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Foreword

This Joint Strategic Needs Assessment (JSNA) 2010-2012 brings together up to date information about health and well being needs from NHS Enfield, Enfield Council and key stakeholders. Most importantly however, the JSNA has been informed by the views and opinions of local people that have enhanced the ‘professional’ understanding of what is important and relevant in achieving ‘well being’ for local people.

Listening to residents and identifying evidence of need has been fundamental to the development and selection of the priorities described here. The list of priority health and wellbeing needs focuses on those segments of the population where there is significant evidence of poor health and wellbeing outcomes and of health inequalities. These priority areas combine empirical data about what the local needs are and ‘what works’ in terms of strategic approaches to meeting need, with some strongly held views about needs based upon experience and also information from national and/or local sources.

The JSNA process has provided an opportunity to develop a credible evidence base by bringing together factual information, the expertise of staff in the Council and the local NHS, and the views of the residents of Enfield. Many staff and members of partner organisations have provided valuable insights and information, for which we are grateful.

Although we have identified priorities for the next three years, we will continuously refresh our supporting data and encourage challenge to our priorities for action, well aware that we can further improve our knowledge and that we still need to hear more from our residents. We may need to revise commissioning plans as we improve the depth and quality of our understanding of needs, the aspirations of our residents and our knowledge of what works.

It is also certain that the ongoing developments in health and social care – to increase choice and independence and to transform the way that health and social care needs are met, will ensure that the conversation about well being that we have started with Enfield residents through this JSNA will grow and increasingly enable the engagement of more residents, including some of those whose voices are seldom heard.

Shahed Ahmad
Director of Public Health
NHS Enfield

Ray James
Director of Health and Adult Social Care
Enfield Council

Neil Rousell & Andrew Fraser
Co-Directors of Education, Children’s Services and Leisure
Enfield Council
Introduction

There is a significant life expectancy gap between deprived and more affluent wards within the borough. The gap is currently 8.8 years for males and 10 years for females, and this gap is predicted to widen.

This Joint Strategic Needs Assessment (JSNA) is critical to the work we must do if we are to reduce this startling inequality. It brings together what we know about health and well being in Enfield and the views and experiences of the people of Enfield, to inform the decisions we make about existing and future health and wellbeing services. It identifies our health and wellbeing priorities and provides the information, including the opinions of residents, that explain why these are priorities for Enfield.

Enfield Council and NHS Enfield have a duty under the Local Government and Public Involvement in Health Act (2007) to prepare a JSNA. The Department of Health guidance states that the “JSNA is a process that will identify the current and future health and wellbeing needs of a local population, informing the priorities and targets set by Local Area Agreements and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities.” The guidance goes on to say that the Government “will therefore look for evidence that commissioning decisions have been informed by the Joint Strategic Needs Assessment, to achieve improved health and wellbeing and reduced inequalities at best value for all.”

Wellbeing is much more than being free from illness. The World Health Organisation defines health and wellbeing as: “A state of complete physical, mental and social well being and not merely the absence of disease and infirmity” and whilst this definition is too wide for our purposes, it does rightly point us towards the wider context in which people live their lives and the range of influences that directly affect an individual’s risk to good health and wellbeing. This focus is set out succinctly in a recent paper produced by the Improvement and Development Agency for Local Government (I&DeA): “Our individual actions are powerfully shaped but not fully determined by our social situations. Poverty makes a big difference. Social class and social status, gender and sexuality, age, ethnicity and race all have a strong impact on our health.” The I&DeA goes on to reflect on the importance of individual and community actions in wellbeing: “Individually and collectively, we will need to change if we are to avoid burdening ourselves, our children and our grandchildren with unsustainable levels of poor health. The JSNA provides us with a shared tool to better understand and tackle these problems.”

The development of this JSNA has throughout been underpinned by effective joint working between the Council and NHS Enfield. This has brought together expertise and knowledge in a powerful partnership that we must sustain if we are to reduce existing health inequalities and improve the wellbeing of all our residents in ways that fully reflect their needs and aspirations.
Acknowledgements

The JSNA process has been managed by a Steering Group set up by the Enfield Health Improvement Partnership.

The Steering Group was chaired by Bindi Nagra, Assistant Director for Health and Adult Social Care Strategy and Resources, until October 2009 when responsibility was transferred to Shahed Ahmad, Director of Public Health.

Other members of the Steering Group have been as follows:

**Health and Adult Social Care**
- Felicity Cox – Partnership Manager Health and Wellbeing
- Peter Feldon – Project Lead Strategic Needs Assessment
- Peter Lister – Head of Commissioner and Procurement Team
- Margaret Ryder – Head of Strategy and Performance

**NHS Enfield**
- Nicole Klynman – Mental Health Consultant
- Dawn Jenkin – Public Health Manager
- Glenn Stewart – Assistant Director Public Health

**Education, Children’s Services and Leisure**
- Marie Janaway - Head of Service: Policy, Quality and Performance
- Tony Theodoulou - Assistant Director, Children and Families

**Place Shaping and Enterprise**
- Mary O’Sullivan – Senior Project Manager for Sustainable Communities

**Community Safety**
- Libby Ranzetta – Alcohol Harm Reduction Co-ordinator

**Corporate Policy and Performance**
- Melissa McFadden – Performance and Information Officer

**Barnet, Enfield and Haringey Mental Health Trust**
- Frank Harrington – Mental Health Projects Lead

**Enfield Community Empowerment Network**
- Tony Watts – Secretary Enfield Over-50’s Forum

**Enfield LINK**
- Allan Brown – CEO Enfield Mencap
- Savi Hensman – Community Investors Development Agency

Many staff and members of partner organisations have participated in discussions which have informed the shape and content of this document, and also many sections of the report were written by specialist analysts employed by the Council and NHS Enfield. Equally important were the many contributions of material and ideas which were not included in the final document for a variety of reasons – without these contributions we would not have been able to determine priorities.
### Summary of Priority Health and Wellbeing Needs

These are the priorities identified by the JSNA process and are set out in greater detail in subsequent chapters.

| **Poverty** | Poverty and unemployment were identified as significant risks to good health and wellbeing in consultations with the public. Average income in Enfield is in the worst 10% of local authorities in England, going from 54th worst in 2004 (out of 354, with 1st being the lowest) to 25th worst 2007. This is reflected in some other indices of deprivation i.e. Enfield’s unemployment rate (6.7% Mar 2009) is above the London and national averages, and Enfield has the 4th largest number of households in temporary accommodation in England. |
| **Health Inequalities** | Inequality in health outcomes mirrors the patterns of deprivation seen within the borough. The differences are so significant that it is judged essential to have this as a priority – albeit one that is reflected across all other areas. Life expectancy at birth in Enfield over the past 15 years has been higher than London or national averages for both males and females. However there is a significant life expectancy gap between deprived and more affluent wards within the borough, and there is evidence that this gap is widening for both men and women. |
| **Obesity** | Obesity was identified as a significant risk to good health and wellbeing in consultations with the public and consumes very significant amounts of NHS spend. Enfield has the 3rd highest prevalence of obese people in London (27% Enfield, 18% London – Health Survey For England 2007 London Boost). Obesity levels among Enfield’s young people are a particular concern with 37.6% of Enfield’s young people in year 6 and 24.8% in reception year being overweight or obese. |
| **Infant Mortality** | Enfield has the highest infant mortality rate in London, and is significantly higher than national rates. Infant mortality is regarded as a good indicator of the overall health of a society and is to be seen as the ‘tip of the iceberg’, signalling more widespread problems for some groups, families and individuals. |
| **Long-term Conditions** | It is estimated that there could be over 32,000 people in Enfield with long-term-conditions aged 45-64 by 2012. It will be important to consider this population for health checks and screening for risk to enable early intervention and prevention, and to plan for the growth in demand for services. |
### Mental Health
There is a widely held belief amongst professionals that there are poor health outcomes for people with mild/moderate mental illness, dementia, young people in transition from Child and Adolescent Mental Health Services and for people from some black and minority ethnic groups. There is also evidence of high demand on GP services from people suffering from lower level mental health conditions.

### Healthy Lifestyle
In addition to factors listed above, it is a priority because:
- Higher than London average binge drinking over 55 (13.9%)
- Teenage conceptions are higher than the London average – 48.1 per 1000 (2007)
- 55% of all adults living in Enfield are not participating regularly in any moderate intensity sport and physical activity, which is above the London average.

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

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

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

Places the JSNA in context – how the JSNA should be used and responded to by the local strategic partnership and by commissioners. Considers its application to World Class Commissioning and how it relates to ‘Putting People First’.

Who is the JSNA written for?

The JSNA is for everyone who has an interest in and responsibility for improving services to better meet the health and wellbeing needs of the people of Enfield. This will include people who have a wide range of responsibilities such as Councillors and NHS Enfield Board members and those who have particular responsibilities such as members of the local Health and Wellbeing Board, as well as people who receive services and those who care for them, and organisations that aim to represent the interests of patients, service users and carers. However, the primary purpose of the JSNA is to provide evidence to inform the development of joint health and social care commissioning strategies and it is upon this that the JSNA will ultimately be evaluated.

So the JSNA focuses on evidence of need, evidence of what residents believe is important and evidence of what works. It does not specify what changes to services might be required, neither does it evaluate existing commissioning responses to need. The intention is to provide information about need to guide commissioners at a strategic partnership level. The Department of Health Guidance on the JSNA states that “Local Authorities are to ensure that the JSNA is taken into account in its preparation of the Sustainable Community Strategy”, so in due course the Local Area Agreement (agreed between the Government and the Enfield Strategic Partnership) will need to take into account the JSNA.

It should be noted that the evidence is not intended to provide information to help people to manage their own health.

By looking at need as broadly as possible, priorities have been identified that lend themselves to an integrated approach to commissioning. For example it is well known that there is an association between poverty and above average mortality, but causality is complex and there isn’t an easy solution. Issues like reducing obesity are rightly seen as a challenge for us all, the JSNA aims to define problems in such a way that encourages working together to maximise the impact of available resources.

The Priority Needs also have implications for activities that Enfield Council is responsible for or has influence over, other than health and social care. Those responsible for community safety and place-shaping will be informed by the Priority Needs, and it is likely that all of the Thematic Action Groups which co-
ordinate the delivery of the Sustainable Community Strategy will be influenced by the evidence.

**Commissioning for Health and Wellbeing**

The JSNA is integral to the delivery of the Enfield Strategic Partnership and its key commitments to the people of Enfield. It summarises the evidence basis of health and wellbeing need in the borough and in turn informs:

- The Sustainable Community Strategy
- The targets and priorities of the Local Area Agreement
- The baseline requirements of World Class Commissioning
- Strategic alignment with the Children and Young People’s Plan

The JSNA will inform the development of joint health and social care commissioning strategies. It will facilitate an integrated health and social care response to improving health outcomes and enable a stronger focus on commissioning services that will reduce inequalities and improve quality of life. This will enable commissioners to work together with key partners to coordinate their planning so that services are better placed to meet these current and future needs.

The Department of Health (DH) vision for commissioned services includes moving to a focus on health and wellbeing, quality and outcomes. From the *Commissioning Framework for Health and Wellbeing (DH March 2007)*:

“We now need to keep the focus on people – not just people who are ill, but everybody. And we need to look further than just physical health problems, to promote well-being, which includes social care, work, housing and all the other elements that build a sustainable community.”

The JSNA supports this vision by bringing together evidence from the entire spectrum of experience of the local communities of Enfield. It considers health outcomes together with the wider determinants of health, and focuses not only on ill health but on areas of need for prevention and support at community level.

Much of the evidence set out in the JSNA is already known and is already informing the commissioning process and service planning. The particular value of the JSNA is bringing the evidence together to provide a strategic assessment of need that is distinct and separate from the commissioning process.

The *Commissioning Framework for Health and Wellbeing (DH March 2007)* sets out a particular role for commissioners which makes the following points:

- the vision is for a wider range of more innovative providers that work with commissioners to offer services better tailored to the changing needs of individuals and make a reality of commitment to shift care closer to home and towards a greater emphasis on prevention and early intervention
commissioners have a key role to play in shaping the market through dialogue and procurement to stimulate providers to produce innovative solutions and create an environment where these can be sustained.

- more strategic, earlier discussion with provider communities about need (e.g. by making available the Joint Strategic Needs Assessment and the Prospectus), transparent fair procurement, and introducing or increasing contestability by addressing potential barriers to entry
- commissioners to develop effective and strong partnerships with current and potential providers

This vision has been developed in *Putting people first: a shared vision and commitment to the transformation of adult social care (DH December 2007)* and *World Class Commissioning: Competencies (DH December 2007)*.

### Putting People First

This landmark document establishes the collaboration between central and local government, the sector’s professional leadership, providers and the regulator. It proposes that localities should be working towards having “a single community based support system focussed on the health and wellbeing of the local population”, and that this system will bind together “local Government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training”.

It visualises “a system-wide transformation, developed and owned by local partners”. The JSNA is seen as having a key role in this process and it also proposes that the JSNA be “accompanied by an integrated approach with local NHS commissioners and providers to achieve specific outcomes on issues including:

- relevant preventative public health policies, for example, infection control, immunisation and screening;
- hospital discharge arrangements;
- the provision of adequate intermediate care;
- the management of long term conditions;
- packages of support with a health and/or nursing care element;
- co-located services, bringing together social care, primary care and other relevant professionals;
- community equipment services;
- universal information, advice and advocacy;
- carer support and public/patient involvement;
- complaints systems”

To deliver all of this commissioning is required which “incentivises and stimulates quality provision offering high standards of care, dignity and maximum choice and control for service users”.

10
World Class Commissioning

A robust JSNA is vital to effective joint commissioning and Government have made clear the importance they attach to the JSNA to inform World Class Commissioning, particularly Competencies 2 and 5.

**Competency 2**

“PCTs should not commission services in isolation. In addition to commissioning healthcare services, they will need to consider the wider determinants of health and the role of other partners in improving the health outcomes of their local population. PCTs also share responsibility for undertaking a Joint Strategic Needs Assessment (JSNA) with local authorities.”

*World Class Commissioning Assurance Handbook (DH June 2008)*

**Competency 5**

“The Joint Strategic Needs Assessment (JSNA) will form one part of this assessment but when operated at world class levels will require more and richer data, knowledge and intelligence than the minimum laid out within the proposed duty of a JSNA.”

*World Class Commissioning Assurance Handbook (DH June 2008)*

The JSNA aims to contribute to the world class commissioning process on several levels:

- working in partnership with the local authority to conduct needs assessments, with clear and demonstrable outputs and conclusions
- assessing need using a consistent and validated methodology
- drawing on both qualitative and quantitative information from a variety of stakeholders
- understanding the key reasons why health and wellbeing outcomes vary from what is expected
- developing a fact-based list of the major health risks and priorities facing different communities in the local population
- identifying trends over time in major health and wellbeing issues
- gaining key insights from public, patients, clinicians and other stakeholders
- giving a view of unmet needs for the local population at ward level
- benchmarking against national and peer groups on local health needs and priority health outcomes
2. Consulting the People of Enfield and Involving Stakeholders

Describes how residents were consulted and how the JSNA has been informed by their views. Also sets out how staff, third sector organisations, private sector providers, Councillors, NHS Enfield Board members and the Strategic Partnership were engaged in the process of developing the JSNA.

2.1 Listening to residents

The views of residents of Enfield have been fundamental to the development and selection of the priorities outlined. These views and opinions have sometimes challenged the ‘professional’ opinion about what is important and relevant in achieving ‘well being’ for local people.

As section 2.2 below demonstrates, views and opinions have been sought in a variety of ways. Making sure that the JSNA is ‘fit for purpose’ will demand that the Council and NHS Enfield listen to what people have to say and act on it.

It is certain that the ongoing developments in health and social care – to increase choice and independence and to transform the way that health and social care needs are met, will ensure that the conversation about wellbeing that has been started with Enfield residents through this JSNA will grow and increasingly enable the engagement of more residents, including some of those whose voices are seldom heard.

2.2 List of those Consulted

Information was sought through a Health and Wellbeing survey, which was made available as follows:

- included in the Citizen’s Panel questionnaire
- circulated to libraries, GP surgeries and sent to people who responded to the publicity
- electronically provided on the Council website and linked to PCT website

Live consultations were held with particularly vulnerable and hard-to-reach groups, which were identified in consultation with Enfield Community Empowerment Network, Enfield Racial Equality Council, Enfield Disability Action and Enfield LINk. These were as follows:

- MIND
- One-to-One
- Hard-of-Hearing and Deafened group
- BSL users
Stakeholder involvement was further sought via the Enfield Strategic Partnership (ESP) through the:

- Health and Wellbeing Board
- Health Improvement Partnership
- Thematic Action Groups
- Health and Social Care Partnership Boards

In addition a specific event was held by the ESP to consult on the developing priority needs.

Staff in NHS Enfield and Health and Adult Social Care within the Council were consulted via email and existing consultation mechanisms. Key staff were asked to contribute ‘expert opinion’.

Third sector organisations were involved in planning and applying the survey, and they also provided further evidence in relation to the Priority Needs. The results of the survey are set out below in 2.3 and the wider stakeholder engagement and the Scrutiny process is described below in 2.4.

2.3 Results of the Consultation

The Health and Wellbeing Survey was available as a questionnaire on the Council and PCT websites as well as a paper version. Most of the questions required a tick-box response, and there were two free-text options. The same questions (except for the omission of one of the free-text options) were also included in the most recent Citizen’s Panel questionnaire. Questions were asked about individual health and wellbeing, as follows:

a) factors impacting on chances of living a long and healthy life
b) where people get the most useful advice from
c) factors that facilitate good access health and social care services
d) unmet need.

In addition opinion was also sought about what are the greatest risks to health and wellbeing in Enfield.

A copy of the survey questions is available at the end this chapter (Appendix 1).

Consultation events were also undertaken with groups that are particularly vulnerable and hard-to-reach, asking similar questions that allowed for a free-text response. Voluntary organisations helped to plan the consultation and to facilitate the process, and to provide additional evidence to support the Priority Needs.
There were 471 responses from members of the Citizen’s Panel. Those responses that were relatively high in number can be regarded as being statistically significant. Where the numbers are lower the results are referred to as indicative.

131 people elected to complete either the online or paper questionnaire. Although the overall number of responses is not statistically significant, they are valuable in demonstrating the opinions of those people who were motivated to complete a questionnaire. 35 people completed the paper questionnaire from the postal code area EN1, many of whom would have received it via a mailing from the Bush Hill Park Association.

At the consultation events 82 people provided responses. Of this number, 24 people with a learning difficulty completed an easy-to-read version of the questionnaire. The results for each of the five questions are summarised below. A ranking system is used which corresponds to the number of recorded preferences.

Much of this evidence was used to inform the development of the priority needs. Additional uses for these results are also suggested below.

Some comparisons are also made with responses to the Enfield Place Survey 2008/9.

What follows considers the various responses to each question in turn.
RISKS TO GOOD HEALTH AND WELLBEING

This question was intended to identify priority health and wellbeing needs.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Citizen’s Panel</th>
<th>Elective Questionnaire</th>
<th>Easy-to-read Questionnaire</th>
<th>Consultation Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of crime</td>
<td>1st*</td>
<td></td>
<td>6</td>
<td>5th=</td>
</tr>
<tr>
<td>Poor parenting</td>
<td>2nd</td>
<td>3rd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dirty streets</td>
<td>3rd=</td>
<td></td>
<td>5th=</td>
<td></td>
</tr>
<tr>
<td>Pollution (including noise pollution)</td>
<td>3rd=</td>
<td></td>
<td>5th=</td>
<td></td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>3rd=</td>
<td></td>
<td>1st=</td>
<td>5th=</td>
</tr>
<tr>
<td>Unemployment</td>
<td>3rd=</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td>3rd=</td>
<td>2nd=</td>
<td>3rd=</td>
<td></td>
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<tr>
<td>Poverty</td>
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</tr>
<tr>
<td>People living alone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of suitable sport and leisure facilities</td>
<td></td>
<td>1st=</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unhealthy lifestyles</td>
<td></td>
<td></td>
<td>1st*</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td>3rd=</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Use</td>
<td>4th</td>
<td>5th</td>
<td></td>
<td></td>
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<tr>
<td>Sexual Health</td>
<td></td>
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<td>2nd</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td>3rd=</td>
<td></td>
</tr>
<tr>
<td>Clean Hospitals</td>
<td></td>
<td></td>
<td>3rd=</td>
<td></td>
</tr>
<tr>
<td>Anti-social behaviour</td>
<td></td>
<td>1st</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Significantly higher score than 2nd preference

In the questionnaires completed at the consultation events with hard-to-reach and particularly vulnerable groups, 30% of the respondents identified a need for the promotion of healthy lifestyles, fitness and healthy diet with an emphasis on parents and young people. The second most common identified risk was sexual health (20%), and the common theme from the proposals was improvements to services for gay men. The most commonly mentioned mental health conditions were neuroses.

The following points are taken from the Citizen’s Panel responses which are based on sufficient data to be regarded as statistically significant:

- Age appears to have an influence on residents’ views on which risks to good health and wellbeing are important to address in Enfield - those aged 65 or over are more likely than residents in general to see pollution...
(27%* compared to 20%) and people living alone (25% compared to 9% overall) as important risks to address, while residents aged 55-64 are particularly concerned about obesity (26% compared to 19% overall)

- those residents with children under the age of 16 who are more likely than other residents to cite poor accommodation as a risk in need of addressing (26% compared to 14% overall)

*Please note: each person could choose up to 3 options so total percentages add up to nearly 300%.

The following points from the Citizen’s Panel responses in relation to social class are indicative only:

- There was a significant variation for pollution. The average figure was 20%. It was more important for people in social class C2 (skilled manual) being cited by 29%, but it was cited by only 15% of people in social class DE (unskilled manual and unemployed). However the position is reversed for Dirty Streets with 12% of C2s citing this and 24% of DEs.
- The widest variation for the risks of alcohol consumption was again between C2s and DEs, 15% and 27% respectively.
- Unemployment was cited by 32% of C2s compared with 19% of ABs (managerial and professional).
- Obesity was a significantly higher concern for ABs (31%) than the other social classes, where it was more less their 10th priority
- For C2s their second highest priority was heavy traffic (29%), whereas this was much lower for the others

The following comparative evidence is taken from the Enfield Place Survey 2008/9:

- Respondents were asked to identify what is most important in making somewhere a good place to live, and then asked to identify what was most in need of improvement. For the latter the top 6, which accounted for the majority of responses, which were (in order): level of crime, road and pavement repairs, activities for teenagers, level of traffic congestion, clean streets, and health services. Affordable decent housing was 7th and pollution was 17th.
- Asked about whether people felt safe or unsafe after dark, 41% of respondents felt fairly unsafe or very unsafe, compared with the Outer London average of 39%. The daytime figure was 9%, compared with the Outer London average of 8%.

Pupils in years 6, 8 and 10 from across a sample of schools in Enfield participate in an annual national survey (TellUs). This covers a range of issues including aspects about their health. 1,361 pupils completed the latest survey (TellUs 3). The key messages are as follows:

- Enfield’s children and young people feel marginally less healthy than national average. On healthy eating and participation in physical activity we are also below national average, although a more recent survey shows
that participation in sport and physical activity in and outside school is better than the national average.

- On Information & Advice available to them, their perceptions of quantity and quality information and advice on health issues are below national. They’d like to have better information and advice on alcohol, smoking and drugs.
- Enfield young people compare well against the national average on issues such as drugs, alcohol and smoking.
- On mental and emotional health issues the sorts of things Enfield pupils worry about the most are: school work and exams, my future, my parents or family, getting into trouble, crime, my body and friendships. They worry less about bullying, being healthy, money, and girlfriends or boyfriends. 62% say they feel happy about life at the moment and 95% have one or more good friends.

