100,000 population in 2009-2011. This represents an increase of 6%, similar to the national and regional increase in incidence rates.

Figure 3.45: Directly standardised incidence rate for all persons all ages, for all cancers



Source: HSCIC Indicator Portal

3.3.4 Screening and Survival rate

Poor survival is closely linked with stage of diagnosis. National screening programmes for cancer also impact on the number and stage of new cancer diagnoses, which in turn impact on survival and prevalence.

- 1 and 5 year survival rate for Breast cancer and Lower Gastrointestinal (Lower GI) cancer in Enfield (Table 5) are similar to England and London.
- Enfield’s 1 year survival rate for Lung cancer is similar to England but slightly lower than London, whilst 5 year survival rate for lung cancer in Enfield is higher than England.
- In 2012 in Enfield the proportion of invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin’s lymphomas and melanomas of the skin diagnosed at stage 1 or 2 was 40%. This is not significantly different to England (41.6%).

Table 5: Survival rate (1-year, 5-year) by site, Enfield and London, 2008-2010

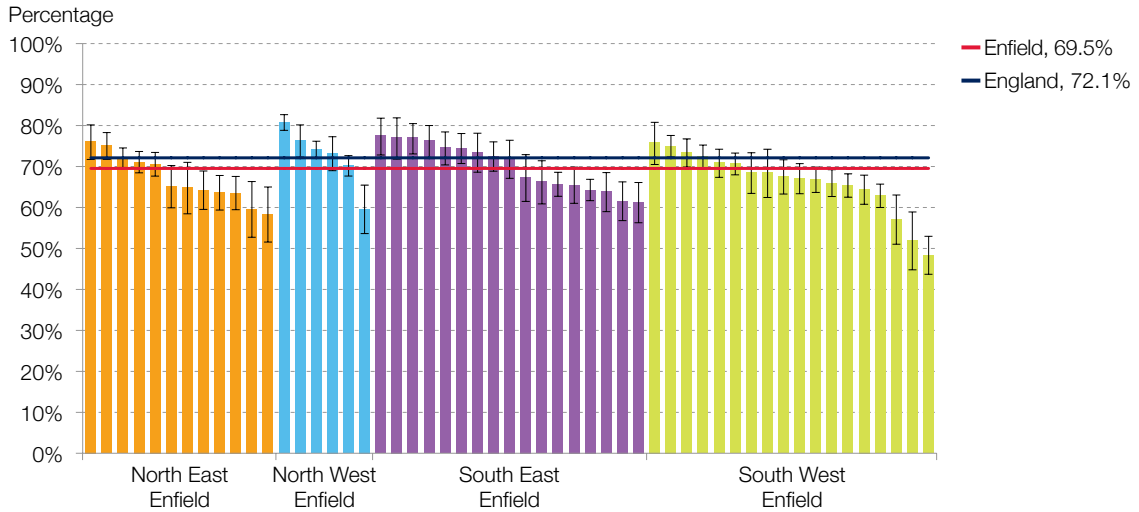
Cancer site	1-year survival rate			5-year survival rate		
	Enfield	London	England	Enfield	London	England
Breast	96.6%	96.8%	96.5%	85.7%	85.9%	85.3%
Lower GI ²⁰	76.4%	76.4%	76.4%	52.9%	54.7%	53.8%
Lung	31.9%	35.7%	32.8%	10.1%	10.1%	8.7%

Source: National Cancer Intelligence Network (NCIN)

²⁰ Lower gastrointestinal cancers include colorectal and anal cancer.

In 2012/13, Enfield had a high uptake of breast screening compared with other London boroughs, ranking 6th highest out of the London boroughs. However, the percentage uptake of 69.5% is considerably lower than the England average (72.1%). There is great variation in breast screening within Enfield GP practices, ranging from under 50% to over 80% (Figure 3.46).

Figure 3.46: Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, % 2010/11-2012/13)

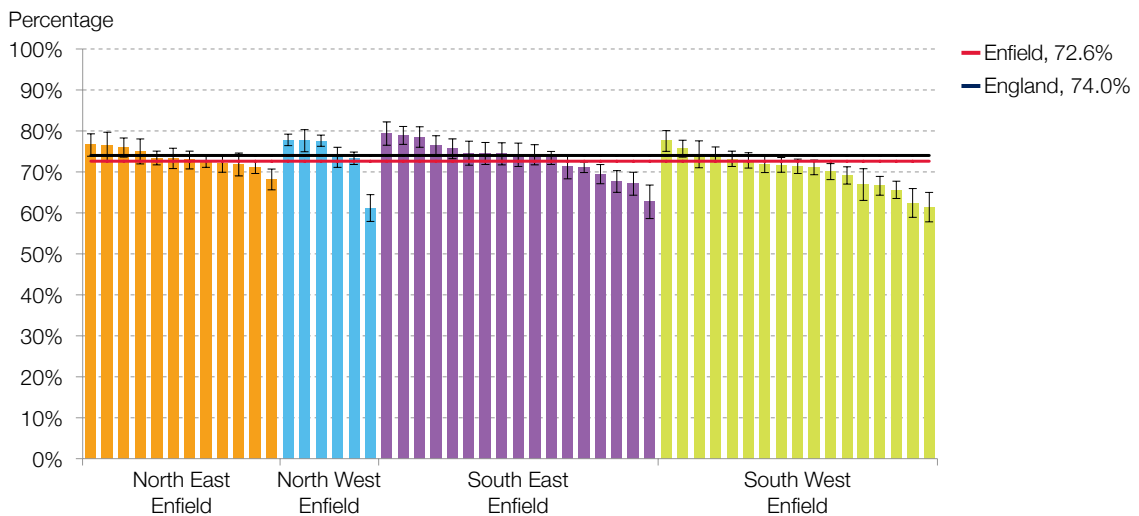


Source: GP practice profiles, National Cancer Intelligence Network (NCIN)

Most London boroughs have a significantly lower rate for cervical screening compared to the England average (Havering and Bexley are the only boroughs not significantly lower than England in 2013 (Public Health Outcomes Framework)).

Between 2007/08 Q3 – 2012/13, Enfield coverage rate for cervical screening (72.6%) was considerably below England (74.0%). Enfield has seen a slight fall in cervical screening since 2009/10, with variation at GP practice level ranging from 61% to 80% (Figure 3.47). Reducing any unwarranted variation may have a considerable impact on the incidence of cervical cancer.

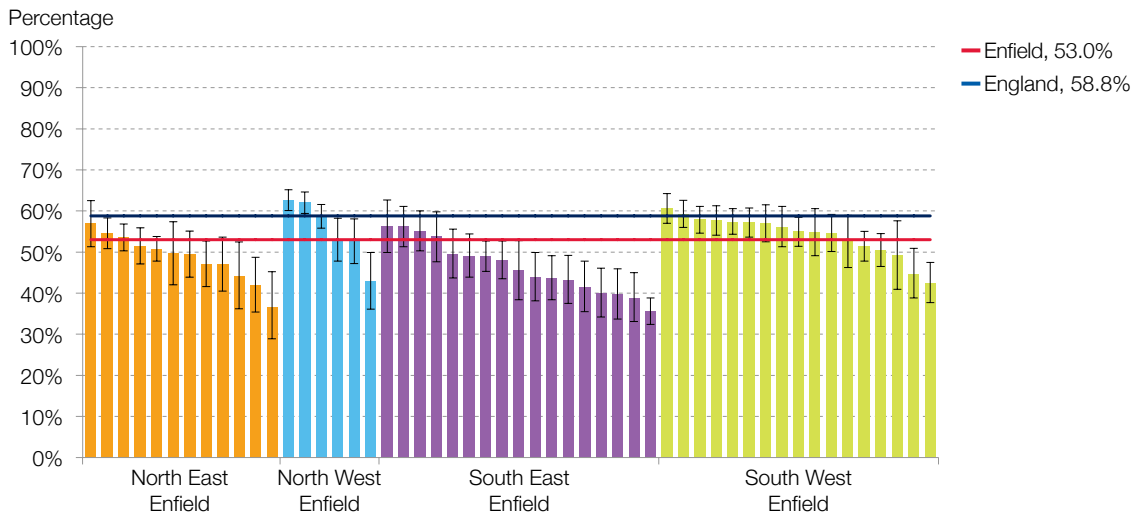
Figure 3.47: Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %) 2007/08 (Q3)-2012/13



Source: GP practice profiles, National Cancer Intelligence Network (NCIN)

Bowel screening uptake rate for Enfield was 53.0%, which was considerably lower than the England rate of 58.8% (2010/11 Q3 – 2012/13). There is variation in uptake rates within the last 30 months between GP practices in Enfield, ranging from under 40% to over 60%. A number of the GP Practices within the east of the borough are significantly below the England and Enfield average bowel screening percentages (Figure 3.48).

Figure 3.48: Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) 2010/11 (Q3)-2012/13

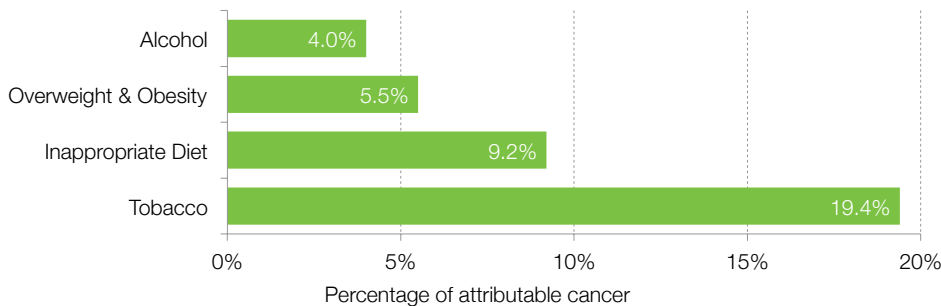


Source: GP practice profiles, National Cancer Intelligence Network (NCIN)

3.3.5 Lifestyle and environmental factors

The aetiology of cancer is not fully understood but it is believed that there are risk factors that can increase or influence a person’s risk of developing cancer. The impact of lifestyle on the development of cancer is very important (Figure 3.49). Interventions that address lifestyle factors will be discussed in detail in Chapter 4.

Figure 3.49: The fraction of cancer attributable to lifestyle and environmental factors



Source: Adapted from Parkin and colleagues. The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010. *Br J Cancer* 2011; 105:S1-S82.

NHS Bowel Cancer Screening

The NHS Bowel Cancer Screening Programme is offered every two years to everyone (registered with a GP) in England aged 60 to 74 years. People over 75 can also request a screening kit. Expanding the age range is being considered at a national level. The test aims to detect polyps and other changes in the bowel that might develop into bowel cancer in the future. It can detect bowel cancer at a much earlier stage, before people are experiencing any obvious symptoms. This is very important, because bowel cancer is usually a very slow growing disease, and can be cured with a straightforward operation if it is detected before it has started to spread. Benign (harmless) polyps can also be removed quickly and easily in a simple procedure that will significantly reduce the risk of bowel cancer developing later.



3.4 Chronic obstructive pulmonary disease (COPD)

Key messages

- **3,118** people (1% of registered population) are diagnosed with COPD in Enfield, but it is estimated that a further **6,500** remain undiagnosed.
- Around **50** people of under 75 years die from respiratory disease (includes COPD) in Enfield each year. Late diagnosis results in poorer outcomes and hospital admissions.
- **Almost half** of these deaths are considered preventable.
- Respiratory disease is the **third biggest** cause of mortality among Enfield men and women.
- There is a clear difference in number of **deaths** occurring in the most deprived areas of Enfield compared with the least deprived areas.

3.4.1 Why is COPD important in reducing the gap in life expectancy?

Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases and represents the most common respiratory problems in the UK. People with COPD have difficulties with breathing, primarily due airflow obstruction, which is a narrowing of their airways (National Institute for Health and Care Excellence, 2010a). COPD is a condition which is predominantly found in people who smoke. It is also prevalent in passive smokers and in people who have been exposed to pollutants over a significant period of time.

In the UK, it is estimated that more than 3 million people currently have COPD and an estimated 2 million people have COPD which remains undiagnosed (NHS Choices, 2014b). Most patients are not diagnosed until they are in their fifties. COPD is closely associated with levels of deprivation, with higher rates of COPD found in more deprived areas. COPD is often associated with comorbidities, particularly cardiovascular disease, lung cancer, osteoporosis, muscle weakness and cachexia (Decramer & Janssens, 2013). COPD causes around 25,000 deaths each year in the UK (NHS Choices, 2014b).



In July 2011, the Department of Health published: “An Outcomes Strategy for COPD and Asthma” (Department of Health, 2011). The strategy sets out several objectives which include improving respiratory health and wellbeing of all communities and minimizing inequalities between communities. It also means proactively addressing health inequalities, with a particular focus on disadvantaged groups and areas with high prevalence.

The number of people with COPD dying prematurely can be reduced through a proactive approach involving early identification, diagnosis and intervention, especially in more deprived areas. This approach also requires proactive care and management at all stages of the disease. Giving up smoking is a key “treatment” for COPD, slowing down disease progression and prolonging life. The impact of short term interventions, particularly in the early identification, diagnosis and intervention of COPD can have significant impact on life expectancy.

Restriction of other potential risk factors, such as occupational dusts and chemicals, can also reduce the risk of COPD, as well as reducing the risk of other exacerbations (e.g. influenza and pneumococcal immunization).

NICE guidance

National Institute of Health and Clinical Excellence. Management of COPD in adults in primary and secondary care. London: NICE. CG101, 2010.

3.4.2 What do we know about COPD in Enfield?

Prevalence

Around 1% of the registered population of Enfield (3,118 people) are diagnosed with COPD. However, the gap between diagnosed and expected prevalence of COPD is large, although narrowing, with an estimated 6,500 people living with undiagnosed COPD in Enfield. The main reason for so many people remaining undiagnosed is late presentation to a GP for persistent cough and a significant overlap in diagnosis with asthma which presents with similar condition symptoms.

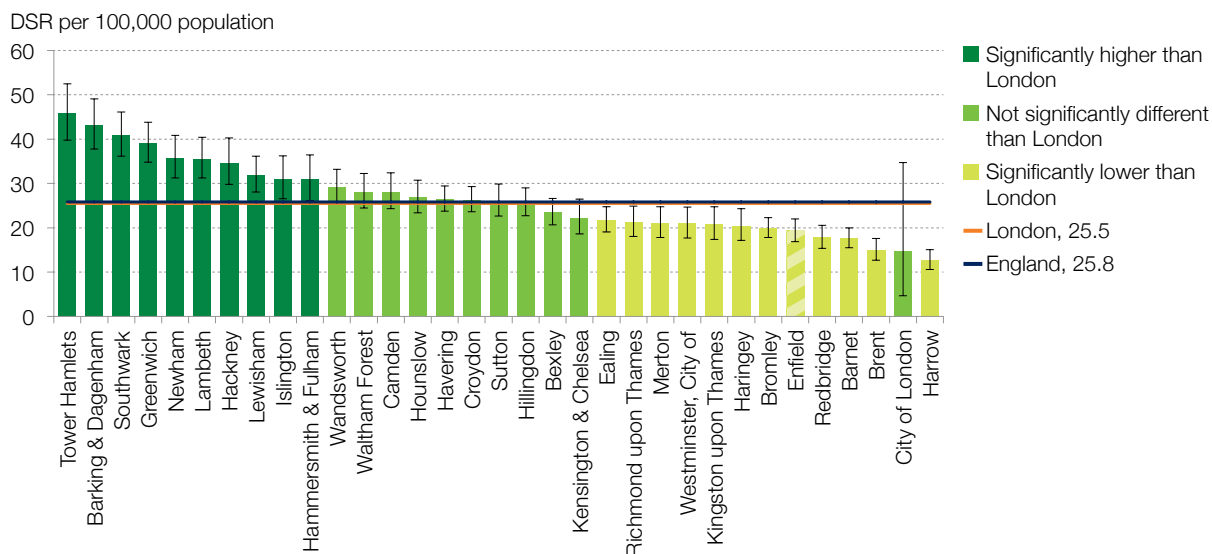
Mortality

Respiratory conditions (including COPD) are the third biggest cause of death for people in Enfield. On average, respiratory disease is responsible for around 80 deaths per year and two-thirds of these deaths occur in persons under 75 years of age. Almost half of these premature deaths are considered preventable.²¹

²¹ ONS defines “preventable deaths” as “A death is preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense”. The cause of preventable deaths from respiratory disease includes Chronic bronchitis, Emphysema and other Chronic Obstructive Pulmonary Disease (COPD) to 0-74 year olds.

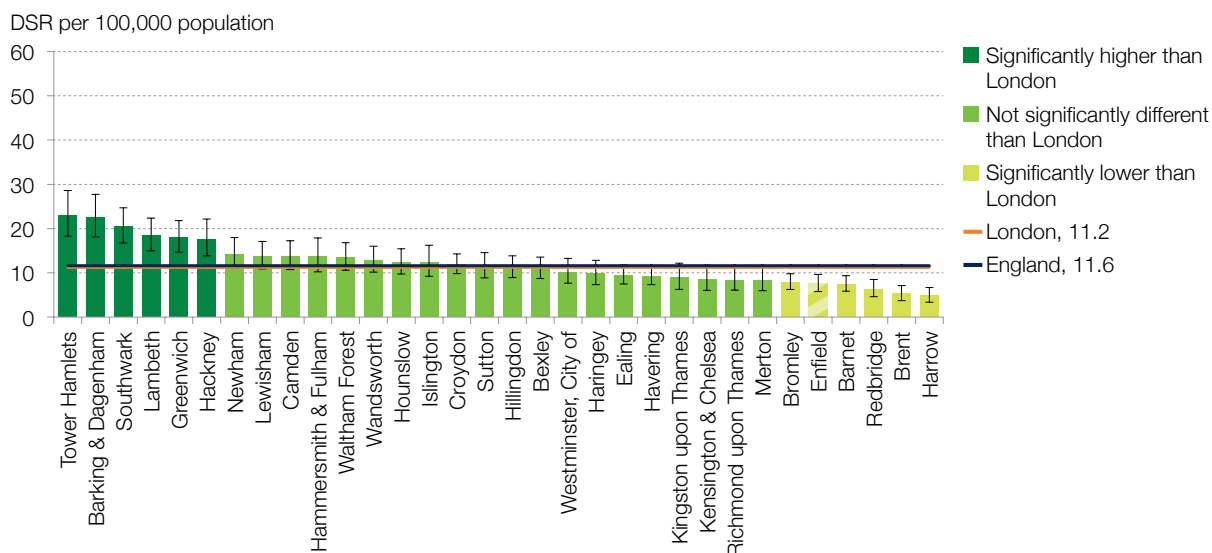
Enfield has the 5th lowest rate of mortality due to COPD in people of all ages within the 32 London boroughs (Figure 3.50).²² The Enfield rate of 19.3 per 100,000 is significantly lower than the corresponding rates for both London and England (25.5 and 25.8 per 100,000 population respectively).

Figure 3.50: Directly standardised rate, mortality due to all COPD, persons all ages, 2010-2012



Source: Health and Social Care Information Centre Indicator Portal

Figure 3.51: Directly standardised rate, mortality due to all COPD, persons under 75 years, 2010-2012

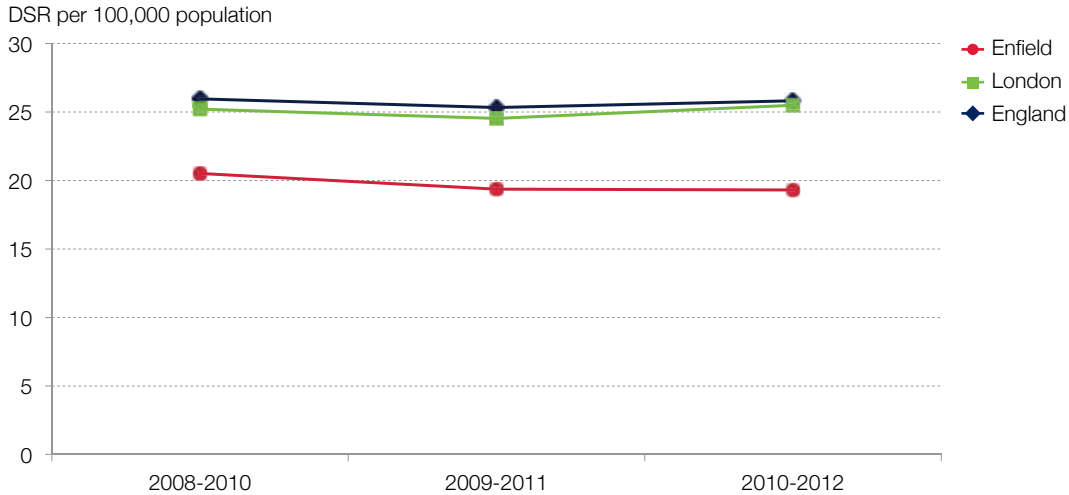


Source: Health and Social Care Information Centre Indicator Portal

²² Note due to small numbers data for males and females cannot be published. This is also true for premature mortality i.e. under 75 years.

Enfield has the 5th lowest rate of mortality due to all COPD for people under 75 years old. The Enfield rate (7.5 per 100,000) is lower than both London (11.2 per 100,000) and England (11.6 per 100,000 population) (Figure 3.51). Since 2008-2010, mortality from COPD has been decreasing in Enfield (Figure 3.52).

Figure 3.52: Directly standardised rate, mortality due to all COPD, persons all ages, 2008-2010 to 2010-2012



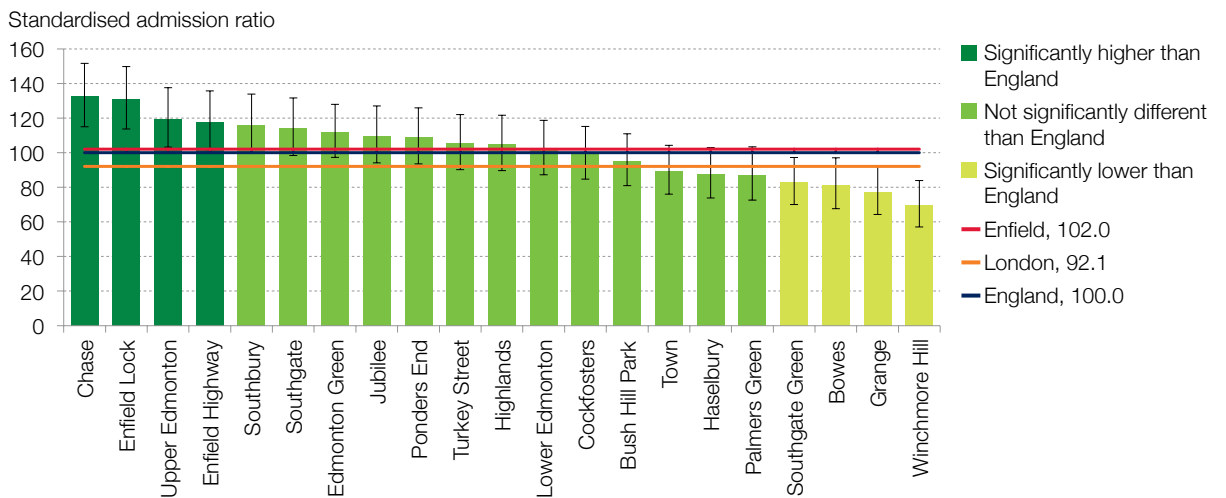
Source: NHS Indicator Portal

3.4.3 Hospital admissions

There is convincing evidence that people with COPD who are diagnosed in hospital following an emergency admission for acute exacerbation, often presenting with severe symptoms could have been diagnosed in primary care. Late diagnosis of COPD results in poorer health outcomes and is likely to increase unscheduled use of secondary care (Figure 3.53).

Nationally, the majority of excess winter mortality (63%) was caused by respiratory diseases and circulatory diseases in 2009/10-2011/12. In particular, respiratory diseases caused 40% more deaths during winter compared to the non-winter period.

Figure 3.53: Standardised admission ratios (SARs) for respiratory disease, persons all ages, Enfield wards, 2010/11



Source: London health programmes, needs assessment toolkit.

There are clear differences for hospital admissions due to respiratory disease²³ between wards in Enfield as compared with the England average (Figure 3.53). Southgate Green, Bowes, Winchmore Hill and Grange standardised admission ratios are significantly lower than the England average. However, Enfield Highway, Enfield Lock, Chase and Upper Edmonton ratios are significantly higher than England. This means that people of all ages living in Chase ward are 32% more likely to have a hospital admission for respiratory disease, compared to England. In contrast, people in Winchmore Hill ward are 30% less likely to be admitted for COPD, compared to England (2010/11).

For people aged under 75 years in 2010/11, Winchmore Hill, Grange, Bush Hill Park, Bowes, Town, Southgate Green and Cockfoster show ratios significantly below the England average. In contrast, people in Enfield Lock are 25% more likely to be admitted to hospital for respiratory disease, compared to England (Health Needs Assessment Toolkit, London Health Programme).

3.4.4 Lifestyle and environmental factors

Smoking is the greatest cause of avoidable death and disability in the borough responsible for a number of conditions. Stopping smoking is a key priority in Enfield, as it is a risk factor in the development of chronic obstructive pulmonary disease (COPD), a higher prevalence of which is seen in people from deprived backgrounds.

Studies have shown that offering stop smoking advice to COPD patients at diagnosis can increase their motivation to quit (Gorecka et al., 2003). A long history of smoking, failed quit attempts and strong nicotine addiction means that more intensive support is required (Tashkin et al., 2001).

There is a significant role of physical activity in the secondary prevention of COPD. Improvements in the overall condition of patients with long term conditions, including COPD are observed when increases to physical activity levels have been achieved (NICE, 2006; Cavill et al., 2011).

Pulmonary rehabilitation is seen as a key component of high quality care for patients with COPD as recommended within the National Outcomes Strategy for COPD and Asthma in England (Department of Health, 2011). Pulmonary rehabilitation has been proven to reduce breathlessness and improve the quality of life in people with COPD, and NICE recommends it should be offered to people who consider themselves functionally disabled by COPD (NICE, 2010).

²³ SAR definition – Admission ratios standardised for age and sex were calculated by the indirect method; numbers greater than 100 represent more admissions than expected and numbers less than 100 represent fewer admissions than expected.



3.5 Diabetes

Key messages

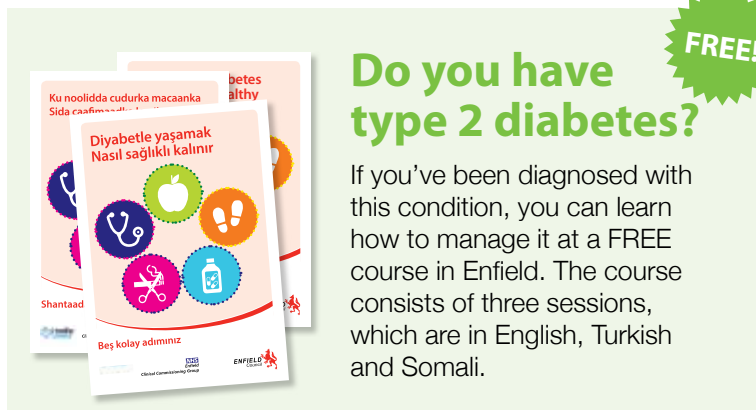
- Roughly **16,000** people aged 17 and over (**6.8%** of registered population) are diagnosed with Diabetes in Enfield.
- Over **1,800** people are estimated to be living with diabetes without diagnosis.
- **36%** of people with diabetes have uncontrolled blood glucose levels.
- People living in the most deprived areas in the UK are **2.5** times more likely to have diabetes.
- There is **large variation** in Enfield in monitoring and controlling blood pressure, blood glucose levels and other key diabetes related conditions between patients with diabetes.
- Enfield had the **4th highest** age standardised hospital admission rate for diabetes in females in London.

3.5.1 Why is Diabetes important in reducing the gap in life expectancy?

Diabetes is a common, chronic and complicated condition in which the amount of sugar (glucose) in the blood is too high so that the body's cells cannot use glucose properly. There are two types of diabetes; Type 1 and Type 2. Type 2 diabetes used to be called 'maturity-onset diabetes' because it was normally only seen in people in their late 50s and 60s. However, it is now seen in younger adults and in an increasing number of children. The principal cause of the rise in early onset diabetes is overweight and obesity and this is significant. As an increasing number of people become overweight and subsequently obese, we can expect an increasing number of people to develop diabetes (Diabetes UK, 2012). In 2013, there were an estimated 3.2 million people with diabetes in the UK and this is predicted to rise to 4 million by 2025 (NHS Confederation, 2014).

Diabetes is the fifth most common cause of death in the world (Roglic et al. 2005). People with diabetes account for an estimated 15 to 16 per cent of deaths occurring in England (The NHS Information Centre, 2011). Life expectancy is reduced, on average, by more than 20 years in people with Type 1 diabetes and up to 10 years in people with Type 2 diabetes (Department of Health, 2001).

Diabetes often causes distress and disability. However, there is extensive evidence to show that the complications of diabetes can be prevented by appropriate care, and people with diabetes can enjoy a good quality of life. Treatment for diabetes is estimated to account for 10% of healthcare costs (Department of Health, 2006) and nationally 90% of all diabetes is estimated to be Type 2 diabetes (Department of Health, 2007a).



Do you have type 2 diabetes?

If you've been diagnosed with this condition, you can learn how to manage it at a FREE course in Enfield. The course consists of three sessions, which are in English, Turkish and Somali.

Type 2 diabetes is up to three times more common amongst people from a black, minority ethnic groups and up to six times more common in people of South Asian descent (Department of Health, 2001).

Deprivation is also an important predictor of whether or not someone is living with diabetes. The most deprived in the UK are 2.5 times more likely to have diabetes. Complications of diabetes such as heart disease, stroke and kidney damage are three and a half times higher in the lower socio economic groups.

Inequality of health outcomes in people with diabetes has many causes. Around 50 per cent of increased morbidity is due to smoking and uncontrolled hypertension. Other factors include poor blood glucose control, raised cholesterol, obesity, lack of education, inaccessibility (e.g. older adults living alone), unemployment, housing status, ease of access to services and referral bias (Diabetes UK, 2012).

The National Institute for Health and Clinical Excellence (NICE) recommends that all people with diabetes should receive nine key tests at their annual diabetes review. These important markers ensure diabetes is well controlled and are designed to prevent long term complications. The nine key care processes are:

1. Blood glucose level measurement
2. Blood pressure measurement
3. Cholesterol level measurement
4. Retinal screening
5. Foot and leg check
6. Kidney function testing (urine)
7. Kidney function testing (blood)
8. Weight check
9. Smoking status

This review discusses the importance of markers of improved long-term care of patients.

There will always be a degree of variation in care outcomes, and a few patients will decline or not need some of the care processes. However, most patients should have all of the care processes and achieve the outcomes recommended in national guidance.

Of the quality indicators for diabetes care (i.e. body mass index (BMI) recorded, smoking status recorded or smoking advice given, HbA1c recorded, retinal screening, blood pressure recorded), several have been found to be adversely associated with deprivation and ethnicity (Diabetes UK, 2012). This in turn means that these population are more likely to develop serious complications like heart disease, kidney failure, strokes, nerve damage and blindness.

Diabetes is a progressive condition so older people are much more likely to develop complications. They are more likely to be admitted to hospital with a foot ulcer than with any other complication of diabetes (Diabetes UK, State of the Nation, 2012).

3.5.2 What do we know about Diabetes in Enfield?

Diabetes is a commonly diagnosed long term condition in Enfield.

Statistical models suggest that there are a large number of people living with unknown diabetes. It is estimated that between 1,800 and 3,100 people are living with undiagnosed diabetes in Enfield (see Chapter 3.1). The reason for this range in estimates stems from the underlying differences in models used to calculate prevalence. The gap between estimated and recorded prevalence shows much variation between GP practices in Enfield, with prevalence of diabetes ranging from 4.3% to over 11%.

Increasing awareness among the general population and healthcare professionals aims to improve presentation and recognition of the early symptoms of long term conditions. There is good evidence that targeted case finding for diabetes (in ethnic populations and in middle-aged adults who are overweight and/or have high blood pressure) identifies previously undiagnosed cases (Diabetes UK, 2012).

Targeted diabetes case finding, together with screening for Chronic Kidney Disease (CKD) (based on high blood pressure), forms part of the NHS Health Checks programme which aims to detect at least 25,000 new cases of diabetes or CKD nationally each year (Diabetes UK, State of the Nation, 2012).

Improvements in diabetes care and management can be made in the short term (within 5 years), particularly following best practice and using guidance developed by the Health Inequality National Support Team (HINST, 2011).

NICE guidance

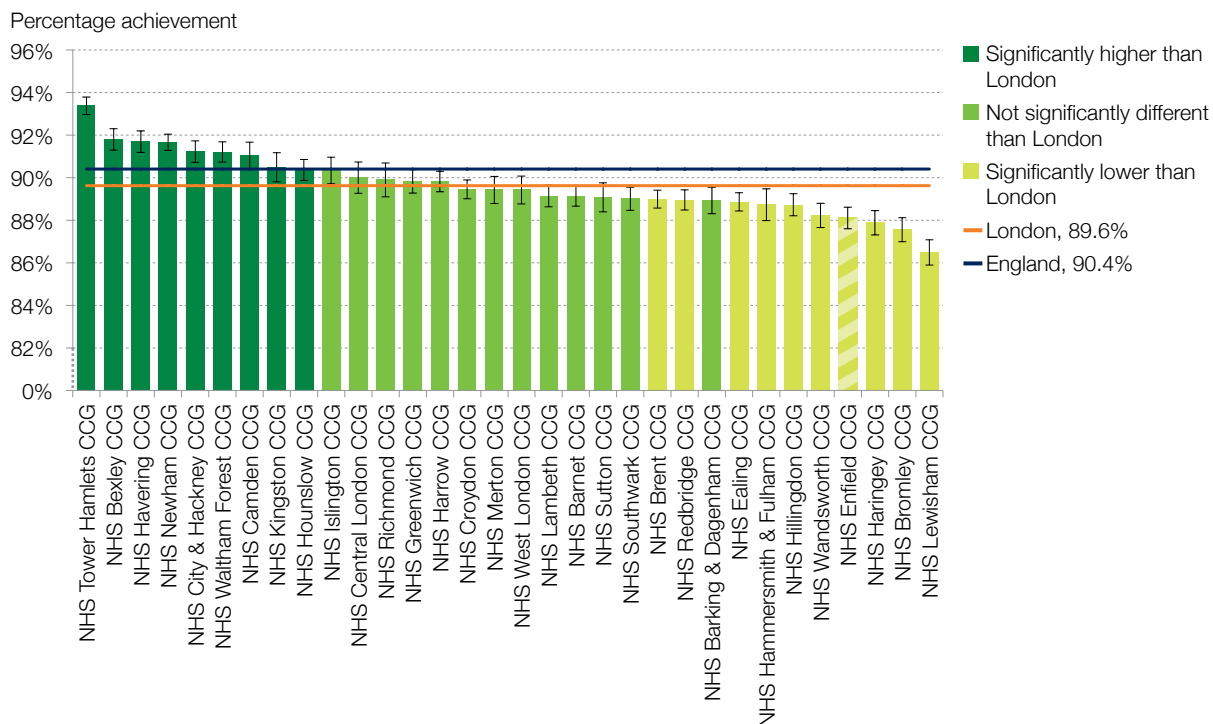
National Institute of Health and Clinical Excellence (NICE): Type 2 diabetes: The management of type 2 diabetes. London: NICE. CG87, 2009 (Updated, 2014).

3.5.3 Diabetes outcomes

Blood pressure control

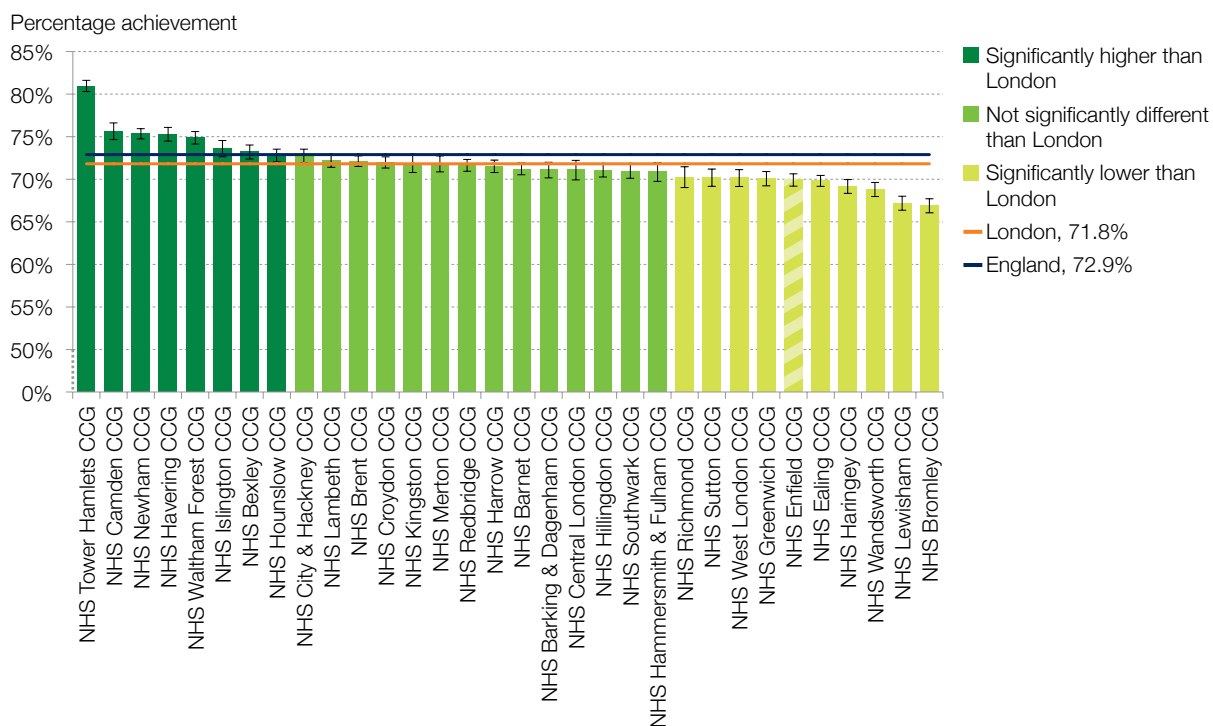
Diabetes patients are at an increased risk of developing heart disease and at a higher risk of stroke. To help reduce these risks it is important to control the blood pressure of patients with diabetes. Figures 3.56 and 3.57 depict the control of blood pressure in patients with diabetes at 150/90 or less and 140/80 or less (National Institute for Health and Care Excellence (NICE) recommendation) in London.

Figure 3.54: Percentage of patients with diabetes in whom the last blood pressure is 150/90 or less in last 15 months, London CCG's, 2012/13



Source: Quality and Outcomes Framework 2012/13

Figure 3.55: Percentage of patients with diabetes in whom the last blood pressure is 140/80 or less in last 15 months, London CCG's, 2012/13

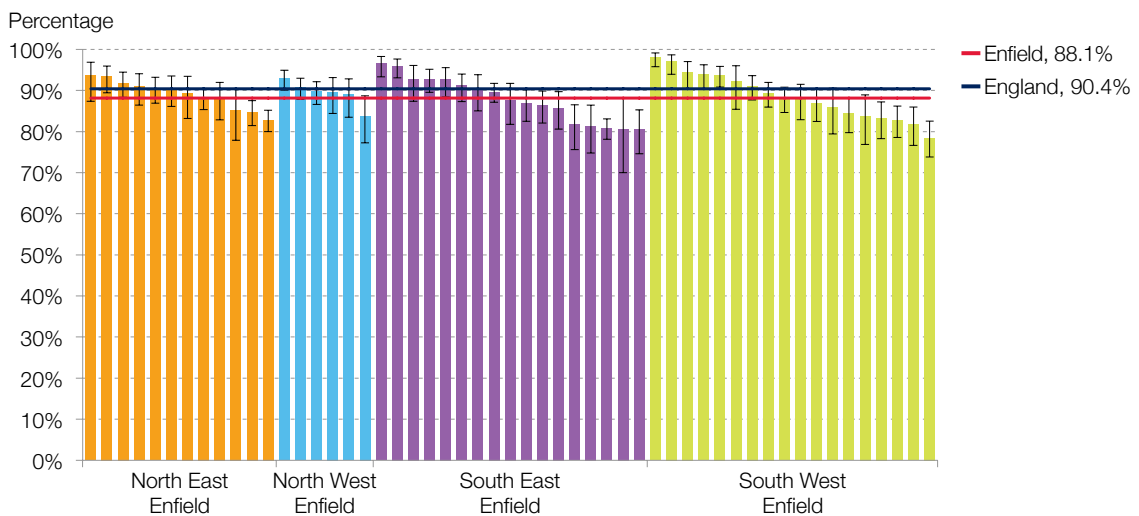


Source: Quality and Outcomes Framework 2012/13

In Enfield, the percentage of patients with diabetes whose last recorded blood pressure in the last 15 months was 150/90 or less was 88%, this was significantly lower than both London and England (both 90%), in 2012/13 (Figure 3.54). Similarly, the percentage of diabetes patients whose last recorded blood pressure in the last 15 months was 140/80 or less (Figure 3.55), in Enfield (70%) was significantly lower than both London (72%) and England (73%).

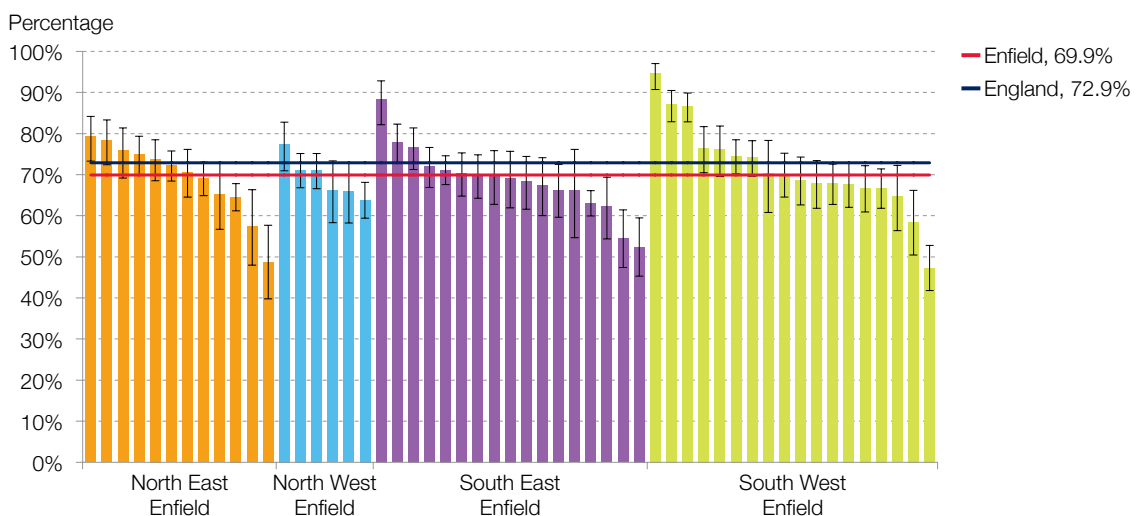
Within Enfield, there is evidence of variation amongst GP practices (Figure 3.56), ranging from 79% to 98%. There were ten GP practices where the percentage of patients with diabetes whose last recorded blood pressure in the last 15 months was 150/90 or less was significantly less than the Enfield average, which itself significantly lower than London and England. Addressing this underlying variation at GP practice level within Enfield (Figure 3.58) will have a positive impact on the reducing inequalities in outcomes.

Figure 3.56: Percentage of patients with diabetes whose last BP is <=150/90 in last 15 months, 2012/13



Source: Quality and Outcomes Framework 2012/13 [DM 30 indicator]

Figure 3.57: Percentage of patients with diabetes whose last BP is <=140/80 in last 15 months, 2012/13



Source: Quality and Outcomes Framework 2012/13 [DM 31 indicator]

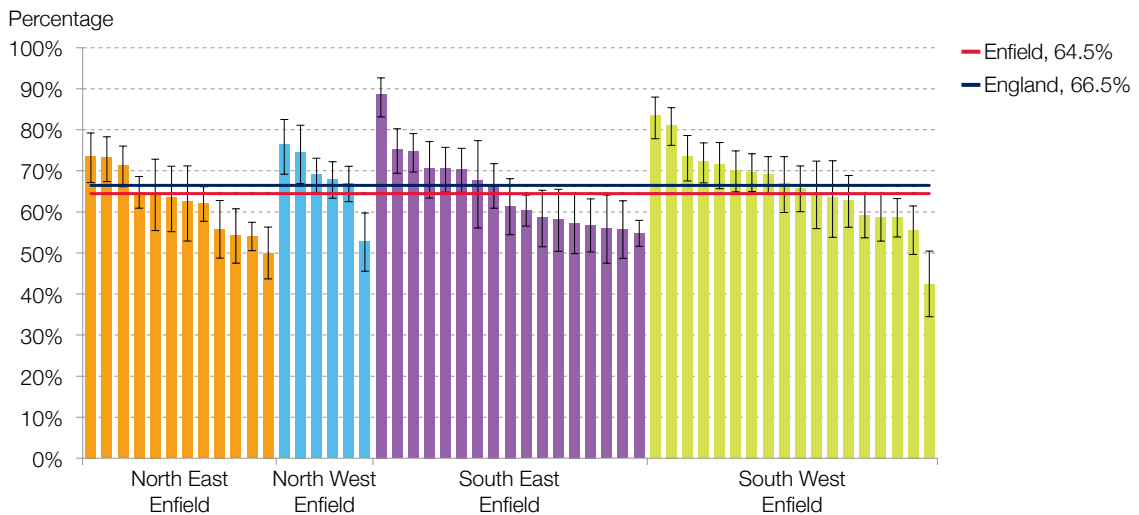
In 2012/13, 70% of patients with diabetes in Enfield had a blood pressure of 140/80 in the last 15 months, compared to 72% in London and 73% in England (Figure 3.57). There is considerable variation within the practices of each locality, with percentages ranging from 47% to 95% across Enfield. This suggests that many people with diabetes in Enfield who are not receiving adequate monitoring of their condition, which may lead to the development of heart disease and/or stroke in later life. There may be a variety of reasons for this variation. However, it is crucial to reduce any unwarranted variation.

Blood glucose control

Haemoglobin is a chemical that carries oxygen in red blood cells, which also has glucose attached to it to form HbA1c.²⁴ HbA1c tests show average blood glucose levels over a sustained period of time. A high HbA1c level means that blood glucose levels have been consistently high over recent weeks. HbA1c measurements provide important information to help manage diabetes control effectively.

In Enfield, the percentage of patients with diabetes where the last HbA1c recording in last 15 months was <7.5% was 64% in 2012/13. This was equal to London (64%), but was significantly lower than England (66%) (QOF 2012/13).

Figure 3.58: Percentage of patients with diabetes where the last HbA1c recording in last 15 months was <7.5%, localities, 2012/13



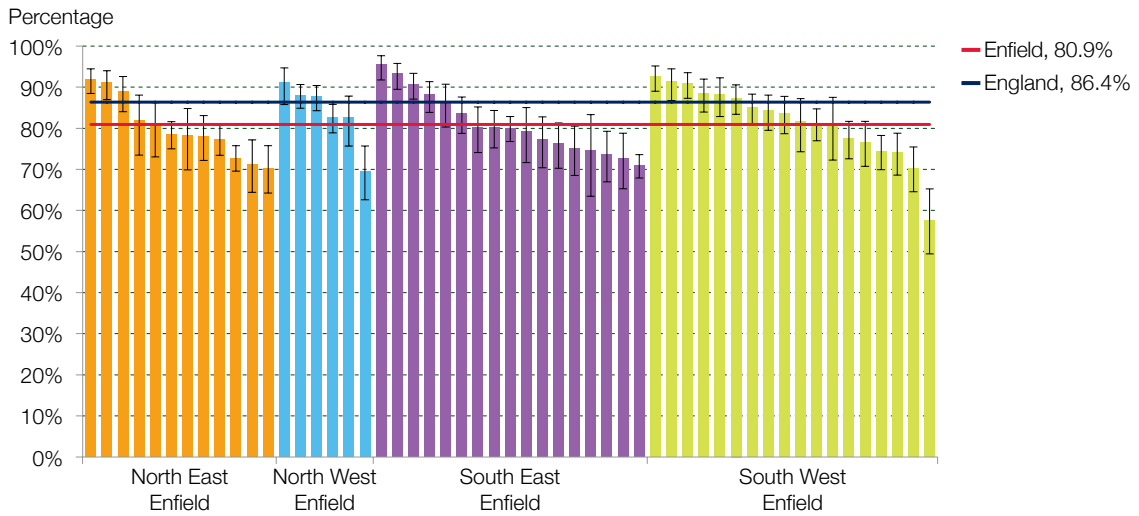
Source: Quality and Outcomes Framework 2012/13 [DM26]

In Enfield, there is large variation amongst practices in the proportion of diabetes patients with a HbA1c reading in the last 15 months of less than 7.5% (Figure 3.58). Within each locality, the percentage ranged from 42% to 89%. This suggests that management of diabetes for some people in Enfield is not as controlled as it could be which can lead to complications of the condition.

Another diabetes indicator for HbA1c is, the proportion of patients with diabetes in whom a HbA1c reading in the last 15 months was less than 9%. The Enfield average (81%) was significantly lower than London (83%) and England (86%) and was the 3rd lowest CCG in London, in 2012/13. There is evidence of large variation amongst GP practices, with proportions ranging from 58% to 96% (Figure 3.59).

²⁴ HbA1c is glycated haemoglobin and more of it is produced in the body by high blood glucose levels.

Figure 3.59: Percentage of patients with diabetes where the last HbA1c recording in last 15 months was <9%, localities, 2012/13



Source: Quality and Outcomes Framework 2012/13 [DM28]

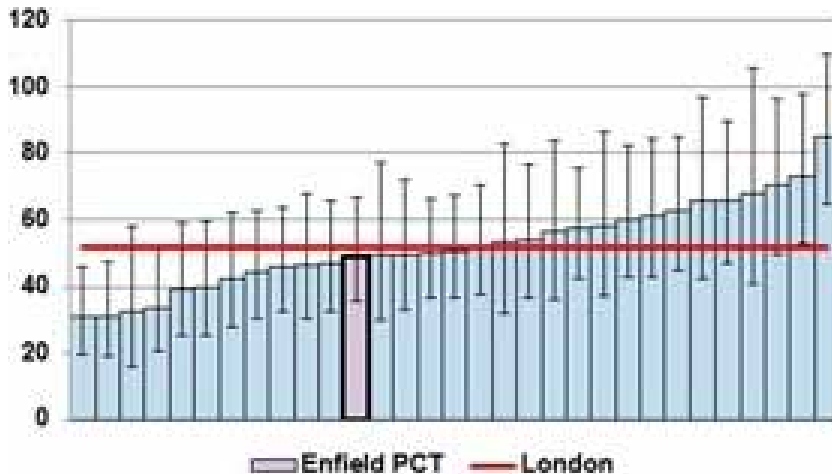
Blood lipid control

Patients with diabetes are at an increased risk of developing heart disease and at a higher risk of stroke. To help reduce this risk it is important to monitor the blood lipids of diabetes patients. In 2012/13, the proportion of patients with diabetes whose last cholesterol reading in the last 15 months was 5mmol/l or less in Enfield (79%) was not significantly different to London (80%), but was statistically significantly lower compared to England (81%). There was large variation throughout the practices, with proportions ranging from 63% to 94%. Six GP practices had percentages significantly lower than the Enfield average, whilst nine GP practices showed a significantly higher percentage than Enfield overall.

Diabetes complications

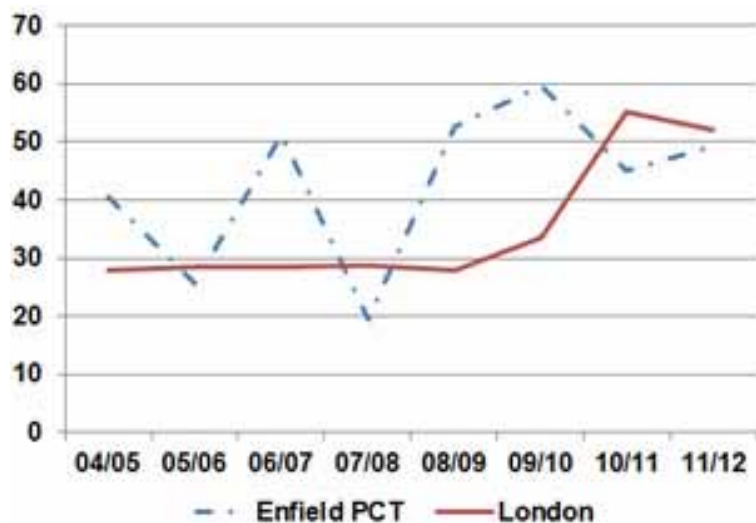
Management of patients with diabetes is also reflected through the rate of unplanned admissions related to diabetes complications. In 2011/12, Enfield had an emergency admission rate for patients with diabetes (under 19 years) of 49 per 100,000 (Figure 3.60). This rate was not significantly different to London and was ranked 38th of all 151 PCT's nationally. The rate of emergency admissions in Enfield has been increasing since 2004/05, implying that there is an opportunity for short term intervention (Figure 3.61).

Figure 3.60: Emergency admissions for diabetes (in persons under 19 years old), per 100,000 population, London Boroughs, 2011/12



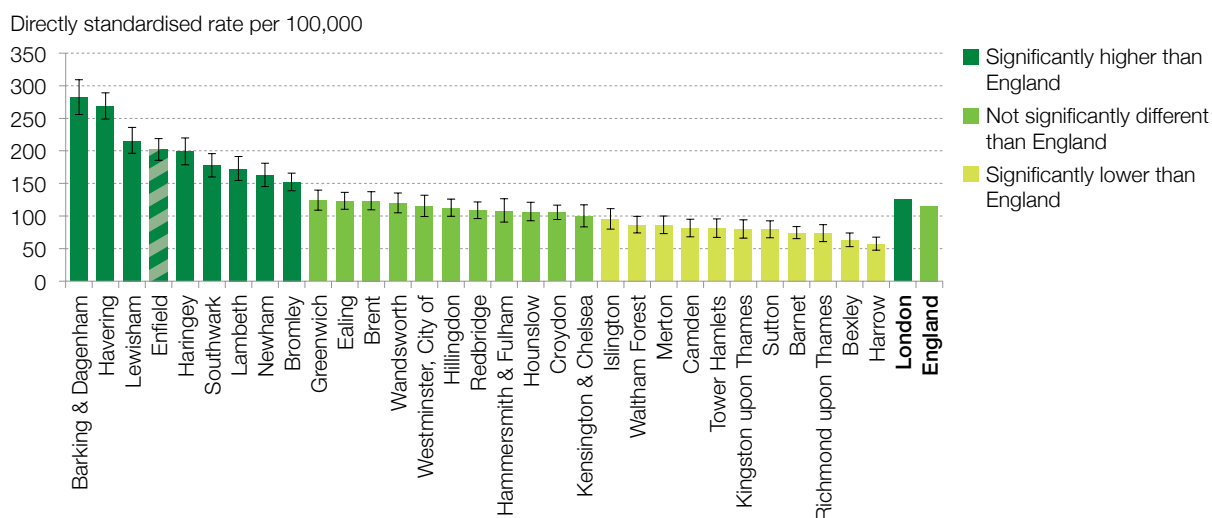
Source: Hospital Episode Statistics (HES), Information Centre for Health & Social Care

Figure 3.61: Emergency admissions for diabetes (in persons under 19 years old) per 100,000 population, London Boroughs, 2004/05-2011/12



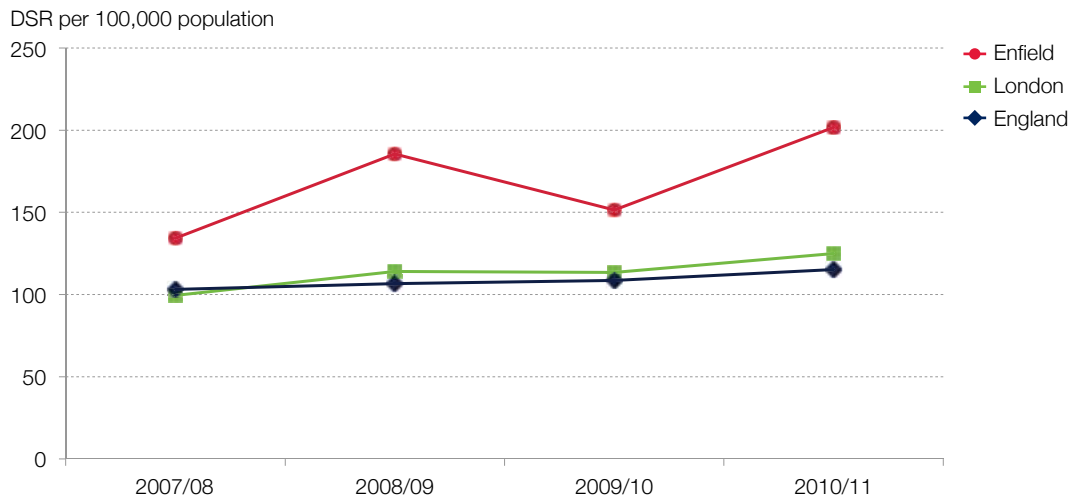
Source: Hospital Episode Statistics (HES), Information Centre for Health & Social Care

Figure 3.62: Directly age standardised rates, hospital admissions due to diabetes as a primary cause, persons, London Boroughs, 2010-11



Source: London Health Programmes, HNA toolkit

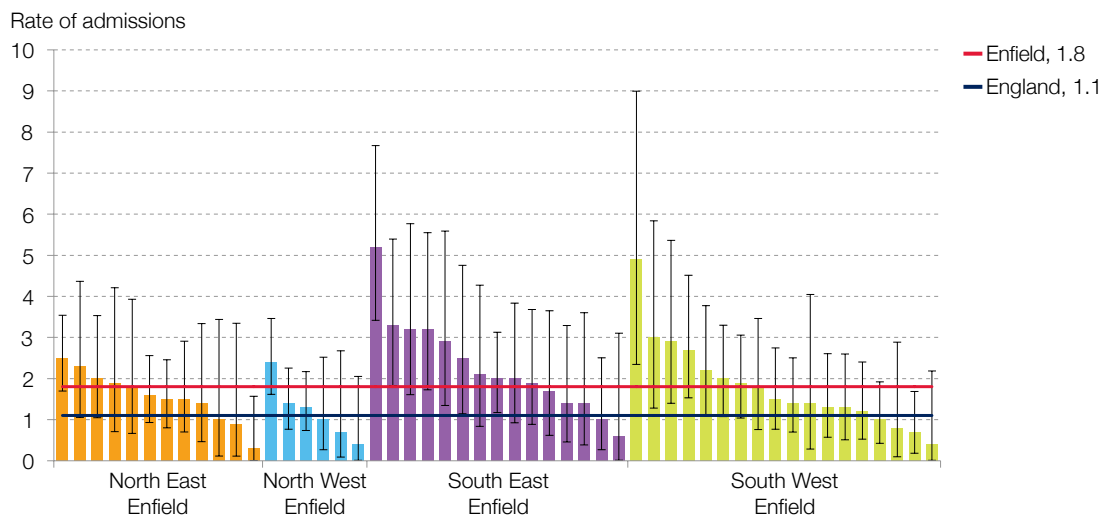
Figure 3.63: Directly age standardised rates, hospital admissions due to diabetes as a primary cause, persons, London Boroughs



Source: London Health Programmes, HNA toolkit

In 2010/11, Enfield had the fourth highest age standardised admission rate for diabetes in (Figure 3.62). This rate was significantly higher than both London and England. Hospital admission rates due to diabetes have been increasing in Enfield, London and England (Figure 3.63).

Figure 3.64: Crude rate of diabetes admissions per 1000 population, Enfield GP practices, 2010/11



Source: National General Practice Profiles, Public Health England (PHE)

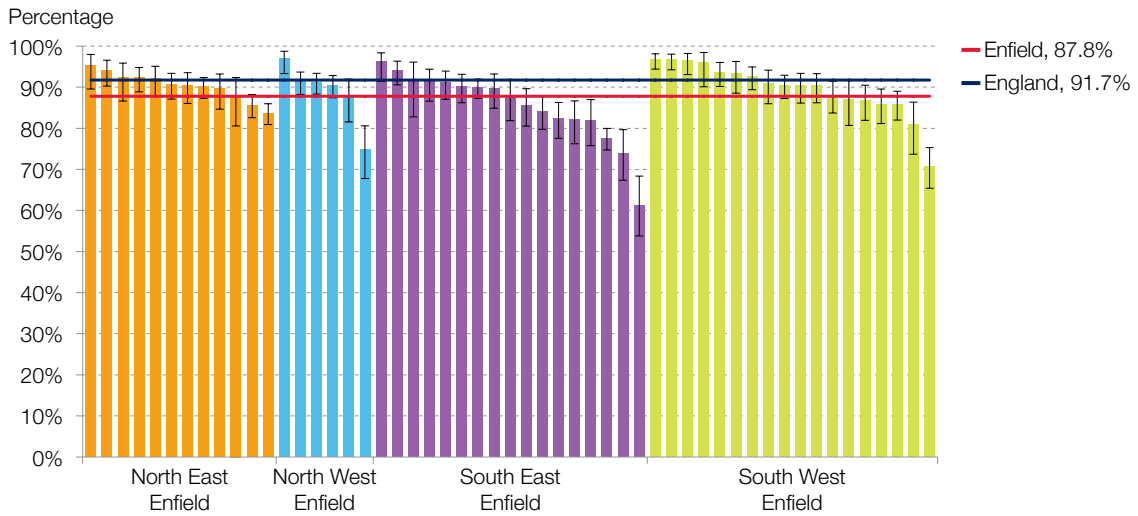
Amongst GP practices in Enfield, the crude rate of diabetes admissions rates range from 0 to 5.2 per 1,000 population (Figure 3.64). Two practices have rates significantly lower than Enfield average (1.8 per 1,000 population).

Diabetic Retinopathy Screening

Retinopathy is a condition where the retina of the eye is damaged resulting in vision impairment. High levels of glucose in the blood increase the risk of people developing retinopathy and patients with diabetes are at a higher risk. Patients with diabetes are entitled to retinopathy eye screening annually.

In Enfield, 88% of patients with diabetes had retinal screening in the last 15 months. This is statistically significantly lower than the London (90%) and England (92%) averages.

Figure 3.65: Percentage of patients with diabetes with a retinal screening recording in last 15 months, localities, 2012/13



Source: Quality Outcomes Framework 2012/13 (DM21)

Amongst GP practices in Enfield, the percentage of patients with a retinal screening record varied between 61% and 97%. Ten GP practices presented screening rates that were statistically significantly lower than Enfield average of 88%. However, retinal screening in 14 practices was significantly higher than the Enfield average (Figure 3.65).

3.5.4 Lifestyle and environmental factors

Excess weight is a leading cause of type 2 diabetes, heart disease and cancer. It can lead to complications in childbirth for mother and baby. The costs of obesity to the NHS have been estimated to be over £5 billion (Department of Health, 2011). Being overweight and obese is more common in lower socioeconomic and socially disadvantaged groups, particularly among women.

Addressing risk factors for diabetes would not only have an impact on complications, but also on health service costs which result from treatment and prescribing costs, as well as the long term nature of the conditions. Therefore, total health and care savings could be very high.



Prevention

It is now well accepted that many cases of Type 2 diabetes could be delayed or prevented with lifestyle interventions (Diabetes UK, 2012). A Diabetes UK report (2012) advises that the Government needs to act to restrict the advertising of foods high in sugar, salt and/or fat and ensure that food manufacturers adhere to government guidelines. This will help consumers to be better informed about the contents of processed foods.

Targeted interventions are also needed to help those people at particularly high risk of diabetes. The Diabetes Prevention Program, undertaken in the US, showed that modest changes to diet, such as reducing fat intake combined with 30 minutes of routine physical activity a day are effective in reducing the risk of diabetes by 64 per cent (NIDDK, 2002). A similar study in Finland reported that losing weight by making lifestyle changes could prevent the development of diabetes in up to 58 per cent of people with impaired glucose tolerance (Tuomilehto et al., 2001).



3.6 Infant mortality

Key messages

- In Enfield, **28** babies die each year (on average) before their first birthday.
- Enfield's infant mortality rate is ranked **3rd highest** in London.
- **Infant mortality is 60% higher** for babies of teenage mothers.
- Smoking during pregnancy increases infant mortality by around **40%**.
- **9 in 100** babies (live and still born) in Enfield are born with low birth weights.
- Upper Edmonton, Lower Edmonton and Ponders End have the **highest rate** of infant mortality in Enfield.

3.6.1 What is infant mortality?

Infant mortality refers to the death of a live born baby in the first year of life.²⁵ Infant mortality is usually expressed as a population rate, that is, the number of infant deaths per 1,000 live births. This allows comparison with other populations or areas. Babies can be born after 24 weeks gestation with no signs of life (stillbirth). The risk factors for stillbirths are very similar to those for infant deaths in the first few weeks of life.

A variety of infant death statistics are used, but most commonly they are;

- Perinatal Mortality (still births and deaths less than 7 days)
- Neonatal Mortality (infant deaths less than 28 days)
- Postneonatal Mortality (infant deaths 28 days to 1 year)

Infant death statistics are an insightful measure of the overall health of a population and can reflect association between the cause of infant mortality and other risk factors that are likely to influence the health status of whole populations. In other words, an area with a high infant mortality rate is also likely to be an area with poorer health. Infant mortality is strongly linked with lower socio-economic status both nationally and internationally. Other factors associated with a higher risk of infant mortality include;

- Inappropriate infant sleeping position and environment;
- Maternal age (under 20 years and 35 years and over);
- Birth outside marriage/sole parental registration;
- Late booking for antenatal care;
- Smoking during and or after pregnancy, high exposure to second hand smoke;
- Maternal obesity;
- Maternal morbidity e.g. diabetes or mental illness;
- Domestic violence (Koenig, MA et al. (2010));
- Low birth weight;
- Not breast feeding;
- Low immunisation coverage.

Interventions that are effective in reducing infant mortality will also improve the general health of the population. The impact of many interventions on infant mortality can be realised in the short term.

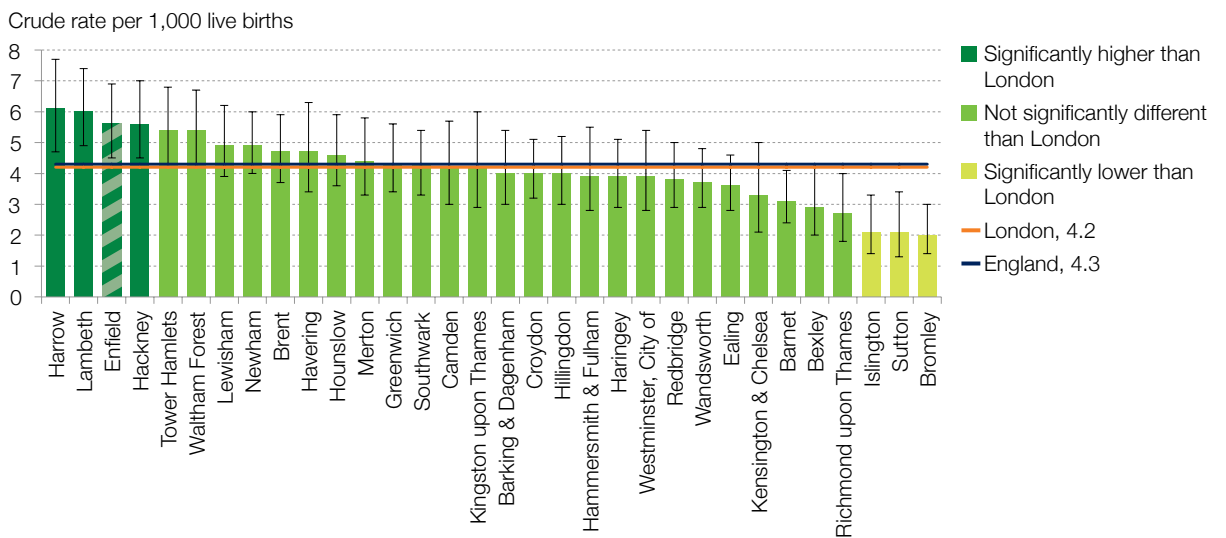
²⁵ Note that some infant mortality data, such as perinatal deaths, do include stillbirths. This is highlighted in the text.

3.6.2 What do we know about infant mortality in Enfield?

Infant mortality rate in Enfield in 2010 to 2012 was 5.6 per 1,000 live births. This means that for every 1,000 babies born alive, an average of 5.6 babies died in the first year of life. Enfield's infant mortality rate was significantly higher than that of London (4.2 deaths per 1,000 live births) and the national average (4.3 deaths per 1,000 live births) – see Figure 3.66. For the three year period 2010-2012, Enfield had the third highest infant mortality rate of the 32 London boroughs.

In 2012, the number of live births in Enfield was 5,094 with highest number of live births in Lower Edmonton, Edmonton Green and Upper Edmonton. The average number of infant deaths in Enfield per year is around 28, but this varies from year to year. For example, there were 21 infant deaths in 2011 and 28 in 2012. Whilst numbers are small, each death represents a tragedy for a family and infant mortality is a sensitive measure of the overall health of the population (Macfarlane & Mugfirs, 2000).

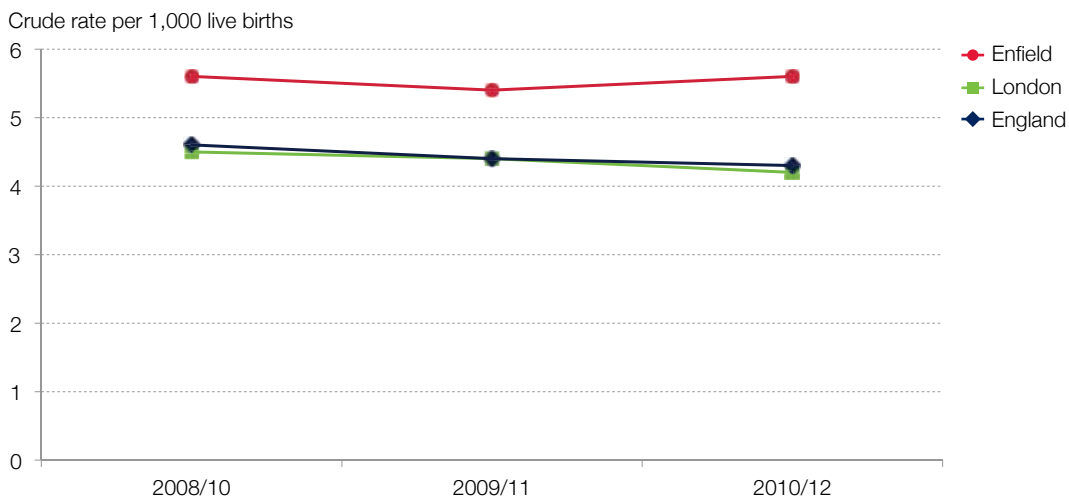
Figure 3.66: Infant mortality rate by London borough, regional and national average in 2010-2012 (3 years pooled)



Source: NHS Indicators portal

Figure 3.67 shows that in 2008 and 2012, the infant mortality rate in Enfield was consistently higher than the regional and national averages.

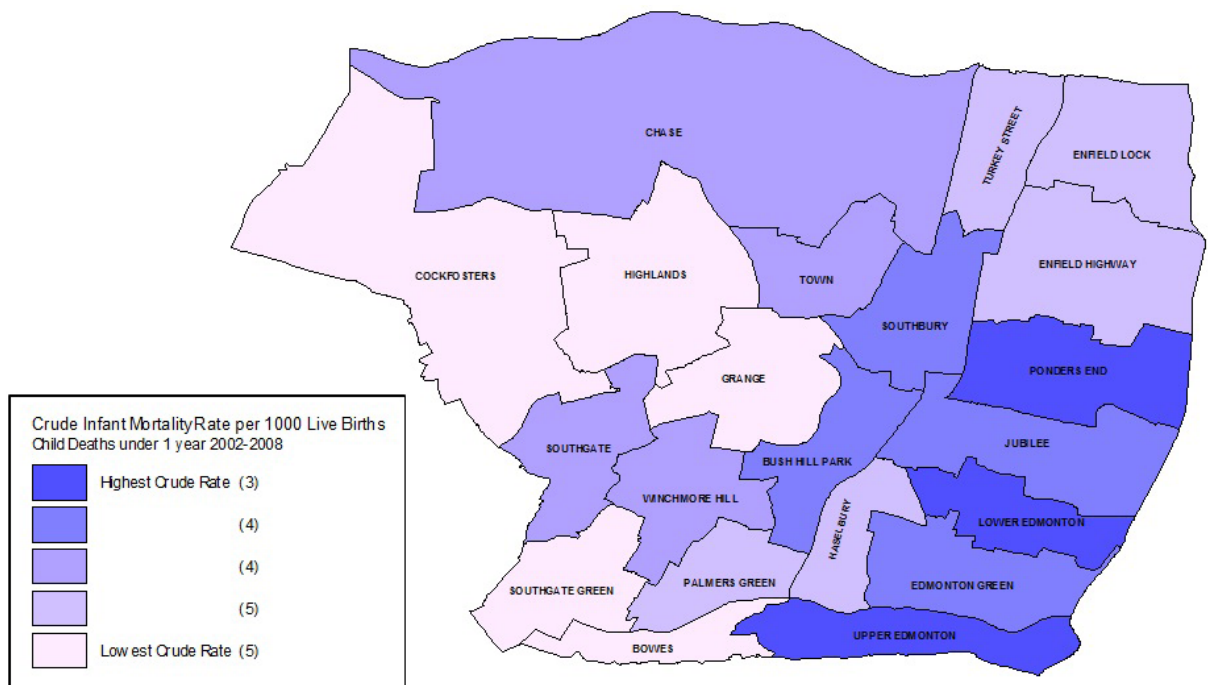
Figure 3.67: Infant mortality rate, 2008-2010 – 2010-2012



Source: Health and Social Care Information Centre

Upper Edmonton, Lower Edmonton and Ponders End have the highest rate of infant mortality in Enfield (Figure 3.68).

Figure 3.68: Infant mortality per 1,000 live births by Enfield ward, 2002-2008

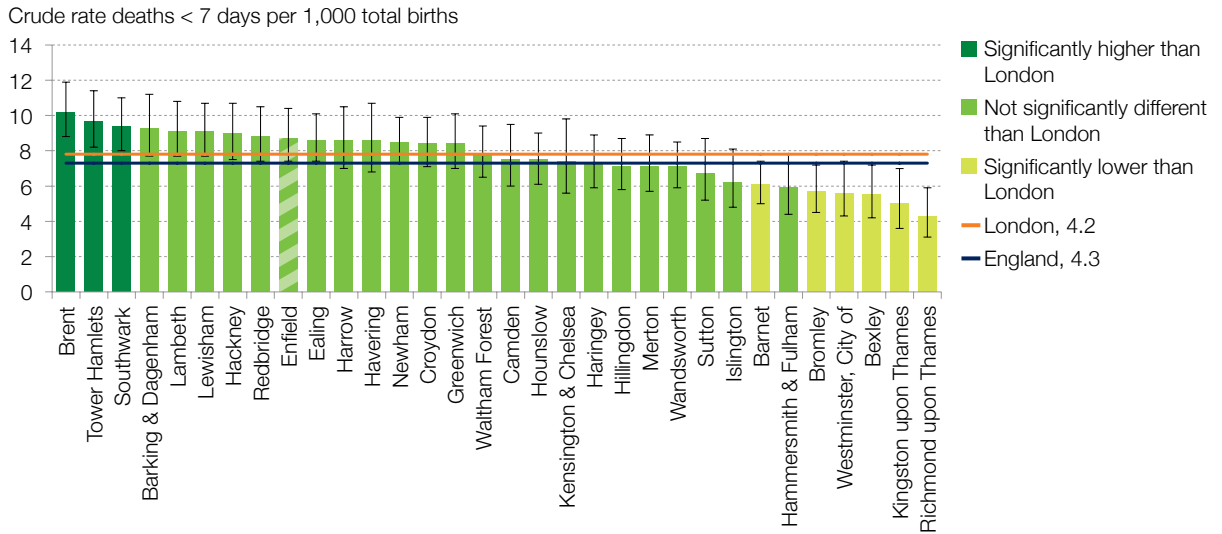


Source: Enfield Public Health based on ONS annual district death extract.

Perinatal mortality is defined as stillbirths and neonatal deaths in the first week of life. Reporting of perinatal mortality plays an important role in providing the information needed to improve the health status of pregnant women, new mothers and newborn babies. It is an important indicator of maternal care and of maternal health and nutrition but it also reflects the quality of obstetric and paediatric care available. Perinatal mortality accounts for 0.3 years of the life expectancy gap between the most and least deprived areas in Enfield (London Public Health Observatory, 2008).

Between 2010 and 2012, there were 8.7 perinatal deaths per 1,000 total births in the London Borough of Enfield (Figure 3.71). This is above London (7.8 deaths per 1,000 total births) and England (7.3 deaths per 1,000 total births) – statistically significantly higher than England. Perinatal mortality in Enfield is ranked 9th highest in London (Figure 3.69).