See Appendix 2 for key results.

**FACTORS IMPACTING ON CHANCES OF LIVING A LONG AND HEALTHY LIFE**

The majority of respondents to all forms of consultation identified lifestyle as being the most significant, with social circumstances coming second.

For respondents who participated in the consultation events, the most common description of lifestyle was in relation to poor diet (both quality and quantity), drinking too much alcohol and lack of exercise.

This information will be of value in the planning of services that seek to change people’s behaviour.

**WHERE PEOPLE GET THE MOST USEFUL ADVICE FROM**

<table>
<thead>
<tr>
<th>Source</th>
<th>Citizen's Panel</th>
<th>Elective Questionnaire</th>
<th>Easy-to-read Questionnaire</th>
<th>Consultation Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>1st*</td>
<td>1st*</td>
<td>1st*</td>
<td>1st</td>
</tr>
<tr>
<td>Internet web site</td>
<td>2nd</td>
<td>2nd</td>
<td>2nd</td>
<td></td>
</tr>
<tr>
<td>Pharmacy or chemist</td>
<td>3rd</td>
<td>3rd</td>
<td></td>
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</tr>
<tr>
<td>Friend or family</td>
<td>4th</td>
<td>3rd</td>
<td>3rd</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>4th</td>
<td>2nd</td>
<td></td>
<td></td>
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<tr>
<td>Voluntary organisation</td>
<td></td>
<td></td>
<td>4th</td>
<td>4th</td>
</tr>
</tbody>
</table>

*Significantly higher score than 2nd preference

This information will be helpful in targeting health and wellbeing advice.
FACTORS THAT FACILITATE GOOD ACCESS TO HEALTH AND SOCIAL CARE SERVICES

<table>
<thead>
<tr>
<th>Good Access Factors</th>
<th>Citizen’s Panel</th>
<th>Elective Questionnaire</th>
<th>Easy-to-read Questionnaire</th>
<th>Consultation Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being treated with dignity and respect by staff</td>
<td>1st*</td>
<td>1st</td>
<td>1st</td>
<td>1st*</td>
</tr>
<tr>
<td>Cleanliness of the places where services are provided</td>
<td>2nd</td>
<td>3rd</td>
<td>3rd=</td>
<td>2nd</td>
</tr>
<tr>
<td>Not having to wait too long</td>
<td>3rd</td>
<td>2nd</td>
<td>2nd</td>
<td></td>
</tr>
<tr>
<td>How seriously staff take your concerns</td>
<td>4th</td>
<td>4th</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The attentiveness of the staff</td>
<td></td>
<td></td>
<td>3rd=</td>
<td></td>
</tr>
<tr>
<td>The availability of public transport to the services</td>
<td></td>
<td></td>
<td>3rd=</td>
<td></td>
</tr>
<tr>
<td>Better information</td>
<td></td>
<td></td>
<td></td>
<td>3rd</td>
</tr>
<tr>
<td>More joined-up working</td>
<td></td>
<td></td>
<td></td>
<td>4th</td>
</tr>
</tbody>
</table>

*Significantly higher score than 2nd preference

The responses from most of the particularly vulnerable and hard-to-reach groups were broadly in line with those of the respondents to the questionnaires, although there were some variations. However consultation with British Sign Language (BSL) users (mainly people deaf from birth), identified a strong belief that people are experiencing poor interaction with health professionals because of communication barriers, in some cases resulting in poor health outcomes.

The purpose behind this question was to identify what needs were important in the delivery of services. This needs-based approach contrasts with most surveys of service users which seek to measure satisfaction.

UNMET NEED

This question did not produce any meaningful information. It was not used in the Citizen’s Panel, and only a minority of elective and easy-to-read questionnaire respondents completed this section. Those who did respond mainly repeated answers they had given to previous questions.

This question was intended to identify need that was not being met, where the right type of service is not available. It proved to be too complex an issue to produce a result via a questionnaire.
2.4 Stakeholder Engagement

A JSNA Steering Group was set up which includes representatives at Assistant Director level from NHS Enfield and the Council. In addition senior staff from specialist sections of the Council and NHS Enfield are represented. The Mental Health Trust, Enfield LINk and Enfield Community Empowerment Network are also represented.

Staff from Enfield Council, NHS Enfield, third sector and private social care providers, and representatives of user-led organisations have participated in shaping the JSNA via the Enfield Strategic Partnership network and other established networks e.g. the Enfield Community Empowerment Network. In addition to participating in awareness-raising on the role of the JSNA, some staff and representatives from third sector organisations with particular expertise have contributed by providing evidence of effectiveness.

A key component of the JSNA process was developing a list of priority needs that will inform commissioning and influence other strategies. Representatives from the Enfield Strategic Partnership Thematic Action Groups and the Health and Social Care Partnership Boards, have participated in the development of this list.

All Enfield Councillors and members of the NHS Enfield Board have been made aware of the JSNA process. It has been considered by the Health Scrutiny Panel, and by the Health and Adult Social Services Scrutiny Panel.

Inevitably there are some views that are not as strongly represented as perhaps they could have been. Although much good work on involvement in identifying need has been undertaken via the Children and Young People’s Plan, in future revisions of the JSNA there will be value in more explicitly obtaining the views of children and young people. As previously acknowledged many contributions of material and ideas were not included in the final document for a variety of reasons, but these contributions were essential to the process of determining priorities. The JSNA Steering Group will be undertaking a review of the whole JSNA process to ensure that the process is improved next time, and stakeholder engagement will form a significant part of this review.
APPENDIX 1: Health and Wellbeing Survey

Joint Strategic Needs Assessment

Health and Well-being Survey 2009

Enfield Council and Enfield NHS want to get a better idea of what residents think is important about health and well-being. This is so we can effectively plan for future services, and ensure we continue to meet the needs of the local community by identifying any gaps in current provision.

Your opinion is sought about what are the greatest risks to health and well-being in Enfield.

Questions are also asked about individual health and well-being:

- what affects your chances of living a long and healthy life
- where people get the most useful advice from
- what is important when using health and social care services
- needs that are not met satisfactorily, because the right types of service are not available.

The questions are designed to be self-explanatory, but if you would like more information this is available online at www.enfield.gov.uk and www.enfieldpct.nhs.uk/publications/index.shtml (Follow links for Joint Strategic Needs Assessment)

Alternatively, you can contact Peter Feldon for more information or if you require this questionnaire in another language or format.

020 8379 3957
Email Peter.Feldon@enfield.gov.uk

Everyone who completes this questionnaire will be entered into a prize draw to win one of five £50 vouchers to spend at Marks and Spencer.

The closing date for this questionnaire is 30 June 2009.
Listed below are a number of possible risks to someone’s good health and well-being

Q1. Which TWO or THREE, if any, do you think are most important to address in Enfield?
   Please tick ✓ up to three boxes only in the left column below

Q2. Which ONE, if any, do you think is the MOST important to address in Enfield?
   Please tick ✓ one box only in the right column below

<table>
<thead>
<tr>
<th>Risk</th>
<th>Q1</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People living alone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pollution (including noise pollution)</td>
<td></td>
<td></td>
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<tr>
<td>Poor accommodation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td></td>
<td></td>
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<tr>
<td>Drug use</td>
<td></td>
<td></td>
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<tr>
<td>Diet</td>
<td></td>
<td></td>
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<tr>
<td>Sexual health problems</td>
<td></td>
<td></td>
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<tr>
<td>Poor parenting</td>
<td></td>
<td></td>
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<tr>
<td>Safety of children and young people</td>
<td></td>
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<tr>
<td>Smoking</td>
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<tr>
<td>Poverty</td>
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<tr>
<td>Allergies</td>
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<td></td>
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<tr>
<td>Heavy traffic</td>
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<tr>
<td>Dirty streets</td>
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<tr>
<td>Depression and anxiety</td>
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<td></td>
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<tr>
<td>Fear of crime</td>
<td></td>
<td></td>
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<tr>
<td>Anti-social behaviour</td>
<td></td>
<td></td>
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<tr>
<td>Stress</td>
<td></td>
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<tr>
<td>Unemployment</td>
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<td></td>
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<tr>
<td>Personal debt</td>
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<td></td>
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<tr>
<td>Lack of suitable sport and leisure facilities</td>
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<td></td>
</tr>
<tr>
<td>Q1 – Other (Please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2 – Other (Please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None of these</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q3. What, if anything, do you think should be done to improve health and well-being for the risk you identified in Q2?

Q4. How likely, if at all, are you to attend a meeting to tell the Council and local NHS what you think is important about health and well-being in Enfield? (Please tick ✓ one box only)

Very likely ✓  Fairly likely ✓  Not very likely ✓  Not at all likely ✓  Don't know ✓

Q5. From the following list, which ONE or TWO factors, if any, do you think have the biggest impact on your chances of living a long and healthy life? (Please tick ✓ up to two boxes only)

Your lifestyle (for example, what you eat, whether you smoke or drink alcohol)

Whether you are male or female

Your genes (genes determine characteristics that you might inherit from your parents such as eye colour or being tall)

You social circumstances (your living and working conditions)

Financial circumstances

Having a university degree

The National Health Service (NHS)

Other (please specify)

None of these

Don't know
Q6. From who or where are you most likely to seek advice or get information about health and well-being? (Please tick ✓ up to three boxes only in the left column below)

Q7. Which one do you feel is most important? (Please tick ✓ one box only in the right column below)

<table>
<thead>
<tr>
<th>Q6</th>
<th>Q7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your GP</td>
<td></td>
</tr>
<tr>
<td>Other doctor</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
</tr>
<tr>
<td>Pharmacy or chemist</td>
<td></td>
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<tr>
<td>Enfield Primary Care Trust (PCT)</td>
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<tr>
<td>Your local hospital</td>
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<tr>
<td>Enfield Council</td>
<td></td>
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<tr>
<td>The Government</td>
<td></td>
</tr>
<tr>
<td>Voluntary organisation (for example, Age Concern)</td>
<td></td>
</tr>
<tr>
<td>Council employee (for example, social worker)</td>
<td></td>
</tr>
<tr>
<td>Friend or family</td>
<td></td>
</tr>
<tr>
<td>Someone you know who has had similar health and well-being concerns</td>
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<tr>
<td>Local community leader</td>
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<tr>
<td>Local religious leader</td>
<td></td>
</tr>
<tr>
<td>Public figure/celebrity</td>
<td></td>
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<tr>
<td>TV or radio</td>
<td></td>
</tr>
<tr>
<td>Newspaper or magazine</td>
<td></td>
</tr>
<tr>
<td>Book</td>
<td></td>
</tr>
<tr>
<td>Internet website</td>
<td></td>
</tr>
<tr>
<td>Telephone advice services</td>
<td></td>
</tr>
<tr>
<td>Leaflets</td>
<td></td>
</tr>
<tr>
<td>Q6 – Other (Please specify)</td>
<td></td>
</tr>
<tr>
<td>Q7 – Other (Please specify)</td>
<td></td>
</tr>
<tr>
<td>None of these</td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
</tr>
</tbody>
</table>
Q8. From the list below, which TWO or THREE, if any, do you think are the most important considerations for you when you are using health and social care services in Enfield? (Please tick ✓ up to three boxes only)

- Being treated with dignity and respect by staff
- Sensitivity to cultural needs
- Sensitivity to language needs
- Sensitivity to other communication needs
- Not having to wait too long
- Not having too far to travel
- The availability of public transport to the services
- The cost of car parking
- The availability of car parking
- Physical access to the buildings
- Cleanliness of the places where services are provided
- How seriously staff take your concerns
- The friendliness of the staff
- The attentiveness of the staff
- The explanations provided to you during your visit
- Your needs being met
- Other (please specify)
- None of these
- Don’t know

Q9. What type of service, that is currently not available to you, would you like? Can you also show the corresponding health/well-being need that is not being met satisfactorily, for example,

<table>
<thead>
<tr>
<th>Desired service</th>
<th>Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air conditioning</td>
<td>Breathing difficulties that result in hospital admission</td>
</tr>
<tr>
<td>Someone to take me to the pub, shops, etc.</td>
<td>Loneliness</td>
</tr>
<tr>
<td>Exercise facility in the workplace</td>
<td>Overweight/unfit</td>
</tr>
</tbody>
</table>
...and finally

Q10. Please let us know the postcode area in which you live

- EN1
- EN4
- EN11
- N18
- Other
- EN2
- EN8
- N13
- N21
- EN3
- N9
- N14
- N22

If 'Other', please specify

Q11. Please tick the box which best suits your ethnicity

- White
- Asian or Asian British
- Black or Black British
- Mixed
- Any other ethnic group
- If other, please specify
- I do not wish to state my ethnic origin

Q12. Are you: Male ☐ Female ☐ Transgender ☐ Prefer not to say ☐

Q13. Do you have any physical or mental impairment that has a substantial and long-term adverse effect on your ability to carry out normal day-to-day activities?

- Yes ☐ No ☐ Prefer not to say ☐

If 'Yes', please state the nature of your long-term illness, disability or progressive condition

Q14. Your age:

- 16-17
- 18-19
- 20-24
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50-54
- 55-59
- 60-64
- 65-69
- 70-74
- 75-79
- 80-84
- 85+
- Prefer not to say

Thank you for taking the time to complete this questionnaire. Please return to the freepost address below or in the envelope provided. You do not need a stamp.

Joint Strategic Needs Assessment Survey
Health and Adult Social Care, Enfield Council, FREEPOST NW 5036, Civic Centre, Enfield EN1 3BR

Prize Draw

If you want to take part in the prize draw, please let us have your contact details below. Please be assured that the details you give us will only be used to contact you if you win a prize and will not be used for any other purpose. If you have won a prize you will be notified by Friday 31 July 2009.

Name
Address

Telephone number

Postcode

Email
APPENDIX 2: The key results from the TellUs 3 survey

How healthy are you most of the time?
Very healthy   30%
Quite healthy  54%
Not very healthy 13%
Don’t know     3%

How many portions of fruit and vegetables do you usually eat each day?
None          4%
1 – 2         30%
3 – 4         39%
5 or more     21%
Don’t know    6%

In the last 7 days, on how many days have you spent at least 30 minutes doing sports or other active things?
None          6%
1 – 2 days    30%
3 – 5 days    32%
6 – 7 days    28%
Don’t know    5%

Have you ever had alcohol?
I have never had an alcoholic drink 33%
I have never been drunk            37%
I have been drunk but only once or twice and not recently 14%
I have been drunk once within the last 4 weeks 4%
I have been drunk twice within the last 4 weeks 2%
I have been drunk 3 or more times in the last 4 weeks 2%
Prefer not to say                   7%

Have you ever smoked cigarettes?
I have never smoked a cigarette    79%
I have smoked cigarettes only once or twice 11%
I used to smoke regularly but I don’t now 1%
I sometimes smoke, but not every week 2%
I smoke regularly, once a week or more 0%
I smoke cigarettes every day       3%
Prefer not to say                   4%

Have you ever taken drugs?
Yes            7%
No             89%
Prefer not to say 4%
3. Priority Needs

Summarises the supporting evidence for each of the Priority Needs under these headings:

- Evidence of need and poor outcomes
- Evidence of the views of the public and patients / users of services
- Evidence of what works

Further detail is provided in chapters 4 and 5.

1. Poverty

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

Evidence of need and poor outcomes

The most important factors influencing the health of a population are the ‘wider determinants of health’ such as poverty, income and housing. These in turn have powerful impacts on peoples’ lifestyles. For example, it is well established that social deprivation is strongly associated with higher smoking rates, poorer diets, lower levels of physical activity and higher rates of substance misuse.

A report to Enfield Council Management Board noted that “the recession is likely to affect sooner and more severely, those residents who are in vulnerable situations and/or already experiencing poverty, deprivation and unemployment”.

Evidence of the views of the public and patients / users of services

Poverty and unemployment were in the top three of risks to good health and wellbeing identified by respondents to the local survey.

Unemployment was cited by 32% of skilled manual workers compared with 19% of people employed in managerial and professional roles.

Evidence of what works

Government advice set out in Taking Up: The Challenges proposes actions local authorities and partners can take to increase take up of benefits and tax credits by parents. They are asked to ensure that efforts to increase take up are
integrated within existing services and personalised to help parents to access all the financial support to which they are entitled, alongside other support they need to address wider issues, for example:

- a parent accessing a wide range of existing services, for example a children’s centre, childcare, health services (including mental health services), employment support or housing advice, should be able to receive information on benefits and tax credits, or be helped to access a specialist agency
- services working with parents should be able to take an overview of the personal needs and concerns of a family, and help the family identify how to tackle all these issues wherever possible.

### 2. Health Inequalities

There is a significant gap in life expectancy for men and women between deprived and more affluent wards (8.8 years for men and 10 years for women) and there is evidence that this gap is widening. This is a key indicator for serious underlying inequalities in health outcomes. Patterns of inequality mirror the patterns of deprivation seen within the borough. Deprived areas are experiencing poor outcomes across multiple areas of health and wellbeing.

#### Evidence of need and poor outcomes

Life expectancy at birth in Enfield over the past 15 years has been higher than London or national averages for both males and females. However, the rate of increase in life expectancy has not matched that seen in London and nationally, and there is a significant life expectancy gap between deprived and more affluent wards within the borough. There is evidence that this gap is widening for both men and women. The gap in life expectancy is currently 8.8 years for males and 10 years for females between more and less deprived wards in Enfield.

Inequalities in health are expressed using two key population measures: Infant mortality and life expectancy at birth. Infant mortality is considered separately.

**Tackling Health Inequalities: 10 Years On – A review of developments in tackling health inequalities in England over the last 10 years** reports that the health inequality gap between the well off and the poorest groups has not narrowed and seems to be widening: everyone has got healthier, but the health of the rich has improved faster than the poorest.

*The Health Select Committee Report on Health Inequalities* stated that "Health inequalities are not only apparent between people of different socioeconomic groups – they exist between different genders, different ethnic groups, and the elderly and people suffering from mental health problems or learning disabilities also have worse health than the rest of the population. The causes of health inequalities are complex and include lifestyle factors – smoking, nutrition, exercise to name but only a few – and also wider
determinants such as poverty, housing and education. Access to healthcare may play a role, but this appears to be less significant than other determinants.

The London Health Observatory (LHO) Health inequalities intervention tool identifies the main causes of mortality which contribute to the gap in life expectancy for Enfield: Circulatory diseases (including CHD and stroke), cancer and respiratory disease.

Evidence of the views of the public and patients / users of services

The majority of respondents to a question in the local survey about ‘Factors Impacting on Chances of Living a Long and Healthy Life’ identified lifestyle as being the most significant, with social circumstances coming second.

Evidence of what works

The Local Government Information Unit commentary on Tackling Health Inequalities: 10 Years On – A review of developments in tackling health inequalities in England over the last 10 years notes that Local Area Agreements have the potential to have a significant impact on health inequalities, and recommends that the impact be robustly evaluated via the Marmot Review – the Strategic Review of Health Inequalities in England Post 2010. The key objective of the review is to focus on the social determinants of health and in particular, the way they influence health inequalities.

The LHO Health Inequalities Intervention tool models the potential gain in life expectancy in Enfield resulting from implementation of four evidence based interventions:

1. Reducing infant mortality
2. Smoking cessation
3. Prescribing antihypertensives
4. Prescribing statins.

3. Obesity

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

Evidence of need and poor outcomes

The Select Committee on Health has identified that “obesity has grown by almost 400% in the last 25 years and on present trends will soon surpass smoking as the greatest cause of premature loss of life. It will entail levels of sickness that will put enormous strains on the health service. On some
predictions, today’s generation of children will be the first for over a century for whom life expectancy falls”. Diseases related to overweight and obesity were estimated to cost the NHS in Enfield £75 million in 2008 and it is expected this will rise to £84 million by 2015.

Looking specifically at childhood obesity, London is the English region with the highest prevalence of obesity in reception and year 6 children, and in Enfield obesity in reception and year 6 is above the London average.

**Evidence of the views of the public and patients / users of services**

Obesity was in the top three of risks to good health and wellbeing identified by respondents to the local survey.

Respondents from the Citizen’s Panel aged 55-64 were particularly concerned about obesity (26% compared to 19% overall). Obesity was a significantly higher concern for people employed in managerial and professional roles (31%) than for others, where it was more or less their 10th priority.

**Evidence of what works**

National strategy is set out in *Healthy Weight, Healthy Lives: One Year On* (April 2009). The focus is on aspiration and there is little evidence of effectiveness. The next steps are to:

- help people make healthier choices
- continue to create an environment that supports healthier choices
- provide quality services for those in need of weight management advice and support
- enable all those involved in delivery to work effectively together.

There is some evidence on interventions for treating obesity in children i.e. family-based, lifestyle interventions (which include a behavioural programme aimed at changing diet and physical activity) provide significant and clinically meaningful decreases in overweight and obesity in both children and adolescents, compared with standard care or self-help regimes.

The importance of providing better evidence of effectiveness is demonstrated by the recent setting up of the *Healthy Weight Healthy Lives: Independent Expert Advisory Group*.

**4. Infant Mortality**

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

Nationally infant mortality rates are falling in all socio-economic groups. Contrary to this trend, the infant mortality rate in Enfield appears to have increased in recent years. The highest rates are in Upper Edmonton, Lower Edmonton and Ponders End.

The following risk factors for infant mortality may be contributing to this trend:

- poverty affecting children – many areas in the east and south of the borough rank in the most deprived 10% nationally
- Enfield’s teenage conception rate has been above the London and national averages since 2002 although has fallen recently from 55 per 100,000 in 2006 to 48.1 per 100,000 in 2007
- late booking for antenatal appointments – against a 2008/9 target of 88% of pregnant women having a first appointment by 12 weeks, Enfield achieved 60.4%
- inadequate housing – Enfield has the 4th largest number of households in temporary accommodation in England and in the first 9 months of 2008 had the 6th highest rate of acceptance for homelessness
- maternal obesity – Enfield is estimated to have the third highest prevalence of adult obesity in London.

Evidence of the views of the public and patients/users of services

Poor parenting was in the top three of risks to good health and wellbeing identified by respondents to a local survey.

Evidence of what works

The Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide suggests that the gap in infant mortality can be reduced:

1. reducing the prevalence of obesity
2. meeting the national target to reduce smoking in pregnancy from 23% to 15%
3. reducing sudden unexpected death in infancy (SUDI) by persuading women to avoid sharing a bed with their baby and avoid putting their baby to sleep prone (on its front)
4. achieving the teenage pregnancy strategy to reduce the under-18 conception rate
5. meeting the child poverty target to halve the number of children in relative low-income households between 1998-99 and 2010-11, by increasing the income
6. reducing housing overcrowding
7. promoting early antenatal booking among disadvantaged groups
8. Other contributing interventions include optimising preconception care, reducing maternal and infant infections, improving access to culturally sensitive health care and improving infant nutrition.
NICE guidance exists:
- **NICE 2006** – Prevention, identification, assessment and management of overweight and obesity in adults and children.
- **NICE 2008 (PH8)** Physical activity and environment.

### 5. Long-term conditions

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

**Evidence of need and poor outcomes**

The Department of Health, in its publication *Raising the Profile of Long Term Conditions Care: A Compendium of Information (DH January 2008)*, identifies age as the most significant driver of prevalence of long term conditions (LTC) which tend to become apparent from the age of 45 onwards. The Enfield population growth is expected to be greater in the 45-54 age group in this period (between 6 and 10%) so an increasing number of residents in this age group may be expected to present with long term conditions and potentially need access to related health and social care. It will therefore be important to consider this population for health checks and screening for risk, to enable early intervention and prevention strategies which will improve health and wellbeing outcomes.