Figure 3.69: Perinatal mortality rate by London borough, regional and national average in 2010-2012 (3 years pooled)

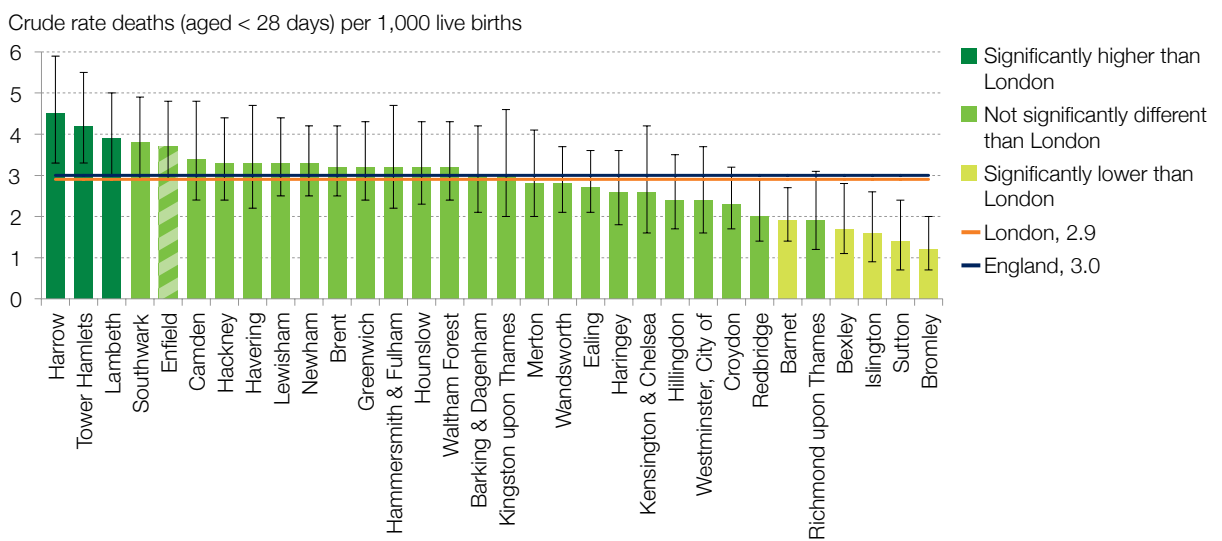


Source: HSCIC Indicators portal

Neonatal deaths (deaths in the first 28 days) are particularly sensitive to events during pregnancy, delivery and the neonatal period, and to the care given to mothers and their babies. In Enfield, neonatal mortality rate for 2010-2012 (3.7 per 1,000 live births) was almost twice the postneonatal rate of 1.9 per 1,000 live births. For both London and England, the postneonatal rate was 1.3 per 1,000 live births compared to neonatal rates of 2.9 per 1,000 for London and 3.0 per 1,000 for England. So a similar pattern emerged for Enfield, London and England, with the rate of infant deaths in the first month (neonatal mortality) being roughly twice that of the subsequent 11 months (postneonatal mortality).

In the three year period between 2010 and 2012 there were a total of 56 neonatal deaths in Enfield. Figure 3.70 illustrates the neonatal mortality rate between 2010 and 2012; there were 3.7 neonatal deaths per 1,000 live births in the London Borough of Enfield which represents the 5th highest in the London region. However, this is not significantly different from either the London or national averages.

Figure 3.70: Neonatal mortality rate by London borough, regional and national average in 2010-2012 (3 years pooled)

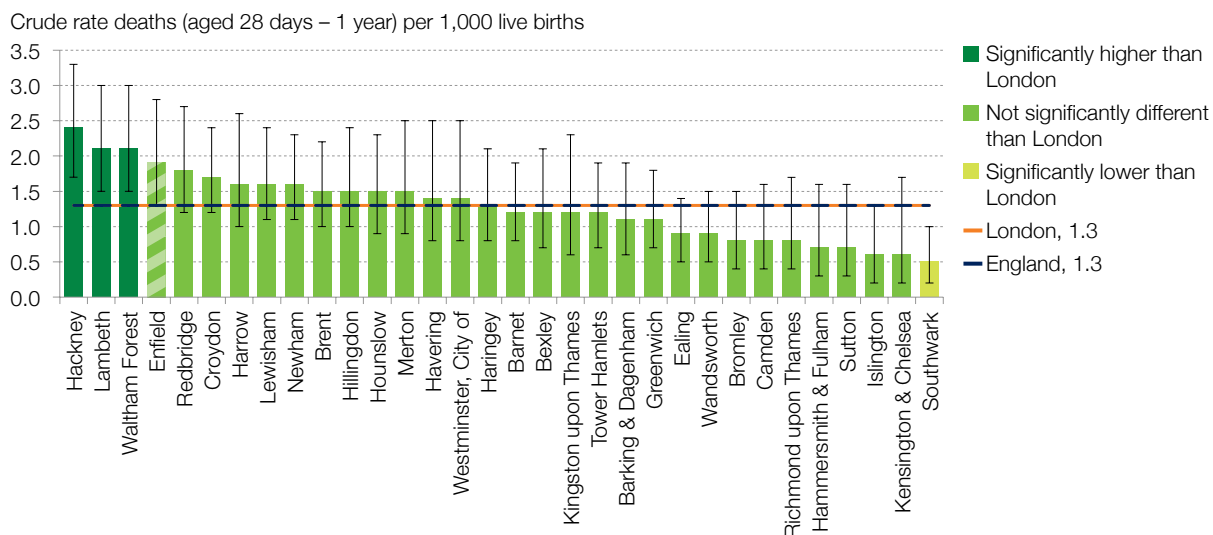


Source: HSCIC Indicators portal

Post-neonatal mortality occurs in children aged 28 days to one year. The major factors thought to influence post-neonatal death are malnutrition, infectious diseases, parental circumstances including socio economic position and problems with the home environment.

Between 2010 and 2012, there were 1.9 post-neonatal deaths per 1,000 live births in Enfield which represents the 4th highest in London (Figure 3.71). This is considerably higher than the regional average (1.3 deaths per 1,000 live births) and the national average (1.3 deaths per 1,000 live births), but not statistically significant.

Figure 3.71: Postneonatal mortality rate by London borough, regional and national average in 2010-2012 (3 years pooled)



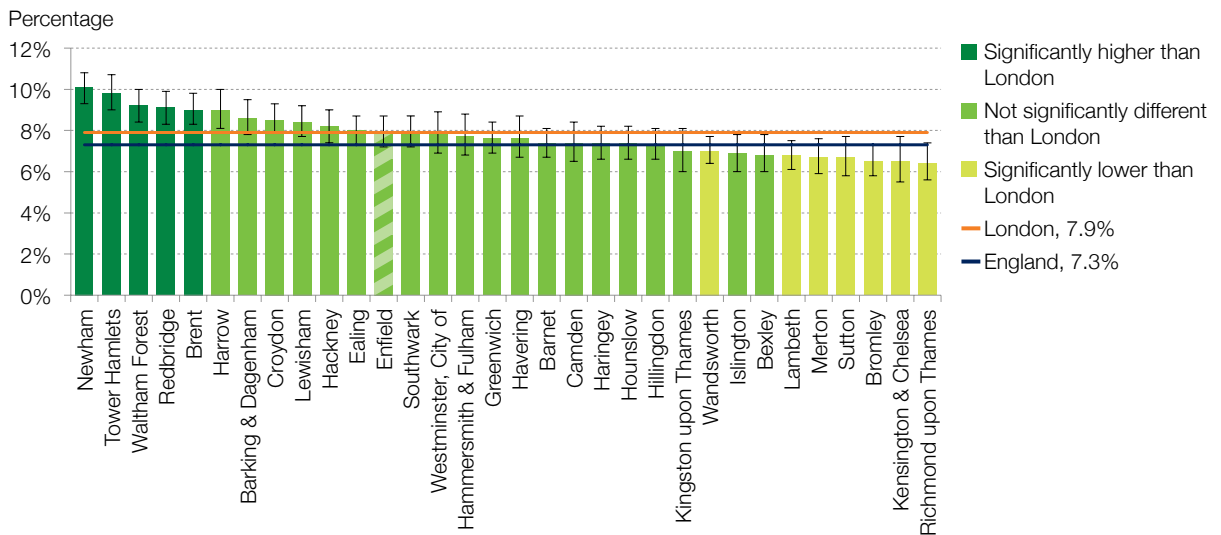
Source: Health and Social Care Information Center Indicator Portal

3.6.3 Risk factors

Many of the risk factors associated with high rates of infant mortality relate primarily to deprivation, particularly child poverty and overcrowding. Other key risk factors include; teenage conceptions, domestic violence, late booking for antenatal care and maternity services and unhealthy lifestyles, such as smoking and obesity (Allen et al., 2009). Sudden unexplained death in infancy is also more common in disadvantaged populations (Gray et al., 2009).

Nationally, babies of mothers who smoked during pregnancy are more likely to be born prematurely, twice as likely to have a low birth weight and are up to three times as likely to die from sudden unexplained death (Green et al., 2005). Smoking in pregnancy is much higher in routine and manual socio economic groups and nationally, 45% of mothers under 20 years smoke through their pregnancy, nearly three times higher than smoking rates for all pregnant mothers (NICE, 2010b). National analyses show successively higher infant mortality rates in successively more deprived quintiles. Women in deprived areas also have higher rates of low birth weight and prematurity.

Figure 3.72: Proportion of all live and still births with low birth weights (under 2,500g), London boroughs, 2012



Source: Health and Social Care Information Centre Indicator Portal

In 2012, Enfield had the joint 5th highest percentage of live and still births weighing less than 1,500 grams (1.8%) in the London boroughs, which was not significantly different to London (1.5%). In the same time period, Enfield had the joint 12th highest proportion of births weighing less than 2,500 grams (7.9%) within the 32 London boroughs. This percentage is not significantly different to either London (7.9%) or England (7.3%).

Breastfeeding protects the health of mothers and babies both in the short- and long-term. Breastfeeding services can be a cost-effective intervention, contributing to savings from reduced hospital admissions for gastrointestinal and respiratory infections (UNICEF, 2013).

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. In the longer term, infants who are not breastfed have higher prevalence of high blood pressure and blood cholesterol in adulthood and may also be at a greater risk of type 2 diabetes (London Borough of Croydon, 2011). For mothers, breastfeeding is associated with a reduction in the risk of breast and ovarian cancers (Cancer Research UK, 2014). A recent study also suggests a positive association between breastfeeding and parenting capability, particularly among single and low-income mothers (London Borough of Croydon, 2011). Table 6 shows key outcome measures in maternity and child health.

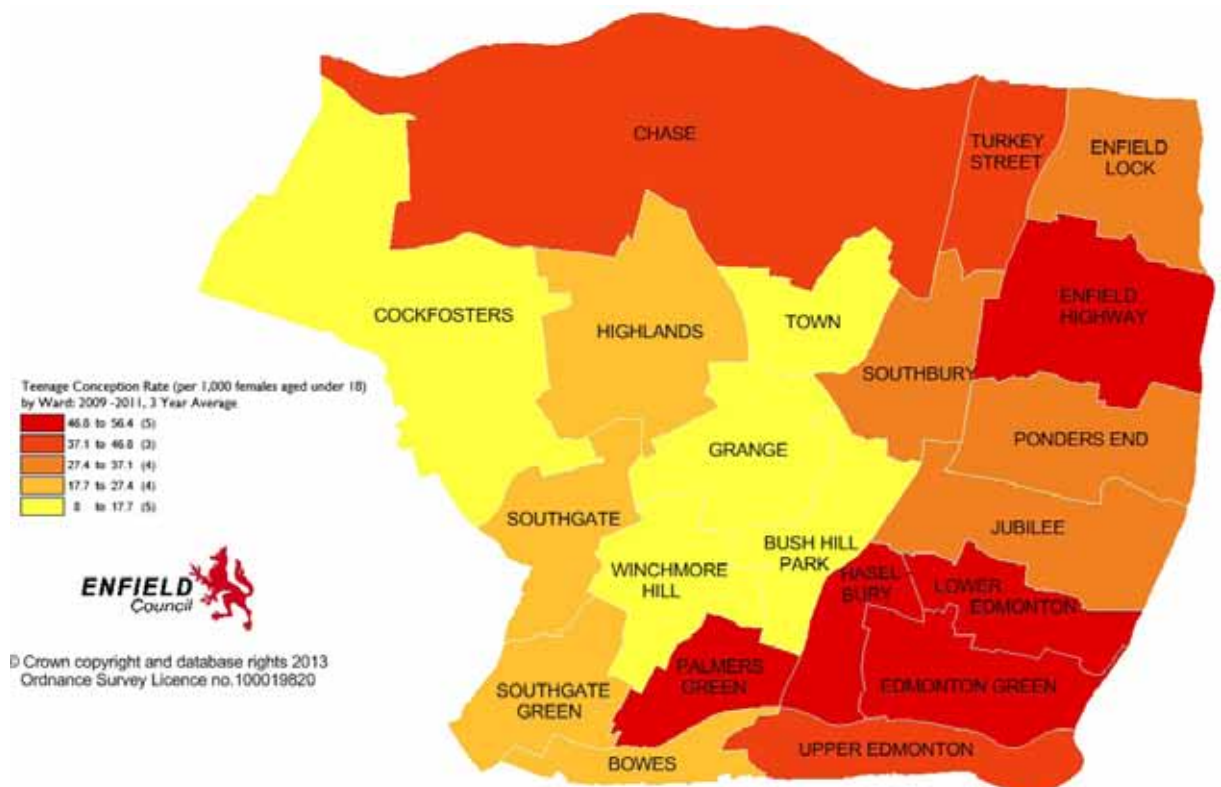
Table 6: Maternity and child health outcome measures

Indicator Name	Period	Enfield no.	Enfield	London	England
Smoking status at time of delivery	2012/13	241	5.5%	5.7%	12.7%
Breastfeeding Initiation	2012/13	3,884	88.8%	86.8%	73.9%

Source: Public Health Outcomes Framework

Maternal age (under 20 years and 35 years and over) is also an associated risk factor for infant mortality. Within Enfield, there are several wards where teenage conception is high, particularly Edmonton Green, Lower Edmonton and Haslebury (Figure 3.73).

Figure 3.73: Teenage conception rate by ward, Enfield, 2009 to 2011



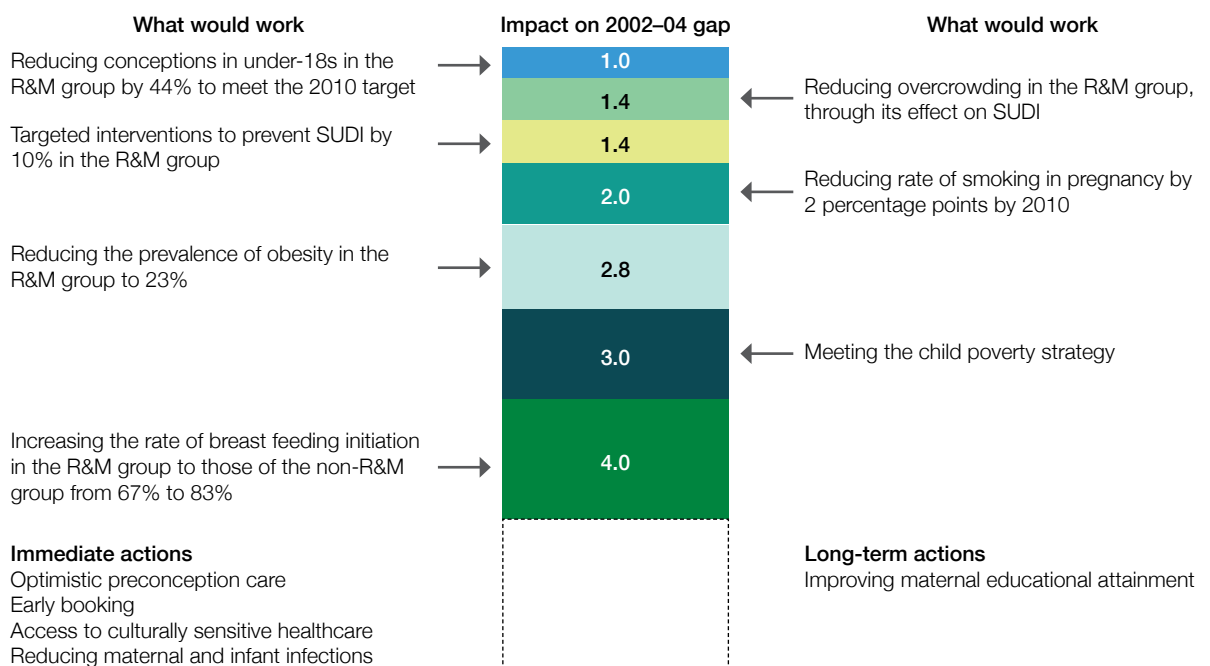
Source: ONS

3.6.4 How can we reduce infant mortality?

Reducing infant mortality and the inequalities associated with infant mortality has been a policy aim for successive governments for a number of years. In 2003 the government set a national health inequalities public service agreement (PSA) target: To reduce inequalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy at birth. One of the targets underpinning this was: Starting with children under one year, by 2010 to reduce by at least 10% the gap in infant mortality between the routine and manual group and the population as a whole (Department of Health, 2007c).

In 2007, the Department of Health published a framework of specific evidence based interventions that reduce infant mortality and the inequalities associated with infant mortality (Department of Health, 2007d) (Figure 3.74).

Figure 3.74: Nationally identified interventions to reduce inequalities in infant mortality



Source: Department of Health. Implementation plan for reducing health inequalities in infant mortality: a good practice guide. London: 2007

More recently, the executive summary of The Marmot Review “Fair society, healthy lives” (2010, p.14) identified six policy objectives to reduce health inequalities. The first objective emphasises the need to give every child the best start in life with actions starting before birth and followed throughout the life of the child. One key recommendation is to give priority to pre and postnatal interventions that reduce adverse outcomes of pregnancy and infancy.

Following on from The Marmot Review, there was the public health white paper; “Healthy lives, healthy people” (Department of Health, 2010a). It adopts a life course approach, recognising the profound impact early experiences have on the entire life of an individual: physically, emotionally and socially. It recognises that although there has been significant progress in reducing infant deaths, there is much that can be done to reduce rates further. The white paper highlights the importance of reducing maternal obesity, increasing breastfeeding rates and reducing smoking rates in pregnancy as public health interventions that will reduce infant mortality.

Reducing deaths in babies and young children is an objective within the NHS outcomes framework for 2011/12 (Department of Health, 2010b). Infant mortality and a range of related outcomes such as low birth weight, breastfeeding, teenage pregnancy and child poverty are also part of the public health outcomes framework (Department of Health, 2013b).

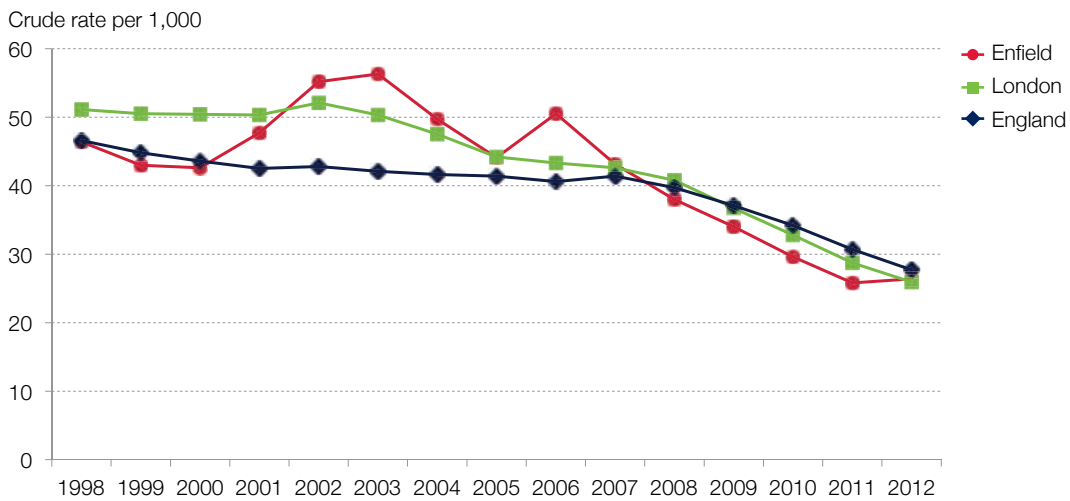
3.6.5 What are we doing in Enfield?

In Enfield there are a number of programmes to address risk factors for infant mortality. These include tackling teenage pregnancy, promoting safe sleeping, reducing smoking in pregnancy and improving rates of breastfeeding. Ensuring the best start in life is the first priority of the Health and Wellbeing Board of Enfield.

Enfield has successfully reduced teenage pregnancy rates since 2006 with a fall of 43.1% between 1998 and 2012 (Figure 3.75).

Enfield’s teenage pregnancy rate in 2012 was 26.4 per 1,000 females aged 15 to 17 years. This was below the England rate of 27.7 per 1,000, but above the rate for London (25.9 per 1,000).

Figure 3.75: Rate of conceptions, females under 18 years, Enfield, London and England, 1998 to 2012



Source: Office of National Statistics (ONS), 2012

The Enfield Breastfeeding Welcome Scheme encourages businesses to allow breastfeeding on their premises. To date eighty-one businesses have signed up to the scheme. This includes the All Saints Church Edmonton, which was the first place of worship to embrace the scheme.

Breastfeeding helpers were recruited from the community 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 follow-up training session has been commissioned to refresh and retain existing breastfeeding helpers and to recruit more.

A community breastfeeding policy was developed and agreed with provider services.

A Tobacco control strategy is also in place for Enfield, and support for smoking cessation for women who smoke during pregnancy.



Other strategic efforts include;

- Ensuring high coverage of childhood immunisations by working in partnerships
- Improving maternal educational attainment
- Routine enquiry and support regarding domestic violence and mental illness
- Providing more intensive parenting support for women with complex needs
- Providing information and education on the antenatal and newborn screening programme
- Promoting health maternal nutritional status
- Provision of specialist services for obese pregnant women
- Reducing exposure of infants to environmental tobacco smoke
- Providing information and education on risks associated with consanguinity
- Promotion of safe sleeping
- Promotion and support of breastfeeding





3.7 HIV

Key messages

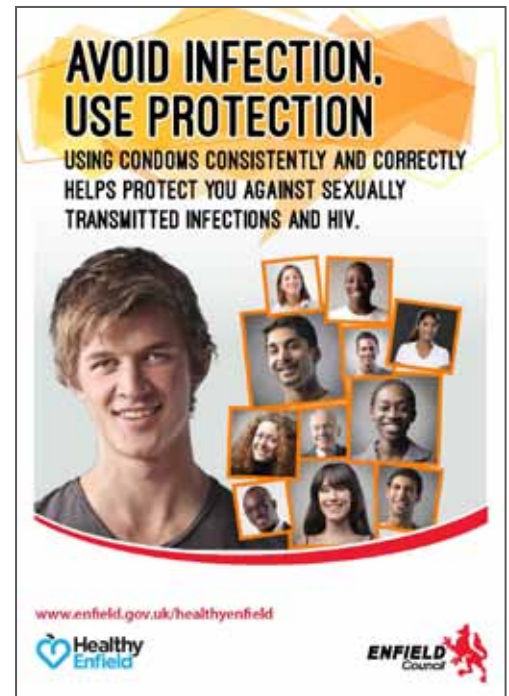
- ▶ HIV has been transformed from a fatal to a chronic life-long infection.
- ▶ **814** Enfield residents diagnosed with HIV accessed services in 2012.
- ▶ **54%** of people with HIV were diagnosed late in Enfield (2010-2012). The largest group were heterosexual women and men.
- ▶ HIV late diagnosis in Enfield is ranked **10th** highest in London.
- ▶ Around a **quarter of deaths** among HIV positive individuals in the UK are among those diagnosed too late for effective treatment.
- ▶ Late diagnosis results in increased onward transmission and higher treatment costs overall.

3.7.1 Why is HIV important in reducing the gap in life expectancy?

Human Immunodeficiency Virus (HIV) is a retrovirus that damages the body by destroying certain blood cells known as CD4 cells, which are vital to the body to help it fight diseases. As HIV continues to attack these cells, it makes the person infected with the virus less able to fight off infection and disease, eventually resulting in the development of Acquired Immune Deficiency Syndrome (AIDS). There is usually a time lag of several years from infection with HIV to the development of AIDS so people may be unaware of their infection for a long period of time.

HIV is a public health issue it is associated with severe morbidity, high treatment and care costs, substantial mortality and high number of lost potential years of life (British HIV Association, 2006). Even though there are treatments available, there is still no cure.

Earlier HIV diagnosis reduces both morbidity and mortality and ensures that newly diagnosed people with HIV can receive effective treatment and support to reduce onward transmission. National evidence shows that individuals diagnosed at a late stage of infection (CD4 count of under 350 cells per mm³) have higher rates of morbidity and mortality. Mortality within a year of HIV diagnosis is ten times higher for people diagnosed late, and 90% of people who died within a year of diagnosis between 2000 and 2009 were diagnosed late (British HIV Association, 2006). Around a quarter of deaths among HIV positive individuals in the UK are among those diagnosed too late for effective treatment (British HIV Association, 2006), and individuals starting antiretroviral therapy with CD4 count below 350 cells/mm³ have a significantly increased risk of contracting opportunistic diseases (Antinori, A. et al. 2011).



In England half of the new HIV diagnoses reported in 2010 were after the point at which the diagnosed individual should have commenced treatment. The proportion of late HIV diagnoses has been included as an indicator in the Public Health Outcome Framework (Department of Health, 2013b).

Knowledge of HIV status is associated with a reduction in risky behaviour for HIV transmission (British HIV Association, 2006).

HIV infection has been transformed from a fatal to chronic life-long infection due to the introduction of effective antiretroviral therapy (ART) in the mid-1990s. Consequently, the number of people living with diagnosed HIV has risen year on year. There has been an increase in the number of new diagnoses among men who have sex with men (MSM) and people born in high prevalence countries.

In the short term, there is the potential to save lives through earlier HIV diagnosis.

3.7.2 What do we know about HIV in Enfield?

In 2012, a total of 814 Enfield residents diagnosed Human Immunodeficiency Virus (HIV) accessed HIV services, a rate of 4.1 per 1,000 population aged 15 to 59 years. There was a rise in the number of people with a diagnosis accessing HIV services in Enfield between 2002 and 2011. This increase is similar to London and England. Of those people with HIV accessing care in Enfield, 45% were male and 55% were female (2012).

In Enfield, those most at risk of HIV infection are heterosexual black African women, followed by heterosexual black African men.

In 2012, 58% of people accessing care in Enfield were aged 45-54 years compared to 45% in 2008, which compares with the reduction seen in persons aged 25-34 (48% in 2008 to 32% in 2012). The highest proportion accessing services amongst males are in the 45-54 age group, (36%) and the lowest is in the 16-24 age group. This compares to the highest proportion in females in the 35-44 age group (43%). The lowest proportion in females also falls in the 16-24 age group (4%).

There is variation in HIV prevalence at middle layer super output area (MSOA) level, ranging from 0.4 to 5.1 per 1,000 population. Two third of Enfield (MSOA level) has a rate of 2 or above per 1,000 population which is considered high prevalence.

The largest proportion of people accessing HIV care in Enfield were infected through sex between men and women; this accounted for 74% (656 cases) of all cases in 2012. Men having sex with men (MSM) accounted for the next highest number of infections; 16% (144 cases).

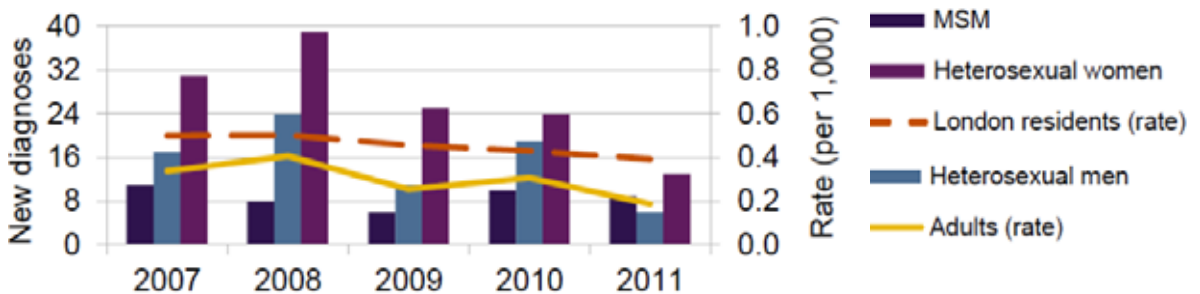
Enfield has the 10th highest rate of all London boroughs for patients presenting with HIV at a late stage of infection (CD4 count of <350 cells per mm³; 2009/11) with 55%. This is not significantly different to either London (47%) or England (50%). Late diagnosis may result in increased onward transmission; this would impact life expectancy, quality of life and lead to higher treatment costs.

The cost of treatment and social care is high. It is estimated that the annual cost of treating someone with HIV is around £18,000 per year, but this varies depending on the type and number of drugs taken and the stage of HIV infection and could rise to £48,000 per year (British HIV Association, 2006).

HIV incidence and prevalence

The number of people aged between 15 and 59 years newly diagnosed with HIV in Enfield has fallen by 34% in one year, from 56 diagnoses in 2010 to 37 in 2011 (Figure 3.76). 842 Enfield residents accessed HIV related care in 2011 (372 males and 470 females), an increase of 26 from 2010. The lower number of new cases, combined with late diagnosis may result in increased onward transmission; this would impact life expectancy, quality of life and lead to higher treatments costs.

Figure 3.76: Incidence of HIV by route of transmission, gender and year of diagnosis, Enfield, 2007 to 2011

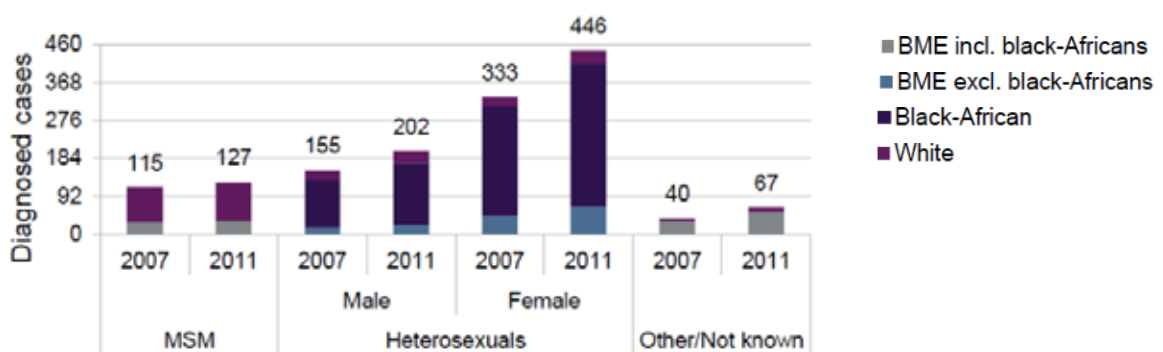


Source: Health Protection Agency (HPA)

Between 2007 and 2011, there has been a 31% increase in the number of people living with HIV in Enfield. In 2011, HIV prevalence in Enfield was 4.0 per 1000 population aged 15-59, compared to 2.0 per 1,000 in England and 5.4 per 1,000 in London.

In Enfield, those most at risk of HIV infection are heterosexual black African women, followed by heterosexual black African men (Figure 3.77).

Figure 3.77: Prevalence of HIV by route of transmission, ethnicity and gender, Enfield, 2007 and 2011



Source: Health Protection Agency (HPA)

In Enfield, 38% of men who have sex with men were diagnosed late, compared to 31% in London, and 65% of heterosexuals in Enfield were diagnosed late, compared to 61% in London. The median age of those accessing care for HIV in Enfield was 41 years. The greatest numbers of patients accessing care were in the Black African (64%) and White (20%) ethnic groups.

Late diagnosis of HIV

Late diagnosis of HIV is an issue in Enfield. In 2011, 58% of people with HIV were diagnosed late (with a CD4 count of less than 350) in Enfield compared to 44% in London. 65% of heterosexuals living in Enfield were diagnosed late compared to 61% in London. Earlier HIV diagnosis reduces morbidity and mortality and ensures that newly diagnosed people with HIV can receive effective treatment and support to reduce onward transmission.

Reducing late diagnosis is therefore crucial to improved health outcomes and life expectancy of people infected with HIV. There are also public health implications, such as greatly reduced transmissibility of HIV in those receiving treatment. Those who are aware of their infection are less likely to engage in unsafe sex, so knowledge of the diagnosis can protect their sexual partners. Also, early diagnosis affords the opportunity to provide partner notification as well as counselling to promote behaviour change such as practicing safer sex.

Expanded HIV testing will be instituted in primary care following sexual health in practice (SHIP) training. Pilot SHIP training was delivered in Enfield in 2012/2013 following the development of a business case that examined and recommended a number of HIV testing initiatives by Public Health. In the coming year the following are planned:

- Training of GPs to increase HIV testing in primary care.
- A pilot community HIV prevention project targeting the African community.
- HIV awareness and testing campaign, particularly in Upper Edmonton.

SHIP is a multifaceted educational intervention for primary care which addresses all aspects of sexual health including sexually transmissible infections, sexual health promotion and contraception. It teaches a systematic clinical model of HIV testing which aims to remove the barriers to HIV testing.

Current UK guidelines aim to 'normalise' and increase HIV testing in different healthcare settings in order 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 recommendation is that an HIV test is considered for everyone at GP registration and hospital admission. This is already taking place in some areas, e.g. the Blood Transfusion Service.

Enfield is committed to raising awareness of HIV. Access to services is essential to prevention, early intervention and better health outcomes, especially where campaigns publicise the impact of late diagnosis on an individual's health outcomes. Indicators in the Public Health Outcomes Framework (Department of Health, 2013b), include reducing the proportion of people diagnosed with HIV at a late stage of infection. Targeted interventions and training should have a positive impact in the short term, and contribute to reducing the gap in life expectancy.



3.8 Seasonal excess deaths

Key messages

- Excess Winter Mortalities are the **'extra'** deaths that occur in the winter months compared to the rest of the year.
- There were **170** excess winter deaths in 2011/12.
- **63%** of excess winter mortality is caused by respiratory diseases and circulatory diseases.
- In many GP practice areas less than half the 'at risk' population have flu vaccination.
- **12%** of Enfield households suffer from fuel poverty.
- Enfield the **5th** highest rate of fuel poverty in London.

3.8.1 What are seasonal excess deaths?

Seasonal excess deaths (SED) are deaths that are greater than the annual average. The term is often used to describe winter deaths. However, seasonal deaths also occur in very hot weather conditions, such as heat waves. Data on summer deaths are not routinely reported at local level.

Excess winter mortality (EWM) is the 'extra' deaths that occur in the winter months compared to the rest of the year. Excess winter mortality is calculated using the average number of deaths over the non-winter periods from the deaths that occurred during winter period.

England, in common with some European countries, experiences higher levels of mortality in the winter than in the summer (Healy, 2003). Excess Winter Mortality is more prevalent amongst older people, and mostly caused by circulatory and respiratory diseases (Office for National Statistics (ONS), 2013).

Excess winter mortality is associated with socio-economic inequalities, and especially fuel poverty and cold homes. Excess winter deaths are most common in the over 65 age group, in people with pre-existing long term conditions, such as CVD and/or respiratory disease (including influenza) and in vulnerable groups (Tanner et. al., 2013). There is strong evidence that a large number of these deaths are preventable (HINST, 2010). Professor Christine Liddell, University of Ulster, produced a policy briefing on the impact of fuel poverty commissioned by "Save the Children". The report looked at the cost benefits of tackling fuel poverty. It identified that for every £1 spent on fuel poverty grants schemes, the health service saved 42p as a by-product, of which 41% related to excess cold and 24% to mental health and well-being (Liddell, 2008).

The Department of Health public health support team developed practical guidance on how to tackle variation and reduce inequalities in levels of excess deaths, mainly in the elderly. The national team observed that actions taken through services are often fragmented and that there is significant potential to have an immediate impact on mortality by implementing a targeted, systematic and scaled-up programme. Success of such programmes depends on good partnership and effective joint commissioning and joint provision of health, social care and housing services (HINST, 2010). The 'Christmas tree' diagnostic is particularly relevant to such a programme, with a strong focus on known intervention efficacy, engaging the public, responsive services and networks, leadership and coordination (HINST, 2010).

National public health campaigns and publicity by groups such as Age UK campaigns are examples of population level short term interventions.

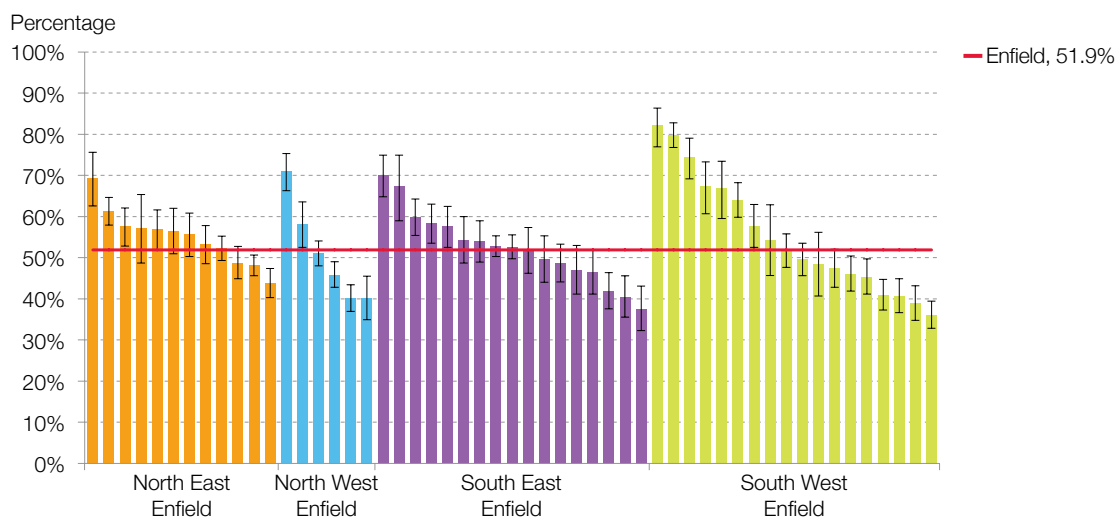
3.8.2 What do we know about excess winter deaths in Enfield?

In 2011/12, there were 170 excess winter deaths in Enfield. The Excess Winter Mortality Index (EWMI) for Enfield was 29.3%, above London (18.8%) and England (15.8%) averages. This is a 13% increase compared to the winter 2010/11. Enfield's EWMI for 2011/12 is amongst the worst 10% in the 326 local authorities in England, and was the worst amongst London boroughs. It is important to note that EWM figures for local areas tend to be quite variable from one year to the next and there is no consistent pattern in EWM for any of the local authorities in England or Wales.