From the General Household Survey 2005, 35% of those aged between 45 and 54 say they have one or more long-term conditions. This figure rises to 53% in the 60 to 64 age group. Applying these estimates to the Enfield population aged between 45 and 64 years, we find that between 30,158 and 30,600 are likely to be affected by one or more long-term conditions in 2009. This number is projected to rise to between 31,330 and 32,535 by 2012. This is an increase of between 1,172 and 1,935 over the next 3 years.

There is no evidence of needs not being met, however people with long-term conditions are intensive users of health and social care services, including community services, urgent and emergency care and acute services. People with long-term conditions account for a significant and growing amount of health and social care resources. The Department of Health’s best estimate is that the treatment and care of those with long-term conditions account for 69% of the total health and social care spend in England. Looking at social care expenditure, this too is focused on those with long-term conditions and will be put under pressure by an ageing population.

**Evidence of the views of the public and patients / users of services**

In recent national consultations, people have voiced their opinions about what matters most to them in the care and the services they receive. A number of
common themes and key messages have emerged. People want services that will support them to remain independent and healthy and have increased choice. They want far more services to be delivered safely and effectively in the community or at home; and they want seamless, proactive and integrated services tailored to their needs.

Feedback from *Your health, your care, your say* consultation:

- Of nearly 1,000 participants at the National Citizens’ Summit, 86% of people thought that professionals in their local GP practice should provide more support to help them take care of their own health and well-being.
- Some 61% said that being given more information about their health and the services available to them locally would make a big difference. They particularly want to know more about the availability of social care services.

Department of Health MORI Survey 2005 – supporting statistics:

- Some 82% of those with a LTC say that they already play an active role in their care but they want to do more to self care.
- More than 90% are interested in being more active self carers.

More than 75% say that if they had guidance/support from a professional or peer they would feel far more confident about taking care of their own health.

There is relatively little national survey evidence available on the views of social service users and carers about how services can be best provided, and the extent to which people wish to consider personal budgets. In Cambridgeshire (one of the few local authorities to do this) 62% of service users responding to their consultation welcomed the opportunity to have a personal budget. Of the remainder 8% did not welcome the opportunity and 30% were unsure.

**Evidence of what works**

In 2008 the prime minister Gordon Brown called on the NHS to develop in a way that ensure it gives “all of those with long-term or chronic conditions the choice of greater support, information and advice, allowing them to play a far more active role in managing their own condition in partnership with their clinicians”.

*Raising the Profile of Long Term Conditions Care: A Compendium of Information* (DH January 2008) recommends:

- Self care is a well proven and highly effective means of improving LTC care.
- Good disease management involves identifying needs early and responding promptly with the right care and support. Personalised care planning actively supports this approach.
- Evidence has shown that intensive, ongoing, personalised case management can improve quality of life and outcomes for people who have an intricate mix of health and social care needs and simple problems can cause their condition to deteriorate rapidly, putting them at risk of unplanned hospital admission.
Bringing staff together into multi-disciplinary teams can avoid fragmentation, confusion and duplication of effort in working with people with a range of complex needs, who often require care or support from a range of different professionals and agencies.

*Putting People First: A shared vision and commitment to the transformation of Adult Social Care* (DH December 2007) advocates a system-wide transformation, which involves an “integrated approach with local NHS commissioners and providers to achieve specific outcomes on issues... including the management of long-term conditions.” Key to this transformation is the mainstreaming of person centred planning and self-directed support, with personal budgets being available for everyone eligible for publicly funded adult social care support. Personal health budgets that will allow people greater control over the services they use and who provides them are now being piloted.

### 6. Mental Health

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

#### MILD/MODERATE MENTAL ILLNESS

**Evidence of need and poor outcomes**

1. It is estimated that 16% of people of working age (approx 29,000 people) suffer from depression and other neurotic disorders.
2. Between 10-15% (3,700 and 5,500) older people are estimated to suffer from depression.
3. Local survey data shows that Enfield would appear to have poorer low level mental illness in comparison with other London Boroughs, for the following categories: women, 16-34 age group and 55+ age group.
4. People who lose their jobs during a recession are at greater risk of suicide – and that for the least well-educated, the risks are even higher.
5. It is believed that dealing with patients with mental health problems consumes significant amounts of GP time.

**Evidence of the views of the public and patients / users of services**

JSNA consultation with mental health users did not identify any priorities that were distinctively related to mental illness.

Satisfaction surveys of patients demonstrate dissatisfaction with waiting times for psychological therapies.
Evidence of what works

The Improving Access to Psychological Therapies (IAPT) programme aims to help PCTs implement NICE Guidelines for people suffering from depression and anxiety disorders. The Government has provided funding, but an application from the Mental Health Trust was not successful in obtaining funding for Enfield.

Psychological treatments are recommended by NICE for common mental health problems – to be offered by GPs either before the prescription of psychoactive medication, or alongside their use.

DEMENTIA

Evidence of need and poor outcomes

The number of older people with a diagnosis of dementia is estimated to be between 2,500 and 3,300, with a higher prevalence among women, and this number is predicted to rise by 10% over the next 5 years (as the numbers of older people increases). Approximately 30% are likely to be living alone in their own homes, and 10% are in care homes.

Evidence of the views of the public and patients / users of services

None at present

Evidence of what works

Living well with dementia: a national dementia strategy draws on evidence from several recent reports and research which highlight the shortcomings in the current provision of dementia services. It proposes improvements are made to dementia services across three key areas:

- improved awareness
- earlier diagnosis and intervention
- a higher quality of care.

TRANSITION FROM CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES

Evidence of need and poor outcomes

Research suggests that early detection and treatment of first episode psychosis reduces the duration of untreated severe mental illness and results in less distress to young people.

Evidence of the views of the public and patients / users of services

None at present
Evidence of what works

The final report of the National CAMHS Review *Children and young people in mind* recommends that young adults who are approaching 18 and who are being supported by CAMHS should:

- know well in advance what the arrangements will be for transfer to adult services of any type
- be able to access services that are based on best evidence of what works for young adults
- have a lead person who makes sure that the transition between services goes smoothly
- know what to do if things are not going according to plan
- have confidence that services will focus on need, rather than age, and will be flexible.

BLACK AND MINORITY ETHNIC GROUPS

Evidence of need and poor outcomes

National research shows that people from black and ethnic communities may face difficulties including higher rates of mental illness in some communities, and subsequent problems with access to the right care and treatment, but they are less likely to have mental health problems detected by a GP.

Evidence of the Views of the Public and Patients / Users of Services

Local satisfaction surveys undertaken in June and July 2009 of in-patients’ experiences of their care in the Barnet, Enfield and Haringey Mental Health Trust (BEH-MHT) report that 88% and 98% respectively stated that they had been treated with dignity and respect.

Consultation undertaken by Health Link (commissioned by BEH-MHT) highlighted:

- barriers to accessing care, such as language barriers.
- importance of achieving a culturally appropriate service.

Evidence of What Works

Collecting data on ethnicity is an important part of building the local picture. The DH commissioned report *No Patient Left Behind: how can we ensure world class primary care for black and minority ethnic people?* says “that if PCTs are to continue to improve, they will need access to accurate and consistent information about performance and progress.”
7. Healthy Lifestyle

In addition to factors listed in other Priority Needs:

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

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

ALCOHOL CONSUMPTION

Evidence of need and poor outcomes

1. Excessive drinking is a major cause of disease and injury. Evidence suggests that rates of disease associated with alcohol are increasing e.g. death from alcoholic liver disease has risen nationally by 20% since 2001.
2. Enfield had the third highest increase of alcohol-related hospital admissions in England between 2002/03 and 2005/06. The local rate tripled between 2002/03 and 2006/07.
3. There is evidence that admissions due to alcohol related harm have been sharply rising in Enfield in recent years.

Evidence of the views of the public and patients / users of services

Alcohol consumption was in the top three risks to good health and wellbeing identified by respondents to a local survey.

Respondents from the Citizen’s Panel in the unskilled manual and unemployed category were most concerned about alcohol consumption (27% compared to 19% overall).

Evidence of what works

Government guidance set out in Signs for improvement – commissioning interventions to reduce alcohol-related harm has identified a number of High Impact Changes which are calculated to be the most effective actions for the reduction in alcohol-related harm:

- work in partnership
- develop activities to control the impact of alcohol misuse in the community
- influence change through advocacy
- improve the effectiveness and capacity of specialist treatment
- appoint an alcohol health worker
- provide more help to encourage people to drink less
- amplify national social marketing priorities
TEENAGE PREGNANCY

Evidence of need and poor outcomes

Having children at a young age can damage young women’s health and wellbeing and severely limit their education and career prospects. While individual young people can be competent parents, the evidence shows that children born to teenagers are much more likely to experience a range of negative outcomes in later life.

Evidence of the views of the public and patients / users of services

None at present

Evidence of what works

One of the priority actions identified by the Department of Health is to ensure equitable access to the full range of contraception methods and provision of high quality advice and support.

SPORT AND PHYSICAL ACTIVITY

Evidence of need and poor outcomes

Local survey information suggests that participation is less likely in the wards of Turkey Street, Southbury, Ponders End, Haselbury, Edmonton Green and Upper Edmonton.

Evidence of the views of the public and patients / users of services

In the questionnaires completed at health and wellbeing consultation events with vulnerable groups, 30% of the respondents identified a need for the promotion of healthy lifestyles, with better access to fitness facilities being a key element.

Evidence of what works

Sport and physical activity add value to community life and positively impact on well being. It also helps to reduce obesity, improve health, provide positive activities, develop skills and create jobs.
8. Feeling Safe

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

Evidence of need and poor outcomes

1. Enfield has lower rates of crime as a whole, than London or nationally.
2. Crime rates are relatively higher in areas where there is higher deprivation.
3. The Home Office Fear of Crime Toolkit identifies that fear can be because of:
   - people’s own experience of crime or where they live.
   - intrinsic reasons related to gender, ethnicity, ability, health, age and sexual orientation

Evidence of the views of the public and patients / users of services

1. ‘Fear of crime’ was identified by 38% of respondents to the Citizen’s Panel as a risk to good health and wellbeing that requires addressing in the Borough.
2. Respondents to the Enfield Place Survey 2008/9 were asked to identify what was most in need of improvement. ‘Level of crime’ was the highest priority for 44% of respondents (compared with 59% in the 2003/4 survey).
3. Asked about whether people felt safe or unsafe after dark, 41% of respondents felt fairly unsafe or very unsafe, compared with the Outer London average of 39%. The daytime figure was 9%, compared with the Outer London average of 8%.

Evidence of what works

The Government’s updated crime strategy Cutting Crime – Two years on – 2008-11 identifies seven priority areas for reducing crime and anti-social behaviour and recommends approaches to bring about improvements. These approaches should focus on:

- The people who cause most damage to communities or who are at most risk of being victims of crime
- The places that need targeted attention to prevent or reduce crime
- The products and substances that cause crime problems or help us to fight crime.

The Engaging Communities in Fighting Crime review of 2008 by Louise Casey also supports the public confidence and sustainability agenda.
9. Access to Health and Wellbeing Information

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

BLACK AND MINORITY ETHNIC GROUPS

Evidence of need and poor outcomes

The Department of Health Report *No Patient Left Behind: how can we ensure world class primary care for black and minority ethnic people?* describes communication problems as follows:

- language differences can compound difficulties of generic dysfunctional communication between GPs and patients – with implications for patient safety.
- healthcare professionals can feel uncertain and apprehensive in responding to different needs of BME patients and this can cause them to be 'hesitant and professionally disempowered'.

Evidence of the views of the public and patients / users of services

Enfield Racial Equality Council (EREC) believes that people have experienced poor outcomes through not being able to access information. The main reasons are:

- lack of qualified interpreters
- lack of information available in other languages / formats
- lack of information in particular on diseases/conditions affecting the BME community
- professional’s lack of listening skills – not enough information given
- lack of information to explain healthcare system and how you access it

Evidence of what works

The Department of Health Report *No Patient Left Behind* proposes dedicated training and education for doctors can improve communication with BME people.

BRITISH SIGN LANGUAGE USERS*

Evidence of need and poor outcomes

According to SignHealth, a healthcare charity for deaf people “Deaf people are facing constant difficulty with telephone appointment booking systems, verbal prompts when their doctor is ready to see them, and rarely have a clear understanding of their diagnosis and treatment.”

The GP Patient Survey 2008/9 reported that “Those who are deaf and use sign language are less likely than hearing patients to say they had confidence and trust in the doctor (89%, compared with 95%).”
Evidence of the views of the public and patients / users of services

The Enfield Disability Association (EDA) has provided examples of BSL users who have experienced poor outcomes through not being able to access information. The main reasons are:

- BSL users lack of basic health knowledge due to poor literary skills
- Lack of awareness of the benefits of using interpreters from some medical practitioners
- Lack of availability of interpreters.

Evidence of what works

SignHealth recognises the importance of providing evidence which is not available at present, and is leading a group of organisations which promote the needs of deaf people to produce this. They are urging GPs and hospitals to start using the online sign language interpreting service SignTranslate.

PEOPLE WITH LEARNING DIFFICULTIES*

Evidence of need and poor outcomes

The Department of Health Independent Inquiry into Access to Healthcare for People with Learning Disabilities found that people with learning disabilities have worse health and get worse care.

Disability Rights Commissions (DRC) report Equal Treatment Closing the Gap found that people with learning disabilities had higher rates of respiratory disease and were more likely to be obese.

Evidence of the views of the public and patients / users of services

One-to-One (a local user-led organisation) has provided examples of people who have experienced poor outcomes through not being able to access information. These include:

- Evidence of under-diagnosis of diabetes
- Lack information on health services and about making healthy choices
- Face barriers to accessing healthy leisure activities.

Evidence of what works

The Department of Health Independent Inquiry into Access to Healthcare for People with Learning Disabilities recommended that “DH should direct to commission more appropriate, proactive, health services for people with learning disabilities including health checks and staff to support access to the NHS “.

*An Enfield Community Engagement Network sponsored conference identified vulnerable people with communication difficulties as a priority. BSL users and people with a learning difficulty were subsequently identified by the EDA as experiencing particularly poor outcomes.
4. The Evidence for the Priority Needs

A considerable amount of evidence has been collected for each of the Priority Needs. This chapter sets this out and provides references to enable readers to obtain more detail where required.

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4.1 Poverty

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

More detail is set out in chapter 5 in the following sections:

5.9 Deprivation
5.10 Unemployment
5.11 The Recession and Health and Wellbeing
5.12 Housing and Homelessness

The most important factors influencing the health of a population are the ‘wider determinants of health’ such as poverty, income and housing. These in turn have powerful impacts on peoples’ lifestyles. For example, it is well established that social deprivation is strongly associated with higher smoking rates, poorer diets, lower levels of physical activity and higher rates of substance misuse.

Evidence of ‘what works’ is set out in Take Up: The Challenge – The role of local services in increasing take up of benefits and tax credits to reduce child poverty (DCSF June 2009), which proposes actions local authorities and partners can take to increase take up of benefits and tax credits by parents. They are asked to ensure that efforts to increase take up are integrated within existing services and personalised to help parents to access all the financial
support to which they are entitled, alongside other support they need to address wider issues:

- A parent accessing a wide range of existing services, for example a children’s centre, childcare, health services (including mental health services), employment support or housing advice, should be able to receive information on benefits and tax credits, or be helped to access a specialist agency.
- Services working with parents should be able to take an overview of the personal needs and concerns of a family, and help the family identify how to tackle all these issues wherever possible.

This document goes on to recommend that in order to embed the take up of work within an integrated and personalised package of support, local authorities and partners will need to:

- Have a joined-up approach to take up at a strategic level that can drive forward joint commissioning for take up activity. To achieve this it may be necessary to build a local business case that can be used to gain the necessary engagement of all services and partners needed to provide a holistic package of support. Maximising parent income can make a contribution to a number of high-level strategic objectives including:
  - Tackling child poverty – by focusing on increasing take up of benefits and tax credits by parents, children can be both lifted out of poverty, and prevented from falling into poverty.
  - Improving health and wellbeing – it is well established that children from disadvantaged groups are more likely to have poorer health outcomes than those from more affluent groups. By working to maximise parent income, a contribution can be made to tackling health inequalities.
  - Promoting inclusive communities – action to increase take up will help to increase contact with, and support given to, families that are ‘hard to reach’ and vulnerable to social exclusion.
  - Bringing additional income into the local economy – money that is awarded to families with children is likely to be spent in the local area, which helps to boost the local economy.
  - Increasing parental employment – lack of knowledge about available in-work benefits can prevent parents from both moving into and sustaining work. Efforts to increase employment will therefore be most effective when combined with action to increase take up of in-work benefits and tax credits.

- Integrate take up into existing partnership plans, strategies and needs assessments. For example:
  - Making the link between ill health and poverty in the Joint Strategic Needs Assessment.
  - Link take up to progress against the Children and Young People’s Plan outcome of ‘achieve economic wellbeing’.
• Encourage both universal and targeted services to signpost parents to information and integrate benefits checks into existing processes. For example certain criteria could prompt a GP to refer a patient for a benefits check such as if they had been unable to work due to a long period of sickness or were suffering from stress.

• Co-locate experienced benefits advisers within local services such as housing offices (including where housing is managed by another organisation on behalf of the local authority) and children’s centres on a part-time or full-time basis.

• Ensure parents can obtain comprehensive advice and information on the full range of financial entitlements in one place. A parent should be able to access one service and find out about, or be signposted to information about, tax credits, getting a benefit check to establish entitlements when moving into work, Jobseeker’s Allowance, Housing and Council Tax Benefit, help for childcare costs, and support available when caring for a child with a disability.

4.2 Health Inequalities

Overview

Inequalities in health are expressed using two key population measures: Infant mortality and life expectancy at birth.

Infant mortality is addressed as a separate identified priority need for Enfield, elsewhere within this report.

Life expectancy at birth is one of the key measures for the health inequalities 2010 national target. The target is a 10% reduction in the relative gap (i.e. percentage difference) in life expectancy at birth between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and England as a whole.

National Trends

Nationally, life expectancy at birth is increasing for both men and women, including in the Spearhead areas. But it is increasing more slowly there, so the gap continues to widen, and it is widening more for women than men.

In 2004-06, for males the relative gap was 2% wider than at the baseline (the same as in 2003-05), for females 11% wider (compared to 8% wider in 2003-05). The 2010 target therefore remains challenging.
Figure 1: Life Expectancy for both sexes from all London boroughs, ranked by male life expectancy, (National life expectancy, Male: 77.65 years, Female: 81.81 years), 2005-07

Source: NCHOD
Life Expectancy in Enfield

Enfield is not a Spearhead area, i.e. does not fall into the fifth of areas nationally with the worst health and deprivation indicators. Life expectancy at birth in Enfield over the past 15 years has been higher for both males and females than London or national averages. However, the rate of increase in life expectancy has not matched that seen in London or nationally, and there is a significant life expectancy gap between deprived and more affluent wards within the borough. There is evidence that this gap is widening for both males and females. Figure 2 shows this, and indicates that the life-expectancy in London is higher than the national average.

Figure 2: Three Year Rolling Average Life Expectancy at Birth, 1991 to 2007, Enfield, London and England

Source: Office for National Statistics (ONS)
Figure 3: Male expectancy of Enfield by ward, 2006-06

Source: Office of National Statistics (ONS)
**Figure 4: Female life expectancy of Enfield by ward, 2002-06**

Source: Office of National Statistics (ONS)
Figure 5: Enfield Gap in Male Life Expectancy at Birth – Highest and Lowest Wards
1999 - 2006

Source: Office of National Statistics
Figure 6: Enfield Gap in Female Life Expectancy at Birth – Highest and Lowest Wards, 1999-2006

Source: Office of National Statistics
Whilst life expectancy in the more affluent wards of Enfield has risen progressively since 1999, life expectancy for both males and females in the more deprived wards has remained constant or worsened.

To support Primary Care Trusts and local authorities, the Association of Public Health Observatories and Department of Health have developed Health Inequalities Intervention Tools. These tools are designed to support evidence-based local service planning and commissioning, including Joint Strategic Needs Assessments (JSNAs).

The tools show the causes of death that are driving local health inequalities, with breakdowns by gender and age. They also show the impact evidence-based interventions can have on local health inequality gaps.

Using the health inequalities intervention tool, we can identify conditions which contribute to the difference in life expectancy between the most and least deprived quintiles of the borough. This indicates that between 55 and 60% of the life expectancy gap is accounted for by mortality due to circulatory disease, cancers and respiratory disease.

Figure 7: Breakdown of life expectancy gap between the Most Deprived Quintile (MDQ) of Enfield LB and the least deprived quintile in the local authority by cause of death.

Source: London Health Observatory (LHO) Health Inequalities Intervention Tool
We can further identify the potential gain to life expectancy by condition if mortality rates in the most deprived quintile of Enfield were the same as those in the least deprived quintile. Figure 8 shows that the condition that contributes most to health inequalities is cardiovascular disease (coronary heart disease and stroke).

**Figure 8: Breakdown of life expectancy years gained by cause of death for males and females living in Enfield**

![Graph showing life expectancy years gained by cause of death](image)

Source: London Health Observatory (LHO) Health Inequalities Intervention Tool

Exploring inequality in health outcomes we see that patterns of poor health and wellbeing across all areas largely mirror the patterns of deprivation seen within the borough. This clearly indicates the importance of addressing the wider determinants of health, such as poverty, transport, education, and unemployment, in order to holistically address the needs of Enfield’s residents.
By understanding the geo-demographic patterns in poor health outcomes for the major conditions contributing to the gap in life expectancy in Enfield we can develop a picture of the population groups and areas requiring targeted intervention.

**Tackling Health Inequalities: Best Practice Guidelines**

From *Tackling Health Inequalities – A Programme for Action*, a number of key interventions were identified. These reflect the need to tackle not only disparity in health outcomes, but also the underlying determinants of inequality, requiring action across all government agencies.

The actions likely to have the greatest impact over the long-term:

- improvements in early years support for children and families
- improved social housing and reduced fuel poverty among vulnerable populations
- improved educational attainment and skills development among disadvantaged populations
- improved access to public services in disadvantaged communities in urban and rural areas, and
- reduced unemployment, and improved income among the poorest.

To achieve the 2010 target of a reduction in the gap in life expectancy, key areas include:

- reducing smoking in manual social groups
- preventing and managing other risks for coronary heart disease and cancer such as poor diet and obesity, physical inactivity and hypertension through effective primary care and public health interventions – especially targeting the over-50s
- improving housing quality by tackling cold and dampness, and reducing accidents at home and on the road
- closing the gap in infant mortality rates (see Priority Need – Infant Mortality)

Further evidence to support these priorities has emerged from the Wanless report on NHS spending, *Securing our Future Health: Taking A Long-term View*:

- The impact of smoking cessation on cardiovascular hospital admissions
- Statins to reduce cholesterol and flu vaccinations potentially reduce pressure on hospital capacity.
- Improved nutrition and increased physical activity reduce instances of cardiovascular disease, diabetes and some cancers.

It is also noted that action should not be confined to the most disadvantaged and socially excluded. To reduce health inequalities and achieve the targets will require us to improve the health of the poorest 30-40 per cent.
Health Inequalities in Circulatory Disease: Coronary Heart Disease

The 2008 Coronary Heart Disease Statistics by the British Heart Foundation report dramatic reductions in death rates from cardiovascular disease over the last 16 years, which they attribute to “major shifts in thinking on public health measures to prevent cardiovascular disease (CVD) and strenuous efforts to provide timely and appropriate treatment for people living with CVD, most commonly middle aged and elderly.” However, they note a worrying trend, that the fall of premature deaths from coronary heart disease in people under 45 years of age, particularly women, has slowed and may be starting to rise, likely linked to lifestyle factors such as high prevalence of smoking, obesity and low levels of physical activity.