In 2011/12, the majority of excess winter mortality (63%) was caused by respiratory diseases and circulatory diseases. In particular, respiratory diseases caused 40% more deaths during winter compared to the non-winter period. Health promotion programmes such as "keep warm, keep well" campaign and seasonal flu vaccination will be effective in reducing excess deaths during winter.

There is variation amongst GP practices in Enfield in the uptake of flu immunisation for at-risk population (Figure 3.78). It will be important for practices to ensure all those over 65 and at-risk population are offered immunisation.

Figure 3.78: Flu immunisation at-risk population, 2012/13



Source: ImmForm 2012/13, Enfield Clinical Commissioning Group

3.8.3 Fuel Poverty in Enfield

The UK priority has been largely focused on addressing excess winter deaths (EWD), linked to activities to tackle fuel poverty. Fuel poverty is defined as having to spend 10% or more of income on all fuel use, including heating the home, to an adequate standard of warmth. Tackling fuel poverty is therefore important as cold homes are associated with higher risk of health problems such as infectious diseases and circulatory diseases.

The UK Government has pledged to tackle and eradicate fuel poverty by prioritising assistance to the most vulnerable households (Department of Trade and Industry and Department for Environment, Food and Rural Affairs, 2001). Vulnerable households include those who fall into three categories:

- older people
- people with a disability or a long-term illness
- young people and children.

The UK Fuel Poverty Strategy indicates that people over 60 years of age have lower resistance to respiratory diseases and increased blood pressure at lower household temperatures, affecting their physical and mental health. These factors can contribute to increased levels of illness specifically during the winter months as people spend more time at home but are unable to heat their homes adequately for longer periods due to the cost. Those with a disability or long-term illness are additionally at risk as fuel poverty may worsen ill-health and suffering, and may lengthen their recovery time. Children are particularly vulnerable to respiratory conditions such as asthma, which have been linked to cold and damp homes. Evidence suggests that cold homes can increase the time taken to recover from a range of other illnesses that can affect a child’s physical, social and educational development (Liddell, 2009).

In 2010, 12% of Enfield households were suffering from fuel poverty, giving Enfield the fifth highest rate of fuel poverty in London, and the fourth highest number of households (13,124) in fuel poverty. Public Health will be working with other Council departments, the Clinical Commissioning Group and voluntary groups on the issue of fuel poverty and excess winter deaths. Plans include social marketing to raise awareness of cold weather and increase uptake of flu vaccinations, as well as working with housing providers and GPs tackling fuel poverty.

3.8.4 Key risk factors

The risk factors for seasonal excess deaths include;

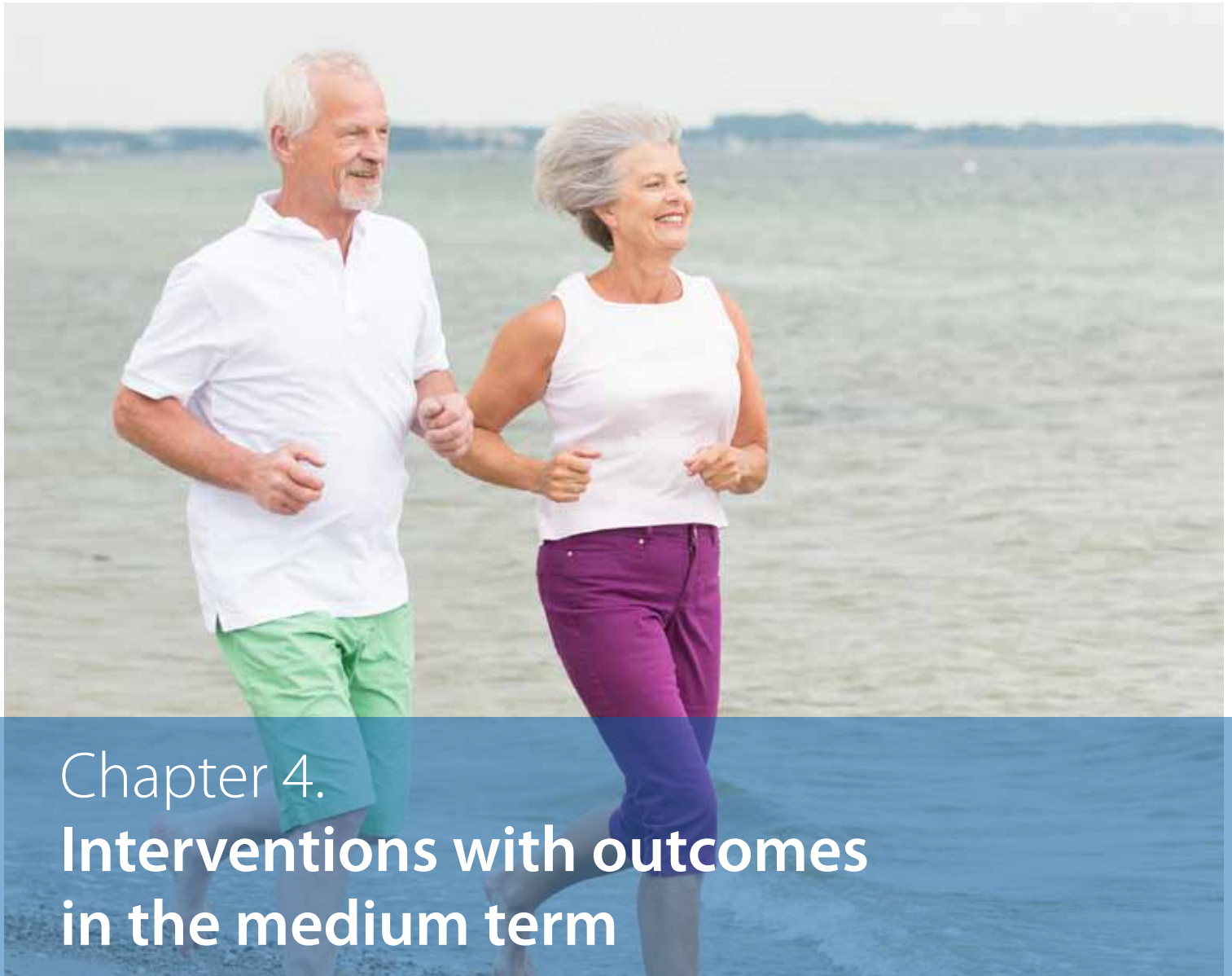
- older age – especially for people aged 65 years and over or those who are frail
- chronic and severe illness – including heart conditions, respiratory insufficiency, asthma, COPD (chronic obstructive pulmonary disease) and disability
- co-morbidities
- living with and experiencing deprivation, particularly in relation to housing tenure and fuel poverty
- energy inefficient homes
- living alone
- long term impairment or mental ill-health.

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Chapter 4.

Interventions with outcomes in the medium term

We know that many illnesses which cause premature death are, in part, preventable through lifestyle issues such as physical activity and healthy eating. Smoking remains a cause of many preventable deaths, and alcohol and substance misuse also contribute heavily to poor health.

Mental health is closely linked with physical health and contributes to differences in life expectancy, as well as wellbeing and quality of life.

In this section the focus is on medium term interventions, which refers here to actions that can have an impact in 0-10 years and largely centre on lifestyle changes. The 'medium term' refers to the gestation period between intervention and desired outcome. It does not reflect the time taken to make the strategic change to support the intervention. Changes in lifestyle can be achieved by implementing key interventions at three levels (Bentley, 2007).

1. **Population health level** – direct input at population level through legislation, regulation, taxation, mass media.

2. **Personal health level** – applying effective personal health interventions systematically, and at a scale such that improvements add up to population-level change.
3. **Community health level** – engaging, developing and empowering communities effectively and systematically enough that resulting health-improving and health-seeking behaviours lead to percentage change at population level.



4.1 Lifestyle – smoking

Key messages

- Smoking contributes to **1 in 5 deaths** in Enfield.
- Smokers have a life expectancy **ten years** less than non-smokers.
- **Over 43,000** people smoke in Enfield.
- Approximately **820** young people aged 11 to 15 years in Enfield are regular smokers.
- **241** women in Enfield who gave birth were still smoking at delivery (2012/13).
- People who live in more **deprived** circumstances are more likely to smoke and also to expose themselves to multiple other behavioural risks.

4.1.1 Why is smoking important in reducing the gap in life expectancy?

Smoking contributes to 18% of all deaths, and 26% of cancer deaths. Those who smoke have ten years' less life expectancy than non-smokers (Action on Smoking and Health, 2014; Health and Social Care Information Centre, 2012).

Smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking-related death rates are two to three times higher in low income groups than in wealthier social groups (The Marmot Review, 2010).

Smoking is the leading preventable cause of death and ill health in UK. It causes heart disease, lung disease and damages nearly every organ. Smoking while pregnant harms the growth of the foetus in the womb. There is also the impact on smokers' families: each year, UK hospitals see around 9,500 admissions of children with illnesses caused by secondhand smoke (Department of Health, 2013a).

Habits such as smoking whilst drinking alcohol in the home or lighting up in bed are responsible for one in three (36 per cent) of all accidental house fires resulting in deaths (Department for Communities and Local Government, 2011).

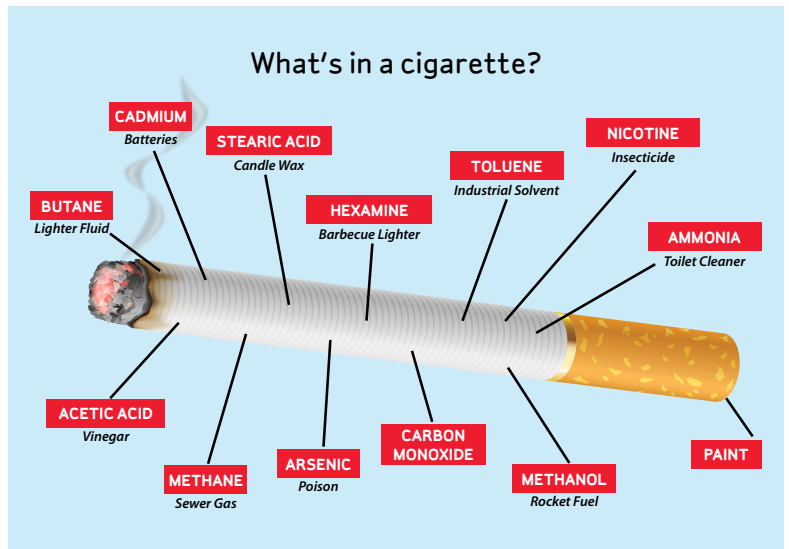
Apart from teenage years, men are slightly more likely than women to smoke. For both men and women, smoking rates are highest in the 25-34 age band and then fall with age.

Smoking rates are higher in routine and manual socio-economic groups and lowest in professional and managerial groups.

The white ethnic group has higher smoking rates than nearly all non-white ethnic groups. However, within ethnic groups there are wide differences; in nearly all groups, women smoke less than men.

The government have aimed to reduce smoking in adults, children and pregnant by the end of 2015. Several policies and campaigns are in place to support this directive, including:

- **Smoking ban** – A population level intervention banning smoking in nearly all enclosed workplaces and public spaces in 2007.
- **Ban in promotion of tobacco** – Most forms of tobacco advertising have been banned since 2003, and visible displays were banned from supermarkets in April 2012.
- **Implementing Tobacco taxes** – making smoking less affordable, regulating tobacco products.
- **Anti-smoking campaigns** – Healthy Lives, Healthy People: a tobacco control plan for England (Department of Health, 2011a) sets out government plans to 2015. It includes details of plans on stopping tobacco promotion, helping smokers to quit and reducing exposure to second hand smoke.
- Further research into E-cigarettes.



To attain impact in the medium term, interventions for smoking will be implemented at three different levels using the national support team guidance (HINST, 2010);

- **Population health level** – direct input at population level through legislation, regulation, taxation, mass media, e.g. preventing smoking in enclosed public spaces and implementing NICE guidance
- **Personal health level** – applying effective personal health interventions systematically, and at a scale such that improvements add up to population-level change, e.g. smoking cessation
- **Community health level** – engaging, developing and empowering communities effectively and systematically enough that resulting health-improving and health-seeking behaviours lead to percentage change at population level

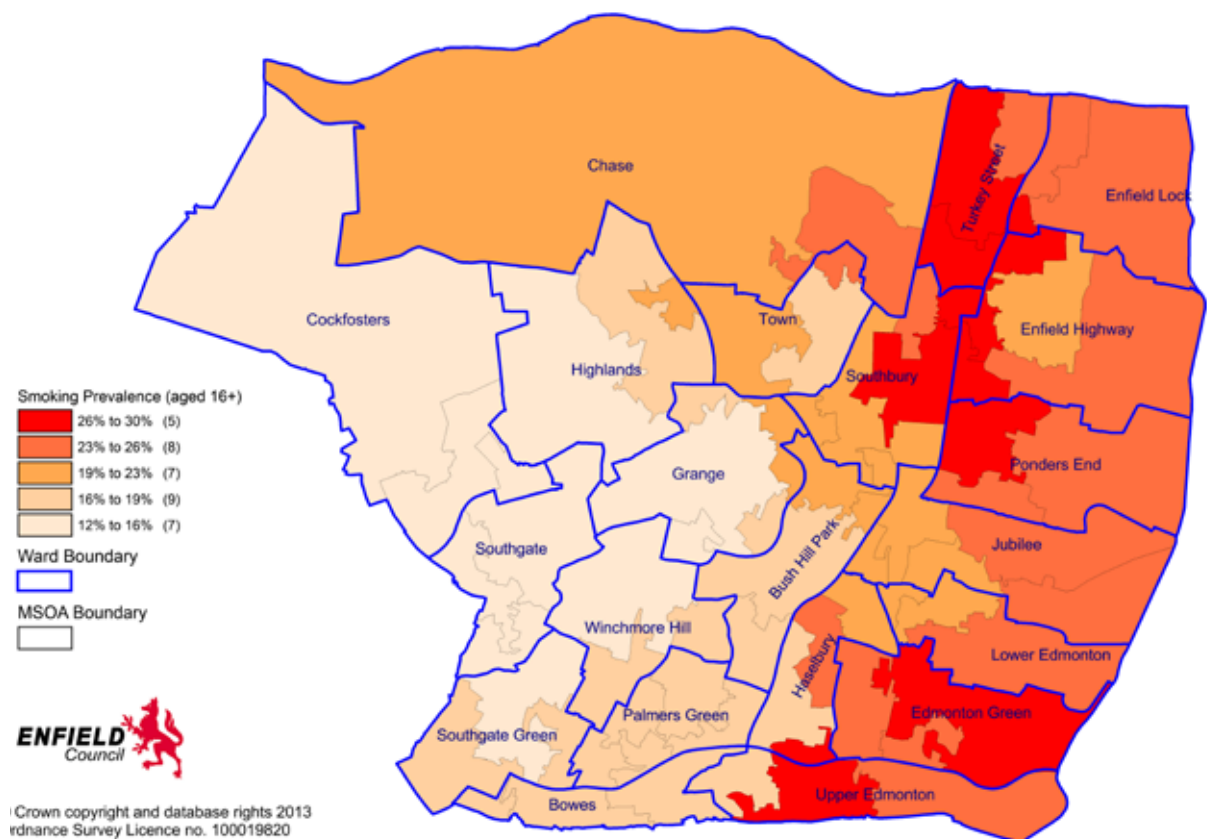
4.1.2 Smoking in Enfield

Smoking is a particular concern in Enfield. It is estimated that around 43,000 people smoke in Enfield (18.0% of adults; London Health Observatory (LHO), 2012). National data suggest that around 4% of young people aged 11 to 15 years are regular smokers, smoking more than one cigarette per week. This equates to around 822 children smoking in Enfield.

The map below shows the prevalence of smoking across Enfield (2006-08). We know that it was highest in the South East of the borough (18%) and lowest in the North West (14%).²⁶ It is important to note that due to the nature of recording smoking prevalence, this is likely an underestimate.



Figure 4.1: Smoking prevalence amongst persons aged 16 years and older in Enfield (Modelled estimate), 2006-2008



Source: Association of Public Health Observatories, based on Health Survey for England

²⁶ Locality level smoking prevalence was derived using QOF clinical indicator (SMOKE08) and is likely to be an underestimate.

In 2011/12, over 50% people in Enfield said that they had never smoked, and 18.5% were current smokers, similar to the rates for London (18.9%) and England (20.0%) (Integrated Household Survey, Office for National Statistics).

Since 2009/10, almost 8,000 people in Enfield have quit smoking as result of smoking cessation services.

4.1.3 Illness and mortality

In Enfield smoking contributes to one in five deaths. Between 2010 and 2012, there was an average of over 300 deaths attributable to smoking per year in Enfield. Each year around 9,500 children are treated in hospital for exposure to second-hand smoke nationally.

While the mortality rate for Enfield is below London and England averages, smoking is still the biggest single preventable cause of ill-health and premature death in Enfield and across the country.

During 2010/11 in Enfield, smoking is estimated to have caused around 2,000 hospital admissions with a cost of over £5.8m (Local Tobacco Control Profiles, Public Health England (PHE)).

Box 2: Reducing the prevalence of smoking

Preventing people from starting to smoke

40% of smokers started to smoke before the age of 16 and very few start after the age of 24. Interventions should focus on schools and preventing illegal sales of cigarettes to young people.

Helping smokers give up smoking

Most (61% of men and 66% of women) smokers would like to quit. Most smokers who quit do so without help, but many smokers who do not succeed in quitting by themselves will succeed if they get help.

Making non-smoking the norm

Banning smoking in public places, removing cigarettes and cigarette advertising from public view and emphasising that most people do not smoke will help to reduce smoking.

4.1.4 Evidence of Best practice

Helping a smoker to become smoke-free is often the best thing that can be done for their health but at a population level there is much more benefit to be gained from ensuring that people do not start smoking. Enfield is therefore focusing more attention on tobacco control; working with young people and those factors that affect smoking uptake, reducing the attractiveness of smoking products wherever possible, targeting underage sales, restricting access to tobacco products and working to 'de-normalise' smoking wherever possible.

The following have been identified as '10 High Impact Changes' by the Department of Health (DH) to achieve excellence in tobacco control:

1: Work in partnership

Effective partnerships are central to moving the tobacco control agenda forward. Partnerships need to be strategic and create a joined-up approach to tackling the public health issue of tobacco as a shared priority.

2: Gather and use the full range of data to inform tobacco control

Collecting robust data to determine the scale of the challenge in a given area will inform local tobacco control goals, helping to ensure that efforts are focused in the right places. The available knowledge can then be translated into informed planning and commissioning.

3: Use tobacco control to tackle health inequalities

A locality committed to addressing health inequalities will need to intelligently commission tobacco control if more significant reductions in smoking-related inequalities are to be achieved. Interventions targeted at the substantially untapped group of smokers within the routine and manual group must be a priority as this is the main means of tackling health inequalities.

4: Deliver consistent, coherent and co-ordinated communication

Bringing communications into the local strategic approach to tobacco control increases the effectiveness of national and local smoke free campaigns, is central to social marketing and is fundamental to tobacco control advocacy.

5: An integrated stop smoking approach

The local NHS Stop Smoking Service should be viewed as just one element of an overall strategic and comprehensive programme rather than the sole agency delivering tobacco control at a local level, albeit acknowledged as a function that underpins many other parts of a comprehensive programme.

6: Build and sustain capacity in tobacco control

Capacity building is a long-term process but in order to maintain progress and momentum in tobacco control it is essential that local capacity is strengthened and sustained. Successful tobacco control will require infrastructure, resources and political will.

7: Tackle cheap and illicit tobacco

Tobacco smuggling seriously undermines the impact of other tobacco control measures. There needs to be greater effort to reduce both the demand and supply of cheap illicit tobacco. This is a cross-cutting issue that requires engagement from all partners in a local Alliance.

8: Influence change through advocacy

Tobacco control advocacy is about changing the political, economic and social conditions that encourage tobacco use and gaining public, political and media support for tobacco-related issues.

9: Helping young people to be tobacco free

Smoking prevalence among 11-15 year olds has remained at 9% in recent years, but at age 15, 16% of boys and 24% of girls are regular smokers. Youth prevention should be part of a comprehensive tobacco control programme based on demoralising smoking across the wider population.

10: Maintain and promote smoke free environments

A concerted effort is required to sustain the profile of tobacco control and maintain the momentum provided by the Smoke free legislation of July 2007 if the significant benefits to be had from de-normalising smoking are not to be lost (London Health Observatory (LHO), 2012; Public Health England (PHE), 2014a).

4.1.5 Services in Enfield

The Enfield Stop Smoking Service provides a range of specialist stop smoking services across Enfield. The service is provided by Innovision Healthcare Ltd, and includes one-to-one and group support, either on an appointment or drop-in basis. For more information about quit smoking clinics call 0800 652 8405 or 020 8370 1022.

People can also go to their GP for smoking cessation advice and support. GPs can prescribe a range of smoking cessation treatments.

Enfield has already implemented a number of innovative tobacco control interventions; it was the first London Borough to implement smoke-free children's areas in parks and Fixed Penalty Notices (FPNs) for smoking related litter. There is also a discount for stopping smoking through NHS Stop Smoking Services.

Reducing smoking prevalence by even 0.5% will reduce the number of smokers in the borough by approximately 1,000. Enfield Public Health has therefore undertaken a literature review of best practice in reducing tobacco usage. This has included lessons from California where smoking prevalence is 11% (compared to 18% in Enfield) and 'Fresh – Smokefree North East' where prevalence has dropped from 29% to 24%. The Tobacco Control Alliance will be taking this work forward.

Enfield Stop Smoking service continues to meet annual targets of helping approximately 1,600 people to stop smoking each year. This is at a cost of £181 per smoker, lower than the London overall and England averages.

The proportion of those who set a quit date and go on to quit four weeks later is higher in Enfield (61%) than that for services in London or England.

See also: case studies on Tobacco Control and Smoking Cessation.



Don't go broke for a smoke!
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For appointments please call 0800 652 8405 or 020 8370 1022 www.smokefree.nhs.uk

In partnership with
SMOKEFREE ENFIELD & HAVANT
Healthy Enfield
ENFIELD Council



4.2 Lifestyle – Alcohol and substance misuse

Key messages

- Between 2007/08 and 2011/12, the rate of alcohol related hospital admissions in Enfield increased by **114%**.
- Around **46,000** adults (16 years and over) in Enfield are estimated to drink at a level which may be dangerous to health.
- Enfield's total acute hospital cost amount to approximately **£4.8million** annually.
- There are over **60 health conditions** strongly associated with alcohol misuse.
- An estimated **1,500** opiate and crack users live in the borough.

4.2.1 The impact of alcohol and substance misuse in life expectancy

Alcohol misuse is the third largest contributor to ill-health after cardiovascular disease and smoking; it is a major Public Health priority (National Institute for Health and Care Excellence, 2012a). In 2010 to 2011 there were around 15,000 deaths caused by alcohol in England (Department of Health, 2013b).

“Alcohol misuse is one of the biggest health problems we face as a nation. Last year there were 1.2 million admissions to hospital associated with alcohol”, Department of Health, 2013b

This isn't only a burden on individuals and families but also a drain on hospital resources and public money: every year, alcohol-related harm costs society £21 billion (Department of Health, 2013b).

Drinking alcohol is a very common behaviour in this country and, although the majority of people drink responsibly, there is still an estimated 9 million people in England who drink alcohol at levels that pose risks to their health.

Drinking regularly above the NHS recommended sensible drinking levels (i.e. 2-3 units a day for women 3-4 units a day for men) increases the chances of suffering more serious health harms including: Depression and anxiety, high blood pressure, liver disease, pancreatitis, heart disease or irregular heartbeat, stroke and some cancers. Despite information on the recommended daily limit for alcohol being widely publicised drinking above the guideline limits is becoming more common.

The Coalition Government's Alcohol Strategy, published in March 2012, accepted a need to improve the UK public's poor understanding of and adherence to the current drinking guidelines, with around a third of adult men and a fifth of adult women drinking above the recommended limits (HM Government, 2012).

Alcohol misuse not only impacts on the individual's health but it also increases the risk of harm to others and the community as a whole. Someone who is under the influence of alcohol is more likely to engage in risky behaviours such as unsafe sex or illegal activities like drink-driving. It is important to note that:



- Regular excessive alcohol intake is associated with physical and psychological dependence;
- In 2011 there were 8,748 deaths in the UK directly related to alcohol;
- Driving under the influence of alcohol substantially increases the risk of having a serious accident;
- An estimated 9,990 people were injured or killed in drink-driving accidents in England in 2011;
- Excessive alcohol intake is associated with anti-social behaviour and street violence;
- Alcohol consumption is a major contributor to domestic violence (WHO, 2014);
- 40% of violent crime, 78% of assaults, and 88% of criminal damage cases are committed by offenders under the influence of alcohol (Home Office, 2010).

Despite drinking less than their counterparts, people in lower socio-economic group are more likely to suffer adverse health consequences, including suffering from other people's drinking habits partly due to higher deprivation levels, including associated poorer health and lifestyle choices, leaving them less able to protect themselves from negative health and social consequences (NICE, 2010). Compared to people living in more affluent areas, those who live in more socio-economically deprived areas are:

- Two to three times as likely to die of causes influenced, in part, by alcohol;
- Three to five times more likely to die of an alcohol-specific cause; and
- Two to five times more likely to be admitted to hospital because of an alcohol-use disorder (NWPFO, 2007).

Among adults aged 16 to 74, 9% of men and 4% of women show some signs of alcohol dependence (HSCIC, 2013a).

Change in drinking behaviour and reducing the harm that excessive drinking causes - to individuals' health and wellbeing and to society is a priority in Enfield. Health measures included in the Health and Wellbeing Strategy build on public health becoming a responsible authority under the Licensing Act, for the first time giving them the power to intervene in licensing decisions. The Licensing Act also includes health as an objective to allow local areas to limit the total number of licensed premises in their area.

The Alcohol Strategy encourages greater use of effective interventions by health professionals, such as brief interventions, specialized treatment for people dependent on alcohol and alcohol liaison nurses within A&E.

The Public Health Responsibility Deal (Department of Health, 2014) pledged to take one billion units of alcohol out of the market by December 2015, through improving the choice available of lower strength products. Estimates suggest that in a decade this would result in almost 1,000 fewer alcohol related deaths per year, thousands of fewer hospital admissions and alcohol related crimes, and substantial savings to health services and crime costs each year.



83% of people who regularly drink above the guidelines don't think their drinking is putting their long-term health at risk (Department of Health, 2012). The Department of Health has initiated several directives to ensure people get the support to change their drinking behaviour, if they need it. These include;

- Change4Life campaign, informing people about the risks of drinking above the lower-risk guidelines and giving them tools and tips to reduce their drinking
- an alcohol risk assessment in the NHS health check for adults aged 40 to 74
- spending £448 million on improving the lives of the 120,000 most troubled families in the country (many of them have alcohol-related problems)
- developing a model to support young people who go to A&E with an alcohol-related problem, so that they get proper follow-up and care (this may include informing their GP or their parents, where appropriate)
- making sure that hospitals have alcohol liaison nurses to identify people with alcohol-related problems and to help them get the help they need – including treatment for alcohol dependence, where necessary
- reviewing the alcohol guidelines so that people can make responsible and informed choices about their drinking.

In 2010, the national drug strategy, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life' (HM Government, 2010), set out the government's approach to tackling drugs and addressing alcohol dependence. Fundamental to the strategy is the focus primarily on reducing the harms caused by drug misuse, where the proposed solutions are holistic and centred around each individual, with the expectation that full recovery is possible and desirable.

To achieve impact in the medium term, interventions for alcohol and substance misuse need to be implemented at three different levels using the national support team guidance (HNIST, 2010).

- **Population health level** – direct input at population level through legislation, regulation, taxation, mass media, as described above.
- **Personal health level** – applying effective personal health interventions systematically, and at a scale such that improvements add up to population-level change.
- **Community health level** – engaging, developing and empowering communities effectively and systematically enough that resulting health-improving and health-seeking behaviours lead to percentage change at population level.

4.2.2 Alcohol in Enfield

It is estimated that about 46,000 adults in Enfield drink at levels which puts them at risk of harm to their health, known as “increased risk drinking” and “higher risk drinking” (Local Alcohol Profiles for England (LAPE), 2013) and a further 3,648 adults in Enfield are thought to be dependent drinkers (National Treatment Agency, 2012), of which approximately 10% are currently being supported in specialist treatment services.

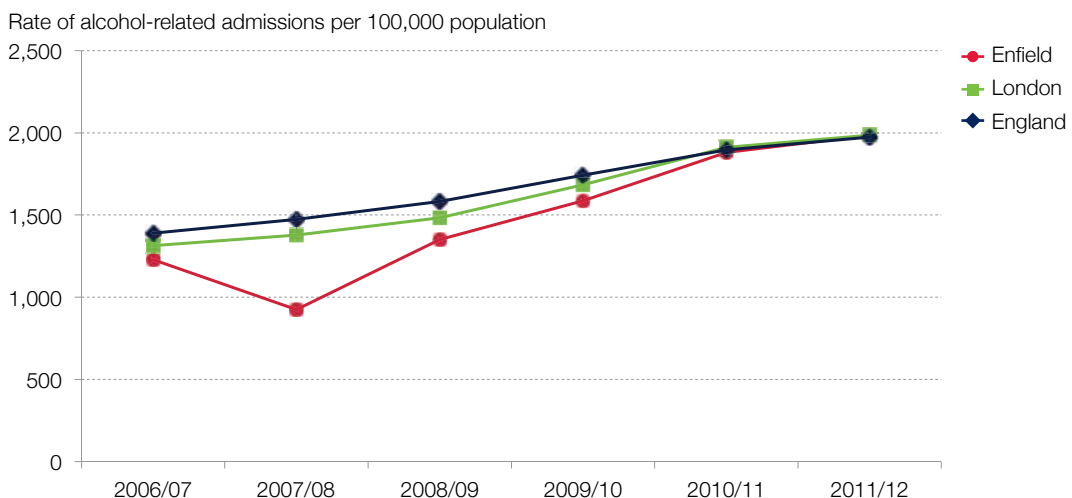
The impact of alcohol misuse upon Enfield’s local hospitals is substantial; Barnet and Chase Farm Hospital NHS Trust incurs £2.2 million and North Middlesex University Hospital NHS Trust a further £2.6 million each year on treating Enfield residents who are dependent drinkers; a total local acute hospital cost of £4.8 million. Based upon the NICE analysis it is estimated that our primary care services in Enfield have to absorb the remaining £1.77 million of alcohol related cost pressures each year (NICE, 2011; NHS North Central London, 2011).

Whilst Enfield has been below both the London and national averages for the number of alcohol-related hospital admissions in the past, numbers have increased in the borough at a faster rate than both London and national averages in recent years. Between 2007/08 and 2011/12, the rate increased by 114%, demonstrating a sharp rise especially in the 45 to 64 year age group (Figure 4.2).

Between 2010 and 2012, there were 56 deaths caused by alcohol in Enfield. 75% of these deaths were in males and 25% in females (LAPE, 2013). The number of deaths where alcohol is a possible cause is higher, a total of 255 deaths (LAPE, 2013).



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



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

Compared to London and the national average, Enfield has significantly lower mortality rates of chronic liver disease, lying on the 75th percentile. For alcohol-related recorded crimes, Enfield is significantly worse than the England average, lying below the 25th percentile, although it has a lower rate than London (LAPE, 2013).

80% of those requiring treatment for harmful drinking reside in those areas of the Borough where life expectancy is almost 10 years lower than for those who live in the more affluent areas.

4.2.3 The impact of substance misuse on life expectancy

Every year, it is estimated that the impacts of drug misuse cost society a total of £15.4 billion in England. This includes the annual costs of drug related crime (£13.9 billion), costs to the NHS (£488 million) and the costs of alcohol-related deaths (£2.4 billion in 2011) (PHE, 2014b).

To the individual, substance misuse can have wide ranging health problems including mental health problems, cardiovascular disease, liver disease and lung damage, poor vein health, blood borne viruses, overdose and drug poisoning with heroin users being thought to have ten times the death rate of the general population) (PHE, 2014b).

Misusing drugs can also have significant impacts upon a person's ability to secure housing and gain and maintain employment, increasing the likelihood of individuals to engage in criminal activities to fund their addiction and according to Public Health England:

- 2.7 million adults used an illegal drug in the past year;
- There is an estimated 299,000 heroin and crack users in England;
- 40% of prisoners say they have used heroin;
- 1.2 million have been affected by drug misuse in their family;
- Parental drug use is a risk factor in 29% of all serious case reviews (PHE, 2014b).

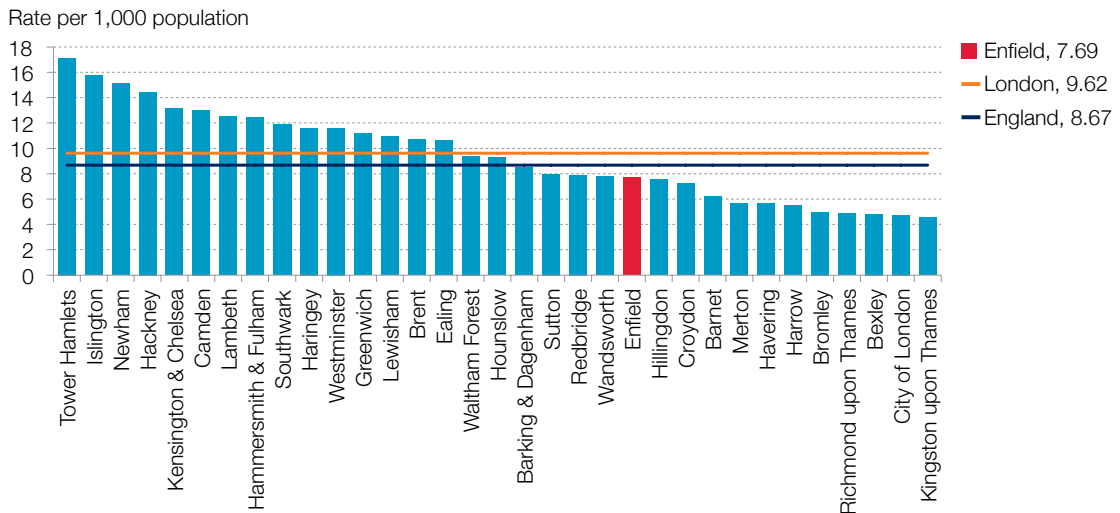


4.2.4 Substance Misuse in Enfield

Public Health England estimates that Enfield has 1,498 opiate and crack users (OCUs) residing in the borough which is the 12th lowest prevalence estimate in London (Figure 4.3).

In 2011/12 approximately 1,128 individuals over the age of 18 received specialist treatment from one or more Enfield’s Substance Misuse Services at some point during the year (NDTMS, 2014).

Figure 4.3: Estimated Prevalence of Opiate and/or Crack Cocaine Users aged between 15 and 64 years, per 1,000 population, by London Borough: 2010/2011



Hay G., Dos Santos A. R. & Millar T. (2013). Estimates of the prevalence of opiate use and/or crack cocaine use (2010/11): Sweep 7 report.

As well as accessing a range of community-based treatments, 2% of the treatment population accessed out of borough residential treatment as part of their treatment journey. Of the 14 people who completed their residential treatment programme, 79% left treatment in a planned way (NDTMS, 2014).

Keeping people in treatment long enough to benefit from the interventions given contributes to improved outcomes for drug users. As people progress through treatment, the benefits to them, their families and their community start to accrue. As such, a key measure of effectiveness of Enfield’s drug treatment services are the proportion of people who enter treatment, who continue to engage with treatment services for 12 weeks or more, or who leave drug free within 12 weeks. This measure is known as effective treatment. In 2011/12, 94% of drug users remained in on going treatment for 12 weeks or longer, in line with the national rate (NDTMS, 2014).

Abusing drink and drugs impacts on a wide range of areas including health, mortality, crime, families and our communities, and for every £1 spent on substance misuse services it saves the wider community £2.50 through reduced crime, hospital admissions and fewer people claiming benefits.

4.2.5 Services in Enfield

Enfield DAAT is currently commissioning a range of proactive services in a variety of settings to improve the life expectancy and crime reduction outcomes for its community members affected by alcohol misuse. This includes making effective provision available in acute, primary care, mental health, community, children's services and other key settings. The 2013/14 commissioning programme includes:

- Hospital alcohol liaison services which specialise in system design and training for medical and nursing staff on Identification and Brief Advice screening programmes, signposting patients into community treatment services and accessing other support groups to reduce unplanned and avoidable re-admissions;
- Enfield Service User Support Group, Break the Cycle, which acts as a pivotal aspect of provision for helping those alcohol misusers who have left treatment achieve independent living;
- Provision of alcohol specific counselling and one-to-one sessions for Enfield's Black and Minority Ethnic population;
- Specialist community alcohol and drug treatment services which provide an array of recovery interventions, such as comprehensive assessment and care planning, prescribing, blood borne virus screening and vaccination, needle exchange amenities, pharmacy supervised consumption for those patients being given medications, toxicology services, one to one and group work psychosocial interventions, in-patient and community detoxification provision, access to residential treatment for those people who need of more intensive treatment programmes in highly structured settings, and personalised community packages of care to support people leaving treatment in a planned manner;
- Specialist treatment for alcohol misusers referred by the criminal justice system to reduce their alcohol related offending behaviour, especially acquisitive crimes and domestic violence;
- Mental Health NHS Trust treatment for patients with a dual diagnosis and who have complex needs;
- Highly specialised treatment for young people who misuse alcohol which includes comprehensive assessment and care planning, one to one and group work psychosocial interventions, access to prescribing services, and an array of crime reduction and healthy living programmes;
- Targeted prevention programmes for young people affected by parental substance misuse and who are at risk of significant harm or are in need;
- Extensive media campaigns to ensure the effective delivery of alcohol related health promotion programmes to promote a safer, healthier, more responsible and prosperous Enfield community.



4.3 Lifestyle – Diet and Obesity

Key messages

- **10.9%** of adults are recorded as obese in Enfield (2012/13).
- **26.4%** of adults are obese in Enfield (2012).
- **64.2%** of adults are overweight or obese in Enfield (2012).
- **24%** of children aged 10-11 years are obese in Enfield.
- Enfield ranks **sixth worst** in London for obesity in children aged 4-5 years with more than one in ten children being obese.
- There is a clear difference in levels of **obesity** between wards in the east and the west of Enfield.

4.3.1 How can diet help in reducing the gap in life expectancy?

Excess weight is a leading cause of type 2 diabetes, heart disease, cancer and maternal obesity. It can lead to complications in childbirth for mother and baby. The costs of obesity to the NHS have been estimated to be over £5 billion (Department of Health, 2011c).

Obesity disproportionately affects those people in the poorest communities. Obesity can reduce life expectancy on average by nine years through premature death (National Institute for Health and Clinical Excellence, 2012b).

Dietary intake and eating behaviours are related to socioeconomic status; those from a higher socioeconomic background tend to eat more healthily than those from a lower socioeconomic background. For example, the Health Survey for England showed that those in the higher income quintiles were more likely than those in the lower income quintiles to consume the recommended five portions of fruit and vegetable per day (Public Health England, 2013).

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

Whilst there is wide agreement on what we should eat, being able to buy the right food is problematic for many. Availability and choice of food depends on social, cultural, political and economic environment. "The importance of access to good, affordable food makes more difference to what people eat than health education (Wilkinson & Marmot, 2003).

The eatwell plate

Use the eatwell plate to help you get the balance right. It shows how much of what you eat should come from each food group.



4.3.2 Diet and obesity in Enfield

Questions on height and weight were added to the Active People Survey in 2012. Data was adjusted at an individual level to account for self-reporting bias e.g. that people tend to under-estimate their weight and/or over-estimate their height. In Enfield, 26.4% of the adult population was found to be obese. The percentage of adults who are either overweight or obese is higher at 64.2% (Public Health England (PHE), 2014c).

In 2012/13, the QOF recorded prevalence of adult obesity in Enfield (10.9%) was higher than both the London (9.2%) and England (10.7%) figures, with the North East locality (14.3%) and the South East locality (12.3%) highest.

Being overweight and obese is more common in lower socioeconomic and socially disadvantaged groups, particularly among women. Local data in Enfield reflect this observation which makes targeting obesity at population level, personal level and community level a priority.

Childhood obesity is also an issue in Enfield. Among Reception Year children (aged 4-5 years) the prevalence of obesity in Enfield was 12.6%, which was the sixth highest in London, for 2012/13. For Year 6 children (aged 10-11 years) the prevalence of obesity was 24.1%, the 10th highest of the London boroughs.

In 2012/13, 26.2% of Reception Year children in Enfield were either obese or overweight, the 6th highest prevalence in London. For Year 6 children, Enfield had the 13th highest prevalence in London, with 39.1% either obese or overweight. In Enfield, there is greater childhood obesity in the south and east of the borough (Figures 4.4 and 4.5).

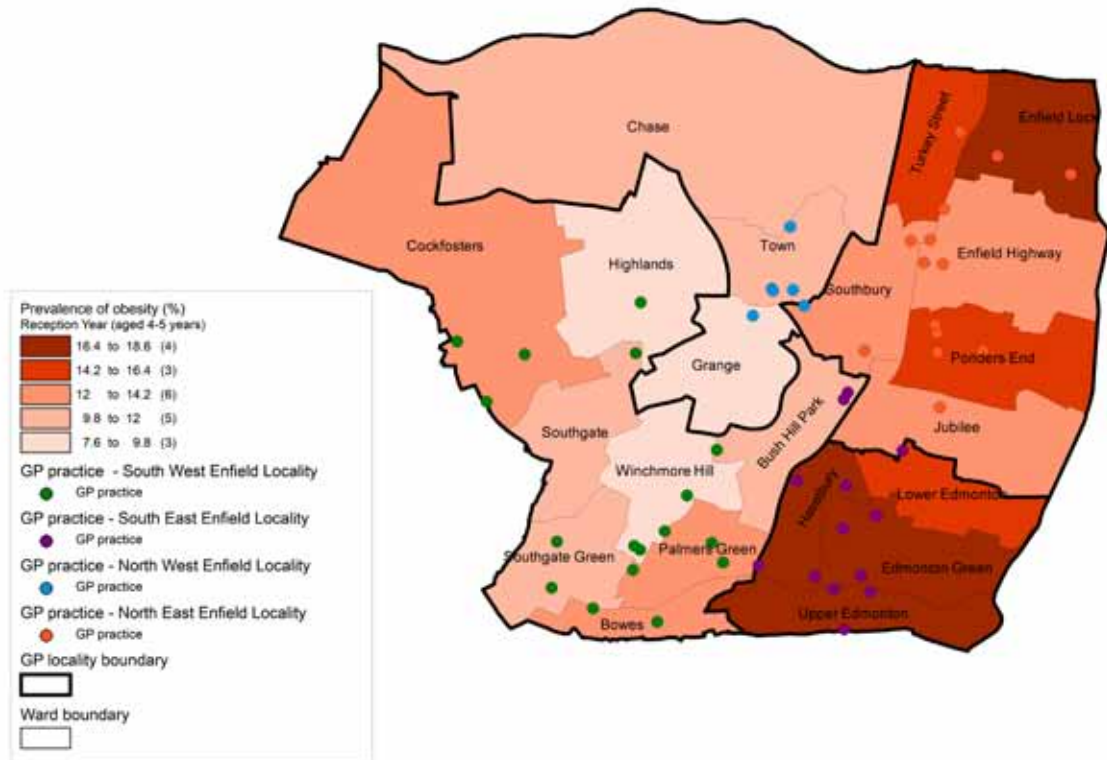
Wards in the east have obesity rates approaching 30% for Year 6. Figure 4.5 shows highest rates of obesity in Year 6 in Enfield Lock, Enfield Highway, Jubilee, Lower Edmonton and Edmonton Green.

Basics of healthy eating

The Government recommends that all healthy individuals should consume a diet that contains:

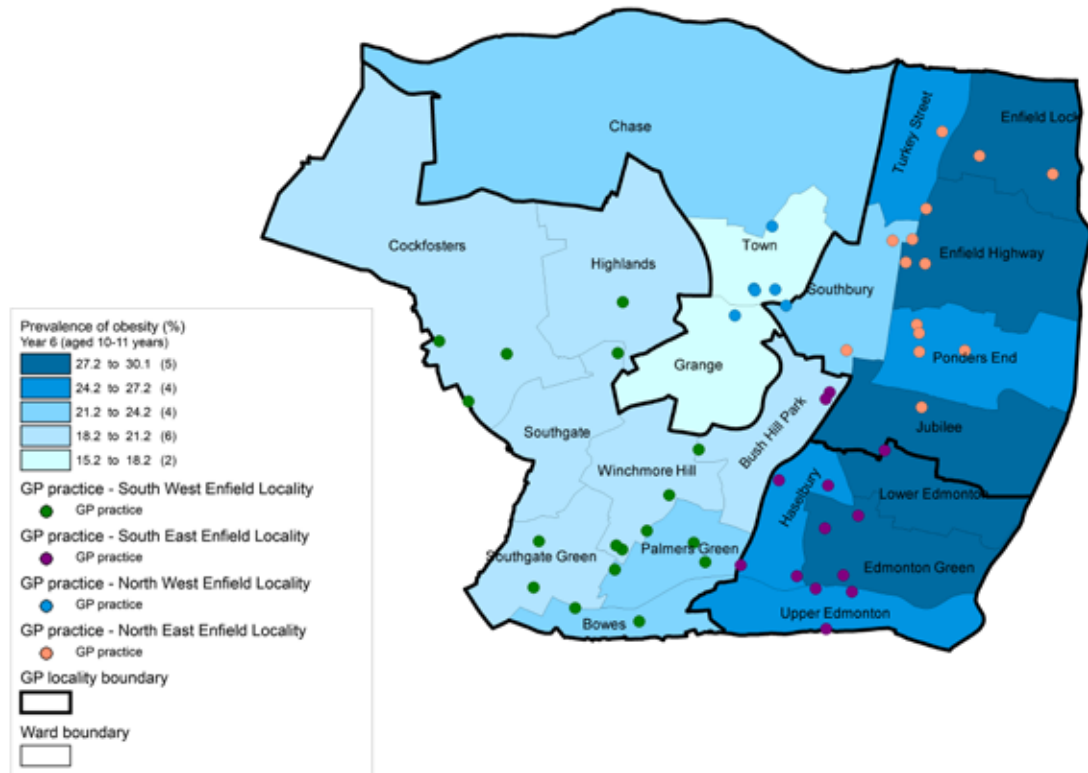
- Plenty of starchy foods such as rice, bread, pasta and potatoes (whole grain varieties when possible)
- At least five portions of a variety of fruit and vegetables a day
- Moderate amounts of protein-rich foods such as meat, fish, eggs, nuts and pulses
- Moderate amounts of milk and dairy
- Less saturated fat, salt and sugar (NHS Choices, 2013).

Figure 4.4: Prevalence of obesity amongst children aged 4-5 years, by ward, Enfield, 2009/10 to 2011/12



Source: National Child Measurement Programme (NCMP)

Figure 4.5: Prevalence of obesity amongst children aged 10-11 years, by ward, Enfield, 2009/10 to 2011/12



Source: National Child Measurement Programme (NCMP)



4.4 Lifestyle – Physical activity

Key messages

- National data from 2008 indicated that 95% of the population may not be meeting recommended levels of physical activity.
- There is emerging evidence that sedentary behaviour (e.g. activities that require very little energy expenditure – sitting/lying down) is associated with increased risk of Type 2 diabetes, cardiovascular disease, metabolic syndrome and all-cause mortality.

4.4.1 Why is physical activity important in reducing the gap in life expectancy?

Being adequately physically active throughout one's life is a critical part of being healthy. Compared to those who are inactive physical activity is associated with a 30% risk reduction of all-cause mortality, a 20-35% lower risk of heart disease, 30-40% lower risk of metabolic syndrome and type 2 diabetes, a 36-68% lower risk of hip fracture, 30% lower risk of colon cancer, 20% lower risk of breast cancer, and a 20-30% lower risk for depression and dementia (Department of Health, 2011b).

Insufficient physical activity is estimated to cost the NHS £1.06 billion per year. In England it is estimated that there are further costs from lost productivity and premature death of £6.5 billion per year. In Enfield in 2006/07 physical inactivity was estimated to cost primary and secondary care £3.5 million (Department of Health, 2009).

Discrepancies between objective and self-report data, data collection and populations mean that there is considerable difficulty in understanding levels of physical activity either nationally or locally. The Health Survey for England (2012) self-report stated that 67% of males and 55% of females (aged 16+) met the Chief Medical Officer (CMO) guidelines of 150 minutes of moderate activity (or 75 minutes vigorous activity, or a combination of the two) per week (Health and Social Care Information Centre (HSCIC), 2013b). However, objective data from the 2008 Health Survey for England (HSE) indicated that only 10% of those who said they met CMO guidelines actually did so (albeit under different guidelines) (Health and Social Care Information Centre (HSCIC), 2009).

There is also emerging evidence that sedentary behaviour in adults (e.g. that occur whilst sitting or lying down and that require very low energy expenditure) is associated with increased risk of type 2 diabetes, cardiovascular disease, metabolic syndrome and all-cause mortality. In children, it is associated with lower levels of aerobic fitness, risk of cardiovascular disease, greater weight and poorer mental health. There is also evidence that sedentary habits tend to be unchanging over time.

4.4.2 What do we know about physical activity levels in Enfield?

HSE (2008) self-report data indicated that 39% of males and 29% of females aged 16+ met the then CMO guidelines of five bouts of moderate intensity physical activity of at least 30 minutes per week. However, objective data from participants who had agreed to wear accelerometers for 10 hours a day for a week indicated that only 6% of males and 4% of females actually met this recommendation.

New guidelines on physical activity were published in 2011 which stated that adults (aged 19+) should undertake 150 minutes of moderate activity per week (or 75 minutes vigorous activity) in bouts of at least 10 minutes. Self-report data from the Health Survey for England (2012), indicated that 66% of males and 56% of females met these new guidelines. Reanalysis of 2008 data using the 2012 questionnaire showed that 65% of males and 53% of females in 2008 would have met the new guidelines. No re-analysis of the objective data from 2008 has been undertaken.



Physical activity can also be cost-saving for residents; it is estimated that Enfield residents spend £14 million/year on journeys under 2 miles and £85 million on journeys under 5 miles. Active transport could have a number of health benefits to both the individual and at a population level in terms of physical activity and reduced external costs from motorised transport; pollution, injuries, congestion etc.

Enfield Leisure Services

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 includes:

- Activities at youth clubs and leisure centres
- An extensive walks programme
- An outreach estates programme
- Coach and instructor development
- Competitive pathways and events
- Dance classes such as ballet, jazz, zumba and street dance
- Disability sport programmes
- Family sport sessions
- Healthy weight projects
- Holiday and term programmes for young people
- Volunteer development
- Women and girls programme

4.4.3 What has been achieved so far?

In the last few years, we have seen a steady increase in attendances at sport development courses, with a large improvement for 2012 due to Olympic and Paralympic activities. Some highlights include:

- In 2014, Enfield won £27 million to increase cycling in the borough. This should significantly impact on levels of physical activity in the borough
- A 90% uptake on summer courses for young people
- A new Active with Ease programme of activities as a result of referrals from health trainers into activities
- Continued top ten placements in London Youth Games competition
- Over 1,000 walkers, joggers and runners for the Mayor Charity Fun Run
- Over 2,000 on our Inclusive and Active programme for disabled young people



4.5 Mental Health

Key messages

- **1 in 4** people will suffer from some form of mental health problem at some point of their life.²⁷
- **1 in 6** adults are thought to be affected by mental ill health at any one time.²⁷
- **32,263** adults aged 18-64 in Enfield are estimated to be living with a common mental health disorder.²⁸
- **3,400** additional people between 18 and 64 years will be living with a common mental health disorder in Enfield by 2020.²⁸
- **4.3%** of the population over the age of 18 are recorded as suffering from depression by Enfield GP's.²⁹
- Mental ill health can have a significant impact upon people's physical wellbeing.
- Mental illness accounts for **23%** of all years of healthy life lost in high-income countries.
- In Enfield in 2011/12, **£219** of NHS money was spent per head on treating the effects of mental health problems.³⁰

²⁷ National Centre for Social Research and the Department of Health Sciences, University of Leicester, 2009.

²⁸ PANSI, 2012

²⁹ Health and Social Care Information Centre (HSCIC), 2013c).

³⁰ YPHO, 2013

4.5.1 Mental health in Enfield

Mental health is as important to wellbeing as good physical health. This is clearly set out in Enfield's Health and Wellbeing Strategy.

Mental ill health is associated with an increased risk of premature death, with people with severe mental illness dying on average 20 years earlier than the general population. In 2010/11, Enfield had the third highest excess mortality rate³¹ for people with severe mental illness in the London boroughs (Health and Social Care Information Centre).

Mental health needs can vary according to gender, ethnicity and age, and are influenced by family, social and environmental determinants. People with long-term mental health problems are at increased risk of long-term social exclusion, including worklessness and insecure housing.

Mental illnesses account for 23% of all years of healthy life lost in high-income countries, and are one of the largest cause of disability in the UK (London Mental Health and Employment Partnership, 2012). The total estimated cost of mental ill health in England in 2009/10 was £105.2 billion, with the highest cost (£53.6 billion) relating to human suffering, followed by lost economic output (£30.3 billion) and health and social care costs (£21.3 billion) (London Mental Health and Employment Partnership, 2012). In Enfield in 2011/12, £219 of NHS money was spent per head of population on treating the effects of mental ill health (Yorkshire and Humber Public Health Observatory, 2013).

About 30% per cent of all people with a long-term physical condition also have a mental health problem. By interacting with and exacerbating physical illness, mental health problems raise total health care costs by at least 45% for each person with a long-term condition and co-morbid mental health problem.

Clearly addressing mental health and wellbeing needs and issues is of considerable importance.

Prevalence

In 2012, it was estimated that 32,263 adults aged 18-64 years in Enfield were living with a common mental health disorder, such as depression, anxiety or obsessive compulsive disorder. Factoring in the increase in population size, it is estimated that around an additional 3,400 people between 18 and 64 years will be living with a common mental health disorder in Enfield by 2020.

Depression

In 2011/12, Enfield GPs had 17,508 people (8% of the population) over the age of 18 on their registers recorded as suffering from depression. This was below both the England and London rates of 11.7% and 8.1% respectively, though Enfield still had the 12th highest rate of recorded depression amongst all London boroughs.³²

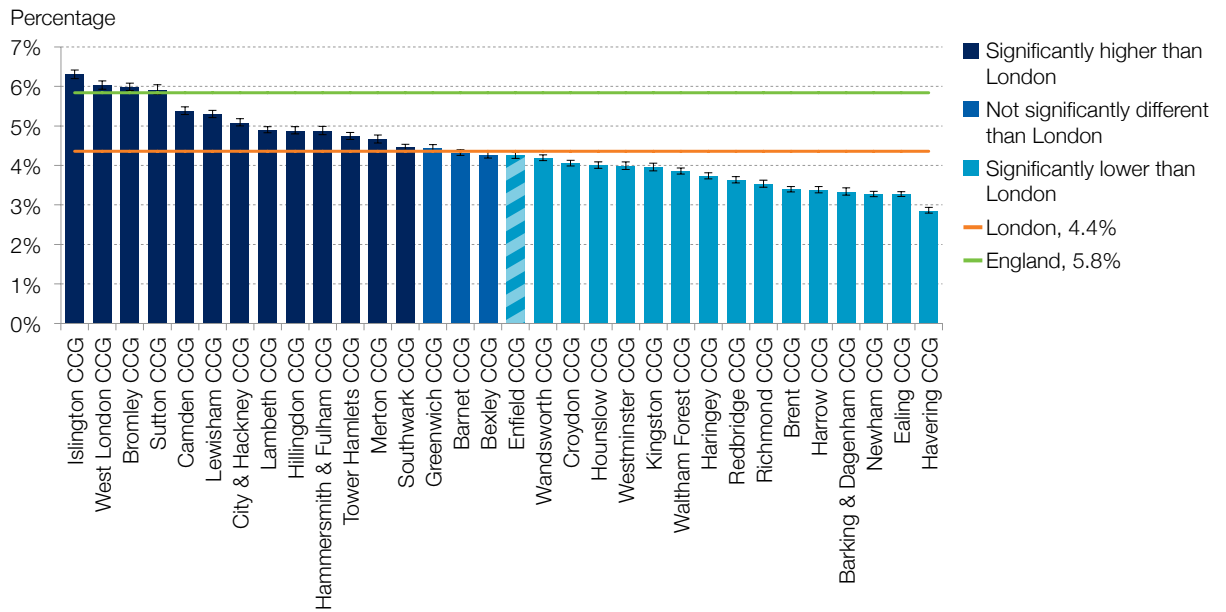
In 2012/13, there was a change in the QOF criteria used by GPs to record depression prevalence³³. This led to a reduction in prevalence figures for depression. For Enfield, the prevalence of depression in the population aged 18+ was 4.3% which was statistically significantly lower than both London (4.4%) and England (5.8%) (Figure 4.6).

³¹ Comparing mortality for people with severe mental illness with the general population in Enfield.

³² QOF 2011/12, HSCIC.

³³ The new QOF criteria excludes patients diagnosed prior to April 2006.

Figure 4.6: Proportion of adults recorded depression on GP disease registers, London Boroughs 2012/13



Source: Health and Social Care Information Centre (HSCIC)

As with all GP disease prevalence data, the numbers reported reflect only people who have been recorded as suffering from depression by their GP, so may well miss cases among people who have very little contact with primary care (Figure 4.6). As such, this is likely to be an underestimate of actual prevalence within the local population.

Common Mental Health

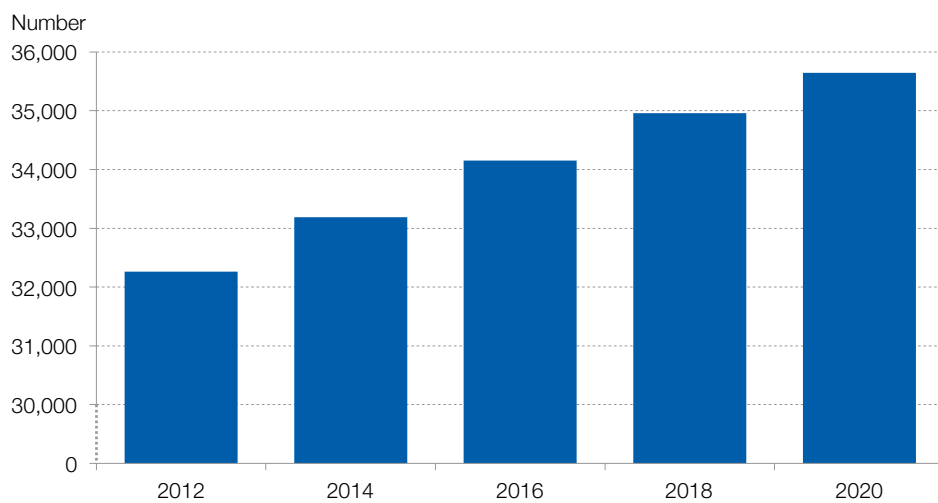
In 2012, it was estimated that 32,263 adults aged 18-64 years in Enfield were living with a common mental health disorder; this includes depression, anxiety or obsessive compulsive disorder. Figure 4.7 shows, factoring in the increase in population size, it is estimated that approximately 3,400 more people between 18 and 64 years will be living with a common mental health disorder in Enfield by 2020.

Serious Mental Illness

Serious Mental Illness comprises of schizophrenia, bipolar disorder and other psychoses. Having a serious mental illness increases mortality. Excess mortality measures the additional deaths of those under 75, within a given subset of the population. Which in this case are adults, with a serious mental illness, against the general population’s under 75 mortality rate.

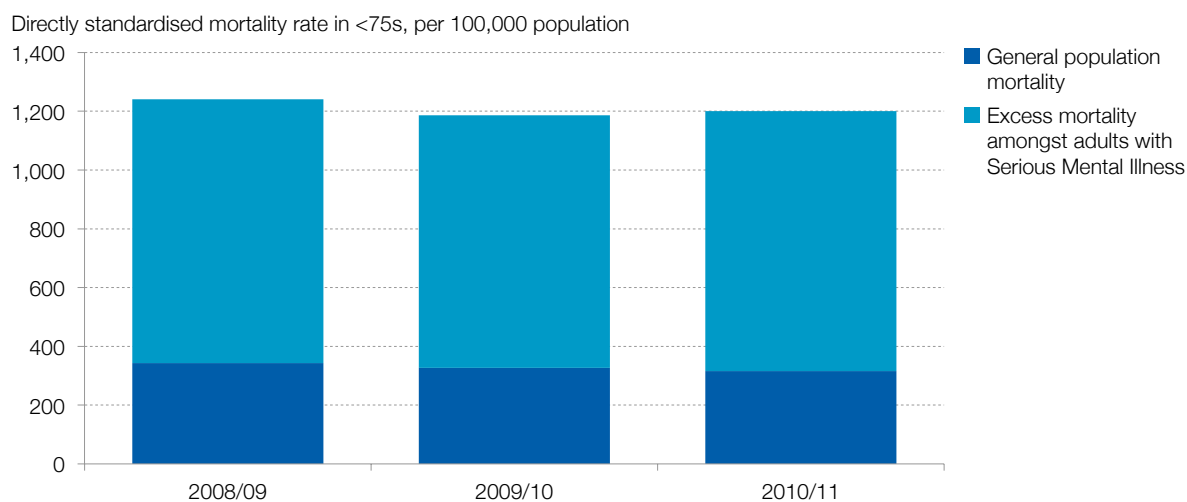
Enfield had the third highest excess mortality rate amongst people with serious mental illness in London in 2010/11, though the rate was lower than the England rate. While the general population mortality rate amongst under 75’s was 316 per 100,000 in 2010/11, mortality amongst adults with mental illnesses was 1,200 per 100,000 for the same period, giving an excess mortality amongst adults with mental illness of 884 per 100,000.

Figure 4.7: Projected Number of Adults aged 18-64 years with a Common Mental Disorder in Enfield 2012-2020



Source: Projecting Adults Needs And Services Information (PANSI), 2013

Figure 4.8: Excess Mortality per 100,000, people aged 18 to 75 years with a serious mental illness. Enfield 2008/2009 to 2010/2011



Source: Health and Social Care Information Centre

In 2012/13, 3,024 Enfield residents registered with GPs were recorded as suffering from schizophrenia, bipolar affective disorder or other psychoses, equating to 1% of the resident population, which was similar to the London prevalence (1.0%) but above the England prevalence of 0.8%. This was a similar prevalence to that recorded in 2011/12, when 2,930 people or 1% of the registered population were identified as suffering from these conditions.

4.5.2 Mortality due to suicide or undetermined injuries

Between 2008 and 2010, Enfield's rate of mortality due to suicide or undetermined injury was 6.2 per 100,000 of the population which equates to 56 deaths. Enfield has a lower rate of mortality due to suicide than England and London rates, which were 7.9 per 100,000 and 7.1 per 100,000 respectively. Rates of mortality from suicide and undetermined injuries were higher amongst men than women across Enfield, London and England, with 75% of those dying due to suicide or undetermined injury in Enfield in 2008 to 2010 being men (Indicator Portal, HSCIC, 2014).

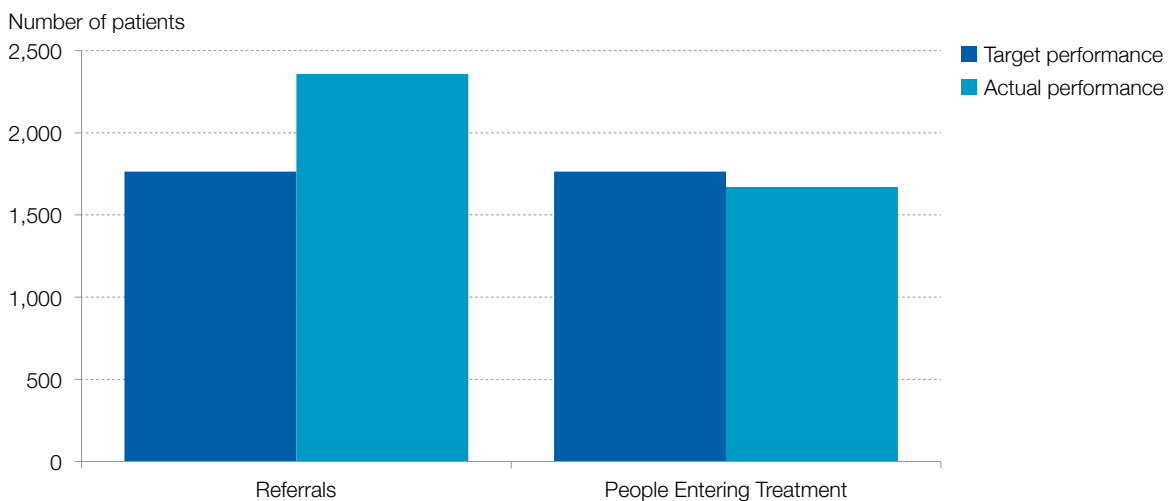
4.5.3 What has been achieved so far?

The London Borough of Enfield has published an Adult Mental Health Strategy Consultation document covering the services commissioned by the Council or Enfield Clinical Commissioning Group, for adults in the borough (London Borough of Enfield, 2014). Further information relating to this document and the services it details or proposes may be found here [http://www.enfield.gov.uk/downloads/file/8495/enfield_joint_adult_mental_health_strategy_2014__2019_draft].

Improving Access to Psychological Therapies

Improving Access to Psychological Therapies (IAPT) is a national NHS programme designed to increase the availability of evidence-based psychological (talking) therapies in local communities to help treat people with depression and anxiety disorders. In Enfield, the IAPT service is delivered by Barnet, Enfield and Haringey Mental Health NHS Trust, in collaboration with Whittington Health.

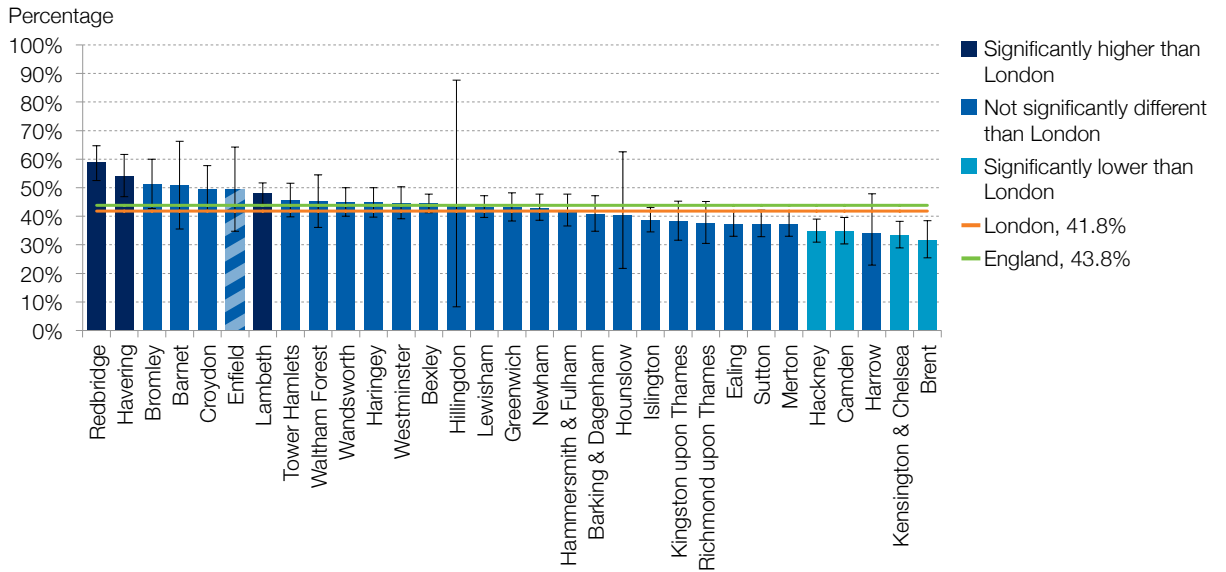
Figure 4.9: Residents aged 16 and over referred to IAPT, and residents entering treatment, compared to target performance, Enfield, 2012/13



Source: Health and Social Care Information Centre

Local data for 2012/13 shows Enfield had a target of 1,763 adults being referred to the service, and 1,763 people entering treatment (Figure 4.9). The number of referrals received by Enfield IAPT surpassed this target, with a total of 2,358 referral being received in 2012/13. However, the actual number of people entering treatment was 1,671, which was 92 people below target, and equating to 71% of referrals entering treatment.

Figure 4.10: Rate of “Moving to recovery”, adults accessing IAPT, London boroughs, 2011/2012



Source: Mental Health Community Profile, Public Health England (PHE)

People with anxiety and depression at their first IAPT session, who complete treatment and are then free from symptoms are said to be “moving to recovery” (Figure 4.10). Enfield had the sixth highest IAPT recovery rate (49%) in London in 2011/12, higher than both the London (42%) and England (44%) rates. Local data for July 2012 to March 2013 shows that Enfield’s IAPT recovery rate varied by quarter; 44% in Quarter 2 (July to September), 35% in Quarter 3 (October to December) and 46% in Quarter 4 (January to March).

Local data also shows that between July 2012 and March 2013, 55 IAPT patients stopped receiving sick pay as a result of improvements in their mental health (Health and Social Care Information Centre, 2013d).

Mental Health and Employment

The Edmonton Life Expectancy Project team is currently working on activities designed to improve mental health outcomes by means of facilitating access to secure employment in Upper Edmonton. This is undertaken in close partnership with both North Middlesex University Hospital and the local Jobcentre.

This activity will continue throughout 2014.

Mental Health Directory

London Borough of Enfield are currently initiating a project to provide a directory of mental health services within the borough, supported as part of the Council’s own public-facing website. This will allow actual and potential mental health service users or others to access information relating to a range of mental health services. This is being developed in conjunction with mental health user-groups.

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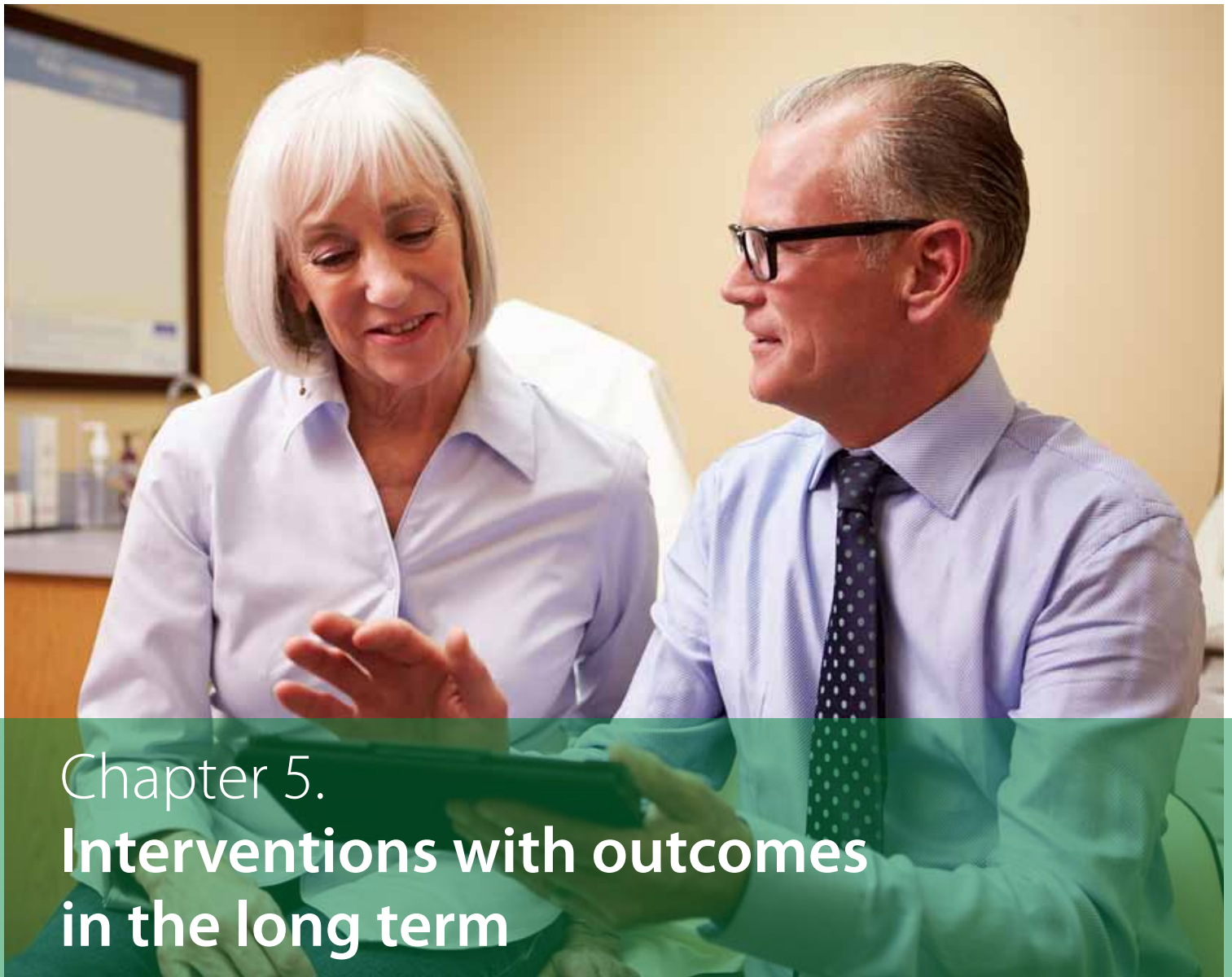
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Chapter 5. Interventions with outcomes in the long term

The environment, social and economic circumstances of people's lives have a huge impact on health and, ultimately, life expectancy.

Issues such as income and poverty, employment, housing, education, environment and crime are referred to as the wider determinants of health. Inequalities in these areas are almost always reflected in inequalities in health and life expectancy for different parts of society.

Any attempt to tackle the gap in life expectancy must also include longer term ambitions to reduce inequalities within society and requires a coordinated approach from many organisations.

The Marmot Review (2010) investigated the differences in health and well-being between social groups and describes how the social gradient on health inequalities is reflected in the social gradient on educational attainment, employment, income, quality of neighbourhood and so on. In addressing health inequalities the Review asserts that it is not sufficient just to focus on the bottom 10 per cent 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.

The actions proposed by Marmot are over the life course, the impact of which will be realised in the long term. In this report, long term interventions are defined as changes which will take over 10 years to have a demonstrable impact in population health, and reduce the gap in life expectancy.

Combined with the life course framework proposed in the Marmot Review and underpinned by systematic diagnostics recommended by the health inequalities national support team (HINST), this chapter focuses on those areas where impact of interventions in the long term can achieve desired population level outcomes.

These include:

- Deprivation and child poverty
- Employment
- Education
- Housing
- Crime
- Environment

For the purpose of this chapter, the 'long term' refers to the gestation period between intervention and desired outcome (0 years to over 10 years) – it does not reflect the time taken to make the strategic change to support the intervention.



5.1 Deprivation and child poverty

Key messages

- Inequalities in **socioeconomic status** have a huge impact on health, health inequalities and the life expectancy gap.
- Enfield is the **14th** most deprived borough in London.
- Enfield is the **64th** most deprived local authority in England out of 326.
- The three Edmonton wards are in the **10% most deprived** wards in England.
- 12 of Enfield's 21 wards are in the **most deprived 25%** of wards in England.
- Almost a **third** of children and young people in Enfield live under the poverty threshold.
- Enfield has the **highest number** child living in poverty in London.
- Enfield has the **6th highest** level of child poverty of in London.
- Enfield has the **10th highest** level of child poverty of in England overall.

5.1.1 Why is socioeconomic status important in reducing the gap in life expectancy?

We know that the causes of good and poor health are complex. The strongest indicators of health inequalities are socioeconomic inequalities and deprivation, which contribute to poorer health outcomes, including incidence of disease and mortality rates.

The Marmot Review (2010) into health inequalities in England, proposed an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age, and which can lead to health inequalities. The review draws further attention to the evidence that most people in England are not living as long as the best off in society and spend longer in ill-health. It proposes a new way to reduce health inequalities in England post-2010, and argues that, traditionally, government policies have focused resources only on some segments of society. To improve health for all of us and to reduce unfair and unjust inequalities in health, action is needed across the social gradient. Premature illness and death affects everyone.

Central to the Review is the recognition that disadvantage starts before birth and accumulate throughout life. This is reflected in the six policy objectives and to the highest priority being given to the first objective:

1. Giving every child the best start in life
2. Enabling all children, young people and adults to maximize their capabilities and have control over their lives
3. Creating fair employment and good work for all
4. Ensuring a healthy standard of living for all
5. Creating and developing sustainable places and communities
6. Strengthening the role and impact of ill-health prevention.