**Figure 9: Rate of Mortality due to Coronary Heart Disease per 100,000 population, Enfield and Comparators, 1993-2007**

Mortality rates from coronary heart disease in Enfield are below those seen nationally and in London but the rate of decline in mortality has been slightly slower than that seen nationally. Assessing mortality rates at ward level reveals areas with higher than expected levels of mortality. Considering standardized mortality ratios at ward level, any ward with an SMR above 100 indicates levels of mortality in excess of that expected when applying national rates to ward level population structures, as shown in the following figure.
Figure 10: Standard Mortality Rate (SMR) of Coronary Heart Disease for all ages in Enfield by ward, 2002-2006

Source: London Health Observatory (LHO)
**Figure 11: Coronary Heart Disease in Enfield**

Enfield Coronary Heart Disease Mortality Ratios ALL AGES, as Compared to England Standard, 2002-2006 pooled

When comparing mortality at ward level with prevalence of CHD recorded in practices, it can be seen that many of those wards with higher than expected mortality also show a low ratio of recorded versus expected prevalence at GP practice level. Expected prevalence is a modelled estimate based on population demographics. For example Edmonton Green has a prevalence ratio of 0.57, indicating that potentially 43% of people with CHD in the Edmonton Green area could remain undiagnosed. This has particular implications in assessing the unmet health needs of the local population. Late diagnosis and poor condition management can lead to increased mortality rates. The following table indicates ratios of recorded versus expected CHD prevalence by Practice Based Commissioning Cluster, based on GP QOF (national Quality and Outcomes Framework) registers.

The ratio set out in the graph on the next page gives an indication of how many people living with CHD have been diagnosed and are aware of their condition. The expected number of people on CHD registers in Enfield is achieved by applying the expected prevalence of CHD to the demographic profile of the patients registered with the practice. This is compared with the observed number of people on the CHD register at the practice. A ratio below 1 indicates fewer people have been identified as having CHD at the practice than we would expect to see.

Source: NCHOD. Analysis by Enfield Public Health
Figure 12: Ratio of Recorded to Expected CHD Prevalence, LHO Practice Profiles Tool, 2007/8

Source: LHO Practice Profiles Tool 2009
Health Inequalities in Circulatory Disease: Stroke

From the British Heart Foundation, 'Stroke Statistics 2009' national figures show:

- Stroke is a major cause of premature mortality, around one in twenty deaths in those aged under 75 are from stroke.
- Social inequalities in stroke are persistent and premature death rates in the most deprived areas are around three times higher than in the least deprived.
- The prevalence of stroke among those aged over 75 is increasing in England. For men, the prevalence in this age group has increased from 9% in 1994 to 13% in 2006.
- Nearly 40% of men and more than 30% of women in England have high blood pressure, a key risk factor for stroke. Half of people with high blood pressure are not receiving treatment.
Figure 13: Rate of Mortality due to Stroke at all ages per 100,000 population, for Enfield and its Comparators 1993-2007

Source: National Centre for Health Outcomes Development (NCHOD)
In 2005-07, there were 547 deaths due to stroke, as compared with 1,017 deaths due to CHD in the same period. Enfield’s mortality rate due to stroke is falling and continues to be significantly below national rates, but is roughly in line with the London average. However the rate of fall in mortality rates is not as sharp as seen nationally – if this trend continues, Enfield may see stroke mortality rates exceeding national rates within the next 5 years.

Data from the ‘Active People Survey’, the ‘Taking Part Survey’, Hospital Incidence data and the lifestyle data from Experian has been compiled by Proactive North London from the Sport England Market Segment to produce the following map for Enfield.

Figure 14: Estimating Enfield Adult Risk of Stroke

Tackling Health Inequalities in Coronary Heart Disease and Stroke: Best Practice Guidelines

With regard to cardiovascular disease, the London Health Observatory models the effect of two key interventions on reducing the gap in life expectancy:

- Antihypertensive prescribing in people with previously undiagnosed/uncontrolled hypertension, but who do not have existing coronary heart disease or history of stroke
- Statin prescribing in those people that are newly identified and have been treated with antihypertensive medication, but do not have existing coronary heart disease or history of stroke
The National Service Framework for Coronary Heart Disease indicates the following guidelines for primary and secondary prevention.

For people without diagnosed CHD but judged at risk:

- Stop Smoking advice and support
- Information about other modifiable risk factors and personalised advice about how they can be reduced (physical activity, diet, alcohol consumption)
- Advice and treatment to maintain blood pressure below 140/85 mm Hg
- Low dose aspirin (75 mg daily)
- Statins and dietary advice to lower serum cholesterol
- Meticulous control of blood pressure and glucose in people who also have diabetes.

For people with diagnosed CHD:

- All of the above plus ACE inhibitors, beta-blockers, warfarin prescription according to clinical guidelines.

Health Inequalities in Cancer

Figure 15: Directly Standardised Rates of Cancer Mortality under 75, Enfield and Comparators, 1993-2007 with trend

Source: National Centre for Health Outcomes Development (NCHOD)
A Directly Standardised Rate (DSR) allows us to compare mortality in Enfield with that elsewhere in London and with national rates. The smaller the figure, the lower the mortality rate as compared to other areas.

Between 2005 and 2007 there were 1,648 deaths from all cancers in Enfield (DSR 161.55 per 100,000 persons of all ages). This compares with 2,252 deaths from all circulatory diseases in the same period (DSR 185.4 per 100,000 persons of all ages).

As with the other major causes of death, Enfield as a whole has a lower mortality rate due to cancers than London or England. Mortality rates are declining roughly in line with national trends. However mortality rates differ significantly by type of cancer, by gender and by ward in Enfield, as the following figures show. At 2005-2007, Enfield showed higher rates of mortality than London or national for breast cancer and cervical cancer.

Lung cancer mortality rates were significantly lower than both the London and National rates.

Table 1: Cancer type Mortality rates for all ages in Enfield, 2005-2007

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Number of Deaths, Enfield</th>
<th>DSR Mortality, Enfield</th>
<th>DSR Mortality, London</th>
<th>DSR Mortality, England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>158</td>
<td>28.69</td>
<td>26.11</td>
<td>27.45</td>
</tr>
<tr>
<td>Bowel Cancer</td>
<td>179</td>
<td>17.07</td>
<td>16.37</td>
<td>17.85</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>12</td>
<td>2.37</td>
<td>2.26</td>
<td>2.37</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>99</td>
<td>21.57</td>
<td>23.63</td>
<td>25.09</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>296</td>
<td>29.35</td>
<td>38.26</td>
<td>38.49</td>
</tr>
</tbody>
</table>

Source: National Centre for Health Outcomes Development (NCHOD)
Figure 16: Directly Standardised Rates (DSR) of Mortality due to all Cancer types. Enfield and London Suburbs comparators, with London and England standards

Source: National Centre for Health Outcomes Development (NCHOD)
Figure 17: Male and Female SMRs for all Cancers by Enfield wards, compared with London, 2002-06

Source: National Centre for Health Outcomes Development (NCHOD)
Tackling Health Inequalities in Cancer: Best Practice Guidelines

In 2007 DH published the Cancer 2012 Visions document that introduced improvement plans for cancer related services. This was produced as part of the Cancer Reform Strategy. Following are the visions that this report stressed:

- Cancer outcomes should be at least equal to the best in Europe.
- There should be full implementation of improving outcome guidance (IOGs) confirmed by peer review and Healthcare Commission assessment.
- Long-term cross-government programmes should be in place to tackle lifestyle factors that impact on the incidence of cancer including smoking cessation, reducing obesity and alcohol consumption.
- Improved cancer registration and mandatory participation in national audits.
- Effective assistance for GPs to stratify risk of possible cancer in patients and identify interventions.
- Increased diagnostic and staging capacity.
- Access to clinically and cost-effective new cancer drugs and treatments based on medical need.
- Increased radiotherapy capacity.
- Long waiting times to be eliminated for all cancer patients.
- Age appropriate services for children and young people.
- All cancer patients to have access to clinical nurse specialists.
- Tumour-specific risk stratification models should be developed to support follow-up of patients both for re-occurrence of cancer and for potential side-effects of treatments.
- All patients to have access to appropriate clinical trials.

Also a guide to practice-based commissioners in developing good cancer care services can be seen in a DH report that supports the Cancer Reform Strategy commitment to developing world class commissioning of cancer services across the NHS. This guidance is one of these tools and sits alongside the cancer commissioning guidance and toolkit providing a range of benchmarked information and data.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_101177

Health Inequalities in Respiratory Disease

Less is known about variation in mortality rate within the borough around respiratory disease, which accounts for between 13 and 15% of the gap in life expectancy between least and most deprived quintiles. This is because respiratory disease as a category encompasses a variety of conditions with equally varied causation and life course. These include asthma, bronchitis, chronic obstructive pulmonary disease, tuberculosis, pneumonia and so on.

The LHO health inequality tool comprises three categories within respiratory disease.

- Chronic Obstructive Pulmonary Disease (COPD)
- Pneumonia
- Other Respiratory Disease
Figure 18: Mortality trend for bronchitis, emphysema and other COPD per 100,000 population in all ages, 1993-2007

Source: National Centre for Health Outcomes Development (NCHOD)

Figure 19: Mortality trend for Pneumonia per 100,000 population in all ages, 1993-2007

Source: National Centre for Health Outcomes Development (NCHOD)
COPD prevalence varies by practice across Enfield from 0.08% to 2.2%, with the average being 0.88%.

**Tackling Health Inequalities in Respiratory Disease: Best Practice**

In May 2009 the Department of Health called for examples of best (or good) practice and innovation as part of their development of national strategies for COPD.

NICE guidelines on COPD (CG12: Chronic obstructive pulmonary disease – Management of chronic obstructive pulmonary disease in adults in primary and secondary care) indicate the following priorities:

- Prioritising diagnosis of COPD in patients over the age of 35 particularly where smoking is a risk factor.
- Encouraging patients with COPD to stop smoking is one of the most important components of their management. All COPD patients still smoking, regardless of age, should be encouraged to stop, and offered help to do so, at every opportunity.
- Use of effective inhaled therapy
- Pulmonary rehabilitation for all who need it
- Use of non-invasive ventilation
- The frequency of exacerbations should be reduced by appropriate use of inhaled corticosteroids and bronchodilators, and vaccinations.
- Multi-disciplinary working – COPD care should be delivered by a multi-disciplinary team.

**Tackling the Major contributors to Health Inequalities: Targeted Interventions**

Guidance on interventions aimed at changing lifestyles and behaviours have been covered under the Healthy Lifestyles chapter.

A number of key services and initiatives can have a significant impact on health outcomes and health inequalities. Some of these are outlined below:

**Health Trainers**

A Department of Health lead initiative, Health Trainers reach out to people who are in circumstances that put them at a greater risk of poor health. They often come from, or are knowledgeable about, the communities they work with. In most cases, Health Trainers work from locally based services which offer outreach support from a wide range of local community venues.

Health Trainers work with clients on a one-to-one basis to assess their health and lifestyle risks. They have facilitated behaviour change, providing motivation and practical support to individuals in their local communities, since 2006.

**NHS Life Check**

In particular the NHS Mid-life LifeCheck is an online health assessment for people aged 45-60. It focuses on factors including smoking, healthy eating,
alcohol use, physical activity and emotional well-being. NHS Mid-life LifeCheck analyses the information people provide and then presents them with detailed feedback.

The service identifies causes for concern and helps people plan for lifestyle change, giving ideas, information and support. Users can set personal goals and request helpful reminders.

**Seasonal influenza vaccination programme**
The objective of the flu immunisation programme is to protect those who are most at risk of serious illness or death should they develop ‘flu: those aged 65 or over, and those over 6 months with an underlying clinical condition.

**Cancer Screening**
Nationally coordinated cancer screening programmes exist for breast, bowel and cervical cancers.

The NHS Breast Screening Programme provides free breast screening every three years for all women in the UK aged 50 and over. Around one-and-a-half million women are screened in the UK each year. Women aged between 50 and 70 are now routinely invited. The NHS Breast Screening Programme will extend the age range of women eligible for breast screening to ages 47 to 73 by 2012.

Cervical screening is not a test for cancer. It is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman’s cervix (the neck of the womb).

The programme aims to reduce the number of women who develop invasive cervical cancer (incidence) and the number of women who die from it (mortality). It does this by regularly screening all women at risk so that conditions which might otherwise develop into invasive cancer can be identified and treated. All women between the ages of 25 and 64 are eligible for a free cervical screening test every three to five years.

Bowel cancer screening aims to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be effective. The NHS Bowel Cancer Screening Programme offers screening every two years to all men and women aged 60 to 69. People over 70 can request a screening kit by calling a freephone helpline when the programme reaches their area.

**HPV vaccination programme**
Human Papilloma virus (HPV) is a sexually transmitted virus that causes 99% of invasive cervical cancer. A national programme to vaccinate against this virus was initiated in September 2008 with all 12- to 13-year-old and 17- to 18-year-old girls being offered the vaccine. A catch-up programme was also announced at this time with 13- to 18-year-old girls being offered the vaccine over the following 2009-10. The vaccine chosen by the Department of Health for the national HPV vaccination programme is Cervarix, which protects against the viruses responsible for about 70% of cases.
4.3 Obesity

‘Around two thirds of the population of England are overweight or obese. Obesity has grown by almost 400% in the last 25 years and on present trends will soon surpass smoking as the greatest cause of premature loss of life. It will entail levels of sickness that will put enormous strains on the health service. On some predictions, today’s generation of children will be the first for over a century for whom life expectancy falls’.

Select Committee on Health, 2004

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

- Obesity is of particular concern in Enfield throughout childhood to adulthood.
- Obesity levels in reception and Year 6 children are above the London regional average.
- Enfield is one of the worst 5 boroughs in London for prevalence of adult obesity (HSE, QMAS)

Reducing levels of obesity will require work across all agencies and partners, not only to influence individual lifestyle choices but also to combat the “obesogenic environment” within which those choices are made. Actions needed will include:

- Increasing awareness of the benefits of maintaining a healthy weight through education.
- Increasing physical activity across the whole population.
- Facilitating active travel e.g. walking and cycling.
• Developing knowledge of nutrition, healthy foods and cooking methods.

Childhood Obesity

Childhood obesity is a high priority in Enfield, as it is not only one of those boroughs in London with the highest levels of overweight and obese children (6th highest for obesity and 15th highest for overweight) in London but the National Child Measurement Programme (NCMP) results also show a worsening trend.

Reducing childhood obesity in Year 6 is currently a target in the Enfield Local Area Agreement.

**Table 1: NI 56 Reducing childhood obesity in Year 6**

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity among primary school age children in Year 6</td>
<td>21.5%</td>
<td>22.01%</td>
<td>21.80%</td>
<td>21.22%</td>
<td>22.5%</td>
</tr>
</tbody>
</table>


The NCMP began in 2005 and measures the weight and height of Reception (4-5 years) and Year 6 (10-11 years) children to assess overweight and obesity levels. PCTs are required to collect data on an annual basis for all Local Education Authority maintained schools. The NCMP was set up in line with the Government’s strategy to tackle obesity and to:

- Inform local planning and delivery of services to children
- Gather population-level data to allow analysis of trends in growth patterns and obesity
- Increase population and professional understanding of weight issues in children
- Be a vehicle for engaging with children and families about healthy lifestyles and weight issues.

The data is collected in schools and is overseen by trained healthcare professionals, which is captured and checked by PCTs and then collated at the national level.

In April-July 2007/08 (academic year) 973,073 primary school children were measured nationwide, which was an uptake of 88%. This was an increase of 8% in participation nationally. In Enfield the participation of both Reception and Year 6 children was 84%. 
Table 2: Trend shows increasing obesity levels, for Reception and Year 6

<table>
<thead>
<tr>
<th>Year</th>
<th>Overweight Reception</th>
<th>Overweight Year 6</th>
<th>Obese Reception</th>
<th>Obese Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07 – Enfield</td>
<td>13.2</td>
<td>14.9</td>
<td>11.9</td>
<td>21.5</td>
</tr>
<tr>
<td>2007/08 – Enfield</td>
<td>11.8</td>
<td>15.1</td>
<td>13.0</td>
<td>22.5</td>
</tr>
<tr>
<td>2006/07 – London</td>
<td>12.0</td>
<td>14.8</td>
<td>11.3</td>
<td>20.8</td>
</tr>
<tr>
<td>2007/08 – London</td>
<td>12.0</td>
<td>14.7</td>
<td>10.9</td>
<td>21.6</td>
</tr>
<tr>
<td>2006/07 – National</td>
<td>13.0</td>
<td>14.2</td>
<td>9.9</td>
<td>17.5</td>
</tr>
<tr>
<td>2007/08 – National</td>
<td>13.0</td>
<td>14.3</td>
<td>9.6</td>
<td>18.3</td>
</tr>
</tbody>
</table>

Source: National Child Measurement Programme (NCMP)³

In 2007/08 the prevalence of overweight in Enfield reception year was slightly lower than that of London or England (11.8%, 12.0% and 13.0% respectively). However, Enfield had higher levels of obesity (13.0% compared to 10.9% and 9.6% respectively). In Year 6 Enfield had a higher prevalence of both overweight (15.1% compared to 14.7% and 14.3%) and obesity (22.5% compared to 21.6% and 18.3%).
Figure 1: Prevalence of Obesity in Reception classes in London and England 2007 and 2008 (graph A)

Source: LHO – The Weighty Matters
Figure 2: Prevalence of Obesity in Year 6 classes in London 2007, 2008 (graph B)

London PCT Prevalence of Obesity Year 6 2007 and 2008

Source: LHO – The Weighty Matters
This pattern is of particular concern, as not only does being an unhealthy weight affect the children’s ability to partake in physical activity and affect their self-esteem and confidence, but it increases their risk of developing health problems associated with obesity in later life, particularly cardio-vascular disease, type 2 diabetes and some cancers. This has been referred to as the obesity “ticking time bomb” where future generations may have much higher prevalence of obesity related illness. There is also evidence of a socio-economic gradient in the obesity data with higher levels of obesity seen in wards with higher levels of socio-economic deprivation (see Figures 3 and 4).

London Trends from LHO Report: Weighty Matters

Enfield had the 11th and 14th highest levels of obesity prevalence in Reception and Year 6 obesity in London 2007. The following are highlights from the LHO Weighty Matters report:

- Eleven percent of children in reception year (ages 4-5) and 22% in year 6 (ages 10-11) were at risk of obesity in London in 2007/8. This was the highest prevalence of all the English regions for both year groups and significantly higher than the English average for both.
- In London boys are at greater risk of obesity than girls in both Reception year (11.7% compared with 10%) and Year 6 (23.6% compared with 19.4%). By the time children reach year 6 obesity has become a much more significant problem than overweight – with 21 out of 31 PCTs having a prevalence of obesity that is significantly higher than England.
- About 12% of children in Reception year, and 14.7% of children in Year 6, were at risk of being overweight in London.
- There is significant inequality in the risk of obesity between the London boroughs. The highest risk was among children from the poorest authorities with a range of 6% to 14% for children in reception year, and from 12% to 26% in Year 6.
- The prevalence of children at risk of obesity was higher in more deprived areas. This relationship was strongest when the location of the child’s home was considered but was also apparent by school location. (LHO, Weighty Matters, 2008).

Enfield Childhood Obesity at ward level:

Enfield Department of Education Children’s Services and Leisure have produced a report analysing trends in childhood obesity by ethnicity and ward, for 2007 and 2008 child measurement data.

It should be noted that large variations in recorded prevalence are seen at ward level between 2007 and 2008 surveys.

Across Reception and Year 6, and in both 2006 and 2007, the highest prevalence of obesity was seen in the east and south of the borough. In Reception, Ponders End (26.9% for 2007) and Bowes (19.3% for 2008) reported the highest prevalence of obesity. On the other hand, in Year 6 the
highest prevalence was found in the wards of Cockfosters (30.7% in 2007) and Haselbury (30.8% for 2008).

Figure 3: Obesity in Enfield at Reception 2008 from National Child Measurement Programme

Source: Data from NCMP, analysis at ward level by ECSL Enfield
In Reception the main ethnicities that are at risk of obesity are shown at the right of Figure 5. Although there is considerable variation by ethnicity, very small numbers measured in some ethnic groups will tend to exaggerate the levels of obesity recorded. Given that overall 37% of Year 6 pupils are either overweight or obese this would indicate interventions are required over the entire school population.
Figure 5: Childhood Obesity by Ethnicity in Reception, 2008

Reception prevalence of Obesity by Ethnic Group, 2008

Source: LHO (London Health Observatory)
Figure 6: Prevalence of Obesity in Year 6 by Ethnic Group in 2008

Source: LHO (London Health Observatory)
Adult Obesity

**Figure 7: Prevalence of Obesity within GP Practices**

![Graph showing prevalence of obesity within GP practices in London 2007/2008 with data from various PCTs.]

Source of data: Quality and Outcomes Framework (Extracts may only be reproduced by permission.) NCHOD⁶
As shown above Enfield has the 4th highest prevalence of GP recorded obesity in London. Nationally obesity prevalence measured through General Practice is 9.38%, in London 8.28% and in Enfield 10.15%. Prevalence recorded in General Practice is likely to be significantly lower than in the population. Adults have their height and weight recorded opportunistically at GP practices, not all patients are measured and not all Enfield residents are registered with a GP. Given these limitations together with data from the NCMP this data may not be robust. The Health Survey for England 2006 London Boost4 indicated that Enfield had the third highest prevalence obesity in London, estimated at 27%.

The following map is derived from the Sport England Market Segment. Each of the 19 segments is defined by a set of characteristics which have been developed using data from the Active People Survey, the Taking Part Survey, Hospital Incidence data and the lifestyle data from Experian. Index values using the England population as standard have been used to create likelihood maps. The maps show the total potential likelihood for the adult population within an output area to exhibit each characteristic. Further evidence from the Sport England Market Segment7 can be found in the chapter on Healthy Lifestyles. This shows that higher levels of obesity are more likely to be found in the South and East of the borough.

Figure 9: Likelihood to be Obese Map in all adults (aged 18+ years)
Tackling Obesity: Best Practice

NICE guidelines on prevention, identification, assessment and management of overweight and obesity highlight their impact on risk factors for developing long-term health problems. It states that the risk of these health problems should be identified using both BMI and waist circumference for those with a BMI less than 35kg/m². For adults with a BMI of 35kg/m² or more, risks are assumed to be very high with any waist circumference.

The NICE clinical guideline on the prevention, identification, assessment and management of overweight and obesity in adults and children covers:

- how staff in GP surgeries and hospitals should assess whether people are overweight or obese
- what staff in GP surgeries and hospitals should do to help people lose weight
- care for people whose weight puts their health at risk.
- how people can make sure they and their children stay at a healthy weight
- how health professionals, local authorities and communities, childcare providers, schools and employers should make it easier for people to improve their diet and become more active.

The Department of Health (DoH) Health Trainers initiative has great potential to support weight loss for those at risk in local communities. The Health Trainers role is to provide one-to-one sessions with adults who want to make lifestyle changes e.g. loose weight, increase physical activity or stop smoking. They contribute to the prevention of heart disease, diabetes and stroke through addressing lifestyle changes. Health Trainers see clients for six sessions, weekly, fortnightly or monthly depending on the clients needs and help set goals and support to achieve them.

Recommendations

- Create a joint obesity strategy which covers the lifespan of local people.
- Implement interventions that combat the obesigenic environment.
- Ensure those interventions in place are evaluated to verify their effectiveness.
- Ensure interventions are targeted at those parts of the borough most in need.
- Encourage GPs to adopt the Physical Activity Care Pathway, including the GP PA questionnaire and Exercise on Referral.
- Work with Healthy Schools Leads, dieticians and Local Authority nutritionist to increase uptake of healthy school lunches, improve awareness within the population of nutritional needs and to encourage healthy contents in packed lunches.
- Encourage Schools to keep children inside school grounds at lunchtime.
- Work with the Local Authority to control fast food outlets near schools.