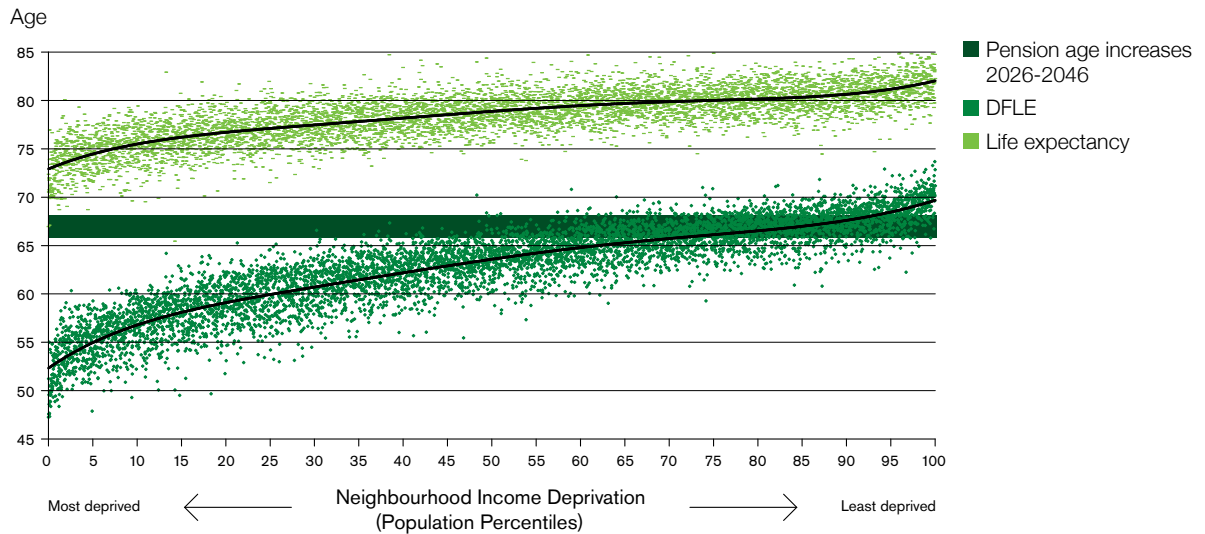
The Marmot Review (2010) is a powerful reminder of the continuing social and economic cost of health inequalities. It presents a robust and well-evidenced case for national and local action to address health inequalities through concerted action. The report identifies local government as a pivotal partner in addressing the social determinants of health inequalities. Local councils have a vital role in building the wider determinants of good health and working to support individuals, families and communities.

Implementation of long term interventions will have an impact in the life course, across all social gradients.

“The benefits of such efforts would be wider than lives saved. People in society would be better off in many ways: in the circumstances in which they are born, grow, live, work, and age. People would see improved well-being, better mental health and less disability, their children would flourish, and they would live in sustainable, cohesive communities” Sir Michael Marmot, 2010.

The Marmot Review (2010) describes the impact of neighbourhood income deprivation on life expectancy and disability free life expectancy (DFLE) nationally (Figure 5.1). This not only shows that people in poorer neighbourhoods have a lower life expectancy, but quality of life is more likely to be affected by disability at an earlier age.

Figure 5.1: Impact of neighbourhood income deprivation on life expectancy and disability free life expectancy (DFLE) nationally



Source: The Marmot Review 2010, Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010. The Marmot Review HM Government 2010

5.1.2 Giving every child the best start in life

The Marmot Review strongly proposes that giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status (The Marmot Review, 2010).

To have an impact on health inequalities the social gradient in children's access to positive early experiences needs to be addressed. Later interventions, although important, are considerably less effective if they have not had good early foundations (Waldfogel, 2004). But more recently concerns have been expressed that child poverty reduction targets cannot be realised through existing policies. The importance of the early years, from pre-birth to the age of 5, to later life outcomes is widely acknowledged and consequently has received considerable policy attention.

Since 1997 the Government has made the reduction of child poverty a top priority and there has been significant investment in the expansion of early year's education and care, extension of parental leave, increased family support through the development of Sure Start Children's Centres and fiscal measures designed to support families with children. This activity represented a revolution in early year's provision and parenting support and, although it takes time to measure the outcomes of early year's interventions, evidence is now emerging that these policies are making an impact (Melhuish et al., 2008).

According to Spencer (2008), experiencing poverty in childhood has important effects on health, including the increased likelihood of:

- Low birth weight
- Unexpected infant death
- Long term illness and disability
- Emotional, behavioural and mental health problems
- Poor nutrition, obesity, smoking, use of alcohol and drugs
- Poor educational attainment.

5.1.3 Deprivation and poverty in Enfield

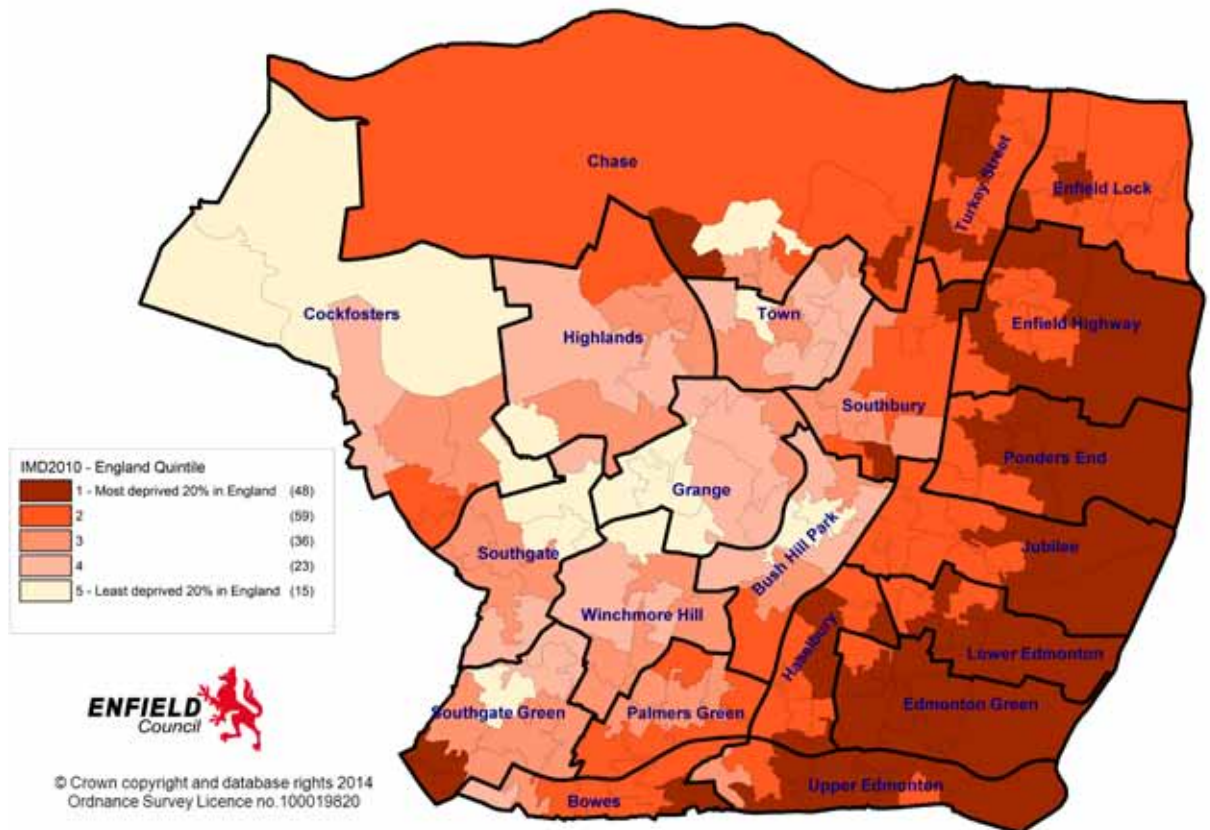
Deprivation can be measured in a number of different ways, but generally the Index of Multiple Deprivation (IMD) is used, which combines a number of social and economic indicators.

Enfield is the 14th most deprived of the 32 London boroughs and the 64th most deprived local authority in England out of 326. The three Edmonton wards, in the South East, are all within the most deprived 10% of wards in England, whilst 12 of Enfield’s twenty-one wards are in the most deprived 25% of wards in England.

The proportion of Enfield’s population living in England’s most deprived areas is increasing.

Overall the deprivation structure in Enfield is very similar to the London average, but more deprived than England, with nearly 60% of the Enfield population falling in the two most deprived quintiles. In Enfield, the more deprived areas, using deprivation quintiles are in the east of the borough, with the south-east of the borough most deprived (Figure 5.2).

Figure 5.2: Index of Multiple Deprivation 2010 for LSOAs in Enfield, based on national quintiles



Source: London Borough of Enfield

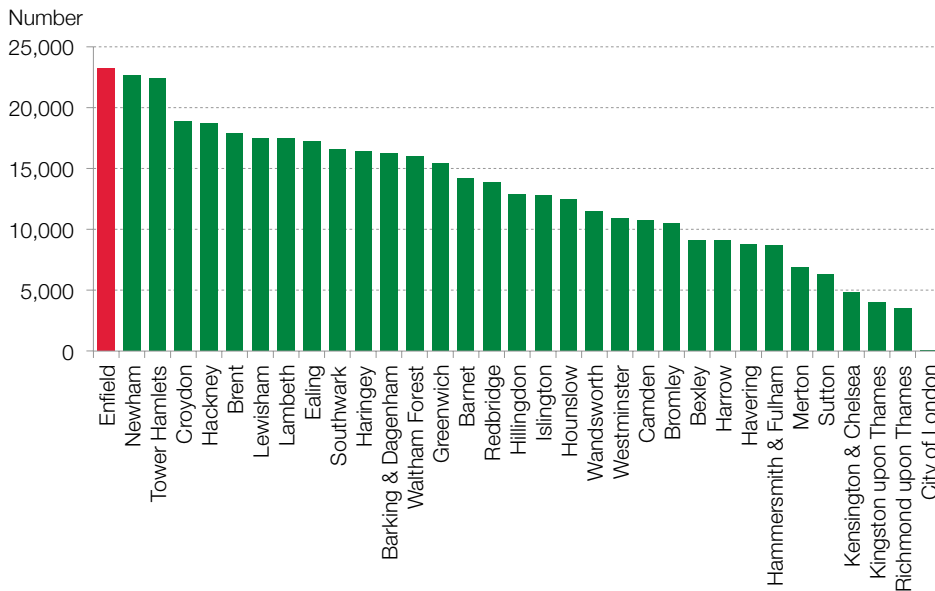
5.1.4 Child poverty in Enfield

The Children in Low-Income Families local measure shows the proportion of children living in families in receipt of out-of-work benefits or tax credits, where their reported income is less than 60 per cent of UK median income.

Enfield’s rate, for all dependent children under the age of 20 was 32.5% in 2011. This was above both the England average (20.1%) and the London average (26.7%). Enfield’s rate was the joint 11th highest in England and the 8th highest in London.

Enfield’s rate, for all children under the age of 16 was 32.8% in 2011. This was above both the England average (20.6%) and the London average (26.5%). Enfield’s rate was ranked 10th highest in England and the 6th highest in London. The actual number of children living in poverty in Enfield is 23,210, which is the highest in London (Figure 5.3).

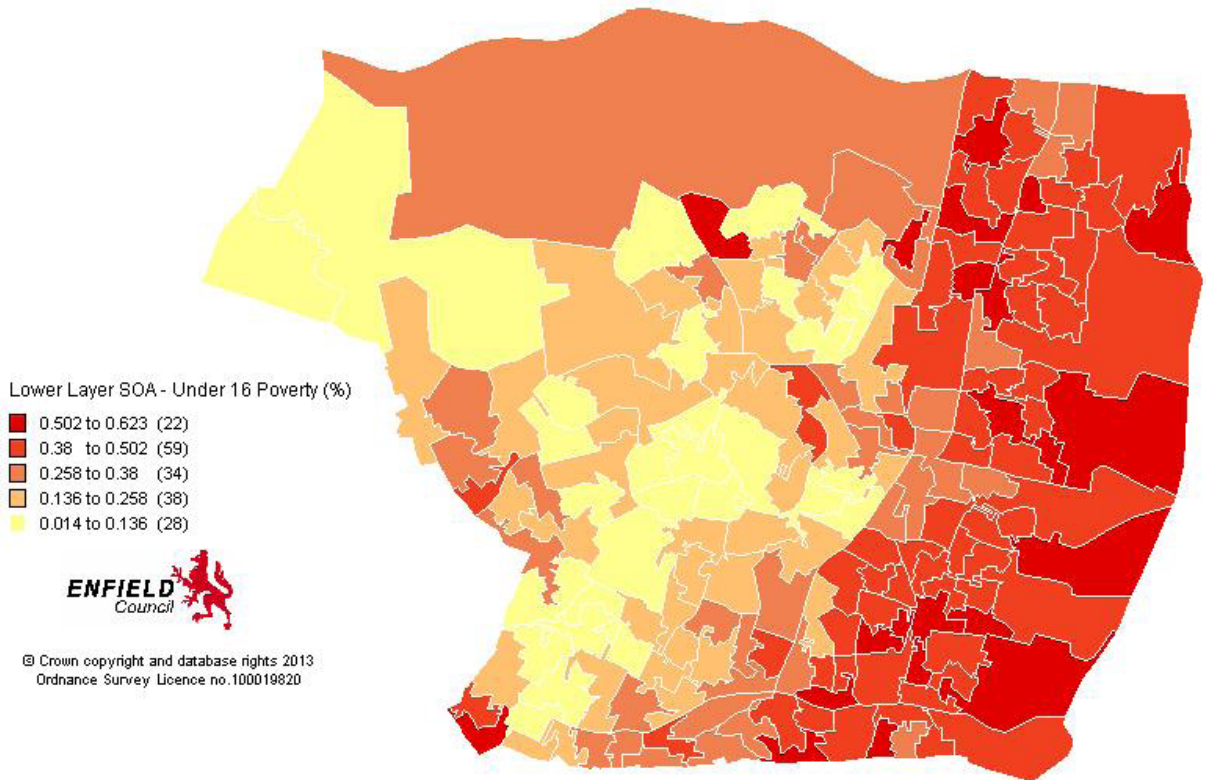
Figure 5.3: Number of children (under 16 years) living in poverty in London, 2011



Source: HM Revenue and Customs – Child Poverty Unit

As with deprivation amongst adults, deprivation amongst children varies widely depending upon geography, with the highest rates in the East of the borough (Figure 5.4).

Figure 5.4: Proportion of Enfield’s Dependent Children Aged under 20 living in Low-Income Families, by LSOA: 2011



Source: HM Revenue and Customs – Child Poverty Unit

Of the 100 areas in London with the highest rates of children in low-income families, four are in Enfield, the highest of any outer London borough.

Tackling child poverty in Enfield is a priority in the Joint health and Wellbeing Strategy with the proposed outcome to reduce child poverty to 25% by 2020. In order to make the high impact improvements in reducing inequalities in child health and reducing child poverty, it is critical to implement Marmot priority objectives (The Marmot Review, 2010):

1. Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
2. Ensure high quality maternity services, parenting programmes, childcare and early year’s education to meet need across the social gradient.
3. Build the resilience and well-being of young children across the social gradient.

There has already been a positive focus on regeneration in Edmonton. In particular, a significant proportion of the ward contains the Meridian Water Regeneration Area, where planning is at an advanced stage to regenerate the area with plans for 8,420 new homes in Meridian Water and its hinterland, new infrastructure and the potential to realise the creation of up to 3,000 new jobs for the area. This means that Enfield Council and all its partners need to ensure that their activities, both in Upper Edmonton and elsewhere, support regeneration.

See also: Enfield’s Child and Family Poverty Strategy (London Borough of Enfield, 2012). Available at: http://www.enfield.gov.uk/ChildrensTrust/downloads/file/77/child_and_family_poverty_strategy_2012

Enfield Employment and Skills Strategy 2014-2017 (London Borough of Enfield, 2014a). Available at: http://www.enfield.gov.uk/download/downloads/id/9228/enfield_employment_and_skills_strategy



5.2 Employment and work

Key messages

- The right kind of work can be **good for health** and helps reduce health inequalities.
- **Unemployment** has significant physical and mental health implications up to and including premature death.
- **13.8%** of the working age population in Enfield overall claim benefits. In Edmonton Green ward the figure is **26.1%**.
- The workplace is also a good place to reach many people to **promote messages** about health.
- Many partners within and outside the Council are working on **increasing employment** prospects for Enfield residents.

5.2.1 Why is employment important in reducing the gap in life expectancy?

Employment is one of the key drivers of health inequalities and therefore the gap in life expectancy.

There is strong evidence that being in work has a positive impact on health and wellbeing – it provides material wellbeing and participation, structure, individual identity, social roles and social status. Most importantly, employment and socio-economic status are the main drivers of social inequalities in health and mortality (Wadell & Burton, 2006).

On the other hand, unemployment has a number of negative effects on health. Unemployed people are more likely to experience limiting long term illness (Bartley, 2004), mental illness (Thomas et al., 2005) and cardiovascular disease (Gallo et al., 2004). They are also likely to use more medication (Voss et al., 2004), have worse prognosis (Jin et al., 1997) and poorer recovery rates (Bartley et al., 2004).

Unemployment has also been consistently associated with an increase in overall mortality.

Unemployment is also associated with increased smoking and alcohol consumption, and decreased physical activity, all of which contribute to poorer health (The Marmot Review, 2010). The 'Working Poor' are also more likely to face poor health. Many are on low pay and can have bad dietary habits along with other issues such as smoking. In fact, having an income sometimes adds to worse outcomes.

To contribute to health, work should be stable, secure pay a living wage, be safe and provide opportunities for work-life balance and personal development. Recent growth in 'zero hours' contracts and other arrangements that restrict job security are of concern.

People who are employed spend a high proportion of their waking hours at work. This means that the workplace can provide an excellent opportunity to promote health messages and encourage healthy behaviour with a view to improving overall health and life expectancy.

Two core policy objectives in The Marmot Review (2010) are important to address inequalities.

1. 'Create fair employment and good work for all'. The priority objectives include;
 - Improve access to good jobs and reduce long-term unemployment across the social gradient.
 - Make it easier for people who are disadvantaged in the labour market to obtain and keep work.
 - Improve quality of jobs across the social gradient.
2. 'Ensure healthy standard of living for all'. The priority objectives include;
 - Establish a minimum income for healthy living for people of all ages.
 - Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies.
 - Reduce the cliff edges faced by people moving between benefits and work.

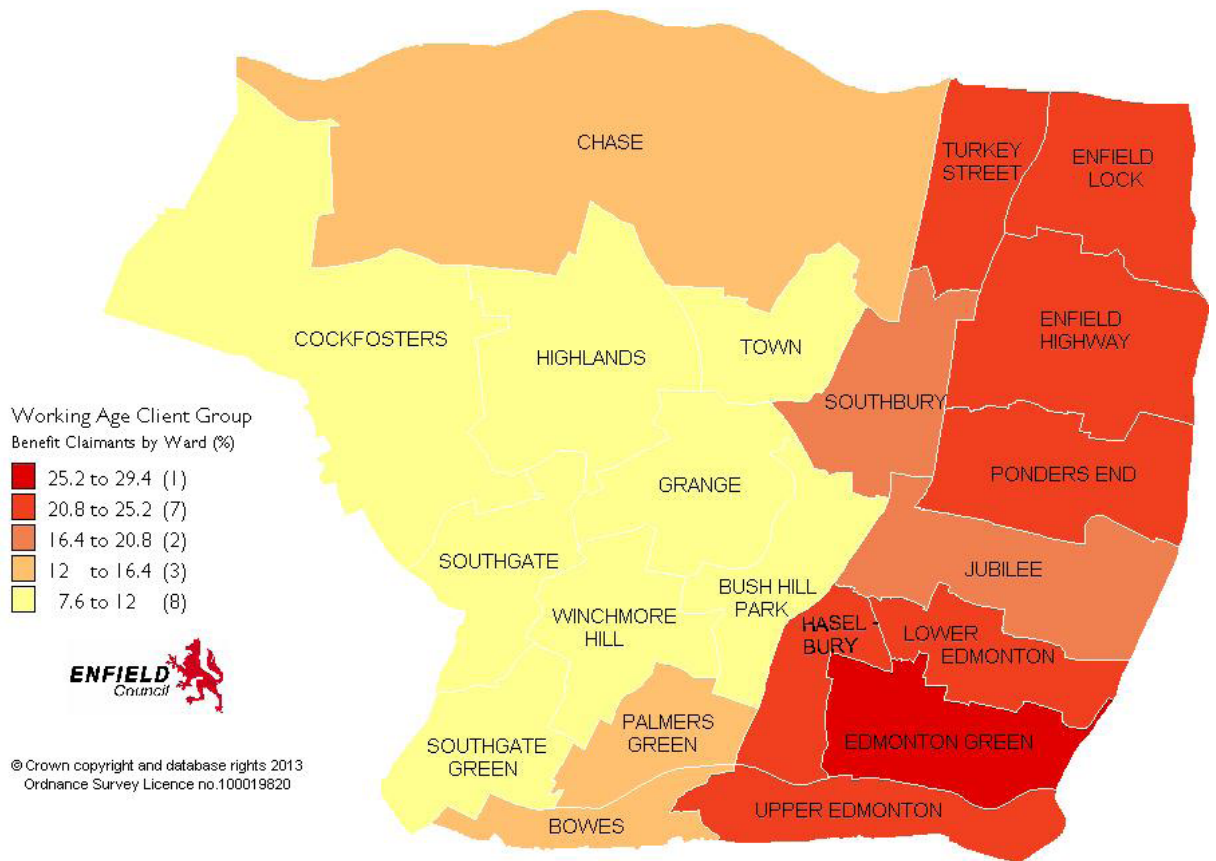
5.2.2 Employment in Enfield

In February 2013, the percentage of the working-age population in Enfield claiming key out of work benefits was 13.8%, above the London (11.3%) and England (11.3%) averages. This includes those on Jobseekers Allowance (JSA), lone parent and other income related benefits, incapacity benefits as well as disability-related benefits, such as Employment Support Allowance (ESA).

These figures vary substantially between wards, whereas Grange, Bush Hill Park, Cockfosters and Winchmore Hill wards all have rates below 10%. In contrast, Enfield Highway, Enfield Lock, Haselbury, Turkey Street, Upper Edmonton, Lower Edmonton and Ponders End all have rates around 20%, whilst Edmonton Green ward has a rate over 25% (Figure 5.5).

However, the numbers of people claiming Jobseekers Allowance has been decreasing over the past year in all areas, in line with national trends.

Figure 5.5: Working age population claiming benefits, by ward, Enfield, February 2013



Source: Office of National Statistics

People in contact with secondary mental health services face particular difficulty in getting paid employment. In 2012/13, only 5% of adults in contact with secondary mental health services (services provided by medical specialists who generally do not have first contact with patients) are in paid employment in Enfield (London Borough of Enfield, 2014b).

It is estimated that 65% of people with learning disabilities would like a paid job (Department of Health, 2009). In 2012/13, 140 of 870 adults (16.2%) who had a learning disability living in Enfield were in paid employment. This figure was the highest seen in recent years.

In a London context, Enfield has the third highest employment rate for adults who have a learning disability. Only Harrow and Bexley perform better than Enfield.

5.2.3 What has been achieved so far?

Increasing employment opportunities in the borough has been a key priority for the Council, in terms of attracting businesses, economic regeneration and improving the skills of residents to meet labour market needs. For more information see the Enfield Council website.

Jobsnet are a team of jobs brokers that work individually with people looking to get into employment. In recent years they have helped hundreds of Enfield residents from all backgrounds into paid work.

Enfield Council has been accredited under the Mayor's office Healthy Workplace Charter for promoting health messages and providing a healthy environment for staff. See case study: GLA Healthy Workplace Charter.

Public Health has been working with partners including Jobcentre Plus, mental health services and the voluntary sector on the issue of mental health and employment. The project has a number of strands, and aims to improve the links between mainstream employment services (such as the Jobcentre) and mental health specialists.

There has been tailored training for Jobcentre staff in Edmonton to be better equipped to recognise and deal with clients with mental health problems.

For overall Council priorities, see Enfield Employment and Skills Strategy 2014-2017 (London Borough of Enfield, 2014a) [Available at: http://www.enfield.gov.uk/download/downloads/id/9228/enfield_employment_and_skills_strategy].



5.3 Education

Key messages

- ▶ **49%** of our children achieve a Good Level of Development at Early Years Foundation Stage.
- ▶ **76%** of primary children achieved the expected level at Key Stage 2, matching the national average.
- ▶ **1-2%** more children made expected progress in Reading, Writing and Maths – Key Stage 1 to 2, compared to national and London performance.
- ▶ **63.2%** of pupils achieve 5 GCSEs at A*-C grade, including English and Maths, compared to national average of 59.2% and 65% for London.
- ▶ **27.8%** of pupils achieved the English Baccalaureate compared to 23% nationally and 28% across London.
- ▶ **4.2%** of 16-18 year olds are not in employment, education or training (NEET), below the national figure of 5.3% but above the London figure of 3.8%.
- ▶ **4** schools have qualified as Silver and **20** at Bronze level in the London Mayor's Healthy Schools London programme.
- ▶ **26** schools at least **Bronze, 15 Gold** as Enfield topped the National School Games Kitemark Awards with the most schools achieving Gold and the highest in North London for the total number of successful applications.

Education and the gap in life expectancy

Education has an impact on health and on life expectancy in a number of ways. Low educational achievement is associated with poverty and deprivation, as well as poor employment prospects, all of which has an impact on life chances and health.

There is also a direct link between education and health; education empowers individuals to make good health choices and people with lower educational achievement are more likely to have poor health throughout life (The Marmot Review, 2010).

Most evidence suggests that investment in the early years is crucial to address inequalities, as is sustained commitment to children and young people through continued family support, education, training and employment.

We know that improving educational attainment and skills, especially amongst disadvantaged groups, is key to reducing health inequalities. Enfield's schools recognise this link and are working hard with pupils and their families to address these inequalities. There are particular concerns around high levels of childhood obesity as observed at Reception and Year 6 and child dental health and tooth decay.

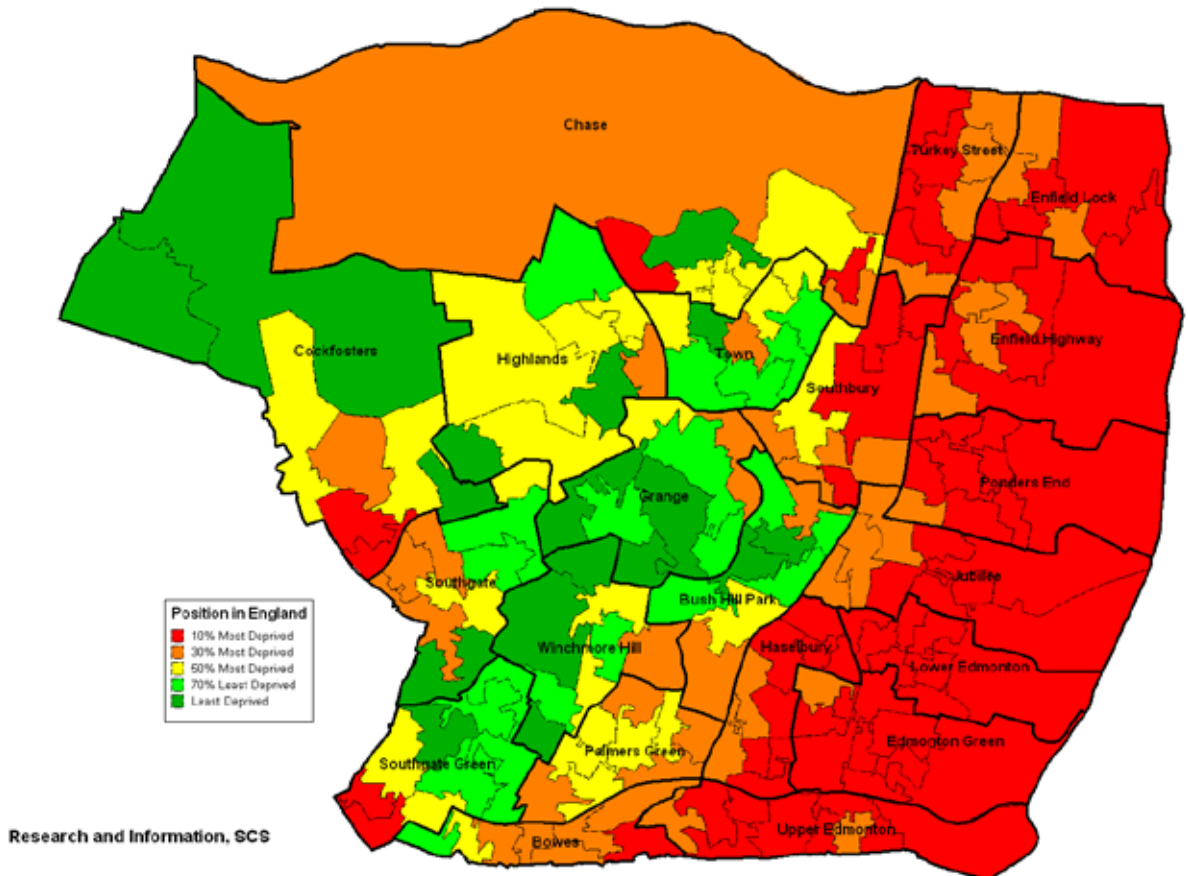
Education in Enfield

Educational attainment has a significant impact on health and health inequalities. Performance across all key indicators shows an improving trend, particularly at secondary school level, but there are still further improvements to be made.

Inequalities in Enfield start at an early age and persist through a child's life. Income Deprivation Affecting Children Index (IDACI) reflects the percentage of children in Enfield living in income-deprived households.

Most of the east and some of south of the borough's LSOAs are in the bottom 10% nationally; but there are also pockets of deprivation across the borough (Figure 5.6).

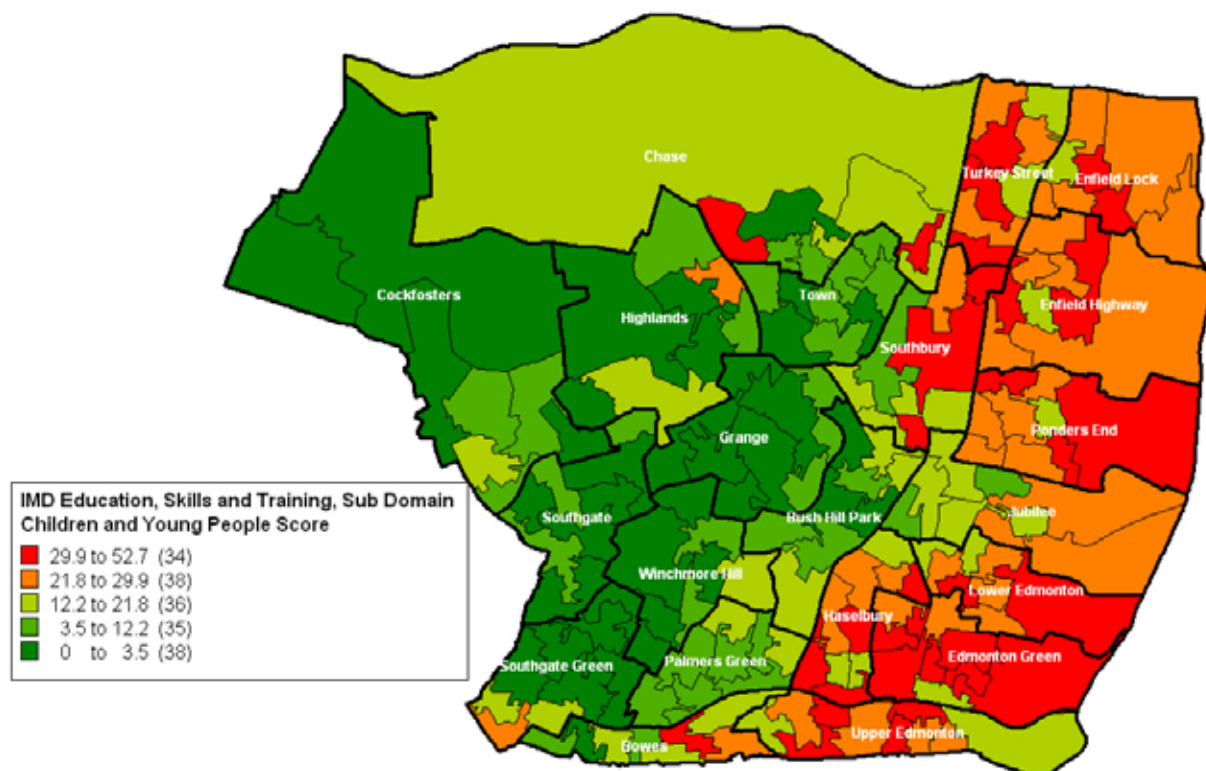
Figure 5.6: Deprivation in Enfield – Income Deprivation Affecting Children Indicator (IDACI) by LSOA, 2010



Source: IMD2010, Department for Communities and Local Government

As these children grow up their relative attainment presents a not dissimilar picture. The Index of Multiple Deprivation (IMD) domain on education, skills and training deprivation, which reflects the ‘flow’ and ‘stock’ of educational disadvantage within an area, captures performance at all key stages throughout a child’s educational career, also highlights that education deprivation is broadly worse on the east of the borough (Figure 5.7).

Figure 5.7: IMD 2010 Education, Skills and Training – Sub-domain: Children and Young People Score by LSOA, 2010



Source: IMD2010, Department for Communities and Local Government

A result of these inequalities is that many children start school well below the expected developmental milestones. This is particularly so in the east of the borough where children are presenting with language, developmental and physical delays. These delays affect the child’s ability to effectively engage with formal learning. Joint working between education and health services in Children’s Centres and other settings is helping to address this issue but more needs to be done.

Whilst the average points score for children at Early Years Foundation Stage Assessment in 2013 at 33 is just above the national figure of 32.8 the proportion of children achieving a Good Level of Development at 49% is below the national figure of 52% and the London figure of 53%.

As children move through Key Stage 1 and 2 and onto GCSEs and A Levels the impact of the work of our schools is seen as these children begin to catch up with their peers nationally.

At Key Stage 2 in 2013 the proportion of Enfield children achieving the expected level of 4+ in Reading, Writing and Maths was 76%, in line with the national figure of 76% but below the London 79%. However, this was a 2% improvement on the 2012 performance, above the national increase of 1% and in line with the London improvement of 2%.

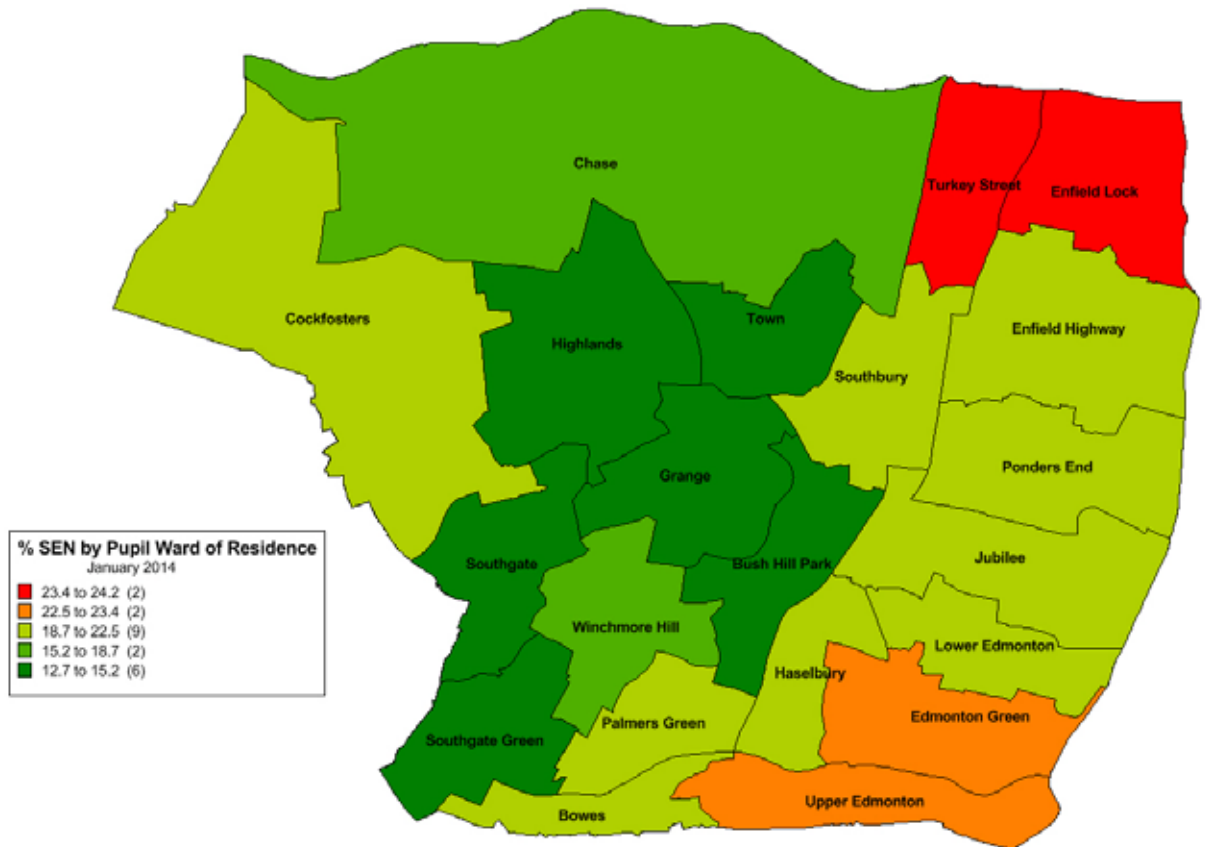
The proportion of Enfield pupils making expected progress was greater across all three subjects than the national – 1% in Reading and 2% in Writing and Maths. The gap between those pupils receiving free school meals and their peers which was already 2% below the national was narrowed by a further 1% and the gap between pupils with Special Educational Needs and Disability and their peers remained 10% below national and 3% below the London gap.

At Key Stage 4 in 2013 the proportion of pupils achieving 5+ GCSEs at A*-C, including English and Maths continued to improve, rising by 7%. At 63% we are 4% above the national and below the London 65%. This improvement is in contrast to the static national figure of 59% and better than the 3% London improvement.

The proportion of Enfield pupils achieving the English Baccalaureate has also improved significantly rising by 8% from 2012 to 28% in 2013. The Baccalaureate is measured on performance at C grade or better across the core subjects. We are well above the national figure of 23% and just below the London figure of 29%.

Some individual children with Special Educational Needs or Disability (SEND) face particular difficulties. There are disparities in the distribution of pupils with SEND across Enfield, with wards in the far northeast and southeast having a higher proportion overall, much higher than the nationally expected proportion of around 20%.