References

4.4 Infant Mortality

Overview

The infant mortality rate (IMR) is defined as the number of deaths under the age of one year, per 1,000 live births. It consists of two components:

1. The neonatal mortality rate: The number of neonatal deaths (those occurring during the first 28 days of life) per 1000 live births and
2. The post-neonatal mortality rate: The number of infants who die between 28 days and less than one year, per 1000 live births.

Reducing the gap in infant mortality in the Routine and Manual socio-economic group and the England average is one of the key measures of the national health inequalities target, and will also contribute to the life expectancy target.

The target is a 10% reduction in the relative gap (i.e. percentage difference) in infant mortality rates between “Routine and Manual” socio-economic groups and England as a whole from the baseline year of 1998 (the average of 1997-99) to the target year 2010 (the average of 2009-11).

Infant mortality is a good indicator of the overall health of a society, and while rates are at an all time low and falling each avoidable death is one too many, and significant inequalities still remain. Mortality during the neonatal period is considered a good indicator of both maternal and newborn health and care.

National Trends

Infant mortality rates are falling in all socio-economic groups. Recent figures show that the mortality gap between Routine and Manual group (the target group) and the rest of the population has stopped widening.

In 2004-06 the infant mortality rate among the “Routine and Manual” group was 17% higher than in the total population in 2004-06, compared with 18% higher than in the total population in 2003-05, 19% higher in 2002-04 and 13% higher in the baseline period of 1997-99. The slight narrowing during the latest period is encouraging; however the target to narrow this gap by at least 10% by 2010 is still a challenging one.
Infant Mortality in Enfield: Trends and Comparators

Contrary to the trend seen nationally, the infant mortality rate in Enfield appears to be increasing in recent years. Due to small numbers involved in assessing rates in infant mortality, and in order to ensure that observed trends are significant, rather than due to random variation in the population, infant mortality is measured as a three-year rolling average rate, as shown below. Pooled data for 2005 to 2007 indicates that Enfield has the worst infant mortality rate in London at 6.7 per 1000 live births. This rate is significantly above the England average of 4.9 per 1000 live births.

Comparing Enfield to the north central London sector, 2003-05 Enfield had the 3rd highest infant mortality rate within the sector, by 2005-07 ours was the highest. Haringey and Islington had managed to reduce their rates whilst Enfield stayed relatively unchanged. A decrease in crude infant mortality was seen across the sector as a whole.

**Figure 1: Infant Mortality 2005-2007 London Boroughs Ranked**

- Enfield Statistical Neighbour

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<table>
<thead>
<tr>
<th>London Boroughs: Crude Infant Mortality Rate per 1000 live births, 2005-2007 pooled.</th>
<th>London Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richmond</td>
<td>8.0</td>
</tr>
<tr>
<td>Kensington &amp; Chelsea</td>
<td>7.5</td>
</tr>
<tr>
<td>Bromley</td>
<td>7.0</td>
</tr>
<tr>
<td>Kingston</td>
<td>6.5</td>
</tr>
<tr>
<td>Hammersmith &amp; Fulham</td>
<td>6.0</td>
</tr>
<tr>
<td>Havering</td>
<td>5.5</td>
</tr>
<tr>
<td>Sutton</td>
<td>5.0</td>
</tr>
<tr>
<td>Ealing</td>
<td>4.5</td>
</tr>
<tr>
<td>Camden</td>
<td>4.0</td>
</tr>
<tr>
<td>Bexley</td>
<td>3.5</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>3.0</td>
</tr>
<tr>
<td>Barking and Dagenham</td>
<td>2.5</td>
</tr>
<tr>
<td>Merton</td>
<td>2.0</td>
</tr>
<tr>
<td>Westminster</td>
<td>1.5</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>1.0</td>
</tr>
<tr>
<td>Lewisham</td>
<td>0.5</td>
</tr>
<tr>
<td>Greenwich</td>
<td>0.0</td>
</tr>
<tr>
<td>Hounslow</td>
<td>0.5</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>1.0</td>
</tr>
<tr>
<td>Islington</td>
<td>1.5</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>2.0</td>
</tr>
<tr>
<td>Brent</td>
<td>2.5</td>
</tr>
<tr>
<td>Hackney</td>
<td>3.0</td>
</tr>
<tr>
<td>Redbridge</td>
<td>3.5</td>
</tr>
<tr>
<td>Lambeth</td>
<td>4.0</td>
</tr>
<tr>
<td>Haringey</td>
<td>4.5</td>
</tr>
<tr>
<td>Newham</td>
<td>5.0</td>
</tr>
<tr>
<td>Croydon</td>
<td>5.5</td>
</tr>
<tr>
<td>Harrow</td>
<td>6.0</td>
</tr>
<tr>
<td>Southwark</td>
<td>6.5</td>
</tr>
<tr>
<td>Enfield</td>
<td>7.0</td>
</tr>
</tbody>
</table>

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84
Figure 2: Three Year Rolling Average – Infant Mortality Rates 1999-2007

Neonatal Mortality Rate

When breaking down all aspects of still birth and infant death, Enfield is seen to have relatively high levels of mortality under each category of early, late and post neonate mortality rate. This combines to result in Enfield having the highest levels of overall infant mortality in London. It should be noted that Enfield has the second highest early neonate mortality rate after Southwark, but a comparatively low stillbirth rate (23rd worst out of 33).
Causes of Infant Mortality

The Department of Health Review of the Health Inequalities Infant Mortality PSA Target identified the major causes of infant mortality nationally as:

- Immaturity related conditions;
- Congenital abnormalities;
- Sudden Unexpected Death in Infancy (SUDI);
- Intrapartum causes, including asphyxia, anoxia or trauma; and
- Conditions originating in the perinatal period.

All causes of neonatal mortality and all but one cause of post neonatal deaths show a socio-economic gradient i.e. highest rates are seen in Routine and Manual occupations.

Infant Mortality in Enfield: Patterns at Ward Level

Within Enfield there is a 10-fold difference between the wards with highest and lowest infant mortality rates, when considering all infant deaths occurring in Enfield between 2002 and 2008 pooled. Variations at ward level are shown in the following map, although differences at ward level should again be treated with caution due to the small numbers of events involved. Exact rates are not published here, for reasons of confidentiality. The highest rates were seen in Upper Edmonton, Lower Edmonton and Ponders End.

Figure 3:

Infant Mortality by Ward in Enfield – Crude rate per 1000 live births 2002-2008

NOTE: small numbers mean differences in infant mortality at ward level should be treated with caution.

NB: Numbers in brackets indicate numbers of wards included in this category, rather than mortality rate.
<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Enfield</th>
<th>Comparators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teenage pregnancy</strong></td>
<td>- 15-17 yr old conception rate:</td>
<td>- 15-17 yr old conception rate:</td>
</tr>
<tr>
<td></td>
<td>o 48.1/1000</td>
<td>o London 45.6/1000</td>
</tr>
<tr>
<td></td>
<td>o Highest rates SE of borough line following socio economic deprivation</td>
<td>o National 41.7/1000</td>
</tr>
<tr>
<td></td>
<td>trends</td>
<td></td>
</tr>
<tr>
<td><strong>Low birth weight</strong></td>
<td>- Proportion of still/live birth rates fairly constant</td>
<td>- London: lower proportion than Enfield (7.9%)</td>
</tr>
<tr>
<td></td>
<td>o 2004 – 8.7%</td>
<td>National: lower proportion than Enfield (7.5%)</td>
</tr>
<tr>
<td></td>
<td>o 2007 – 8.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o 2007 highest proportion live and still born babies &lt;1500g and &lt;2500g</td>
<td></td>
</tr>
<tr>
<td></td>
<td>in north central London sector (2.3% &lt;1500g, 8.14% &lt;2500g)</td>
<td></td>
</tr>
<tr>
<td><strong>Smoking in pregnancy</strong></td>
<td>- Percentage of months smoking at time of delivery</td>
<td>- Enfield lower proportion smoking in pregnancy than London (11.9%) in 2007/8</td>
</tr>
<tr>
<td></td>
<td>o 2006/7 – 15.5%</td>
<td>Enfield significantly lower proportion smoking in pregnancy than national rates in 2008/9 (14.7%)</td>
</tr>
<tr>
<td></td>
<td>o 2007/8 – 7.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o 2008/9 – 6.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Ranks 18th best nationally for low prevalence of smoking during pregnancy</td>
<td></td>
</tr>
<tr>
<td><strong>Late booking for antenatal appointment</strong></td>
<td>- Percentage of pregnant women having a first appointment by 12 weeks:</td>
<td>- National: higher proportion than Enfield (78%)</td>
</tr>
<tr>
<td></td>
<td>o 2008/9 – 60.4%</td>
<td>Lower uptake of early antenatal appointments reported across London.</td>
</tr>
<tr>
<td></td>
<td>o Locally agreed target for percentage of pregnant women having a first appointment by 12 weeks:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o 2008/9 – 88% (Local Target)</td>
<td></td>
</tr>
<tr>
<td><strong>Inadequate housing</strong></td>
<td>- 4th largest number of households in temporary accommodation in England</td>
<td>- Homelessness acceptance 16-17 year olds largely reduced across London.</td>
</tr>
<tr>
<td></td>
<td>- 6th highest rate of acceptance for homelessness (in first 9 months of 2008)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Homelessness acceptance 16-17 year olds remaining constant</td>
<td></td>
</tr>
<tr>
<td><strong>Poverty affecting children</strong></td>
<td>- Income Deprivation Affecting Children Index (IDACI):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Ranked 211/354 in England (worst 10%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o IDACI score between 2004-2007 was worst change in index for all local authorities in England</td>
<td></td>
</tr>
<tr>
<td>Risk Factor</td>
<td>Enfield</td>
<td>Comparators</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Maternal obesity</td>
<td>• 27% adults in Enfield obese (London Boost estimation)</td>
<td>• Outer London estimated prevalence 18.2%</td>
</tr>
<tr>
<td></td>
<td>• 3rd highest prevalence adult obesity in London</td>
<td></td>
</tr>
<tr>
<td>Babies born to couple in routing and manual groups</td>
<td>• LHO ‘Born Equal’ report found:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o 2001-2003 – 30.3% births registered under this category</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(upper middle quartile of London Boroughs)</td>
<td></td>
</tr>
<tr>
<td>Sole registered births</td>
<td>• LHO ‘Born Equal’ report found:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o 7.6% of all births sole registered by mother (upper middle quartile of London Boroughs)</td>
<td></td>
</tr>
</tbody>
</table>

Tackling Infant Mortality: Best Practice

The Department of Health 2007 Review of the Health Inequalities Infant Mortality PSA Target and the Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide highlighted a number of potential actions to reduce the gap in infant mortality by at least 10%.

Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide

Seven modelled interventions to reduce the gap in infant mortality by 11.4%:

1. reducing the prevalence of obesity in the Routine and Manual (R&M) group by 23% to the current levels in the population as a whole;
2. meeting the national target to reduce smoking in pregnancy from 23% to 15% and meeting this target in the R&M group;
3. reducing sudden unexpected death in infancy (SUDI) by persuading 1 in 10 women in the R&M group to avoid sharing a bed with their baby and to avoid putting their baby to sleep prone (on its front);
4. achieving the teenage pregnancy strategy to reduce the under-18 conception rate in the R&M group by 50% compared with 1998 levels;
5. meeting the child poverty target to halve the number of children in relative low-income households between 1998-99 and 2010-11, by increasing the income in the R&M group by an average of 18%;
6. reducing housing overcrowding in the R&M group through the effect on reducing SUDI;
7. promoting early antenatal booking among disadvantaged groups.

Other contributing interventions include optimising preconception care, reducing maternal and infant infections, improving access to culturally sensitive health care and improving infant nutrition.
Further detailed information on effective interventions in practice can be found in the DH 2007 review:

Practical implementation guidance for commissioners and service providers can be found in the Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide:

Infant Mortality in Enfield: Projections of Need

Enfield has a high crude fertility rate of 77 live births per 1,000 women aged 15-44 yrs. Which is significantly higher than fertility rates in the sector (64:1), London (68.1) and England (62.1) The birth rate in Enfield has been steadily climbing since 2000. If this trend continues, Enfield could expect to register 6000 births per year by 2012. This has implications for planning of antenatal care and maternity services, and could in turn have an impact on stillbirth and infant mortality rates.

Figure 4

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Births</th>
<th>Crude Birth Rates</th>
<th>% increase in previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>3736</td>
<td>13.34</td>
<td>6.47%</td>
</tr>
<tr>
<td>2003</td>
<td>3992</td>
<td>14.21</td>
<td>1.84%</td>
</tr>
<tr>
<td>2004</td>
<td>4080</td>
<td>14.47</td>
<td>9.51%</td>
</tr>
<tr>
<td>2005</td>
<td>4484</td>
<td>15.84</td>
<td>0.65%</td>
</tr>
<tr>
<td>2006</td>
<td>4545</td>
<td>15.95</td>
<td>6.86%</td>
</tr>
<tr>
<td>2007</td>
<td>4857</td>
<td>17.04</td>
<td>2.17%</td>
</tr>
<tr>
<td>2008</td>
<td>4997</td>
<td>17.41</td>
<td>-100.00%</td>
</tr>
</tbody>
</table>
4.5 Long-term Conditions (LTC)

The Department of Health, in its publication *Raising the Profile of Long Term Conditions Care: A Compendium of Information (DH January 2008)*, identifies age as the most significant driver of prevalence of long-term conditions which tend to become apparent from the age of 45 onwards. From the General Household Survey 2005, 35% of those aged between 45 and 54 say they have one or more long-term conditions. This figure rises to 53% in the 60 to 64 age group. Applying these estimates to the Enfield population aged between 45 and 64 years, we find that between 30,158 and 30,600 are likely to be affected by one or more long-term conditions in 2009. This number is projected to rise to between 31,330 and 32,535 by 2012. This is an increase of between 1,172 and 1,935 over the next 3 years.

It should be noted that Enfield population growth is expected to be greater in the 45-54 age group in this period (between 6 and 10%) so an increasing number of residents in this age group may be expected to present with long-term conditions and potentially need access to related health and social care. It will therefore be important to consider this population for health checks and screening for risk, to enable early intervention and prevention strategies which will improve health and wellbeing outcomes.

There is no evidence of needs not being met, however people with long-term conditions are intensive users of health and social care services, including community services, urgent and emergency care and acute services. People with long-term conditions account for a significant and growing amount of health and social care resources. The Department of Health’s best estimate is that the treatment and care of those with long-term conditions account for 69% of the total health and social care spend in England. Looking at social care expenditure, this too is focused on those with long-term conditions and will be put under pressure by the ageing population.

In recent national consultations, people have voiced their opinions about what matters most to them in the care and the services they receive. A number of common themes and key messages have emerged. People want services that will support them to remain independent and healthy and have increased choice. They want far more services to be delivered safely and effectively in the community or at home; and they want seamless, proactive and integrated services tailored to their needs.

Feedback from the *Your health, your care, your say (DH January 2006)* consultation:

- Of nearly 1,000 participants at the National Citizens’ Summit, 86% of people thought that professionals in their local GP practice should provide more support to help them take care of their own health and well-being.
- Some 61% said that being given more information about their health and the services available to them locally would make a big difference. They particularly want to know more about the availability of social care services.
• Half of all people with LTCs were not aware of treatment options and did not have a clear plan that lays out what they can do for themselves to manage their condition better. As a consequence, a significant proportion of all medicines are not taken as directed.

Department of Health MORI Survey 2005 – supporting statistics:

• Some 82% of those with a LTC say that they already play an active role in their care but they want to do more to self care.
• More than 75% say that if they had guidance/support from a professional or peer they would feel far more confident about taking care of their own health.
• More than 50% who had seen a care professional in the previous six months said that they had not often been encouraged to self care.

There is relatively little national survey evidence available on the views of social service users and carers about how services can be best provided, and the extent to which people wish to consider personal budgets. In Cambridgeshire (one of the few local authorities to do this) 62% of service users responding to their consultation welcomed the opportunity to have a Personal Budget. Of the remainder 8% did not welcome the opportunity and 30% were unsure.

*Raising the Profile of Long Term Conditions Care: A Compendium of Information (DH January 2008)* recommends:

• Self care is a well proven and highly effective means of improving LTC care.
• Good disease management involves identifying needs early and responding promptly with the right care and support. Personalised care planning actively supports this approach.
• Evidence has shown that intensive, ongoing, personalised case management can improve quality of life and outcomes for people who have an intricate mix of health and social care needs and simple problems can cause their condition to deteriorate rapidly, putting them at risk of unplanned hospital admission.
• Bringing staff together into multidisciplinary teams can avoid fragmentation, confusion and duplication of effort in working with people with a range of complex needs, who often require care or support from a range of different professionals and agencies.

*Putting People First: A shared vision and commitment to the transformation of Adult Social Care (DH December 2007)* advocates a system-wide transformation, which involves an “integrated approach with local NHS commissioners and providers to achieve specific outcomes on issues…. including the management of long-term conditions”. Key to this transformation is the mainstreaming of person centred planning and self-directed support, with personal budgets being available for everyone eligible for publicly funded adult social care support. Personal health budgets that will allow people greater control over the services they use and who provides them are now being piloted.
The latest national evidence, as set out in *Raising the Profile of Long Term Conditions Care (DH January 2008)*, continues to support the clear messages about LTCs:

- People with LTCs are intensive users of health and social care services, including community services, urgent and emergency care and acute services.
- Numbers are predicted to increase due to factors such as an ageing population and certain lifestyle choices that people make.
- Ill health among the working population places a significant burden on health and social care.
- There are huge benefits to the population and financial savings to be made if health and social care communities invest in effective LTC management.
- LTCs are those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. The life of a person with a LTC is forever altered – there is no return to ‘normal’.

### QOF 2006/07 prevalence counts

<table>
<thead>
<tr>
<th>LTC</th>
<th>Number affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>1,899,000</td>
</tr>
<tr>
<td>Heart failure</td>
<td>420,000</td>
</tr>
<tr>
<td>Stroke and transient ischaemic attack</td>
<td>863,000</td>
</tr>
<tr>
<td>Hypertension</td>
<td>6,706,000</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1,962,000</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>766,000</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>321,000</td>
</tr>
<tr>
<td>Cancer</td>
<td>489,000</td>
</tr>
<tr>
<td>Severe mental health conditions*</td>
<td>380,000</td>
</tr>
<tr>
<td>Asthma</td>
<td>3,100,000</td>
</tr>
</tbody>
</table>

*Severe mental health conditions includes all people with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses.*

Other LTCs also include:

- chronic kidney disease
- dementia
- schizophrenia
- depression
- multiple sclerosis
- Parkinson’s disease.

Age is the most significant driver of prevalence of LTCs. The probability of having a LTC increases with age, as the graph indicates. The ageing of our society is driven by a number of factors, including:
• ageing of the baby boom generation
• the increase in life expectancy
• reductions in birth rates.

Health and social care systems need to consider the effect of the ageing population on the future demands on resources.

Proportion of people with LTCs by age

![Proportion of people with LTCs by age](chart)

Source: General Household Survey 2005 and population census estimates 2004 for England

*For those aged 65 or over an adjustment has been made using 2001 census data to account for those living in communal establishments

The percentages of people reporting at least one LTC are:

- 16-44 12%
- 45-64 26%
- 65-74 37%
- 75 and over 47%

The number of people with a LTC will continue to grow. Due to an ageing population, it is estimated that by 2025 there will be 42% more people in England aged 65 or over. This will mean that the number of people with at least one LTC will rise by 3 million to 18 million. Health and social care services will need to be responsive to meet this increase in demand and focus more on earlier detection and better prevention – all key to improving health outcomes for people with LTCs and providing more cost-effective care.
People with limiting LTCs are the most intensive users of the most expensive services. People with LTCs use disproportionately more primary and secondary care services, and this pattern will increase over time with an ageing population. Over 30% of all people say that they suffer from a LTC. This group accounts for:

- 52% of all GP appointments
- 65% of all outpatient appointments
- 72% of all inpatient bed days.

Better LTC management, including improvements in clinical care and support for self care, should lead to reductions in the proportion of services used. People with LTCs are high users not just of primary and specific acute services, but also of social care and community services.

- People with mental health conditions are particularly high users of these services, being twice as likely to have used local social care services in the last six months and almost three times as likely to have used community nurse services.
- Those with other LTCs are also more intensive users of services; for example, those with cancer, muscular problems and diabetes are all more likely to have used community nurse services.

People with LTCs account for a significant and growing amount of health and social care resources. The Department of Health’s best estimate is that the treatment and care of those with LTCs account for 69% of the total health and social care spend in England, or almost £7 in every £10 spent. Looking at
social care expenditure, this too is focused on those with LTCs and will be put under pressure by the ageing population. By 2022:

- The proportion of those aged 65 and over will increase by 37% to 10.8 million.
- The number of people aged 65 and over with some disability will increase by 40% to 3.3 million.
- The number of disabled older people with informal care (in households) will rise by 39% to 2.4 million.
- The number of people in residential care homes will increase by 40% to 280,000.
- The number of people in nursing homes will increase by 42% to 170,000.

4.6 Mental Health

Overview
Prevalence of psychoses in Enfield is above national rates but below the London average at 0.8%. In contrast it is estimated that between 10 and 15% of the over 65 population suffers from depression, i.e. between 3,820 and 5,730 residents in 2010.

Dementia has an all age prevalence of 0.31% in Enfield, below national rates. In 2007 an estimated 2,400 residents over 65 were living with dementia.

Primary care plays a key role in mental health care as 90% of mental health is dealt with in GP surgeries and 40% of all GP consultations are mental health related.

The number of acute inpatient beds for adults of working age (Enfield) is 52. The total number of Enfield patients of working age receiving a service from the Trust was 2,836 in July 2009, and 2,766 in August 2009.

A single overarching Mental Health Strategy 2009-2014 across Barnet Enfield and Haringey PCTs and partner Local Authorities has been developed in 2009. Local borough based joint commissioning strategies will be developed in support of this. These strategies will determine how services can be modernised, moving from a model of dependency to one of wellbeing, mental health promotion, prevention and early intervention.

A review of mental health needs in Enfield conducted in 2006 found that Edmonton had the highest levels of mental health hospital admissions in Enfield between 2003 and 2005. A mental health needs index showed that residents living in Edmonton had the highest estimated levels of psychiatric illness and schizophrenia in the Borough.

The GHQ-12 is measure of mental health. It asks a series of questions such as ‘have you recently lost sleep over worry?’ and ‘have you recently felt constantly under strain?’. A score of 0 or 1 is given to each question and the scores are added up. A score of 4 or more is an indication of poorer mental health.
The Health Survey for England, London Boost 2006 shows that Enfield has a higher percentage of a GHQ 12 score of 4+ for females (24.4%) compared to outer London (16.8%) and London (18.2%). However Enfield has a lower percentage of a GHQ 12 score of 4+ for males compared to London.

Enfield also has a higher percentage of poor mental health in the 16-34 (23%) and 55+ (18.5%) age groups compared to London and Outer London (16% in 16-34 and 13.3% in 55+). Comparing Enfield to other Outer London PCTs it has the 3rd highest percentage for GHQ 12 score 4+ in 16-34 age group.

London and Outer London had similar percentages for GHQ 12 score of 4 or more for deprivation. The least deprived areas had the lowest percentage (10%) and the most deprived areas had the highest percentage (20%).

People with mental health problems face major challenges in daily living, with employment, education and housing. In the past, rather than helping people to integrate into society we have been all too ready to take them out of it, focusing on large inpatient hospitals. These have provided a secure and safe environment but at the cost of preventing people from integrating into their local communities and developing their independence. The aim in 2009 was to reduce the number of acute in-patient admissions by improving community services to reflect the needs of the local population.
Enfield has the lowest rate of suicide in London (4 per 100,000 in 2005-2007)

Enfield has an ageing population with 54% of over 16s aged 60+. For adults the most prevalent mental illness diagnoses are:

- Mild to moderate – depression, anxiety and phobias.
- Moderate to severe – eating disorders, bipolar disorders and schizophrenia.
- Edmonton has highest area of deprivation and also has the highest presentation of mental health acute admissions.
- Edmonton also has the lowest number of GP registered patients and, in comparison, the highest number of presenting patients at the MH Trust’s Emergency Assessment Centre and the least number of GP referrals therefore presenting in a later and more acute phase.
- 22% of the population in Enfield is from black and minority ethnic groups, with a high proportion of asylum seekers in the area and an increased demand for Post-Traumatic Stress Disorder services. Schizophrenia is the most prevalent diagnosis for the in-patients.
- Adults tend to have a high prevalence of common neurotic disorders and mixed anxiety and depressive disorders in Enfield (170.7 per 10,000 Adults – UK average 165.7) suicide, dual diagnosis, and alcohol problems.

MILD/MODERATE MENTAL ILLNESS

Overview:
1. Estimated that 16% of people of working age (approx 29,000 people) suffer from depression and other neurotic disorders.
2. Between 10-15% (3,700 and 5,500) older people are estimated to suffer from depression.
3. Local survey data shows that Enfield would appear to have poorer low level mental illness in comparison with other London Boroughs, for the following categories: women, 16-34 age group and 55+ age group.
4. People who lose their jobs during a recession are at greater risk of suicide – and that for the least well-educated, the risks are even higher.
5. It is believed that dealing with patients with mental health problems consumes significant amounts of GP time.

The Barnet, Enfield and Haringey Mental Health Trust undertook a survey of patients in Enfield who received psychological therapies. During the time period between 1st May 2007 and 30th September 2008, a total of 197 questionnaires were returned. The majority of respondents stated they would recommend the service to others, suggesting an overall positive impression of the service. A number of areas for service improvement have been identified from analysis of the data collected. A number of recommendations have been made including: lobbying for more resources to offer clients more sessions; including service-users in service user satisfaction research and considering ways to ensure that data received is relevant to psychology specifically and not other services.
The Improving Access to Psychological Therapies (IAPT) programme aims to help PCTs implement NICE Guidelines for people suffering from depression and anxiety disorders. The Government has provided funding, but this is not available in Enfield.

Satisfaction surveys of patients demonstrate dissatisfaction with waiting times for Psychological Therapies, which can be up to year and sometimes longer. In the survey almost 45% were either dissatisfied or very dissatisfied with the length of time they had to wait for their first appointment.

Psychological treatments are recommended by NICE for common mental health problems – to be offered by GPs either before the prescription of psychoactive medication, or alongside their use.

OLDER ADULTS

The number of older people with a diagnosis of dementia is estimated to be between 2,500 and 3,300, with a higher prevalence among women, and this number is predicted to rise by 10% over the next 5 years (as the numbers of older people increases). However, within this period there will be an increase in the number of people aged 65-69 years and the number of older people who are aged 85 and over, for whom most health and social care and support is provided, and where dementia is most prevalent.

54% of the population are over 60 years old. Dementia has the highest prevalence. Older Adults: High prevalence for psychiatric disorders in the over 65 age group average prevalence of dementia (82.2 per 1,000 Older Adults (female) and 57.2 per 1,000 Older Adults (male)) UK average 82.0, female, 56.5, male).

Although 14% of people aged 65 and over are currently from black and ethnic minority communities this percentage is set to double by 2025. (This percentage does not include older people whose ethnicity is described as European, Greek, Greek Cypriot, Turkish or Turkish Cypriot who are included in the “Other White” description of the population of Enfield and accounts for 12.9% of the population as a whole). In addition, there is an increased demand for care and support for those older people from these communities who experience an earlier onset of chronic diseases such as coronary heart disease, stroke and diabetes.

36% of older people live alone in Enfield and the number of older people living alone is predicted to increase by 25% by 2025. Living alone can be an indicator of isolation and a lack of access to informal support. Within this cohort of older people, the number of older people who are aged 85 and over will be over-represented and this is the group where dementia is most prevalent.

Three quarters of older people who are over 75 are living with a long-term disease condition, 45% have more than one and many will have a combination of a long-term chronic disease as well as a mental health condition.
Number of carers aged 65+ is estimated at 7,800 with half of them caring for someone over 75 years of age.

_Living well with dementia: a national dementia strategy (2009)_ aims to ensure that significant improvements are made to dementia services across three key areas:

- improved awareness
- earlier diagnosis and intervention
- a higher quality of care

The strategy identifies 17 key objectives which, when implemented, largely at a local level, should result in significant improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia.

The strategy draws on evidence from several recent reports and research, which highlight the shortcomings in the current provision of dementia services in the UK, commenting that dementia presents a huge challenge to society, both now and increasingly in the future. There are currently 700,000 people in the UK. Dementia costs the UK economy £17 billion a year and, in the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year.

Some of the key objectives, supported by the wide-ranging national consultation, include:

- Improving public and professional awareness and understanding of dementia, informing individuals of the benefits of timely diagnosis and care, promoting the prevention of dementia, and reducing social exclusion and discrimination.
- Good-quality early diagnosis and intervention for all, ensuring that all people with dementia have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their carers; and treatment, care and support provided as needed following diagnosis.
- Good-quality information for those with diagnosed dementia and their carers, providing people with dementia and their carers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.

**TRANSITION FROM CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES**

Research suggests that early detection and treatment of first episode psychosis reduces the duration of untreated severe mental illness and results in less distress to young people.

The final report of the National CAMHS Review _Children and young people in mind_ recommends that young adults who are approaching 18 and who are being supported by CAMHS should:
• know well in advance what the arrangements will be for transfer to adult services of any type
• be able to access services that are based on best evidence of what works for young adults
• have a lead person who makes sure that the transition between services goes smoothly
• know what to do if things are not going according to plan
• have confidence that services will focus on need, rather than age, and will be flexible.

The report suggest that three fundamental changes need to take place.

1. Everybody needs to recognise and act upon the contribution they make to supporting children’s mental health and psychological well-being.
2. Local areas have to understand the needs of all their children and young people – at population and individual level and engage effectively with children, young people and their families in developing approaches to meet those needs.
3. The whole of the children’s workforce needs to be appropriately trained and, along with the wider community, well informed. For practitioners, this involves having access to the best evidence and knowledge on improving outcomes for children and young people.

A key recommendation of this report is that these changes do not require substantial shifts in policy. They do, however, require the full implementation of existing policies, as well as shifts in thinking and behaviour within many services. They may also need focused resources – if not of money, then certainly of time and commitment.

BLACK AND MINORITY ETHNIC GROUPS

National research shows that people from black and ethnic communities may face increasing difficulties including higher rates of mental illness in some communities, and problems with access to the right care and treatment, but they are less likely to have mental health problems detected by a GP.

Local satisfaction surveys undertaken in June and July 2009 of in-patients’ experiences of their care in the MH Trust report that 88% and 98% respectively stated that they had been treated with dignity and respect.

Consultation undertaken by Health Link (unpublished report commissioned by Barnet Enfield and Haringey Mental Health Trust) highlighted:

• Barriers to accessing care, such as language barriers.
• Importance of achieving a culturally appropriate service.

This consultation demonstrated that many BME communities experience stigma within their society about mental health, more so than the general population. The Health Link report also included a literature review which
referred to findings of low expectations by some patients which is as a factor in discouraging early access to mental health services thereby perpetuating mental health inequalities.

Many of the groups consulted wished to help with achieving a fully culturally appropriate service. Seven groups explicitly said that they would like to be involved in providing a service for patients who suffer from mental illness or some sort of preventative/well-being service.

Collecting data on ethnicity is an important part of building the local picture. The DH commissioned report No Patient Left Behind: how can we ensure world class primary care for black and minority ethnic people? says "that if PCTs are to continue to improve, they will need access to accurate and consistent information about performance and progress".

4.7 Healthy Lifestyles

Epidemiological theory suggests that even small degrees of change, over time, can result in significant improvements in population-level health (Rose 1985).¹

There is overwhelming evidence that changing people’s health-related behaviour can have a major impact on some of the largest causes of mortality and morbidity.² The Wanless report³ outlined a position in the future in which levels of public engagement with health are high, and the use of preventive and primary care services are optimised, helping people to stay healthy. This ‘fully engaged’ scenario, identified in the report as the best option for future organisation and delivery of NHS services, requires changes in behaviours and their social, economic and environmental context to be at the heart of all disease prevention strategies.

Behaviour plays an important role in people’s health (for example, smoking, poor diet, lack of exercise and sexual risk-taking can cause a large number of diseases). In addition, the evidence shows that different patterns of behaviour are deeply embedded in people’s social and material circumstances, and their cultural context.

A wealth of guidance exists from the department of health, the National Institute of Clinical Excellence (NICE) and others, across all aspects of health behaviour to support the commissioning of effective healthy lifestyles programs, as the following illustrates.

Guidance is underpinned by the government white paper Choosing Health: Making healthy choices easier.⁴

“Small changes in the choices people make can make a big difference. Taken together, these changes can lead to huge improvements in health across society. But changes need to be based on choices, not direction.”
This paper found in consultation that people wanted to take responsibility for their health and make their own choices about lifestyle, but equally that they wanted support to enable them to make healthy choices for themselves. ‘Choosing Health’ lays out in detail the government commitment to providing this support.

HEALTHY EATING

Good nutrition is vital to good health. While many people in England eat well, a large number do not, particularly among the more disadvantaged and vulnerable in society.

Healthy eating is one key way to help reduce the risks of developing a number of health issues in later life, including: heart and circulatory disease, diabetes, some types of cancer and obesity. It has been estimated that diet might contribute to the development of one-third of all cancers, and that increasing fruit and vegetable consumption is the second most important cancer prevention strategy, after reducing smoking. Higher consumption of fruit and vegetables also reduces the risk of coronary heart disease and stroke and a recent study found that each increase of 1 portion of fruit and vegetables a day lowered the risk of coronary heart disease by 4% and the risk of stroke by 6%. Evidence also suggests an increase in fruit and vegetable intake can help lower blood pressure. Other benefits include delaying the development of cataracts, reducing the symptoms of asthma, improving bowel function, and helping to manage diabetes. A healthy diet can also help with the maintenance of a healthy weight.

It is recommended that everyone eats at least 5 portions of fruit and vegetables a day. The figure below shows the modelled estimates of ‘5 a day’ consumption. Enfield has higher consumption than the National average, however it is estimated to have one of the lowest ‘5 a day’ consumptions out of all the London Local Authorities.

Figure 1: Consumption of Fruit and Vegetables by borough, compared with the National average

Source: Model Based Estimate for Consumption of Fruit and Vegetables, 2003-2005 from Neighbourhood statistics
**Best Practice: Healthy Eating Guidelines**

The National Institute of Clinical Excellence (NICE) 2006 guidance on ‘How to have a healthy balanced diet’\(^\text{12}\) includes detailed guidelines on the composition of healthy meals, portion sizes, snacks and meal frequency and notes that children and young people should have regular meals in a pleasant, sociable environment with no distractions (such as television); parents and carers should join them as often as possible.

Guidance covers a variety of settings for improving lifestyles, and emphasises the importance of holistic approaches which are multi-component including healthy eating, physical activity, weight management, alcohol consumption and so on.

**Community programmes:** should address people’s concerns about the availability of services, costs of making changes, the taste of healthy foods, dangers of walking and cycling, and mixed messages in the media about weight, diet and activity. Awareness-raising promotional activities should form part of a multi-component intervention rather than being used on their own.

**Public sector and large commercial organisations** may offer tailored education and promotion programmes to support any action to improve food and drink in the workplace. An example is the Healthier Food Mark, a developing public sector initiative to improve the nutritional quality and sustainability of meals served across the public sector in England, via voluntary self certification of public sector buildings. This scheme is due to be rolled out in 2011. Effective organisational schemes will require commitment from senior management, enthusiastic catering departments, strong occupational health lead and supportive pricing policies.

**Policy and planning:** local initiatives should work with the community to identify environmental barriers to eating healthily and being physically active via audits and health impact assessment which include all sectors of the community. Consideration should be given to the types of tailored information and support that may be needed by vulnerable groups.

**PHYSICAL ACTIVITY: PARTICIPATION IN SPORT AND ACTIVE RECREATION**

There are clear links between physical activity and health; a lack of physical activity is linked to cardiovascular disease (CVD), coronary heart disease, some cancers, obesity, diabetes, depression and musculoskeletal health.\(^\text{36}\)

The Chief Medical Officer (CMO) recommends at least 30 minutes a day physical activity of at least moderate intensity 5 times a week.\(^\text{13}\) In Enfield less than half the population takes part in physical activity on even a weekly basis.
Young People and Physical Activity

PRO-ACTIVE North London recently commissioned a survey (2006) to which 14,000 young people in Years 6 and 9 across all the schools in the sub-region responded (50% response rate).

The aim was to gain an insight into their activity levels as well as their attitude to sport and their knowledge about local opportunities and facilities.

A quantitative survey was conducted, in Enfield schools, amongst pupils from Years 6 and 9 to collect data on participation in sporting activities. 3,356 pupils from Enfield participated. This was part of a wider survey conducted across the four London boroughs (Barnet, Enfield, Haringey and Waltham Forest) that comprise the PRO-ACTIVE North London Partnership area. For Enfield, it was also a repeat of survey work undertaken in 2003 to provide a baseline for the Borough’s Public Service Agreement (LPSA).

The survey included a question on the main means of transport used by pupils to get to school.

Table 1: Primary means of transport to get to school used by Enfield pupils in Years 9 and 6

<table>
<thead>
<tr>
<th>Means of transport</th>
<th>Year 9</th>
<th>Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bus</td>
<td>42.5%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Walk</td>
<td>26.5%</td>
<td>51.7%</td>
</tr>
<tr>
<td>Car</td>
<td>25.0%</td>
<td>40.1%</td>
</tr>
</tbody>
</table>

In Year 9 there was a consistently low proportion of pupils that walk to school. The main exceptions were Highlands and Bush Hill Park. In Year 6 the proportion of young people walking to school is far higher than in year 9 and is highest in the wards of Jubilee, Lower Edmonton, Chase, Southgate Green and Upper Edmonton and lowest in Grange and Bowes.

Just under a quarter (24.9%) of pupils in Year 9 spend the recommended minimum seven hours or more a week on sport and physical exercise. There is a significant gender bias in this picture, with figures of 36.4% for boys and 16.2% for girls.

Figures at Year 9 represent a significant drop from Year 6, where the proportion that participates for seven hours a week or more is 32.3% (39.6% boys; 25.2% girls). They also represent a drop from 2003 (29.2%).

From this survey Enfield exhibits very strong levels of participation at Year 6. It was significantly above the North London average for extracurricular participation, sports club membership/attendance at a regular organised session and leisure centre usage. However, the figures also show sizeable drops in Year 6 participation since 2003. In contrast, participation amongst Year 9 pupils increased since 2003.
In particular, leisure centre usage in Enfield was very strong, being the highest figure amongst the four North London boroughs. Enfield also had the highest proportion of Year 9 pupils taking part in physical activity for 7 hours a week or more. This was significantly above the level in the other boroughs. There was found to be a strongly favourable attitude to sport amongst young people in Enfield.

In all forms of participation, boys participate more than girls. There was significant variation in participation by ethnicity. Pupils describing themselves as White or Black were much more likely to participate than other young people.

Key influencers on participation were familial involvement and car access. Where a family member participates in sport and physical activity, young people were significantly more likely to be active themselves. Car access influenced participation, especially for sports club membership/attendance at a regular organised session. Some geographic variation was seen across Enfield. Participation tended to be stronger in the west and lower in the east.

The Enfield report concluded that:

"In the context of equity, a primary aim should be to reduce gaps in participation between boys and girls, and between the different ethnic groups, to develop opportunities for those from households without access to a car and to ensure, wherever possible, that participation is encouraged for children from households where other family members are not involved in sports."

‘Physical Activity: Adult participation in Sport and Active Recreation Sport England’ conducts the Active People Survey\textsuperscript{12} as a continuous annual survey, assessing participation in sport at all ages over 16.

The Active People Survey provides the largest sample size ever established for a sport and recreation survey and is anticipated to allow levels of detailed analysis previously unavailable. It identifies how participation varies from place to place and between different groups in the population.

The ‘Active People Survey 2008’ showed a 14% participation in sport and active recreation in Enfield, where participation was defined as participation in moderate intensity sport at least 3 days a week for 30 minutes. This placed Enfield adult participation in the lowest quintile for London (Highest participation for London was 30.9%). This was also a decrease from the levels seen in the first Active People Survey (19.7%), although the 2008 survey sample size was half that of the first survey. For Enfield survey respondents aged over 55, 10.1% participated in 3x30 minutes of moderate activity in 2008, which is also lower than its neighbours and a drop from 13.5% in the first Active People Survey.\textsuperscript{10} Of those respondents stating they had a limiting disability 5.8% participated in 3x30 minutes of moderate activity. Using the National Statistics Socio-economic Classification (NS-SEC) there was no variation seen across managerial (NS-SEC 1-4, 13.9%) versus routine and manual (NS-SEC 5-8, 13.8%) social groups.
Figure 2: Active People Surveys 1 and 2 (APS 1 2005/06 and APS 2 2007/08) Participation in Sport – Local Authorities


Figure 3: Likelihood to participate in 3x 30 minutes of sport and active recreational per week in Enfield residents aged 16 and over

Sport Market Segmentation Source: Sport England and Experian Ltd 2007
Physical Activity and Transport

For most people, the easiest and most acceptable forms of physical activity are those that can be incorporated into everyday life. Examples include walking or cycling instead of driving. Despite this, data shows that the contribution of active travel to health has been declining, between 1975-6 and 2000-2001 the average number of miles walked per person fell by 66 miles. For a person of 65kg this represents nearly 1 kg of fat. A similar trend is seen in cycling for transport.

Table 2: Trends in average miles travelled per person per year on foot and by bicycle, England, 1975/76 – 1999/2001

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Walking</td>
<td>255</td>
<td>244</td>
<td>237</td>
<td>199</td>
<td>195</td>
<td>186</td>
<td>189</td>
<td>-26</td>
</tr>
<tr>
<td>Cycling</td>
<td>51</td>
<td>44</td>
<td>41</td>
<td>38</td>
<td>39</td>
<td>38</td>
<td>39</td>
<td>-24</td>
</tr>
</tbody>
</table>

Source: CMO 2004

In Enfield 1.19% of commuters cycle to work and 6.46% walk. This compares to Milton, Cambridge where 24.9% cycle and 13.18% walk.\(^{16}\) 0.8% of Year 9 pupils cycle to school. These figures suggest that there is a great potential for health gain through active transport within the Borough.

Best Practice: Physical Activity Guidelines

Lets Get Moving (LGM)\(^{17}\) is a behaviour change intervention that has been designed to provide a systematic approach to identifying and supporting adults, who are not meeting the Chief Medical Officer’s recommendation for physical activity, to become more active, for the purpose of both prevention and management of inactivity-related chronic disease. The programme can be integrated as a solution with other public health initiatives such as NHS Health Checks.

The LGM approach is based on the recommendations of the National Institute for Health and Clinical Excellence (NICE) public health guidance Four commonly used methods to increase physical activity, which endorses the delivery of brief interventions for physical activity in primary care as being both clinically effective and cost-effective in the long term.\(^{18}\)

The NICE physical activity public health intervention guidance\(^{19}\) covers four common methods used to increase the population’s physical activity levels:

- brief interventions in primary care;
- exercise referral schemes;
- pedometers, and
- community-based walking and cycling programmes.
Local authorities should work with local partners, such as industry and voluntary organisations, to create and manage more safe spaces for incidental and planned physical activity, addressing as a priority any concerns about safety, crime and inclusion, by:

- providing facilities and schemes such as cycling and walking routes, cycle parking, area maps and safe play areas
- making streets cleaner and safer, through measures such as traffic calming, congestion charging, pedestrian crossings, cycle routes, lighting and walking schemes
- ensuring buildings and spaces are designed to encourage people to be more physically active (for example, through positioning and signing of stairs, entrances and walkways)
- considering in particular people who require tailored information and support, especially inactive, vulnerable groups.

More recent guidance\(^1\) also specifies that those responsible for all strategies, policies and plans involving changes to the physical environment should:

- Ensure planning applications for new developments always prioritise the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life.
- Ensure local facilities and services are easily accessible on foot, by bicycle and by other modes of transport involving physical activity.
- Ensure children can participate in physically active play.
- Assess in advance what impact (both intended and unintended) the proposals are likely to have on physical activity levels (for example, will local services be accessible on foot, by bicycle or by people whose mobility is a problem).

SMOKING

Smoking is the greatest cause of preventable ill-health, disability and health inequalities. Increasing the number of ‘smoking quitters’ is therefore one of the top ten priority outcome measures for Enfield, as mentioned in the Enfield Strategic Plan. Although Enfield has one of the lowest percentage deaths attributable to smoking in London, it accounts for over half of the difference in risk of premature death between social classes. This is reflected in Enfield and therefore we need to target our efforts in the areas of greatest deprivation. NHS Enfield has successfully reached its smoking quitter targets for the past three years and continues to achieve and exceed these targets.

The ‘Enfield and Haringey Stop Smoking Service’ is a service jointly commissioned with NHS Haringey and has been targeted towards the South and East of the borough following both prevalence and health inequalities. It aims to reduce smoking rates in Enfield communities with a high smoking prevalence, such as the Turkish and Kurdish communities. It also links with other initiatives such as the Vascular Risk Assessment programme (now known as NHS Healthchecks) and Health Trainers, thus maximising value for
money. It also has a positive financial impact on emergency admissions following immediate potential health benefits.

**Figure 4a and 4b: Smoking Prevalence in Enfield**

![Graph showing smoking status in Enfield compared to London](image1)

![Graph showing current smokers in Enfield by age groups](image2)

*Source: Health Survey for England London Boost 2006*

The ‘Health Survey for England 2006’ found that in 2006-2007 Enfield had a higher percentage of ex-smokers (23.5%) compared to London (15.9%). There were also less current smokers than London. The highest percentage of smokers in Enfield was in the 34-54 age group. Enfield has over 10% less smokers in the 55+ age group compared to London. Efforts to support smoking cessation may therefore be best aimed at the 34-54 age group.

‘Enfield and Haringey Specialist Quit Smoking Service’ offers three different types of support to help people who want to quit smoking:

- **Level 1:** Brief stop smoking advice and/or referral to the Stop Smoking Service
- **Level 2:** One-to-one advice and support from a trained advisor to stop smoking
- **Level 3:** Group support run by Specialist Stop Smoking Advisors

**ALCOHOL**

Reducing alcohol-related harm and encouraging sensible drinking is a key national priority. Enfield hospital admission rates for alcohol related conditions are much lower than England and London averages. However the rate is sharply rising, and could potentially overtake national rates within the next few years. Between 2002/03 and 2006/07 the Enfield rate tripled to 1258 per 100,000 and between 2002/03 and 2005/06 Enfield had the 3rd highest increase in rates in England.
Binge drinking is defined as males and females drinking more than 8 and 6 units (respectively) in one night. Enfield has a lower percentage for binge drinking in the past week than London for the 16-34 and 34-54 age group. However, the 55+ age group is higher in Enfield (13.9%) than London (9.2%). The 34-54 age group has the highest percentage for alcohol consumption of more than 8 units for men and 6 units for women in Enfield.\textsuperscript{19}
The prevalence of binge drinking in the Managerial and Professional group (24.5%) was significantly higher than the Intermediate group (18.0%) and the Routine and Manual group (12.7%) in London. This pattern was repeated in both inner and outer London according to Health Survey for England in 2006.\textsuperscript{44} The survey also states that the White Ethnic group in Outer London had the highest percentage of binge drinking in the past week (22.6%), and then mixed ethnic group (12.8%). The Asian or British Asian ethnic group had the lowest percentage of binge drinking. The least deprived by IMD 2004 in outer London had the highest percentage for binge drinking (22.1%) compared to the most deprived (14.8%) and this pattern is again seen across London.