Figure 5.8: Proportion of Pupils with Special Education Needs in Enfield, by Ward, 2014



Source: School Census, Research and Information, SCS, London borough of Enfield

We are also seeing changes in need in terms of numbers, levels and diagnosis. In line with the rising borough population, and in particular, the numbers of school age children, the number of children with SEND has also increased. Therefore in addition to the pressures we face in providing additional school places we also need to provide additional places in special school provision. The proportional rise in the provision of places in our special schools is greater than that in the mainstream settings.

There is evidence of increasing severity of SEND with schools are reporting that the level of need of some young people is more extreme than they have previously experienced. This is putting further pressure on the range of additional and specialist provision.

The type of need is also changing with a significant increase in the number so pupils are being assessed as being on the Autism spectrum or having Behavioural, Emotional or Social Difficulties.



5.4 Housing

Key messages

- **Overcrowding** and **inequalities** in housing have a significant impact on health.
- **50%** of men and **42%** of women living in social housing are in paid work. The median hourly wage for those in work is in the **bottom fifth**.³⁴
- **A third** of social tenants have net incomes below the poverty line.
- In Enfield, there are around **1,400** overcrowded households, of which **170** are severely overcrowded.
- The majority of overcrowded households are in the **private sector**, and the number is rapidly increasing. Private sector tenants have little security and are at risk of frequent moves. This insecurity risks damage to children's health and wellbeing in particular.

³⁴ Bottom quintile of the overall distribution of hourly wages

5.4.1 How does housing affect life expectancy?

There is a great deal of inequality in relation to housing. People living in social housing tend to have lower levels of formal qualifications, are more likely to be unemployed or earning lower wages. A third of social housing tenants have net incomes that put them below the poverty line.

The increasing proportion of Enfield households living in the private sector in insecure as well as very crowded (and in other ways inadequate) housing is of concern. This is especially so for children for whom this lack of security, with the risk of frequent moves, has a detrimental impact on their health and education.

Housing tenure (whether someone owns, rents privately, is in Council or social housing) links to inequalities of income and resources which contribute to health inequalities, ultimately leading to shorter lives for those in the most disadvantaged situations.

Overcrowding and poor housing conditions have a serious impact on health, and is concentrated among those with the lowest income and resources.

The health impacts of overcrowding are significant, including:

- Spread of infectious diseases
- Respiratory conditions in children
- Common mental health disorders
- Accidents around the home
- Tuberculosis for adults

There are also other impacts on wellbeing and relationships, including:

- Stress, tension, and sometimes family break-up
- Anxiety and depression
- A lack of privacy, particularly for adolescents
- Disrupted sleep patterns

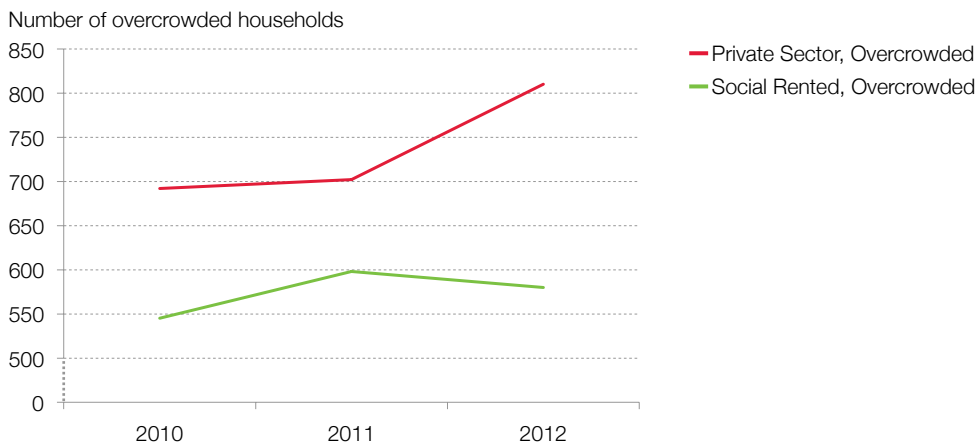
Overcrowding also contributes to health inequalities in other ways, for example disrupting children's education, due to illness and lack of space for homework (Shelter, 2005).

5.4.2 Housing in Enfield

There is a shortage of affordable homes in London (UCL Institute of Health Equity, 2013). Housing problems are particularly acute in the capital because of a shortage of homes and high housing costs. More people may be forced to live poorer housing conditions which may constitute a risk to health (Kaplan, 2012).

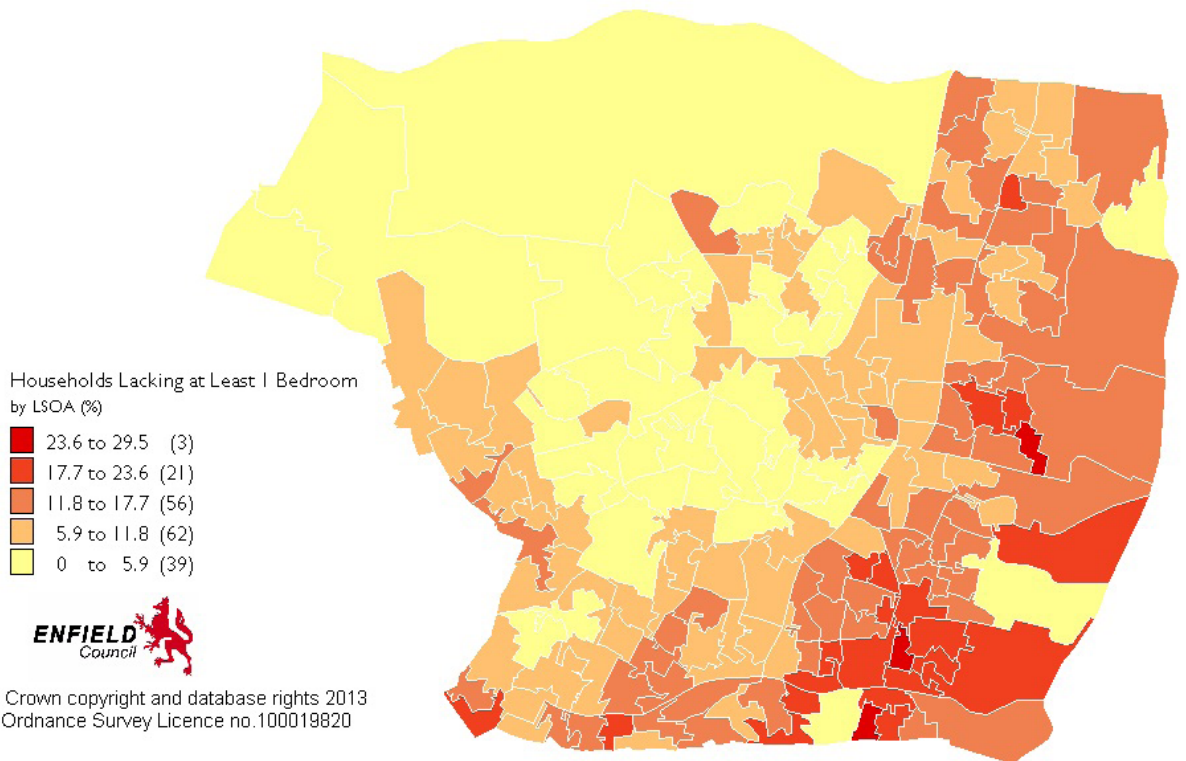
In Enfield, 1,400 households are overcrowded (meaning they lack at least one bedroom), with 170 severely overcrowded (lacking two or more bedrooms). While the problem is decreasing in the social rented sector, it is getting worse in the private sector (Figure 5.9). We also know that overcrowding is a more prevalent problem in the south and east of the borough (Figure 5.10).

Figure 5.9: Overcrowded housing, social and privately rented sector, Enfield, 2010 to 2012



Source: London Borough of Enfield

Figure 5.10: Proportion of households lacking at least one bedroom, Enfield, 2011



Source: Census 2011



5.5 Crime

Key messages

- **22,606 offences** were reported to the police in 2013/14.
- The crime rate in Enfield is **89 offences per 1,000** population, as compared to the London average of 88.7 per 1,000 population.

5.5.1 Why is crime important in reducing the gap in life expectancy?

Crime and how safe people feel in a community is an important indicator of social cohesion and can often reflect inequalities between groups.

While the presence or absence of crime may not impact the life expectancy gap directly, it is an important factor in people's wellbeing and reflects inequalities in socioeconomic status, which lead to differences in health outcomes.

People in the most deprived situations and disadvantaged groups are more likely to be victims of crime, and face the health implications of this.

Furthermore, people in Enfield rated crime and fear of crime as the top concern for good health and wellbeing (London Borough of Enfield, 2014b: see "Enfield Place" chapter of JSNA, p.21).

Although the risk of crime may be over-estimated by some, 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.

5.5.2 Crime in Enfield

In the 12 months to August 2014, the crime rate for all recorded offences in Enfield was 89.0 per 1,000 population compared to the London average of 88.7 per 1,000.

The rate of crimes categorised as 'Violence with Injury' in Enfield (8.4 crimes per 1,000 population) was higher than the London average of 8.1 per 1,000.

Those aged 18-24 and 25-34 years are at most risk of becoming crime victims in Enfield, whilst those aged 15-19 are severely overrepresented as victims of robbery and serious violence, including knife and gun injuries sustained during assaults. Black and Minority Ethnic (BME) groups suffer higher rates of victimisation in most crime categories.

Overall crime rates varied across the borough with those wards in the south and east having rates of up to 120 crimes per 1,000 population. Edmonton Green (120 per 1,000), Upper Edmonton (115 per 1,000) and Southbury (99 per 1,000) all had rates above the London average (93 per 1,000 population), with the lowest rate in Enfield found in Highlands ward with 37 per 1,000 population.

5.5.3 What has been achieved so far?

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

Enfield is one of 33 areas nationally which have been identified as priority area by the Home Office in order to tackle gangs and serious youth violence. The team was awarded the Goldstein Award in 2013 for the work to reduce youth robbery to its lowest recorded levels.

In 2013-14 the Community Safety Partnership Plan focused on;

- Tackling gangs and serious youth violence
- Tackling violence against women and girls
- Reducing serious acquisitive crime (e.g. domestic burglary and robbery)
- Reducing anti-social behaviour.

The SSCB has also identified domestic violence as a particular priority, and is working with health and others to improve responses and early intervention.



5.6 Local environment

Key messages

- The local environment can have an impact on health, especially on **lifestyles**.
- The Council won **£27million** in April 2014 to improve cycling opportunities in the Borough. This will lead to increased levels of physical activity.
- Enfield has **four** large regeneration areas, which will contribute to creating **6,000 jobs** by 2026.
- There are **69** public parks in Enfield.
- Enfield has **2,800** allotment plots for residents.

5.6.1 Why is the local environment important in reducing the gap in life expectancy?

The Marmot Review (2010) highlighted the importance of integrating planning with transport, housing, environment and health in order to create the biggest impact when tackling health inequalities.

The design of local neighbourhoods can have a huge impact on health, for example encouraging cohesion and participation, improving accessibility to services and increasing transport options.

The local environment can enable people to make healthier choices and pursue healthy lifestyles, for example by making it easier to walk, cycle and exercise in the local area. Much has been done to improve the night-time economy by tackling hotspots for violence.

Improving access to green space also has positive impacts on physical and mental health.

The local environment can have a significant impact on increasing physical activity, which helps to prevent a number of diseases including obesity, cardiovascular disease, and cancer, the biggest causes of premature death in Enfield.

5.6.2 Enfield: Environment and Regeneration

There are over 2,000 hectares of publicly accessible open space in Enfield. About a third of this is public parks, a third is playing fields, and the remainder is made up of allotments and green space in residential areas.

5.6.3 Air Pollution

There is categorical evidence that everyday air pollution causes heart disease and lung cancer. The most important air pollutant we breathe is particulate matter (PM). This comprises of soot, carcinogenic part burnt fuel, metal particles from car engines and silica, bitumen, rubber and other waste matter from road surfaces as well as dust and soot from construction and heating. Most PM emissions are caused by road traffic though construction sites with high volumes of dust and emissions from machinery are also significant sources.

The Greater London Assembly (GLA) estimated that in 2008 there were 4,267 deaths in London that were attributable to long-term exposure to small particles.

Manmade PM_{2.5}³⁵ alone is estimated to reduce average life-expectancy in the UK by 6 months. In 2008 29,000 premature deaths were attributed to long-term exposure to PM_{2.5}.³⁶ In Enfield it was estimated that there were 178 deaths. In addition the Health Effects Institute concluded that there is a causal link between exposure to traffic related air pollution and exacerbation of asthma.



The data are suggestive of though not sufficient to fully support causality between onset of childhood asthma, non-asthma respiratory symptoms, impaired lung function, total and cardiovascular mortality, and cardiovascular morbidity. There is a growing body of evidence that prenatal exposure to air pollution is associated with low birth weight, intrauterine growth retardation, and an increased risk of chronic diseases in later life and that long-term exposure to PM at levels seen in major cities can alter emotional responses and impair cognition.

Measures to reduce the speed and volume of motor traffic and increase walking and cycling would also have a number of co-benefits. These could include reducing mortality and morbidity from road traffic collisions, reducing falls and hip fractures, increasing perceptions of safety, increased social connectedness, reduced childhood and adult obesity, reduction of diabetes, increased mental health, reduced deaths from cancer and cardiovascular disease, reduction of noise pollution and increased musculoskeletal health.

³⁵ Particulate matter (PM10 and PM2.5) is a complex mixture of non-gaseous particles of varied physical and chemical composition. It is categorised by the size of the particle (for example PM10 are particles with a diameter of less than 10 microns)

³⁶ Particulate matter (PM10 and PM2.5) is a complex mixture of non-gaseous particles of varied physical and chemical composition. It is categorised by the size of the particle (for example PM10 are particles with a diameter of less than 10 microns)

5.6.4 What has been achieved so far?

The Parks Service has been addressing many health issues through the Healthy Walks programme. The programme is delivered in partnership with the Sports Development Team, and packs of information are passed to GPs to enable referrals into the organised walks project.

The range of facilities for children's play has improved considerably over recent years.

Enfield's Spatial Strategy, set out in the Core Strategy, seeks to focus growth within four broad locations, referred to as Regeneration Priority Areas (London Borough of Enfield, 2010, p.29).

These are:

- Central Leaside: a large area in the south-east of the Borough where growth will be focused south of the North Circular in an area known as the Meridian Water Regeneration Area
- North East Enfield
- North Circular Road
- Enfield Town

A further area at Edmonton has been identified as a focus for growth and regeneration which will be the subject of a master plan.

The Core Strategy states that Enfield will see a growth of a minimum of 6,000 jobs by 2026. It is anticipated that 4,000 of these jobs will be in the Upper Lee Valley and 2,000 will be provided in other town centres and the Regeneration Priority Areas. These numbers are considered to be the minimum level of anticipated growth in the Borough (London Borough of Enfield, 2010).

Proposed developments in these areas include improvements to road networks, public transport and access to open space, new cycle routes and new health, education and community facilities.

Green Gym is an initiative of the BTCV, a UK environmental volunteering charity that can improve your fitness while helping the environment.



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Chapter 6. **Working together to tackle inequalities**

This chapter consists of the independent contributions of over two dozen authors from across Enfield's statutory, voluntary, community, business sectors, London Borough of Enfield colleagues and partners from pan London and national organisations. It describes some, but not all of the partnership work being carried out across Enfield to address the determinants of health and wellbeing described in the report, and to improve local health outcomes.



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Heart Town Partnership

Stephanie Davenport – Fundraising Volunteer Manager – British Heart Foundation

Glenn Stewart – Assistant Director Public Health – Public Health – Enfield Council

Heart Town Partnership – As part of the Heart Town Partnership with the British Heart Foundation (BHF) the Public Health team have promoted the BHF's heart health messages across the Borough. Activities have been focused around healthy eating, keeping fit and quitting smoking. The Public Health department have used a variety of the BHF's free resources to promote these issues.

We will soon have anonymous electronic access to GP records which will allow us to better understand where healthchecks have been offered and delivered and what happened as a result of the healthcheck. This will enable us to ensure that the healthchecks programme is as effective as possible.

Achievements include:

There have been a number of events or initiatives to improve heart health in the borough. These include:

- February Ramp Up in Red event in Edmonton, to promote physical exercise and healthy eating
- Collection points for old clothes/toys/electrical equipment etc. for BHF shops
- Increasing the number of healthchecks delivered to residents from 5,503 to 6,199
- The provision of healthchecks not just through GPs but also in the community targeting areas of deprivation and patients unlikely to be registered with GPs
- Helping over 1,580 people to stop smoking with another 100 from areas of deprivation in the borough.

Future Plans

Heart health is affected by a number of factors including smoking, physical activity, poor nutrition and alcohol consumption. We are therefore developing and delivering training programmes on all aspects of lifestyle (Moving, Eating, Drinking, Smoking – MEDS) throughout the Local Authority.

Enfield has won £27m to improve cycling in the borough. This will help to make physical activity part of people's everyday lives rather than something that needs to be thought about and planned. This is a 6 year project through for which it will be important to implement best practice in changing people's mode of transport. Work is also planned to estimate the amount of pollution avoided through reduced motorised transport.

It is estimated that up to 50% of some BME populations smoke. We have commissioned research into the reasons for smoking initiation and what might prevent it with funding from Public Health and the Chief Executive's Directorate. The greatest health gain from smoking is to ensure that people not start to smoke, we are therefore developing work to not only help people to stop smoking but to help prevent people from starting.

UCLPartners

Academic Health Science Partnership

Professor David Fish – Managing Director – UCLPartners

UCLPartners' purpose is to translate cutting-edge research and innovation into measurable health and wealth gains for patients and populations across our designated area, across the UK and globally. This is achieved through partnership working and ensuring all work is:

- Patient-led and population-focused; taking a system-wide (rather than institution-based) view
- Delivered rapidly and at scale across defined populations with an emphasis on continually improving health outcomes and value
- Cross-boundary; spanning primary, community, secondary and tertiary care, and connecting different phases of academic research – from those focused on discovery to those concerned with improving models of care and capability building
- Drawn from academic expertise within the wide range of disciplines found in multi-faculty universities, from computational sciences to humanities, anthropology to bioengineering.

As a partnership we are committed to focusing programmes of work to support earlier intervention and primary health care, as we believe this is where the biggest differences can be made. For example, the cardiovascular programme has initiatives to address atrial fibrillation (AF), which affects around a million people in the UK. AF is associated with one in eight strokes overall, and one in three in people over 80 years of age. More than half these strokes could be averted by oral anticoagulation (OAC), but the proportion of the population at risk who are on anticoagulant drugs has improved by only 1.5% per year over the last quarter century (only 50% in 2012).

Currently the identified prevalence of known atrial fibrillation across UCLPartners is only 1.07% (61,764 persons QOF 2012/13), much below the national average of 1.52%. We are currently working with six CCGs to increase detection and management of AF. If we increased the detection to meet the national average across the whole partnership we would identify a further 25,698 people with AF who could then have the opportunity for preventative strategies to reduce the risk of stroke. Increasing identification and delivery of evidence-based care for people with known AF could prevent approximately 700 strokes annually across UCLPartners; avoid the associated distress and disabilities caused by strokes, save 210 lives and avoid around £7m in costs.

Achievements to date

The Atrial Fibrillation Programme East London (APEL) has been adapted by UCLPartners in an attempt to increase the pace of change from three years to one year, considering the risk of patients with AF having a stroke in a three year period is greater. It has been successfully applied over a six-month period across a north central London CCG. This adapted model has already delivered significant impact by increasing the CCG QoF anticoagulation rate by 9% – from 55% at start of October 2013 to 64% at start of April 2014. This means an extra 131 patients were anticoagulated since the project started. The exception reporting for AF QoF in the borough has reduced by 5% from 27% to 22%.

Community Engagement

Chartered by nursing directors and medical directors from member organisations across our partnership in 2010, the Quality Forum is a quarterly sharing and learning event hosted in rotation by our members. The Quality Forum began as a group of 15-25 senior clinical leaders from our acute NHS trusts and has progressively grown to span colleagues from primary and community care and mental health. The group now numbers more than 60 and includes clinicians, managers, academics, trainees and fellows.

The Quality Forum has been hosted by partner organisations of all types, and increasingly is hosted jointly by commissioning and provider organisations. As of summer 2013, sixteen forums had been held. Participants come from over 30 organisations with over 95% participants rating the forum excellent or very good in terms of value for time spent. The forum regularly attracts 80-100 people.

Future Plans

The UCLPartners cardiovascular prevention lead chaired the board of the Joint British Societies consensus recommendations for the prevention of cardiovascular disease. The guidelines and a new personalised tool for calculating CVD risk were launched in March 2014. UCLPartners is working with Public Health England on national implementation linked to a health checks programme. Funding for a test site has been secured from a partner CCG. A working group has also been established to develop a 'brain age' metric aligned to the JBS3 'heart age' calculator given the strong link between cardiovascular disease and cognitive decline. An implementation plan for a linked CVD/dementia tool is being developed with Public Health England.

Cancer Early Diagnosis – Cancer Research UK Primary Care Engagement

Steven Prosser – Primary Care Engagement Facilitator – Cancer Research UK

Cancer Research UK (CRUK) is partnering with the NHS and Clinical Commissioning Groups (CCGs) to help improve early diagnosis and cancer outcomes in primary care. The programme has an overall aim to improve 1 year survival rates from cancer and it anticipates doing this by offering intensive support to local Primary Care organisations and commissioners.

The project aims to engage with all general practices in Enfield and support those practices to implement simple action plans to drive early diagnosis and other priorities identified by the practice which leads to improved cancer outcomes.

Achievements include:

1. 34/51 practices have welcomed a visit from a CRUK Primary Care Facilitator.
2. At least one GP has been present at every practice.
3. Cancer specific GP education event was organised in November 2013 at West Lodge Park.
4. 93% of practices expressed an interest in completing an audit of cancer diagnoses and/or urgent cancer referrals.
5. 54% requested additional Cancer Decision Support Tools to support them in deciding which patients to refer urgently for investigation.

Community Engagement

There is the potential for the Primary Care Facilitator to work locally with public health and General Practices to engage communities in key cancer prevention services, such as stop smoking and cervical screening.

Future Plans

Support practices with specific needs around:

- Safety netting
- Read coding and using IT systems
- Promoting patient uptake of cancer screening services.

Continue to organise and support regular cancer specific GP educational events.

Community Cardiology Service

Florence Cante – Transformation Programme Manager – Enfield Clinical Commissioning Group

Community Cardiology Services have been commissioned since April 2013 to serve the needs of Enfield patients by delivering specialist care closer to home, at locally negotiated tariffs that realise some cost savings. The current providers are Barnet and Chase Farm Hospitals NHS Trust, North Middlesex University Hospital NHS Trust and Enfield Community Service (part of BEH Mental Health NHS Trust).

The service incorporates cardiology triage carried out by a specialist who will review all non-urgent referrals for appropriateness, provide access to specialist advice and treatment planning for continuing management of patients within primary care, thereby enhancing the on-going skills and knowledge of GPs and Nurse Practitioners. For those who provide more specialist intervention, community cardiology clinics will provide first and follow-up appointments (including specialist nursing heart failure services), diagnostics including imaging, echocardiograms, ECGs and 24 hours tapes.

The service will be delivered from the current acute trust sites in 2013/14 and 2014/15. Based on the findings of an audit of 100 non-urgent cardiology specific referrals, it has been estimated that the service will provide capacity to manage approximately 40% of referral activity within the community clinics and a further 10% triaged and referred back to the GP with advice and/or treatment planning support.

Achievements include:

The current contract was for one year and has now been extended for a further year to enable redevelopment of services in a timely manner.

ECCG will accept referrals where pre-referral work up diagnostics have not been carried out and will perform diagnostics in acute setting at locally agreed tariff (Referral amnesty). This was put in place to improve activity levels and the referral amnesty will continue until further notice.

Future Plans

A formal review of the service is being planned.

A whole system approach to cardiology in Enfield is being explored and a co-design workshop is to be held in early June 2014 to discuss the opportunities for further integration within cardiology through acute, community and primary care settings.

Enhancing Cardiology in Primary Care Pilot Project (1)

Atrial Fibrillation Pilot Project (Enfield – Edmonton 17 GP practices)

Susan Lloyd – Public Health Consultant – Public Health – Enfield Council

Florence Cante – Transformation Programme Manager – Enfield Clinical Commissioning Group

Mirek Skrypak – Prevention Programme Manager – UCL Partners

The main objectives of this pilot project are to:

- Prevent strokes and reduce hospital incidents and costs in the care for patients with stroke
- Increase in anticoagulation over next 3 years
- Decrease in proportion of people with Atrial Fibrillation on aspirin

Improved management of blood pressure, cholesterol and other risk factors would yield further reductions in stroke and improved monitoring and reduction of aspirin (including inappropriate 'dual' therapy) would reduce major bleeds.

The following would be implemented by the pilot GP practices in the South East locality of Enfield for the service delivery of AF. If the pilot is proved successful, the service deliverables will be reviewed to ensure a smooth roll out across the borough in 2015/16.

Deliverables

The following would be implemented by the pilot GP practices in the South East locality of Enfield for the service delivery of Atrial Fibrillation.

1. Integrate the GRASP-AF/APEL tools into each Enfield GP pilot practice

The National Improvement Team has developed the GRASP-AF tool to support the increased identification of people with atrial fibrillation and to improve the medical management of this condition. The North East London Clinical Effectiveness Group (NEL CEG) have developed a more advanced tool.

The GRASP-AF/APEL tools provides a set of MIQUEST/Emis Web queries to identify patients with a diagnosis of AF, calculates their stroke risk using the validated CHADS2 scoring system and the CHA2DS2-VASc scoring system. The tools highlight patients with a CHADS2 score of 2 or more or CHA2DS2-VASc of 1 or more not receiving warfarin who would benefit from review to assess the appropriateness of anti-coagulation.

The National Improvement Team and the CEG recommend that the tools should be re-run as part of an audit cycle to optimise the management of AF to reduce the risk of stroke; this project would look to implement this recommendation by providing training to practices so that the use of this tool can be sustained beyond the life of the project.

Training will be provided to Enfield GP IT lead (and team) so that on-going technical support for the GRASP-AF/APEL tools can be provided to GP services after this project has been completed.

2. Promote opportunistic screening initiatives in GP pilot practices

The GRASP-AF/APEL tool also identifies patients with possible or probable AF, highlighting patients who would benefit from targeted screening. As part of the GRASP-AF/APEL tools implementation this project would support practices to integrate a pulse check into existing reviews that this group of patients may attend.

Evidence³⁷ suggests that diabetes mellitus (DM) and Atrial Fibrillation share common antecedents such as hypertension, atherosclerosis and obesity.

3. Identify and target Enfield specific at risk populations for Atrial Fibrillation screening

Utilising existing information sources; QoF, HES, Public Health data, Stroke Sentinel National Audit Programme (SSNAP), map the population of the borough, applying criteria to identify the volume of the population with AF risk factors.

Communicate this information to those involved in the care delivery for people within these populations and provide education opportunities to highlight AF screening and management.

This in-depth analysis will enable localised targeted screening opportunities to developed and conducted across the borough.

37 Sun Y, Hu D. The link between diabetes and atrial fibrillation: cause or correlation?. J Cardiovasc Dis Res [serial online] 2010 [cited 2012 Jun 8];1:10-1. Available from: <http://www.jcdonline.com/text.asp?2010/1/1/10/59978>

4. Providing all pilot practices with best practice information on the management of AF

Provide GP services with a copy of/access to the ESC guidelines (2012) on the management of Atrial Fibrillation³⁸ or similar. Integrate best practice information into regular communications from the project team and into the education suite.

5. Deliver AF education sessions for pilot practices

When implementing the GRASP-AF/APEL tools, discuss with GP services the take home messages from the ESC guidelines (2012) on the management of Atrial Fibrillation as well as the key messages from the RCPE UK Consensus Conference on “Approaching the comprehensive management of Atrial Fibrillation: Evolution or revolution?” consensus statement³⁹, and workshop how these can be integrated into the service’s current practice.

In addition the following would be provided:

A. Run education workshops for primary care professionals to include –

- Enfield’s AF public health profile
 - Atrial Fibrillation clinical sessions led by expert GP/Cardiologist/Stroke Physician
 - Best practice anticoagulation

B. Provide practices with knowledge of, and access to, appropriate local anticoagulation pathways

6. Develop and integrate alerts and a clinical template for all primary care systems in pilot practices

Pop-up reminders/template modification to those groups of patients identified as being at risk of AF and that could therefore benefit from a pulse check. This would be based on the public health analysis outlined above as informing the development of screening opportunities. This could include, but is not limited to; long term conditions review for those patients registered with DM in the at risk age group for AF. This would be developed in conjunction with EMIS and Vision, so that they are integrated seamlessly into existing primary care IT environments.

7. Establish mechanisms for regular (quarterly) practice performance reporting utilising existing data sources and infrastructure

Develop localised Map of Medicine anticoagulation pathway so that existing service details and referral information is included.

Review the method that results from anticoagulation clinics are communicated back to GP services, highlight possibilities for further development. It is potentially possible to integrate results of blood tests ordered by hospital anticoagulation clinics with practice electronic systems which would further integrate services and improve patient experience. However, this would be beyond the first phase scope of this project.

8. Provide all pilot practices with knowledge of, and access to, appropriate local anticoagulation pathways

- Delivery Team
- Project Manager to be recruited
- Clinical Effectiveness Group – Queen Mary University London
- Enfield CCG hosting this project with Enfield Public Health and UCLPartners steering and overseeing project delivery

Achievements include:

1. Recruiting to posts.
2. Engagement plan which includes local primary care localities and GP sites and secondary care cardiovascular pathways including stroke, haematology and cardiology directorates.

Future Plans

Aim to start the pilot project in July 2014 for a period of 12 months. Pending evaluation and outcomes this project will inform the primary care prevention strategy and direction, potentially being rolled out across the remaining CCG GP sites.

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38 The Task Force for the Management of Atrial Fibrillation of the European Society of Cardiology (ESC), Guidelines for the management of atrial fibrillation. *European Heart Journal* (2010) 31, 2369–2429 doi:10.1093/eurheartj/ehq278. Available from: <http://www.escardio.org/guidelines-surveys/esc-guidelines/GuidelinesDocuments/guidelines-afib-FT.pdf>

39 Authors/members of Consensus Panel: Stott DJ (Chair); Dewar RI, Garratt C J, Griffith KE, Harding NJ, James M A, Lane D A, Petty DR, Smith PA, Somerville M H, Trueland J. RCPE UK Consensus Conference on “Approaching the comprehensive management of Atrial Fibrillation: Evolution or revolution?” (1 & 2 March 2012). Available from: <http://www.rcpe.ac.uk/clinical-standards/standards/rcpe-af-consensus-statement-2012.pdf>

Enhancing Cardiology in Primary Care Pilot Project (2)

Secondary Prevention: retrospective case records review pilot project (Enfield – Upper Edmonton 17 GP practices)

Susan Lloyd – Public Health Consultant – Public Health – Enfield Council

Florence Cantle – Transformation Programme Manager – Enfield Clinical Commissioning Group

Mirek Skrypak – Prevention Programme Manager – UCL Partners

It appears that secondary prevention management is affected by numerous factors and as much as 30% of patients, who have had heart attacks and strokes, may not be on appropriate secondary prevention even though there are financial incentives for it.^{40 41}

The project will review 3 years of data from the Myocardial Infarction National Audit Project (MINAP) at the National Institute for Cardiovascular Outcomes Research (NICOR) for Enfield patients with diagnosed heart attacks and 3 years of data for Enfield patients diagnosed with stroke from North Middlesex Hospital. The Enfield Stroke Register has every stroke admission recorded since January 2009. The MINAP database has the equivalent for myocardial infarction admissions for Enfield patients. These two patient related data sets will identify the case records that will propagate the reviews of case records in secondary care and later on in primary care. Retrospective case record reviews of secondary care admissions for heart attack and stroke from the years of 2009 to 2012 will be able to be conducted, and likewise these will then be followed through to primary care. A research fellow trained and guided by cardiac and stroke clinical academic leads, who are part of the research team, will conduct the retrospective case record reviews according to predetermined templates.

This will give us insight into secondary prevention of CVD following a CVD event. This will be a retrospective audit and will allow us to communicate findings relatively early on to Enfield CCG and Enfield Public Health from a service improvement point of view.

The project manager then visit the GP practices where these patients are based and review the registers with the GP to see if patients are appropriately managed as per the NICE guidance.

Elements of the retrospective case recorded review methodology will be repeated in primary care and this information will create a detailed database for each acute coronary and stroke patient who consents to the project. This will determine the type of stroke or acute coronary event and identifiable risk factors together with a detailed analysis of health records. The patient's GP who would have been involved in the care pathway will be contacted and permission sought to access and study all relevant health records in detail. This will enable searching of not just electronic records but also written medical notes, especially if the patient had a cardiovascular disease history before 1997 when electronic records in primary care were commissioned.

The retrospective case record reviews will enable data sets for each cardiovascular disease presentation to secondary care, combined with primary care records, to be categorised into as many categories as possible according to the modifiable cardiovascular disease risk factors such as hypertension, smoking, cardiovascular disease history, cholesterol and atrial fibrillation. The information that is captured from the retrospective case record reviews will then inform emerging themes.

Evaluation of the retrospective case records review

Aims:

- Quantify the number of people who are and who are not accessing the optimal secondary prevention pathways
- Work with the local GP population to improve optimal secondary prevention for their patients
- Reduce number of subsequent CVD events post heart attack and stroke diagnosis through optimal secondary prevention
- Collaboratively develop with Enfield CCG and Enfield Public Health approaches to secondary prevention of CVD events that are patient focused and led through appropriate empowerment and support from primary care
- Generate hypotheses following analyses of anonymised project data focusing on future research

40 French, J & Blair-Stevens, C (2010) "Using social marketing to develop policy, strategy, and operational synergy". In J. French, C. Blair-Stevens, D. McVey & R. Merrit (Eds). *Social Marketing and public health: Theory and practice*. Oxford, UK: Oxford University Press. pp 67-79

41 Keller H & Thackeray R (2011) "Social Marketing and the Creative Process, Staying True to Your Social Marketing Objectives" *Health Promotion Practice* September 2011 Vol 12 No 5 pp 651-653

Delivery Team

- Project Manager to be recruited
- Stroke Clinical Lead (from North Middlesex Hospital)
- Cardiac Clinical Lead (from North Middlesex Hospital or UCLH)
- MINAP dataset from the National Institute for Cardiovascular Outcomes and Research
- Enfield CCG hosting this project with Enfield Public Health and UCLPartners steering and overseeing project delivery

Achievements include:

3. Recruiting to posts.
4. Engagement plan which includes local primary care localities and GP sites and secondary care cardiovascular pathways including stroke, haematology and cardiology directorates.

Future Plans

Aim to start the pilot project in July 2014 for a period of 12 months. Pending evaluation and outcomes this project will inform the primary care prevention strategy and direction, potentially being rolled out across the remaining CCG GP sites.

Integrated Diabetes Programme of Care

Florence Cantle – Transformation Programme Manager – Enfield Clinical Commissioning Group

The Integrated Diabetes programmes focuses on systemic change of care delivery, integration of services and a whole system approach to managing patients with diabetes. It is aligned with the national best practice guidance to commissioning diabetes services (Diabetes UK, March 2013).⁴²

The programme looks to integrate specialist and primary care diabetes services. The enhanced model places a much stronger emphasis on ensuring coordination and collaboration between the providers of diabetes services, and moving further away from silo organisational working.

There will be a four-pronged approach to management of diabetes in Enfield which is:

1. Primary prevention and early identification
2. Enhanced initial management of diabetes (including self-management)
3. Integrated community based multidisciplinary diabetes care
4. Diabetes hypoglycaemia pathway optimisation

It is proposed that GP practices in Enfield work in 'networks' in order to enhance the diabetes care in primary care for patients with diabetes. The aim of the network based diabetes care package is to:

- Identify people at risk of developing diabetes
- Provide appropriate interventions to enable patients to be managed in primary care
- Ensure that patients are actively engaged in care planning of the management of diabetes
- Ensure a multi-disciplinary team approach is in place within the network to provide an integrated diabetes programme of care to the diabetes population in Enfield

Achievements include:

Funding has been secured to pilot the network based diabetes care package in the South East Locality of Enfield. The implementation plan is underway to ensure that this will be in operational in September 2014.

Enfield CCG have agreed to expand the community diabetes specialist service during the transitional period in 2014/15 and the additional resource will support the shift of diabetes activity from acute to community and will

also support the hypoglycaemia management pathway for patients with hypoglycaemia following discharge from A&E and from London Ambulance Service.

The community diabetes specialist nursing team will be part of the multidisciplinary team to support the network based diabetes care package in South East locality of Enfield.

Future Plans

- Pilot network based diabetes care package in the South East Locality in September 2014
- Roll out to the entire borough for 2015/16
- Expand the community diabetes specialist nursing team during the transitional period 2014/15

⁴² Diabetes UK and partners, Best practice for commissioning diabetes services: An integrated care framework, Diabetes UK, 2013. Available at <http://www.diabetes.org.uk/Documents/Position%20statements/best-practice-commissioning-diabetes-services-integrated-framework-0313.pdf>

Enfield Diabetes Support Group

Ruth Waxman – Chair – Enfield Diabetes Support Group

Enfield Diabetes Support Group was started in 2005 by me, Ruth Waxman, the chair, and David Petts, the vice chair of the group, with the support of Diabetes UK and others.

Our meetings are held at the Diabetes Centre, Chase Farm Hospital, Enfield on every second Tuesday of the month from 7.30pm to 9pm.

We provide support for both patients and GP practices.

Support for Patients

At our monthly meetings people can get support from and meet others with diabetes; get information from our guest speakers; access to contact phone numbers; information about online access to our website which is run by Diabetes UK and booklets provided free of charge by Diabetes UK.

As many patients may not take in all they are told about diabetes when first diagnosed, we give additional help and advice. There is also the opportunity for people to meet others with diabetes so they know they are not alone. Patients attending our group seem better informed about diabetes and know what questions to ask their healthcare professional and know where to go for help.

Newly diagnosed patients with an Enfield GP will receive our easy to understand booklet 'Living with Diabetes' which is now in its 4th reprint. This booklet was compiled by a small interest group and agreed by physicians with input from the diabetes support group.

Support for GP surgeries

By alleviating some of the worry people have when diagnosed; clarifying some of the terminology used. We would always suggest patients contact their GP or pharmacist for clarification and advice on their medication.



What happens at our meetings

We have guest speakers who are all specialists in the field of diabetes, speakers from the Diabetes Research Network, Health trainers and exercise/lifestyle information. The local MP and others from NHS Enfield have also come to talk to us as well as speakers from Diabetes UK.