In 2005/06 4625 hospital bed days in Enfield hospitals were occupied with conditions directly related to alcohol misuse, and a one month audit in 2007 found that 50% of patients arriving at North Middlesex Hospital A&E were drinking at levels that were hazardous to their health.

\textit{Figure 7: Hospital Rate Per 1,000, population by Age and Sex, Alcohol Related Harm, 2008/09}

![Figure 7: Hospital Rate Per 1,000, population by Age and Sex, Alcohol Related Harm, 2008/09](image)

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

The rate of males admitted into hospital due to Alcohol related harm is much higher than the rate of females, especially between the ages of 41-70 years. Although the majority of admissions are due to acute intoxication and mental behavioural disorders due to alcohol, admissions due to alcoholic liver disease occur primarily in the 41 to 70 age group.\textsuperscript{22}
Figure 8: Diagnosis at admission of alcoholic liver disease by age group, Enfield 2008-09

Source: Health Informatics Service. Analysis by Public Health, Enfield

Actions and recommendations to further address this issue include:

- Further training on early detection and raising awareness about alcohol harm reduction issues for relevant staff in the PCT
- Delivering alcohol education to children and young people including interventions aimed at those most at risk of harm from alcohol abuse
- Maintaining the shared care nurse service for alcohol prevention and treatment in the community
- Delivering an alcohol health promotion and education campaign for adults in health and non-health settings, to include community safety messages

In June 2007, the Department of Health and the Home Office jointly launched an updated government alcohol strategy titled ‘Safe, Sensible, Social. The next steps in the National Alcohol Strategy’ setting out targets and action plans for promoting sensible drinking and reduce the harm that alcohol can cause. As part of this initiative, the ‘Safe, Sensible, Social.’ alcohol strategy local implementation toolkit was produced that recommends key aspects of developing a local alcohol strategy that include:

- Building the evidence base of wide ranging local data on alcohol related problems.
- Involving stakeholders like service users, local business, the licensed trade, health and social care professionals and those working in criminal justice system as well as general public.
- Negotiating 35 improvement targets in the LAA and planning implementation.
- Agreeing strategic frameworks for delivery.
- Identifying local priorities identified in local plans such as CDRP’s strategic assessment, JSNA, LAA or local Children and Young People’s Plans.
The toolkit also sets out a detailed list of targets and activities that are divided into broader topics: health, community safety and crime and social behaviour and children and young people.

Signs for Improvement: Commissioning interventions to reduce alcohol-related harm provides further guidance designed to direct commissioners in areas where tackling alcohol harm is an identified priority.

SEXUAL HEALTH

Chlamydia

Chlamydia is a sexually transmitted infection (STI) caused by bacterium - Chlamydia trachomatis. It is the most common bacterial STI in the UK and affects both sexes, although young women are more at risk.

Chlamydia can be easily treated, but is often asymptomatic so can remain undetected. Infection may sometimes be diagnosed once Chlamydia has led to complications - when treatment can sometimes be too late to stop permanent damage. Complications include:

- Pelvic inflammatory disease (PID), also known as pelvic infection. It can damage the Fallopian tubes that carry eggs from the ovaries to the womb. The tubes may stop working properly and can become completely blocked
- Infertility
- Ectopic pregnancy - pregnancy developing in the fallopian tubes rather than the womb
- Epididymo-orchitis - inflammation in the testicles and sperm-conducting tubes
- Joint inflammation in some men

The National Chlamydia Screening Programme (NCSP) provides screening to asymptomatic people aged 15-24 years in healthcare and non healthcare settings across England. Its goal is to control genital chlamydia through the early detection and treatment of asymptomatic infection, to prevent development of sequelae and to reduce onward disease transmission, thereby reducing the pool of infection within the community. The ‘Vital Signs’ Indicator for 2009/10 includes a target of 25% coverage of chlamydia screening and testing in young people between 15 and 24 years of age. The National Chlamydia Screening Programme (NCSP) therefore aims to:

- Prevent and control Chlamydia through early detection and treatment of asymptomatic infection;
- Reduce onward transmission to sexual partners;
- Prevent the consequences of untreated infection.

The Enfield & Haringey Chlamydia Screening Programme (CSP) commenced in 2004. The Enfield and Haringey Chlamydia Screening Programme (EHCSP) is a control and prevention programme targeted at the highest risk group for Chlamydia infection; young people under 25 who are sexually
active. The PCT total spend on Chlamydia screening delivered under NCSP in 2007/08 was £118,304.

**Table 3: Chlamydia Targets for Local Area Agreement (LAA) and Vital Signs**

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Description of Indicator</th>
<th>TARGET 09/10</th>
<th>TARGET 10/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI 113</td>
<td>Prevalence of Chlamydia in under 25 year olds - volume of resident population aged 15-24 accepting test/screen for chlamydia</td>
<td>3,370 (10%)</td>
<td>5,020 (15%)</td>
</tr>
<tr>
<td>VSB 13</td>
<td>Prevalence of Chlamydia in under 25 year olds - volume of resident population aged 15-24 accepting test/screen for chlamydia</td>
<td>9,250 (25%)</td>
<td>12,800 (35%)</td>
</tr>
</tbody>
</table>

NB: NI 113 refers to the national target for LAA.

The target agreed with NHS London for Enfield in 2008/2009 is - screening and testing 8% of young people aged 15-24 years. The total screened in Q1 and Q2 2008/2009 was 824 with a positivity rate in index cases of 8.4%. The Chlamydia programme has reach in many parts of the community but to achieve the higher London target of 25% coverage all parts of the programme are likely to need expansion.

Also, the target under Vital Signs (VSB 13) is to opportunistically screen 25% (9250 of the Enfield population aged 15-24 years resident in 2009/10).

**Figure 9: Uptake of Chlamydia Testing by Ward April 2008 to February 2009**

- Percentage positives
- Total number of tests
Figure 10: Positivity rate in Chlamydia tests in London 2008 reported to the National Chlamydia screening programme
HIV in Enfield

There were 636 cases of diagnosed HIV (Human Immunodeficiency Virus) in Enfield in 2007 (SOPHID 2008) data.25

Table 4: HIV diagnosis in Enfield and its comparators

<table>
<thead>
<tr>
<th>London Sector</th>
<th>PCT of residence</th>
<th>Overall 2005-2006</th>
<th>&lt;200</th>
<th>&gt;=200</th>
<th>Total with CD4</th>
<th>% &lt;200</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Central London</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barnet</td>
<td>31</td>
<td>61</td>
<td>92</td>
<td>34%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camden</td>
<td>51</td>
<td>101</td>
<td>152</td>
<td>34%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enfield</td>
<td>50</td>
<td>80</td>
<td>130</td>
<td>38%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haringey Teaching</td>
<td>58</td>
<td>110</td>
<td>168</td>
<td>35%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islington</td>
<td>36</td>
<td>118</td>
<td>154</td>
<td>23%</td>
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</tr>
</tbody>
</table>

A breakdown of diagnoses made in the North Central London sector in 2005 to 2006 shows the sector as having the highest percentage of new diagnoses being made late (i.e. when CD4 count has dropped below 200 cells per cubic millimetre) and Enfield having the highest prevalence of late diagnosis within the sector.

Earlier diagnosis:

- allows diagnosed people to make behavioural changes to avoid infecting others;
- can reduce infectivity due to earlier initiation of antiretroviral therapy (ART), and
- can reduce the risk of AIDS and death.

Sexual Health: Best Practice

A policy report for the Terrance Higgins Trust titled ‘Blueprint for the Future: Developing Sexual Health and HIV Services’26 sets out various implementation plans to improve sexual health services. It proposes:

- Co-ordinated programmes of evidence-based HIV and STI prevention work across NHS, local government and community sectors and across clinical and community settings.
- Walk-in rapid access community based STI and HIV testing services using non-invasive tests and giving prompt results and rapid access to STI treatment.
- The establishment of Genito Urinary Medicine (GUM) services as the specialist hub at the centre of extended STI service networks with responsibility for clinical governance, network development, support to community based services and treatment of complex cases.
- Enhanced provision of information, training, on-line access to diagnostic tests.
- Establishment of a safety net for people outside statutory and NHS provision through funding and development of community responses.
Furthermore, the report recommends that the following need to be taken into account:

- Patient choice
- Improving patient experiences
- Tackling health inequalities
- Inter-agency joint working and making partnerships work
- Payment by results

NICE has produced guidance (PH3 Prevention of sexually transmitted infections and under 18 conceptions)\textsuperscript{27} for professionals who are responsible for, or who work in, sexual health services. This includes general practitioners and professionals working in contraceptive services, genitourinary medicine and school clinics. This recommends the following:

- Assess people’s risk of having a sexually transmitted infection (STI), when the opportunity arises. For example, this could happen when someone attends for contraception, or to register as a new patient.
- Offer advice to people at high risk of an STI in a structured discussion, or arrange for them to see someone who is trained to give this type of advice. The discussion should cover ways to help people reduce the risks.
- Help people with an STI to get their partners tested and treated. This might involve referring the person to a specialist. People with STIs and their partners should receive information about the infection they have.

Guidance further places responsibility on commissioners to ensure that sexual health services, including contraceptive and abortion services, are in place to meet local needs.\textsuperscript{28,29} All services should include arrangements for the notification, testing, treatment and follow-up of partners of people who have an STI (partner notification).

**Teenage Pregnancy**

Teenage pregnancy is both a cause and effect of deprivation. It is also an inter-generational issue as the child of a teenage parent is more likely to become a teenage parent themselves. The Government target is to reduce the rate of teenage conceptions by 50% from the 1998 baseline by 2010 (46.6 to 23.3). In Enfield the target is to reduce conceptions by 45% from 46.4 to 25.5.

Despite the above target the teenage pregnancy rate has risen to 55.4 in 2006 (latest year for which data is available). The percentage rise in rate between 2005 and 2006 was the second highest in London (second only to Barnet which has relatively low rates). 60% of these conceptions lead to termination, up from 53% in 2001, this compares to 61% in London.

Teenage pregnancy is a serious social problem. Having children at a young age can damage young women’s health and well-being and severely limit their education and career prospects. Children born to teenage parents are also much more likely, in time, to become teenage parents themselves. Teenage pregnancy is, therefore, a key inequality and social exclusion issue.
In London, we ranked 12th highest out of 32 London Boroughs for rate of teenage pregnancies from 2005-2007.

**Figure 11: Conception rates of the London boroughs in under 18s, 2005-07**

![Graph showing conception rates of London boroughs](image)

Source: Department for Children, Schools and Families

However, latest finalised data for Enfield (calendar year 2007) shows a significant decrease in Enfield teenage conception rates (decrease by 13%), in the context of increasing national rates.

**Figure 12: Conception rate in under 18 year olds per 100,000 female population in Enfield, London and England, 1998-2007**

![Graph showing conception rates over time](image)

Teenage pregnancy is not evenly distributed either geographically or by ethnicity: 70% of conceptions take place to residents of four postcodes; **EN1** (Bush Hill Park), **EN3** (Enfield Highway, Enfield Lock, Ponders End, Turkey Street), **N9** (Edmonton Green, Lower Edmonton) and **N18** (Upper Edmonton).
Twenty-nine percent of births are to Black African, Black Caribbean or White / Black Caribbean mothers.

Both the number and the percentage of repeat terminations in Enfield residents aged under 19 appears to be rising. In 2005 there were 175 terminations to women aged under 19 of which 17.5% were repeats, in 2006 there were 186 of which 18.1% were repeats. In 2007 this had risen to 191 terminations of which 18.7% were repeats. This was the 5th highest repeat rate in London. 71% of abortions and 76% of births are from the above four postcodes.

At ward level the conception rate varied 14.3 per 1000 (Southgate Green) and 89.4 per 1,000 (Edmonton Green), a key variation to take note of when targeting strategies in the community. (See Figure 13 below)
Figure 13: Teenage Pregnancy Ward Distribution in Enfield by rolling 3-year average 2001-2006

U-18 Conception Rate 2001 - 2006

Ward Name

Rate per 1000 YP

Bowes
Bush Hill Park
Chase
Cockfosters
Edmonton Green
Enfield Highway
Enfield Lock
Grange
Harbottle
Highlands
Jubilee
Lower Edmonton
Palmers Green
Ponders End
Southbury
Southgate
Southgate Green
Town
Turkey Street
Upper Edmonton
Winchmore Hill

2001-2003
2002-2004
2003-2005
2004-2006
Enfield Teenage Conception Rate 2004-2006

Rate of under 18 conception per 1000 women aged 15 to 17

- 70.9 to 89.4
- 63.3 to 70.9
- 53 to 63.3
- 25.8 to 53
- 14.3 to 25.8

Figure 14: Rate of under 18 conception per 1,000 women aged 15-17, Enfield ward level 2004-2006
References for section on Healthy Lifestyles


27. NICE. 2007. One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups. Accessed from: www.nice.org.uk/nicemedia/pdf/word/PHI003guidanceword.doc


4.8 Feeling Safe

Enfield has lower rates of crime as a whole, than London or nationally. Although crime rates are relatively higher in areas where there is higher deprivation. The Home Office Fear of Crime Toolkit identifies that fear can be because of:

- people’s own experience of crime or where they live.
- intrinsic reasons related to gender, ethnicity, ability, health, age and sexual orientation

The Governments updated crime strategy Cutting Crime – Two years on – 2008-11 identifies seven priority areas for reducing crime and anti-social behaviour and recommends approaches to bring about improvements. These approaches should focus on:

- The people who cause most damage to communities or who are at most risk of being victims of crime
- The places that need targeted attention to prevent or reduce crime
- The products and substances that cause crime problems or help us to fight crime.

The Engaging Communities in Fighting Crime review of 2008 by Louise Casey also supports the public confidence and sustainability agenda.

4.9 Access to Health and Wellbeing Information

Black and Minority Ethnic Groups

The Department of Health Report No Patient Left Behind: how can we ensure world class primary care for black and minority ethnic people? (DH May 2008) was commissioned to review of why patients from black and minority ethnic (BME) groups find it more difficult to access GP services than white populations. There was concern about the findings in the first national GP patient survey conducted in January 2007 which showed that BME patients were less satisfied with GP access.

The review team found a repeated cause of dissatisfaction was dysfunctional communication between GPs and patients. This is a generic issue applicable to both BME and non BME groups, but language differences can compound difficulties, with implications for patient safety.

The other main finding in relation to communication was that healthcare professionals can feel uncertain and apprehensive in responding to different needs of BME patients and this can cause them to be ‘hesitant and professionally disempowered’. One study showed GPs spent less time giving information to South Asian patients even though the patients were fluent in English. While the reason for this isn’t known, the study demonstrates the presence of complex and subtle influences on communication.
Enfield Racial Equality Council (EREC) believes that people have experienced poor outcomes through not being able to access information. The main reasons are:

- Lack of qualified interpreters
- Lack of information available in other languages/formats
- Lack of information in particular on diseases/conditions affecting the BME community
- Professional’s lack of listening skills – not enough information given
- Lack of information to explain healthcare system and how you access it

The Department of Health Report *No Patient Left Behind* proposes dedicated training and education for doctors can improve communication with BME people.

It is also proposed that the receptionist role to evolve into that of ‘gate opener’ and ‘patient navigator’. With better training, reception staff can be empowered to facilitate access by giving information, liaising with bilingual services as appropriate, dealing with patient preferences (for example, the gender of a healthcare professional) and collecting appropriate ethnicity data in a sensitive manner.

Bromley By Bow Health Centre is cited as an example of good practice in the report. This is a healthy living centre that provides holistic care using a multi-agency and community engagement model. It routinely records the ethnicity and first language of all new patients. This information not only helps the practice identify services that patients may require during consultation, for example, an interpreter or advocacy support, but also acts as a prompt to the receptionist booking the appointment. The number of appointments lost through lack of language support has been significantly reduced as a result.

**British Sign Language Users**

According to SignHealth, a healthcare charity for deaf people “Deaf people are facing constant difficulty with telephone appointment booking systems, verbal prompts when their doctor is ready to see them, and rarely have a clear understanding of their diagnosis and treatment.”

The GP Patient Survey 2008/9 reported that “Those who are deaf and use sign language are less likely than hearing patients to say they had confidence and trust in the doctor (89%, compared with 95%)”.

EDA has provided examples of BSL users who have experienced poor outcomes through not being able to access information. The main reasons are:

- BSL users lack of basic health knowledge due to poor literary skills
- Lack of awareness of the benefits of using interpreters from some medical practitioners
- Lack of availability of interpreters.
More than half of deaf and hearing impaired patients say they regularly face difficulties in communicating with their GP surgery, according to a recent survey of 525 people (run by patient information website www.patient.co.uk and the charity SignHealth). Key issues identified in the survey were:

- 56 per cent of respondents said their hearing difficulties had led to poor communication, either in a medical (GP consultation) or a procedural (communication with the surgery – e.g. appointment booking) environment.
- 30 per cent said they had experienced communication problems that were difficult to resolve when discussing their health – leading to missed symptoms, confusion about medication or a lack of time to exchange full information in a consultation.
- 8 per cent of respondents said they experienced difficulties in resolving communication problems on every surgery visit.
- 37 per cent said they had difficulties because staff – both GPs and practice staff – did not consistently face them when speaking.
- 35 per cent said they had missed appointments because they had not heard their name being called.

The survey also identifies the many simple measures that surgeries could undertake to improve communication. These include:

- Staff remembering to face patients when speaking (cited by 84 per cent of respondents); many respondents reported loss of communication when GPs turned to look at computer screens, for example.
- Giving out printed information to support a consultation; only 11 per cent of patients said their surgeries did this, yet 64 per cent said it would be helpful; free patient information leaflets are available to all GP surgeries from www.patient.co.uk, which is embedded in 90 per cent of surgery software.
- Having display screens to announce consultations or fetching the patient from the waiting room (cited by 57 per cent of respondents).

Additional services are available for GPs and hospitals – including the easy-to-use SignTranslate online interpreting service, developed by the SignHealth charity. The service links a British Sign Language interpreter, via a web-cam, to the live consultation – helping both GP and deaf patient to ensure clear communication.

**People with Learning Difficulties**

The Department of Health Independent Inquiry into Access to Healthcare for People with Learning Disabilities (DH July 2008) found that people with learning disabilities have worse health and get worse care.

Disability Rights Commission’s (DRC) report Equal Treatment Closing the Gap (October 2006) found that people with learning disabilities had higher rates of respiratory disease and were more likely to be obese. For other health conditions such as diabetes, stroke and ischemic heart disease, rates were lower amongst people with learning disabilities than in the remaining
population. However, it is believed that the figures in the analysis may be under-estimates: it is known that diabetes, for instance, is often under-diagnosed, primary care records may not accurately reflect the extent of health problems, and the health needs of people with learning disabilities often remain unidentified.

There can be double or triple barriers to good health for people who have additional disabilities or are from minority ethnic communities. (Mir G, Nocon A, Ahmed W with Jones L) ‘Learning Difficulties and Ethnicity 2004, gives examples of how those who are from minority ethnic communities especially those from South Asia face double and triple disadvantages which contribute to poor health and early death.

“The lack of information in accessible formats and Easy Read text can be a fundamental barrier to primary care,” (DRC ibid). They highlighted this as a cause for non-compliance with offers for screening appointments.

One-to-One has provided examples of people who have experienced poor outcomes through not being able to access information:

- Evidence of under-diagnosis of diabetes. Health checks at Healthy Living sessions showed that 46 people were overweight of which 17 people were obese. Six people had high blood pressure, one so high that an emergency referral was made. Seven people were referred to diabetes specialists.

- Lack information on health services and about making healthy choices. This has also been substantiated in the DRC report referred to above: “The lack of information in accessible formats and Easy Read text can be a fundamental barrier to primary care.” (DRC ibid). The DRC highlighted this as a cause for non-compliance with offers for screening appointments.

- Face barriers to accessing healthy leisure activities. Issues identified include lack of choice of supported sport, usually only table tennis and ten-pin bowling. Lack of accessible information about sports and feeling uncomfortable in participating in sport because of the attitudes of sports centre staff.

The Department of Health Independent Inquiry into Access to Healthcare for People with Learning Disabilities recommended that “DH should direct to commission more appropriate, proactive, health services for people with learning disabilities including health checks and staff to support access to the NHS.”
A wide range of data about Enfield and its residents has been brought together. Some of this data has had a significant influence on the Priority Needs. It is intended that this data be a useful source of reference for any purpose that requires data about health and wellbeing.

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5.1 Geography of Enfield

Map of Enfield – land use

Source: Borough Profile 2008, Enfield Observatory

The centre of Enfield is 12 miles from the centre of London. Enfield has good links to the national motorway system, the north of the borough being bounded by the M25, accessed at junctions 24 and 25. The authority covers an area of 8,219 hectares (82.2 square kilometres, or 31.7 square miles).

Enfield is the name of the local authority although parts of the area it covers share that name, including its use by the Royal Mail in having EN postal districts (EN1, EN2 and EN3). Much of the borough’s population lives in London postal districts (N9, N11, N13, N14, N18, N21). The main area distinctions are between Enfield, Edmonton and Southgate (the old boroughs familiar to longstanding residents).
Enfield has 21 wards and 3 parliament constituencies.
5.2 Population

At mid-2007 the population was estimated to be 285,100 (according to the Office of National Statistics) making Enfield the 6th largest amongst the 32 London boroughs. Enfield has a large population of both 0-14s and older people in comparison to the rest of London.

Current and Projected Population structure of Enfield

Source: Enfield Public Health Report

(See 5.17 for an analysis of population growth)

5.3 Births

In Enfield the average number of live births has risen annually since the year 2000. This trend seems to be continuing with 4,649 births between April 2006 and March 2007.
The graph comparing the number of live births in 2008 to the expected number of live births in 2021, shows the wards with the highest number of expected births are Edmonton Green and Upper Edmonton, which due to their location are most likely to put pressure on the maternity services at North Middlesex University Hospital Trust. It is expected that the demand for maternity services will decrease from 2008-2021 in Grange, Haselbury and Town and pregnant women currently use either North Middlesex University Hospital Trust or Chase Farm Hospital Trust.
5.4 Ethnicity

The most demographically distinguishing feature about Enfield is its combination of particular ethnic groups. The Data Management and Analysis Group for London (DMAG) produces annual ethnic population projections for London boroughs, based on ONS mid year estimates and taking into account planned housing developments by borough. Estimated ethnic projections for Enfield are included below.

**DMAG Ethnic Group Population Projections – High Variant, Enfield 2009**

![Ethnicity of Enfield's population 2009](image)

The most up-to-date picture, for part of the school population at least, is provided by the Pupil Level Annual School Census (PLASC). Local education authorities (LEAs) and independent schools across England collect ethnicity information on pupils according to a DfES list of ethnic codes. Within PLASC 2008, Enfield pupils recorded themselves under 88 different ethnic codes. The most significant aggregation of ethnicity codes is ‘White British’, followed by ‘White Other’. ‘White other’ comprises of Eastern European, Greek, Greek Cypriot, Turkish, Turkish Cypriot and Western European ethnicities. Of the 88 different ethnic codes the highest prevalence are English, Turkish, Caribbean, Greek Cypriot and Somali pupils.
5.5 Disability

The number of Enfield residents with a limiting long-term illness (using the 2001 Census definition) is estimated at 44,800 at mid-2006, which was 15.7% of the total population.