Our members come from diverse backgrounds, all wanting to find out more about living with diabetes. For example, anyone with diabetes, their family members or carers; trainee doctors; nurses; healthcare providers; those involved with research into diabetes; people writing PhD's.

London's Primary Care Transformation Programme

Paul Roche – Interim Programme Director – NHS England

There is an unprecedented strain on general practice in London today. NHS England recognises this and is committed to working closely with GPs to support them in making positive changes.

In November 2013, NHS England published 'Transforming Primary Care in London: General Practice A Call to Action', which examined the challenges facing general practice, the case for change and need for urgent action. View the full copy via this bitlink – bit.ly/lhaDtJ

There is a growing consensus that London's general practice services are unsustainable unless we make big changes to the way they are commissioned and organised. Tweaking at the edges will not be an option – London needs solutions that will sustain primary care for the next 50 years and more.

Current activity

NHS England London Region has been working in partnership with CCGs to produce a set of 'development standards' describing the potential service that could be offered by general practice in the future following a period of redesign, development and investment.

The standards can only be delivered through greater collaboration between practices working together at scale to deliver services for whole populations and of practices working with other partners in that care delivery. Practices across the capital are beginning the journey towards scale, debating the pro's and con's of working as networks, federations, super partnerships and other joint models of provision.

These development standards are in pre-engagement/draft form and will be undergoing wider stakeholder testing over the summer months. This will enable the NHS in London to reach a common understanding on what we mean by transformed primary care.

In parallel to the development of these standards NHS England is working closely with CCG's to complete strategies for delivery and implementation of the standards in the context of local CCG plans for out of hospital e.g. looking at workforce, technology and estates implications.

Enhancing and Improving Access to primary care: Text reminders

Jenny Mazarelo – Programme Manager (Primary Care) – Enfield Clinical Commissioning Group

Enfield CCG introduced a system to send text messages to patients' mobile phones, with appointment and healthcare reminders.

As part of its Enhancing and Improving Access initiative, Enfield CCG looked at several ways to increase access to primary care services and decided that a text messaging service would have several benefits, including reducing the number of patients who 'did not attend' (DNA).

All 50 practices use the text messaging system to remind patients about their appointments and communicate health messages around smoking cessation, cervical screening, seasonal 'flu vaccination campaigns, childhood immunisation and a range of other health issues. Patients can also send texts to a dedicated number to cancel appointments.

Practices identified that DNAs were a recurrent problem and, aware that simply forgetting was the main reason for people missing appointments.

By introducing this text messaging system, Enfield CCG aims to:

- Reduce the number of missed appointments, by reminding patients when their appointments are and providing an easy way for them to cancel them
- Increase communication with patients, maximising the reach of health promotion campaigns

The Health Bus

Professor Stanley Okolo PhD, FRCOG – Medical Director – North Middlesex University Hospital

The North Middlesex “Health Bus” – a former ambulance, kitted out with health screening devices and testing equipment, has been undertaking a programme of visits to shopping centres, leisure centres and community events across Enfield and elsewhere.

Under a pilot project funded by Health Education England NCEL, North Middlesex University Hospital is seeking to identify the health needs of local people, work with them to improve their lifestyles and educate them about the healthcare options available to them. We are hoping that the activities of our “Bus” and its staff will increase the number of local people registered with GPs and reduce potentially unnecessary trips to the hospital's accident and emergency (A&E) department and urgent care centre (UCC).

Achievements include:

Operational since 22nd February 2014, the Health Bus has been on the road for a total of 19 days at the end of April 2014, visiting 6 sites across Enfield & Haringey boroughs.

- 375 patients have been on the health bus, of which 50% were Enfield residents and 25% Haringey residents.
- The majority (97%) are registered with a GP and 22% had a pre-existing condition but still wished to get a free health check.

- There were as many women (51%) as there were men (49%), but most (85%) were aged between 40 and 74 years.
- It was significant that 75% of the population screened were obese or overweight, 31% were hypertensive, 30% had hyper-cholesterolaemia and 4.5% had undiagnosed diabetes or pre-diabetes.
- The most common reasons for visiting the health bus rather than the local GP were convenience at shopping centre or close to place of work, and ease of attendance during a break from work. There has also been collaboration with other health promotion activities within the boroughs.

Future Plans

The Health Bus will shortly be expanding to two schools with established breakfast clubs who have signed up to our childhood obesity reduction campaign. Both schools have high proportion of pupils eligible for free school meals; one is in Enfield and the other in Haringey. There will be weekly visits over a 6 week program involving structured ‘bite-size’ sessions primarily delivered by health promotion dieticians focusing on food choices with a view to encouraging healthier eating habits among the children.



The HiLo programme

Dr. David Collier – Research Fellow and Joint Clinical Director – William Harvey Research Institute
Susan Lloyd – Public Health Consultant – Public Health – Enfield Council

Enfield's local clinical professionals are pivotal in enabling our local community to tackle the burdens of CVD. Hypertension remains the most prevalent and preventable cause of cardiovascular disease (CVD) disease, and there is good evidence that antihypertensive drugs are effective.

Blood pressure and lipid control levels achieved in RCT's like ASCOT1, 2 are difficult to replicate in normal practice. Barts Health/QMUL, Europe's largest heart healthcare research centre have developed the HiLo initiative to support primary care. HiLo is a GP based intervention that has developed interventions based on ASCOT criteria for implementation in general practice. HiLo intervention targets individual patients within GP practice who have high blood pressure and/cholesterol which is difficult to treat.

After an initial practice meeting and GP consent, EMIS searches for systolic blood pressure 160mmHg in the last year and/or Total cholesterol 4.5 mmol/l in patients with codes for IHD, CVD, diabetes or hypertension are applied followed by 2 further filters to identify which patients may be in need of further treatment. GP's then consent to problem list flagging of patients for 12 months.

GP practices have HiLo flags for patients. Case management and/or Clinician Educational Support interventions are then delivered to the practice. Blood pressure drug treatment intensity and BP levels, and total cholesterol levels and treatment intensity are recorded every 3 months for a year.

The HiLo intervention was successful in delivering sustained lowered blood pressure and blood cholesterol measures in Tower Hamlets. Currently two practices in Enfield are in the HiLo initiative.

Barts Health/QMUL, are also working on developing a primary care based training programme for CVD. Once this programme is available Enfield will license the programme for all Enfield GPs and practices nurses. Depending on audience interest, the first tranche of training will be offered at the practices where the largest impacts can be made.

Dependent on the final content of the CVD training programme this project will sustain momentum by organising additional sessions using the Enfield's established Protected Learning Events.

Key deliverable:

- Procure and provide education and training events that 'up skill' the local clinical workforce
- Be creative in maintaining an emphasis of CVD management within primary care; and
- Ensure techniques learnt can be applied.

Community Engagement

Sonia Carnegie – Public Health Officer – Public Health – Enfield Council

Community engagement has been key element of the Upper Edmonton Life Expectancy Project. We've worked in partnership with a large number of organisations and communities to address the issues of health inequalities. In this task we have been supported by our community engagement colleagues at Enfield Council.

What has our community achieved?

Since starting on the project we have had the privilege to interact with several community groups, who have then in turn made an impact on the health of their community.

We were welcomed to the Saheli Women's Group (Saheli meaning female friend). Saheli was initially only for Asian Women but now has a totally inclusive policy and is being attended by women from the Turkish, African, Greek-Cypriot, Somali and Afghan communities. It is focused on empowering women and also addresses mental health and domestic violence in a strong and supportive environment.

Through the Saheli group we were able reach over 30 attendees each time we attended the Friday meetings. By engaging with Saheli members and listening to their

stories we have been able to share and disseminate real life inspirational experiences to improve health.

Saheli Group continued to support us at our first stakeholder event "Your Place, Your Health, Your Voice" which was held in The Angel Community Centre in January 2014. At this event the group members shared their holistic skills with the community.

We are continuing engagement with the group, keeping them informed and involved with current and emerging initiatives; for example, cancer awareness and screening.

We have also developed close links with the Central African Youth Enfield (CAYE). CAYE are now in receipt of a small grant fund for a positive, community health project that involves families engaging in physical activity. There are approximately 20 to 30 families who regularly attend this group.

We also work closely with the mosques, particularly Rumi Mosque who were keen to engage with us. The mosques in Upper Edmonton have been active partners and promoted our first "Your Health, Your Place, Your Voice" Event.



Rumi mosque has a good attendance from a variety of communities including Turkish, Somali and Pakistani. In addition to regular prayer meetings, Rumi Mosque organises social activities such as “Community Breakfast Club”. “Community Breakfast Club” provided an excellent forum where we could engage and share information related to health. We have provided health sessions throughout February discussing diabetes, cardiovascular disease and healthy eating. In addition, the sessions were supported by our Turkish Health Trainer in overcoming any language barriers – this was received well, particularly as the majority of members were young Turkish women.

GRACE is a faith based charity which provides day care services for vulnerable and older people. GRACE held their own health community engagement event in April 2014 in Upper Edmonton, attracting nearly 60 people, mainly of black African and Caribbean origin. The event was part of “Your Place, Your Health, Your Voice” project. At the event, health checks and health advice were offered and residents had an opportunity to feed back on their health needs by completing the questionnaire. Almost all of the residents at the event completed the questionnaire. The community event was a great success featuring Gospel singers and a buffet. The feedback of the event was very positive and included “These local events give people a real chance to find out more about how to stay well and what Enfield Council is doing to promote active lifestyles for all its residents”. Grace organisation has been awarded a small grants fund to deliver faith based exercise sessions close to church venues.

Future Plans

Feedback to date has clearly demonstrated the positive impact of the current programmes of work within the community. Our future plan is to continue engaging with communities to spread our public health message of health prevention and management.

Asset mapping

Ella Goschalk – National Management Trainee – Public Health – Enfield Council

An 'asset map' is a "map or inventory of the resources, skills and talents of individuals, associations and organisations" in a community. The aim is to uncover existing resources and relationships in order to make best use of these and build on them.

It is a positive approach to working with communities, looking at what already exists rather than what is lacking. Asset mapping engages the community as an equal partner, and has been identified as a key approach when tackling health inequalities.

Achievements include:

The team in Public Health working on the life expectancy gap in the Edmonton area have been engaging from the start with local communities and groups, starting with the launch workshop which took place in summer 2013. This has been further enhanced by engagement events in the area, each aimed at different groups.

There are many Council resources alongside this which capture local assets and how they are used which can be added to the mix.

The current asset map of Edmonton is currently in the form of a database broken down into four categories:

- Community assets: groups and individuals who create positive value for the community
- Service assets: essential services and institutions (e.g. schools, hospitals)
- Physical assets: buildings and open spaces that can be used by the community
- Economic assets: places that provide economic opportunities (e.g. jobs, shopping)

Future Plans

The aim of an asset map is not to be a static list of local contacts, but rather a live document which will change over time. Asset mapping is a useful approach to use when planning specific activities – identifying what already exists and recognising how it can be enhanced or brought together through Public Health work.



Community Respiratory Service

Florence Cantle – Transformation Programme Manager – Enfield Clinical Commissioning Group

The aim of the service is to deliver an alternative pathway for respiratory patients from an acute setting to a community based service. Introducing clearly defined community based services looks to improve the patient experience by delivering services closer to home, with shorter waiting times. The service acts as an alternative to hospital based treatment for patients being referred by General Practitioners. The current provider is Enfield Community Service, part of BEH Mental Health NHS Trust.

The service includes the provision of:

- Complex review and management of COPD
- COPD acute exacerbation management and intervention
- Pulmonary rehabilitation
- Telephone service
- Home oxygen assessment and follow up
- Early supported discharge

The service objectives are:

- To provide pulmonary rehab that meets national quality standards.
- Provide a respiratory specialist service based in the community using a consultant supported multi-disciplinary team.
- To work in partnership with other social and healthcare services, utilising care management plans.
- To support improvements in respiratory related health outcomes, including prevention of acute exacerbations.
- Creation of a seamless transition of care, as patients move between services by working collaboratively with other providers.
- To reduce A&E attendances and associated admissions and re-admissions for respiratory conditions.
- To support respiratory patients during their discharge from hospital, to reduce risk of re-admission.
- To reduce the number of bed days for patients admitted following an exacerbation.

Achievements include:

A formal review of the service was recently carried out and the feedback from patients was encouraging. This service will continue for 2014/15.

Community Engagement:

Results of recent patient surveys concluded (highlights):

- 100% of those surveyed stated that they were treated with dignity and respect.
- 98% of those surveyed stated that they were given enough information and were involved in decision surround their treatment.

Pulmonary rehabilitation feedback concluded that:

- 100% of those surveyed found the programme helpful
- 92% of those surveyed felt fitter than when they started and had a better knowledge of their condition.

Future Plans

- Service re-design to assess needs for growth and development of the service.
- Continuation of current service into year 2014/15.

Smoking cessation – Enfield Stop Smoking Service

Andy Higham – Quit Smoking Manager – Innovision

The Smoke Free Enfield service provides a range of specialist stop smoking services across Enfield. The service is provided by Innovision Healthcare Ltd.

It includes one-to-one and group-based support, either on an appointment or drop-in basis. Clinic locations in Enfield include Chase Farm and North Middlesex Hospitals, the Evergreen Primary Care Centre, Chase Side St Michael's Community Hospital and Enfield Council.

All NHS stop smoking services are available without charge to any smoker who wants to quit. People contacting the service are encouraged to set a quit date and then supported to quit.

Achievements include:

- The proportion of those who set a quit date and go on to quit four weeks later is higher in Enfield (61%) than for services in London or England.
- Enfield Stop Smoking service continues to meet annual targets for number of quitters, which is set at 1,568 quitters per year.
- The cost per quitter in Enfield was £181 which is less than that for London overall (£284) and England (£220).
- Stop smoking advisers have a presence at many community events.

Future Plans

Continue to meet and exceed quitter targets.



Don't go broke for a smoke!

Do you want to stop smoking?

www.smokefree.nhs.uk

Health Checks

Julie Boyd – Public Health Manager – Public Health – Enfield Council

The Healthchecks programme is intended to detect and treat undiagnosed vascular disease and to offer advice and support to improve lifestyles to those who may be at risk of developing disease. Everyone aged between 40 and 74 is eligible for the programme providing that they are not already on a GP vascular disease register.

Vascular disease includes:

- Heart attack
- Stroke/mini stroke
- Angina
- Diabetes
- High blood pressure
- High cholesterol

Enfield has two means of delivering healthchecks – through primary care and through an independent provider with a remit to offer healthchecks to those who either may not be registered with a GP or may not respond to a GP invite.

In 2013-2014 Enfield offered 17,346 healthchecks and delivered 6,199. This easily exceeded the targets of 15,900 offered and 5,500 delivered. This included delivery at GP practices, supermarkets, community events, leisure centres and shopping centres. We have also partnered with the North Middlesex Hospital to increase the range and extent of healthchecks offer and delivery.

Enfield Council is keen to encourage as many people as possible to participate in the scheme so problems can be identified early. This will help to reduce the number of people with conditions such as heart disease and circulatory problems.

Future Plans

Future plans include developing IT systems so that we can have a much better understanding of where healthchecks are being delivered, to whom, what conditions are being detected and diagnosed and what happens to patients once they have been diagnosed. Part of this will include understanding the risk of vascular disease in different parts of the borough and developing plans to reduce these risks. From 2014 the healthchecks offer will also include screening for risk of excessive alcohol consumption and signposting of memory services for those aged 65+ as a means of diagnosing and then treating dementia if appropriate.

NHS Enfield Clinical Commissioning Group (CCG) Provider Network Development

Jenny Mazarelo – Programme Manager (Primary Care) – Enfield Clinical Commissioning Group

NHS Enfield Clinical Commissioning Group is committed to commissioning services that improve the health and wellbeing of residents in Enfield, through the securing of sustainable and integrated primary medical, community, hospital and social services. Integrated care will enable local GP Practices to collaborate with local health and social services to provide proactive, accessible and co-ordinated care.

Improved integration across the local health economy and access to services delivered closer to patients will reduce variation and deliver improved health outcomes to residents, in turn narrowing the gap of life expectancy.

Achievements include:

NHS Enfield CCG has facilitated a number of workshop events that bring together practice staff to discuss key areas of collaboration.

This will initially be delivered via individual practice Patients Participation Groups, extending to wider community engagement events as networks become established.

Future Plans

NHS Enfield CCG in conjunction with other local commissioning stakeholders is developing services such as diabetes, primary care urgent access, dementia, paediatrics respiratory and cardiology based on local population groups of 50-80,000 patients.



Blood Pressure Programme

Ben Lumley – Blood Pressure Programme Lead – Public Health England

Almost 30% of adults in England have high blood pressure, of whom over 5 million are undiagnosed. High blood pressure is the second biggest risk factor associated with premature mortality in this country.

Public Health England (PHE) is a new government agency working to protect and improve the nation's health and to address inequalities. One part of our work in 2014/15 is stimulating and supporting activity across the system to improve our performance in relation to high blood pressure.

PHE is working closely with a group of system leaders (with representation from local government including Enfield Council, as well as others including health service, voluntary sector and expert groups), to develop a shared vision and action plan to:

- tackle risk factors, to support prevention of high blood pressure
- increase early detection of high blood pressure
- achieve better clinical and community systems for management of high blood pressure
- improve public awareness and understanding of high blood pressure
- reduce inequalities in relation to hypertension outcomes

PHE will also be supporting local leadership on high blood pressure through a resource hub, presenting data on local performance variation and exploring the potential of health marketing in this area.

By addressing high blood pressure at all stages there is a real opportunity to improve local health and avoid some of the consequences of uncontrolled high blood pressure, including stroke, heart attack, chronic kidney disease and cognitive decline.

Within Enfield there is already a focus on hypertension – local update training for GPs is in place with more than 50% of local GPs attending training on preventing hypertension in the population; practice nurses are also attending. The update will be followed by local interventions to support prevention, detection, management and awareness of high blood pressure. This will include enhanced access to NHS Health Checks.



Enfield Dementia Action Alliance (EDAA)

Michael Sprosson – Service Manager Procurement – Health, Housing and Adult Social Care – Enfield Council

Part of a national approach in response to the Prime Minister's Dementia Challenge to develop dementia-awareness, EDAA is a partnership of public, private & voluntary sector organisations who have committed to work together to improve the lives of people living with dementia and families.

It has 25+ members, who are asked to identify three actions they can take on dementia. This could be raising awareness in Enfield's diverse communities, for example, as part of the national Dementia Friends Programme.

Organisations include those who plan and deliver care (e.g. London Borough of Enfield and Age UK Enfield), and any other organisations that impact on the lives of individuals, such as banks, schools, retailers, arts and sports group (including the Tottenham Hotspur Foundation).

An EDAA aim is to ensure people living with condition are diagnosed as early as possible to plan their care and lives.

Awareness-raising is important: most people aged 55+ say they're more worried about acquiring dementia than any other condition.

There are things people can do to reduce their risk of developing (particularly vascular) dementia, such as being fit, active and alert, eating and drinking well as they get older. There are also steps that help people live well with the condition.

Achievements include:

- Formed Enfield Dementia Action Alliance in July 2013 and appointed EDAA Coordinator;
- First and largest Dementia Action Alliance in London, with over 20 organisational members;
- EDAA worked with Alzheimer's Society to raise awareness across Enfield's diverse communities through its Connecting Communities Project which reached out to 20 communities in Enfield, with 550+ attendees;
- Improved training for GPs about dementia, with training available to key community and hospital staff groups;
- £2.4m investment per annum from the Council in voluntary sector organisations that support older people;
- Successful targeting of the over-50s through Enfield's Everybody Active Programme: 5,000 older people are using leisure centres in Enfield with activities such as ballroom dancing or Tai-Chi.

Although the EDAA is a partnership for organisations, networking is based on extensive community engagement through its members. For example, the Connecting Communities Project held awareness-raising events for communities in Enfield, hosted through voluntary-sector groups.

A review of the current support for people with dementia used EDAA's network to listen to the views of people living with dementia and families about the help and support currently available and those they need.

Future Plans

- Phase II of EDAA development focuses on increasing membership amongst "non-care" organisations, such as schools, leisure organisations, retailers etc.
- Work with Public Health to identify opportunities to promote healthy living as part of dementia-awareness
- Strengthen links between a network of dementia champions to raise dementia-awareness and EDAA's organisational membership
- Improve training and awareness-raising for Council staff who work with the public
- Review support and care options for people with dementia and families, including as part of Enfield's Carers' Strategy
- Additional investment in these options as part of future planning for care services, as well as in developing dementia-friendly communities in Enfield.



Lifestyle

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Healthy Eating

Glenn Stewart – Assistant Director Public Health – Public Health – Enfield Council

64.2% of Enfield residents aged 16+ is either overweight or obese. Obesity is linked to some 30+ conditions with risk increasing with BMI.

Enfield has numerous projects to increase awareness of food and healthy eating:

1. Food strategy was launched in 2011
2. School Growing Project in 20 schools
3. The Healthy Catering Commitment
4. 30 schools running Change4life programmes
5. 'Eat Better Start Better' nutritional project in nursery settings

Achievements include:

1. The free school meal (FSM) local campaign which led to a 12% increase in applications and a 5% increase in new registrations. We have achieved the Bronze Catering Mark (and are now aiming for silver) (<http://www.sacert.org/catering>).
2. School menus all meet Government nutrition standards and use seasonal and local produce.

3. In the 'Eat Better Start Better' project, there was a significant improvement in meeting the nutritional guidelines in the early years' settings. Forty-six healthy cooking sessions were delivered to 337 parents/carers in the settings and 12 community cooking sessions delivered to a further 210 family members having a positive impact on confidence to prepare healthy meals from scratch at home.



Enfield Everybody Active Team

Jess Khanom – Business Partnership and Development Manager – Regeneration, Leisure and Culture – Enfield Council

The Everybody Active Team provides a wide range of opportunities for Enfield residents of all ages to take part in sport and physical activity. The activities are promoted to children, young people, adults and the Over 50's. We work in partnership with various agencies including Public Health, Community Safety, Middlesex University and the Over 50's Forum to name a few.

Achievements include:

1. We have been Quest (UK Quality Scheme for Sport and Leisure) accredited and also recently received the Customer Services Excellence Award.
2. We have received Sport England funding in the region of £500,000 to initiate programmes to tackle obesity in adults and young people, as well as ensuring all our activities are inclusive for disabled people.
3. Activities continue to evolve including programmes such as Active with Ease in partnership with Public Health, with consists of an exercise referral scheme for individuals with a BMI over 30. Over 100 residents have benefited from the programme in the last 12 months.

Each year the Everybody Active Team plan and organise various major events within Enfield, including the Mayor's

Charity Fun Run, The Enfield Night Hike and the London Youth Games. Through these events and in conjunction with a wide range of internal and external partners, including local cancer support charities and businesses, the Everybody Active Team engages many different communities across Enfield to ensure the widest range of groups access sport and physical activity opportunities.

Future Plans

The plan for the Everybody Active Team is:

1. To build on current and existing partnerships to effectively maintain and grow our services.
2. To be innovative and creative with our service and remain flexible in our approach to delivering cost-effective sport and physical activity sessions for residents.
3. To work closely with the NHS and Public Health teams to deliver healthy weight campaigns and develop our programme to tackle the obesity crisis.
4. To have a one-stop-shop for individuals to have an accurate health assessment carried out for free as well as programme choices for those individuals based on the results.



Tobacco Control – Enfield Trading Standards Services

Sue McDaid – Head of Regulatory Services – Environment – Enfield Council

Tobacco control includes any initiative which aims to reduce the demand for tobacco products. Enforcement is an example of tobacco control. In Enfield it is carried out in Enfield by Trading Standards Services, who 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' work with other enforcement agencies such as HMRC reduces illicit tobacco sales and contributes to cutting the prevalence of smoking.

Achievements include:

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

- Reducing supply and availability by targeting underage sales
- Regulating tobacco trading by targeting counterfeit or illicit products

- Reducing tobacco promotion by enforcement of advertising and sponsorship restrictions
- Regulating tobacco by packaging and labelling requirements, including smokeless products.

Future Plans

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

- Educate and enforce the advertising and display of products and pricing
- Control the proliferation of shisha premises and ensure they comply with current controls
- Proactively support the initiative of the tobacco control alliance and implementation of the action plan to reduce smoking prevalence from its current 18% to 10% or less by 2020
- Focus on school education in the adverse health effects of smoking
- Denormalise the use of tobacco products and so reduce uptake.



Healthy Schools London (HSL)

Una Archer – Curriculum Access and Support Manager – Schools and Children’s Services – Enfield Council

HSL encourages schools to work with their pupils encouraging them to adopt healthy lifestyles. There is a clear, positive link between this and raising educational achievement.

The programme encourages children from an early age to understand the importance of healthy eating, where food comes from and the importance of regular physical exercise. It also aims to build pupils’ self-confidence, equipping them with the knowledge and skills to lead healthy, happy lives.

The Bronze Review Tool and activities are organised under seven headings:

1. Leadership, management and managing change
2. Policy development
3. Learning and teaching, curriculum planning and resourcing
4. School ethos, culture, environment and SMSC development
5. Provision of support services for children and young people
6. Staff continuing professional development (CPD), health and wellbeing
7. Partnerships with parents/carers, local communities, external agencies and volunteers to support pupil health and wellbeing and includes sex and relationships education; drugs education; safe travel; walking buses; cooking; eating fresh healthy food; anti-bullying; listening to pupils; regular exercise and being positive.

Achievements include:

Twenty Enfield schools have already qualified to receive bronze awards. Four schools, from a total of only 13 across London, have achieved the silver award – Worcesters Primary, Hazelbury Infant, Wilbury Primary and Aylands Special. An award presentation was held in Worcesters School attended by the Deputy Mayor of London and representatives from the schools were invited to attend a celebration event at City Hall attended by Boris Johnson Mayor of London.

Future Plans

Schools engage with their local community and encourage and support volunteering by the children and young people in their schools. More schools are being encouraged to join the programme and those already qualified at bronze to progress to silver and gold level.

Health Trainers

Paulette Yusuf – Public Health Manager – Public Health – Enfield Council

Our Health Trainers provide personalised support to people who want to improve their health. This consists of improving motivation using evidence-based psychological techniques and the application of practical skills and tools that will facilitate a healthier lifestyle.

Health Trainers are local people who have been recruited and trained to deliver sessions to improve health in the community. They provide free one to one advice and support to those who want to make a lifestyle change.

Individuals are usually referred by their GP. Self-referrals are also accepted.

Health trainers can also support people when a health check has identified that a lifestyle change is required in order to prevent particular conditions.

We feel that our Health Trainers are uniquely placed in the community to provide behaviour change support to those living in areas of high deprivation. Their role also includes signposting to local services such as employment and mental health support.

Achievements include:

During 2013, there were 992 referrals to the service, of which about half were GP referrals.

Health Trainers have also been providing support to parents of overweight and obese children who were identified through National Child Measurement Programme. To date they have received 78 referrals of this type.

The “Active with Ease” programme was also initiated to enable those who live sedentary lifestyles to increase their physical activity. A range of programmes have been set up in conjunction with the Sports Development team at the Council so that residents have free access to range of activities for six weeks. These sessions are provided alongside health trainer sessions so that clients can access support and free physical activity.

Further health trainers are being trained. These are from the local community and are seeking opportunities to work with vulnerable and disadvantaged communities.

Future Plans

We will be extending our role by providing training to members of the community on Understanding Health Improvement, a Royal Society of Public Health qualification. This will help to increase knowledge and awareness around health in the wider community and provide additional qualifications to individuals especially in areas of high deprivation.

We have also been commissioned to deliver cancer screening awareness for the Clinical Commissioning Group (CCG). We will deliver outreach sessions in public places on identifying early signs and symptoms of cancer and encouraging individuals to attend screening.





Wider determinants of health

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Changing the environment to increase physical activity (Cycle Enfield)

Glenn Stewart – Assistant Director Public Health – Public Health – Enfield Council

Physical activity is essential for optimal health. Compared to those who are least active sufficient physical activity reduces all-cause mortality and the risk of heart disease, cancer, mental health issues and musculo-skeletal disease by approximately 30%. Guidelines on physical activity have been published by (amongst others) the World Health Organisation (WHO) the US Department of Health and Human Sciences and the Chief Medical Officers of the Four Home Countries.

For many sustaining recommended levels of physical activity is difficult. The Chief Medical Officer has stated that cycling for transport purposes may be one way that physical activity can be incorporated into everyday life. In Enfield this is very possible; 80% of journeys in the borough are less than 10 km and could be cycled in less than 30 minutes. Increasing walking and cycling for transport would not only have other health benefits from increased physical activity and other health benefits through reduced air pollution and community segregation, but would also benefit the borough economically; it is estimated that the cash cost of journeys under 5 miles

in the borough to residents is approximately £85m per year, journeys under 2 miles cost £14 million a year. Traffic congestion is estimated by the CBI to cost the economy £20 billion a year.

Achievements include:

Enfield has tendered for, and won, £27 million to increase cycling prevalence in the borough.

Future Plans

Over six years this will make cycling safer and more convenient (making the healthy choice the easy choice). Infrastructure projects include creating cycle super-hubs in Enfield Town Centre and Edmonton Green, improving links to these areas, new segregated cycle routes along the Hertford Road, Green Lanes and Southbury Road, changing how children travel to school and creating a network of routes and 'neighbourhoods where cycling will be safe and direct.



Parent Engagement Panel (PEP)

Sam Morris – Participation and Partnerships Manger – Schools and Children’s Services – Enfield Council

The aim of the project is to build resilience by engaging positively with and empowering Enfield parents and carers to provide informal support, information and guidance within their own communities. Parent Champions bridge the gap between the community and targeted professional support.

Achievements include:

- Working with Children’s Centre Commissioner and Development Coordinators to establish new Area PEPs in Children’s Centres in Enfield. Two pilot groups have been set up at Lavender Children’s Centre and at Bowes Children’s Centre.
- PEP members continue to volunteer with the National Childbirth Trust (NCT) breast feeding programme and Strengthening Families Programmes (SFP).
- In May PEP members participated in Female Genital Mutilation (FGM) and Money Management training which will be shared in their own communities.

Future Plans

- Three Parent Champion Training programmes will be run during the financial year 2014/15.
- A number of Parent Champions have volunteered to work on a pilot project with Scrutiny Services. They will be trained to work with health professionals offering low level support for future parents at antenatal sessions in community settings across Enfield.
- The Parent Engagement Panel will eventually become an independent organisation.



Enfield Youth Parliament (EYP)

Sam Morris – Participation and Partnerships Manger – Schools and Children’s Services – Enfield Council

EYP is a democratically elected body of 20 people aged 11-19 years (up to 25 years for young people with learning difficulties or disabilities) who represent young people across Enfield. There are also four seats available on the Parliament for young people from a specific background, representing:

- Joint Service for Disabled Children
- Children in Care Council
- Youth Offending Service
- Enfield Children and Young Persons’ Services.

EYP’s priorities are: Awareness of Youth Opportunity, Job and Money Skills, Youth Relations, and Social Education.

Achievements include:

- The Biannual EYP took place in October 2013 and incorporated European Local Democracy week.
- For the youth parliament elections there were 27 Candidates across the four election areas, with 17 schools/colleges holding ballots.
- EYP met with cabinet to discuss the Enfield Council Budget.
- EYP have elected 4 UK Youth Parliament representatives.
- The EYP has advised on the ‘Your Welcome’ evaluation project specifically around sexual health services for young people.

Future Plans

The EYP will be working with Finance Division to increase the number of children and young people who take part in the Budget consultation for financial year 2015/16.



Greater London Authority Healthy Workplace Charter

Julie Mimmagh – Head of Human Resources – Chief Executive’s Service – Enfield Council
Ella Goschalk – National Management Trainee – Public Health – Enfield Council

Promoting good health at work creates a huge range of benefits for both the organisation and the employee.

The Healthy Workplace Charter was set up to provide a framework to support employers develop good practice by promoting health in their organisation in a practical way.

In Enfield, the Council is the biggest employer, with 60% of our staff living in the borough. Promoting health at work also helps support staff in delivering quality services for residents.

In Enfield, we worked together across departments, including Public Health, HR, Health and Safety, Sports Development and more to bring together and build on existing work in order to gain accreditation under this Charter.

Achievements include:

Health fairs for staff, exercise classes and healthy eating initiatives, promoting stop smoking services and more. There has been positive feedback and good uptake from these.

Future Plans

We also plan to promote the Charter to local businesses and support them in applying for accreditation, as a result having a positive impact on large numbers of employees in the borough.

Delivering community engagement on behalf of Enfield Council and working with the Voluntary and Community Sector to deliver support to local communities

Shaun Rogan – Head of Communities, Partnerships and External Relations – Chief Executive’s Service – Enfield Council

We have delivered a programme of activities over the past year that have provided a combination of valuable intelligence-gathering through the flagship ‘On Your Doorstep’ mobile neighbourhood engagement programme, facilitating resident focus groups, and provided grant funding to our local VCS via the Enfield Community Capacity Building Fund.

In addition, management of the Enfield Strategic Partnership and facilitation of joint working between the local authority and local MPs on a range of strategically relevant areas.

Achievements include:

1. A third round of annual ‘On Your Doorstep’ programme working with Public Health (PH) partners supporting the move to narrow the gap in health inequality.

2. Provided support to the PH Team on matters relating to community engagement and Upper Edmonton Pilot programme (now Edmonton pilot programme).
3. Assisted Public Health in their development and promotion of the Joint Health and Wellbeing Strategy and activities of the Health and Wellbeing Board to a wider audience (including the Enfield Strategic Partnership).

Future Plans

We anticipate continuing to assist our partners in public health in the realisation of Enfield Council’s strategic objectives including a further round of ‘On Your Doorstep’, closer working with Public Health to help them realise Council objectives, a new residents’ survey, further working with the local VCS to create better outcomes for local people.



Voluntary sector representation

Vivien Giladi – Health Lead – Enfield Over 50s Forum

The Enfield Over 50's Forum sits as the voluntary sector representative on the Enfield Health & Well-Being Board and the Health Improvement Partnership.

This year they have been particularly concerned with differences in morbidity and mortality between the East & West of the borough and with all the contributors to it: healthy eating, exercise, early identification and treatment and immunisations, particularly MMR.

The Forum is behind the newly formed Dementia Alliance and is forging links with Enfield Carers. They also sat on the Barnet, Enfield and Haringey Clinical Reference Group and raised issues regarding the adequacy of primary care, the establishment of the Urgent Care Centre and the OAPU (Older Persons Assessment Unit), and continue to hold a watching brief on them.

We have helped to raise awareness on a number of key issues:

Early detection of bowel and breast cancer, smoking cessation, dietary care, falls awareness, importance of the flu jab, the availability of a shingles vaccination and the need for caution with alcohol, among others. The Forum promotes healthy living through its link with Fusion and reduced rate entry to its leisure centres.

Future Plans

Continue to use the Forum's newsletter for disseminating information, advice and warnings, expressing support for public health projects, and helping to make Enfield a shingles free borough.

Upcoming campaigns on the role of salt and the health-damaging effects of isolation.

Garden Enfield

Jane Berger – Programme and Projects Manager – Regeneration, Leisure and Culture – Enfield Council

In March, Enfield Council officially launched Garden Enfield, its market gardening project, which aims to combine community growing with large scale food production to create 1,200 jobs and generate income. £600,000 has been received by Enfield Council from the Mayor of London to support the development of this ambitious project to resurrect the borough's food growing heritage.

The aim is to establish Enfield Council as a major supplier of fresh food in London and dramatically increase the amount of communal land that is being used to grow produce.

Achievements

To date the project has established three acres of land set for vegetable growing at Forty Hall Farm, helped 10 schools start growing their own vegetables for school dinners (with another 15 due to join the scheme later this year), and launched a Vegetable Box Scheme serving 30 customers a week.



The Enfield Experiment/New Directions

Simon Gardner – Head of Leisure and Culture – Regeneration, Leisure and Culture – Enfield Council

The Enfield Experiment/New Directions is a whole Council approach that puts Enfield first, its residents and businesses delivering economic and social sustainability through innovation, enterprise and determination to ensure Enfield and its residents fulfil their potential.

Achievements include:

1. £10 million funding from British Gas to improve the energy efficiency.
2. Enfield 2020 – the council committed a £1.7 million investment to improve energy performance.
3. Barnet & Southgate College have 16 trainees on the Insulation training course, launched in September 2013.

Future Plans

1. **Big Business and Corporate Social Responsibility (CSR)** – working with Enfield businesses to support reinvestment for jobs and growth.
2. **Purchasing and Collaboration** – working with small and medium businesses to investigate central and collaborative purchasing to reduce costs and helping business to grow.
3. **Financial Strategies** – releasing pension funds for reinvestment in social and economic regeneration.
4. **Market Gardening** – training local people to grow sell local produce.
5. **Infrastructure Investment** – derisking scenarios to facilitate private sector investment.
6. **Market intervention** – intervening where market is not working effectively.

Police and Court Liaison and Diversion Services

Mark Landy – Assistant Director Forensic Integrated Community Services – Barnet, Enfield and Haringey Mental Health NHS Trust

Liaison and diversion services are intended to improve the health and justice outcomes for adults and children who come into contact with the youth and criminal justice systems, where a range of complex needs are identified as factors in their offending behaviour.

Liaison and diversion is a process whereby people of all ages with mental health problems, a learning disability, substance misuse problems and other vulnerabilities are identified and assessed as early as possible as they pass through the youth and criminal justice systems.

The model has three distinct and inter-related phases:

- Case identification
- Secondary screening/triage
- Assessment (including specialist assessment)

The service will be accessible at the earliest stage once an individual is suspected of having committed a criminal offence, be available at the point of need, and be available at all relevant points of the youth and criminal justice systems.

The model is predicated on a core dedicated team to deliver and co-ordinate an effective and responsive liaison and diversion service linked to, and supported by, an extended team whose roles are not specific to liaison and diversion but are essential to effective liaison and diversion practice.

Barnet, Enfield and Haringey Mental Health NHS Trust are trialling the new NHS England operating model and are the pilot site for London. The cluster is the North Justice Sector encompassing Camden, Islington, Enfield and Haringey boroughs.

This is an opportunity to deliver integrated pathways and not just services. We will develop partnerships across a range of providers and services that will allow greater information sharing and inform more appropriate interventions and disposals. We will also be able to identify unmet needs and service gaps and use this to inform the JSNA and commissioning of services.

Achievements to date

In 2013 nearly one thousand vulnerable people were assessed in police custody suites in just two of these London boroughs.

Future plans

In 2014 the service becomes an all age service and extends into Enfield and Islington custody suites as well as becoming a five days a week service at Highbury Magistrates Court.

Other plans include developing the post-diversion infrastructure and providing reports back to the CCG and LA on unmet need and service gaps. There are also plans to develop the adolescent pathway.

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Public Health
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