At 2001, unemployment amongst the long term ill was double the average and 28.1% of the long-term ill aged 16-74 classed themselves as permanently sick or disabled.

The number of disabled in the 16-75 age group using the definition in the Disability Discrimination Act was estimated at 34,500 (16.4%) at mid-2006, using survey data for London.

The number claiming the main state benefits (Incapacity Benefit, Disability Living Allowance and Attendance Allowance) was 24,190 at August 2006, which was 8.5% of the total Borough population. Nearly half of that total was accounted for by Incapacity Benefit (IB) claimants who represented 6.2% of the 15-64 age group. The increase in IB claimants over three years was 6.4%, well within the top (worst) quartile of English authorities and contrary to a national decrease.

The claimants of Disability Living Allowance and Incapacity Benefit are heavily concentrated in the most deprived parts of the Borough, contrary to the more even spread of long term ill at the 2001 Census.

The broad adult social services client categorisation for 2005/06 was:

- Physical Disability: 6,058 (73.5% of clients)
- Mental Health: 1,517 (18.4%)
- Learning Difficulty: 668 (8.1%)
5.6 Religion

As shown by the 2001 Census, for the first time, Enfield has high proportions in all the main non-Christian religions except Sikh, compared to national averages.

Data Source: Enfield Observatory, Census 2001

5.7 Migrant Population

Enfield is estimated to lose population due to out-migration exceeding in flows although it may reasonably be assumed that an element of illegal immigration may lessen that loss. Population growth in Enfield is primarily natural, by virtue of births exceeding deaths, although immigration has clearly had a significant impact in sustaining growth. It is clear that Enfield attracts residents from other London boroughs and loses residents to mainly nearby shire districts.

In common with the rest of London the age profile is changed by the attraction of young adults aged around 20-24 and the loss of older family forming and retirement age groups. Within the borough the most significant movements for the Council are probably those of school age residents and these appear to be at relatively high levels. The key suspected change since 2001 is increased movement into and within private rented housing but the reasons for this remain to be fully understood. Provision for homeless households and asylum seekers and the buy-to-let investment market have surely played some part of this change. Broadly downward trends in numbers of public sector lettings combined with Housing Benefit claimant increases and the level of surveyed in-migrant demand all suggest that people in housing need have been driving the movement into the private rented sector.
**Enfield migration Flows 2002-03 to 2006-07**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migration In</td>
<td>14,730</td>
<td>14,580</td>
<td>14,480</td>
<td>15,880</td>
<td>15,723</td>
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<tr>
<td>Migration Out</td>
<td>17,540</td>
<td>17,800</td>
<td>17,010</td>
<td>17,280</td>
<td>17,211</td>
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<tr>
<td>Migration Net</td>
<td>-2,810</td>
<td>-3,230</td>
<td>-2,530</td>
<td>-1,400</td>
<td>-1,488</td>
</tr>
<tr>
<td><strong>International</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migration In</td>
<td>4,390</td>
<td>3,530</td>
<td>3,160</td>
<td>3,200</td>
<td>2,137</td>
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<tr>
<td>Migration Out</td>
<td>2,850</td>
<td>2,480</td>
<td>2,260</td>
<td>2,210</td>
<td>3,724</td>
</tr>
<tr>
<td>Migration Net</td>
<td>1,550</td>
<td>1,050</td>
<td>900</td>
<td>990</td>
<td>-1,587</td>
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<tr>
<td><strong>Net Migration &amp; other changes</strong></td>
<td>-1,260</td>
<td>-2,180</td>
<td>-1,570</td>
<td>-380</td>
<td>-2,722</td>
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</tbody>
</table>

Data Source: ONS population estimates

For further information regarding migration please refer to the Enfield Observatory produced Migration study and the GLA London Borough Migration: 2001-2006 report.

**5.8 Demographic Profile**

Enfield’s demographic profile is closer to the national profile than it is to the London profile. Using Mosaic data has allowed us to profile our residents across the borough. Mosaic classifies all household or postcode in the United Kingdom into 61 types, aggregated into 11 groups. Using over 400 data variables and updated annually, it paints a rich picture of residents in terms of demographics, socio-economic, lifestyles, culture and behaviour.

The largest group is group D, people whose lives are mostly played out within the confines of close-knit communities; they make up around 24% of the population, closely followed by group C, people who have successfully established themselves and their families in comfortable homes in mature suburbs. Together they represent 47% of Enfield’s population. The percentage of these groups is significantly higher than the London and national average. However there is less than a third of the London average of people living in social housing with high care needs. Also in Enfield 12.2% of the population are young transient workers, compared with the London average of 45.58% and the UK average of 7.69%.
### MOSAIC Profile Group Descriptions

<table>
<thead>
<tr>
<th>Group</th>
<th>Description</th>
<th>Enfield %</th>
<th>Number of Households</th>
<th>London %</th>
<th>UK %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Career Professionals living in sought after locations</td>
<td>10.99</td>
<td>12,755</td>
<td>19.49</td>
<td>9.68</td>
</tr>
<tr>
<td>B</td>
<td>Younger families living in newer homes</td>
<td>3.74</td>
<td>4,340</td>
<td>3.18</td>
<td>10.57</td>
</tr>
<tr>
<td>C</td>
<td>Older families living in suburbia</td>
<td>22.85</td>
<td>26,522</td>
<td>13.48</td>
<td>14.48</td>
</tr>
<tr>
<td>D</td>
<td>Close knit inner city and manufacturing town communities</td>
<td>23.98</td>
<td>27,832</td>
<td>11.45</td>
<td>16.18</td>
</tr>
<tr>
<td>E</td>
<td>Educated young singles living in areas of transient populations</td>
<td>12.20</td>
<td>14,157</td>
<td>45.58</td>
<td>7.69</td>
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<tr>
<td>F</td>
<td>People living in social housing with uncertain employment in deprived areas</td>
<td>8.27</td>
<td>9,601</td>
<td>27.5</td>
<td>6.38</td>
</tr>
<tr>
<td>G</td>
<td>Low income families living in estate based social housing</td>
<td>0.33</td>
<td>385</td>
<td>1.48</td>
<td>6.53</td>
</tr>
<tr>
<td>H</td>
<td>Upwardly mobile families living in homes bought from social landlords</td>
<td>8.70</td>
<td>10,103</td>
<td>5.93</td>
<td>10.82</td>
</tr>
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<td>I</td>
<td>Older people living in social housing with high care needs</td>
<td>2.03</td>
<td>2,354</td>
<td>6.03</td>
<td>3.67</td>
</tr>
<tr>
<td>J</td>
<td>Independent older people with relatively active lifestyles</td>
<td>6.79</td>
<td>7,878</td>
<td>5.36</td>
<td>7.75</td>
</tr>
<tr>
<td>K</td>
<td>People living in rural areas far from urbanisation</td>
<td>0.14</td>
<td>158</td>
<td>0.13</td>
<td>5.88</td>
</tr>
</tbody>
</table>

Source: MOSAIC
There is a significant pattern of demographics across the borough. Group D and F are prevalent in the east of the borough, whilst there is higher prevalence of Group A and C in Central and western areas of the borough.

5.9 Deprivation

The Indices of Deprivation consist of an Index of Multiple Deprivation, seven ‘domains’ and two separate indices on income deprivation affecting children and older people. They are designed to measure levels of deprivation at the Lower layer Super Output Area (LSOA) level across England. The domains are combined into a single measurement – the Index of Multiple Deprivation (IMD) – that shows the overall level of deprivation into each area. The indices provide what may be viewed as league tables for deprivation and can be used to measure deprivation in larger areas, e.g. at local authority level.
Index of Multiple Deprivation – Enfield, with Geographic Features

Deprivation by Ward
Average IMD2007 Score

- 35.5 to 46.4 Most Deprived in Enfield (3)
- 30.8 to 35.5 (3)
- 23.4 to 30.8 (5)
- 18 to 23.4 (4)
- 13 to 18 Least Deprived in Enfield (6)

- Hospital
- Primary Care Centre
- Reservoir
- Green Spaces
- Major Roads
The Index of Multiple Deprivation (IMD) and composite domains: Enfield National Ranking in 2004 and 2007

<table>
<thead>
<tr>
<th>Category</th>
<th>Rank of score ID 2004 (1 = worst out of 354)</th>
<th>Rank of score ID 2007 (1 = worst out of 354)</th>
<th>Quintile Position Nationally in 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMD</td>
<td>104</td>
<td>74</td>
<td>Worst 25%</td>
</tr>
<tr>
<td>Housing and Services</td>
<td>58</td>
<td>38</td>
<td>Worst 20%</td>
</tr>
<tr>
<td>Income</td>
<td>54</td>
<td>25</td>
<td>Worst 10%</td>
</tr>
<tr>
<td>Living Environment</td>
<td>89</td>
<td>69</td>
<td>Worst 20%</td>
</tr>
<tr>
<td>Crime</td>
<td>85</td>
<td>93</td>
<td>Lower 50%</td>
</tr>
<tr>
<td>Employment</td>
<td>142</td>
<td>96</td>
<td>Lower 50%</td>
</tr>
<tr>
<td>Health</td>
<td>171</td>
<td>143</td>
<td>Lower 50%</td>
</tr>
<tr>
<td>Education</td>
<td>172</td>
<td>202</td>
<td>Upper 50%</td>
</tr>
<tr>
<td>IDACI</td>
<td>40</td>
<td>21</td>
<td>Worst 10%</td>
</tr>
<tr>
<td>IDAOP1</td>
<td>51</td>
<td>56</td>
<td>Worst 20%</td>
</tr>
</tbody>
</table>

- IDACI – Income Deprivation Affecting Children Index – Figures calculated using population of ages 0-15.

- IDAOP1 – Income Deprivation Affecting Older People Index – Figures to be revised using 60+ population; calculated at present using entire population.

Enfield’s position nationally has worsened from 2004 to 2007 across all domains, except Crime and Education. There has been little change in rank for deprivation affecting older people. Enfield ranks in the worst 10% of local authorities for income, and income deprivation affecting children. Enfield’s change in score on IDACI between 2004 and 2007 was the worst change for this index, of all local authorities in England.

There are a significant number of areas in Enfield where children are living in poverty, and a significant number of these areas are in the worst 10% of the country. In fact 20% of all children living in Enfield live in lone parent families on benefits.

5.10 Unemployment

- Enfield’s unemployment rate (6.7% Mar 2009) is above the London and national averages, and average income falls below the London average. Claimant rate is slightly above London average (4.8 versus 4.1)
- A study of working age benefit claimant counts from 2000 to 2008 reveals that Enfield had the largest increase of any London authority.

One of the key measures of worklessness is the number of benefit claimants in the DWP’s ‘Working Age Client Group’. Over the year to August 2008, the number of such claimants rose by 520 (1.8%) in Enfield, compared to minus 1% in London and a 0.9% increase in England. This was the 155th worst change out of the 326 English local authorities and the 2nd worst in London, after Sutton. At August 2008, 16.5% of the working age population in Enfield was estimated to be on working age benefits, compared to 13.7% in England. The level was the 68th highest of the 326 English local authorities, unchanged from August 2006, whereas the relative positions of Barnet, Haringey and Waltham Forest all improved slightly.

Note that the latest Job Seekers Allowance data shows a 63% increase in claimants to the year to June 2009 but this is some way below the national average increase of 87% and Enfield’s relative performance is one of the ‘best’
(38th out of 326). Enfield started from a high base so whereas the absolute increase in numbers seems high, up 3,346 to 8,693, the relative increase is clearly not, compared to most areas with previously low unemployment.

A report to the Council’s Management Board in January 2009 ‘Recession and Enfield’ noted:

- Unemployment increased by 5% over the summer (of 2008) with redundancies rising fastest in the construction and services sector. In September 2008 vacancies were down by 9.3% on the previous year, with falls of 15% in construction, transport and financial services.
- There are signs that the current recession is hitting workers under 50 far harder than the previous downturn in the 1980s, which affected older workers.
- Increasing unemployment will affect a large number of Enfield residents and in particular lead to a reduction in mainstream work opportunities for people who need extra support such as those with learning or physical disabilities and people with mental health problems. The number of people with mental health issues is likely to rise because of redundancy, debt, home repossessions and long-term unemployment.

5.11 The Recession

In the World Health Organisation report *The Financial Crisis and Global Health*, it is estimated that changes associated with the current economic downturn have tipped more than 100 million people back into poverty – “The challenge facing the world now is to prevent an economic crisis becoming a social and health crisis.” 1

Although it is still early to fully assess the health and social impact of the 2008 financial crisis, several publications have noted that the effects of an economic downturn on health and wellbeing can be rapid. A European Union wide study found that rises in unemployment are associated with significant short-term increases in premature deaths from intentional violence (suicide and homicide), while reducing traffic fatalities. 2 Studies on unemployment and mortality in Britain in the 1970s and 1980s showed that unemployed people had a mortality rate 20% to 25% higher than average for people of the equivalent socioeconomic groups. 3, 4 Research into mass unemployment during the 1990s in the United Kingdom found that people in secure employment recovered more quickly from illness and unemployment increased the chance of being ill, especially for those who had never worked or had had poorly paid jobs. 5 Unemployment increases rates of depression, particularly in the young, 6 and with increasing unemployment there is also an increase in work related stress for those still with jobs. 7

It has been estimated that the direct effect of reducing unemployment could prevent up to 2,500 premature deaths a year, but the indirect effects of being employed are thought to be far greater. 8
Beyond these direct effects the human consequences of a recession may be hidden – unemployment may erode women’s growing economic independence, and coping strategies for financial worries may exacerbate vulnerability to ill health (for example, increases in sexually transmitted diseases, alcohol and drug misuse).

It is emphasised that it is not only the poorest nations of the world where health and wellbeing will be impacted by the recession. The poorest and most vulnerable groups in all societies will be at greatest risk.

In light of this early evidence, several recommendations have been made:

1. Strengthening relationships with faith based and voluntary organisations, acknowledging their role in supporting communities through times of hardship.
2. Prioritising health through preventive services, and the provision of a health and social safety net.
3. Participation, public involvement and transparency remain crucial.
4. Careful monitoring of employment, housing, income, use of health services and cost and availability of treatment is needed, to provide an evidence based understanding of the effects of the recession.
5. A call for acknowledgement that the key drivers of health lie outside of healthcare, with the wider determinants such as employment, overcrowding etc.
6. Where public sector budgets are likely to be restrictive, stronger partnership working and a more joined up approach to health and public policy will be beneficial in delivering efficiency and reducing duplication of effort.

Implications for Enfield

Enfield already experiences levels of income deprivation affecting children in the worst 10% of local authorities nationally, and some of the worst homelessness and overcrowding rates in the country. We therefore have a significant vulnerable population and can anticipate a potential rise in the number of residents thrust into poverty by the current financial climate. It will be necessary to robustly plan for additional demands on public sector services as well as strengthening all partnership work, including with faith based and voluntary organisations, to ensure support is available where needed.

A report to Enfield Council Management Board noted that “the recession is likely to affect sooner and more severely, those residents who are in vulnerable situations and/or already experiencing poverty, deprivation and unemployment”.

References

7. Commentary Look after the pennies Jack A. BMJ 2009;338:b1380

5.12 Housing and Homelessness

Homelessness
- Enfield has the 4th largest number of households in temporary accommodation in England.
- Homeless decisions and acceptances have generally declined over the last five years in common with both London and national trends.
- However, the rate of decline in acceptances has been somewhat slower than for London as a whole. In the first 9 months of 2009 Enfield had the 6th highest rate of acceptance for homelessness. Majority of households in temporary accommodation were in the more deprived east of the borough.
- BME groups and White Others are accepted as homeless at a greater rate than their percentage of the population in the borough.
- Homeless acceptances at ages 16-17 are remaining constant in Enfield, despite a large reduction across London.
- An increasing proportion of reasons for homelessness is loss of rented accommodation.

Overcrowding
- Families with adult children living at home figure prominently in the most severely overcrowded households. Over a third of severely overcrowded households have adult children Black African and Somali, are much more likely to be overcrowded and severely overcrowded.
- The number of true voids in larger properties is extremely low leading to limited opportunities to alleviate overcrowding through council transfers
5.13 Transport

Pensioner households with or without transport, 2001

<table>
<thead>
<tr>
<th>Pensioner households</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Living alone with transport</td>
<td>4,332</td>
</tr>
<tr>
<td>Living alone without transport</td>
<td>10,550</td>
</tr>
<tr>
<td>Not living alone with transport</td>
<td>5,824</td>
</tr>
<tr>
<td>Not living alone without transport</td>
<td>2,135</td>
</tr>
</tbody>
</table>

Source: Poppi

Train travel

Five train lines pass through the borough, including the Piccadilly (Underground) Line connecting to Heathrow Airport. The other direct connections are in to London Kings Cross, Moorgate and Liverpool Street, outward to Welwyn Garden City, Hertford North, Hertford East, Letchworth and Stevenage.

The busiest stations have an annual throughput (entries and exits) of over a million per year. The highest throughput has been recorded at Southgate, at over 3.9 million.

5.14 Isolation

An indicator of isolation and access to services is the sub-domain of IMD 2007, which examines distance to key services. This indicator is mapped below.

Geographical Barriers

Source: Enfield Observatory, IMD 2007
The map above indicates that areas within North and North-East have the most areas which have geographical barriers to services.

### 5.15 Crime

Enfield has lower rates of notifiable crime as a whole, than London or national. However burglary from dwellings and theft of motor vehicles is slightly above London average.

The most recent crime and disorder audit (Strategic Assessment) and accompanying partnership plan was completed in March 2009.

Following on from the assessment and face the public meetings a list of priorities were identified for the 2009/10 financial year, which are as follows:

- Reduce burglary / damage to dwellings
- Reduce vehicle crime / damage to vehicles
- Tackle violence and street crime
- Reduce anti-social behaviour
- Reduce weapon enabled crime
- Improve community cohesion and prevent extremism.

Furthermore, the following priorities were identified as cross cutting:

- Improve opportunities for young people
- Reduce substance misuse (drugs and alcohol)
- Better engagement with communities.

In Enfield most crime is committed by males (87%) with almost half of all crime suspects being aged 15-24. Just one in five offences committed in 2008-09 involved groups, or a gang, of offenders with the vast majority of crime being perpetrated by individuals (58%) or in twos (24%). Weapon enabled crime (for example, gun and knife crime) accounts for an insignificant proportion of total crime in Enfield. According to police data victims of personal crime (such as domestic violence or wounding) are more likely to be female. The eastern part of Enfield and in particular Edmonton Green and Upper Edmonton wards experience a disproportionate amount of all types of crime, disorder and anti-social behaviour. High crime and anti-social behaviour areas are generally reflective of where most offenders in treatment are resident.
Comparison of crime rates per 1,000 residents 2007-08

<table>
<thead>
<tr>
<th>Area/ Crime Type</th>
<th>Area/ Crime Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Enfield</td>
<td>8.6</td>
</tr>
<tr>
<td>London</td>
<td>8.0</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>5.4</td>
</tr>
</tbody>
</table>

5.16 Mortality

Deaths in Enfield by Cause as a Percentage of all deaths – 2005-2007

In common with London and national findings, conditions accounting for the largest proportion of deaths are:

1. Circulatory disease (includes heart attack, stroke)
2. All cancers
3. Respiratory Disease (includes bronchitis, emphysema, COPD)
### Mortality and Prevalence Rates for major conditions in Enfield, 2005-2007 pooled

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of Deaths 2005-07</th>
<th>Mortality Rate</th>
<th>Enfield prevalence % (07/08) or Incidence (05/07)</th>
<th>London prevalence % (07/08) or Incidence (05/07)</th>
<th>National prevalence % (07/08) or Incidence (05/07)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>547</td>
<td>43.45</td>
<td>44.82</td>
<td>50.02</td>
<td>1.09%</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>1,017</td>
<td>87.40</td>
<td>90.20</td>
<td>95.00</td>
<td>2.57%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>62</td>
<td>5.59</td>
<td>6.46</td>
<td>4.40</td>
<td>12.38%</td>
</tr>
<tr>
<td>COPD</td>
<td>224</td>
<td>18.91</td>
<td>27.17</td>
<td>26.82</td>
<td>0.88%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>70</td>
<td>6.31</td>
<td>6.39</td>
<td>6.29</td>
<td>4.07%</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>158</td>
<td>21.34</td>
<td>19.9</td>
<td>21.3</td>
<td>106.74</td>
</tr>
<tr>
<td>Bowel Cancer</td>
<td>179</td>
<td>17.07</td>
<td>17.37</td>
<td>17.35</td>
<td>41.98</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>12</td>
<td>2.16</td>
<td>1.83</td>
<td>2.03</td>
<td>ND</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>99</td>
<td>21.57</td>
<td>23.63</td>
<td>25.09</td>
<td>92.81</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>296</td>
<td>29.35</td>
<td>38.26</td>
<td>38.49</td>
<td>36.75</td>
</tr>
</tbody>
</table>

Mortality rates due to all circulatory diseases, cancers and respiratory disease are below those seen nationally, and are falling. However, due to Enfield having a population structure with a higher proportion of over 65s, who are more likely to suffer from long term conditions, numbers of deaths and morbidity in the population is higher for Enfield. This has implications for health and wellbeing need, and the planning of resource allocation to match the age structure of the population.
The standardised mortality ratio (SMR) for under 75s shows causes which have resulted in a larger number of deaths than expected in Enfield. It highlights that the causes of death that may need to be investigated are Diabetes, Cervical and Prostate Cancer, as these are the causes that exceed the National SMR. The SMR for all ages shows that there is one main cause of death, which is Breast Cancer, that is higher than the National SMR.

### 5.17 Population Changes

Immigration, emigration, births and deaths mean that estimating the size of a borough’s population is never an exact science. The most complete data collection is census data collected every 10 years, which in 2001 estimated the population of Enfield to be 273,559. However at mid-2007 the population was estimated to be 285,100 making it the 6th largest of the 32 London boroughs.

The population is expected to grow overall by between 500-1,300 people between 2008 and 2013, which is under 0.5% growth, according to GLA projections.
Enfield borough projected population by age 2009-2012 (2006 projections)

Source: ONS 2006-based sub national population projections
Enfield Expected Percentage Growth by Ward Ages 45 to 64, between 2009 and 2012 (Data Management and Analysis Group Post London Plan High Variant Projections 2008)
The 45-64 age group will show the largest increase (3.9%) between 2007 and 2012, an increase of 2606 people. The fastest growing areas over 5 years are expected to be some eastern parts of the borough.

There are noticeable differences between the Enfield and London populations. The proportion of people aged 20-40 in Enfield is smaller than that of London as a whole. From the age of 40 onwards Enfield has slightly higher proportions of people in all ages. This is relevant as it is from their mid 40s that people begin to develop Long Term Conditions (LTC) such as diabetes, heart disease and cancer.

Enfield is very ethnically mixed with state school pupils recording themselves under 87 different ethnicities. Currently 68% of the population is classified as ‘white’. It is expected that this will fall as Enfield becomes more ethnically diverse. The ‘White’ population is expected to fall by 4.41%, Black Caribbean to rise by 9.7%, Black African by 17.5%, Chinese by 21.6% and ‘Other’ by 28.9%. This will include Enfield’s large Greek, Turkish, Turkish-Cypriot and Kurdish population as well as more recent migration from Eastern Europe.

As ethnic and cultural background may have a profound effect on health and wellbeing, analysis of different groups living in Enfield enables a better understanding of the population.

Table 2: Projected Population Growth by Ethnicity

<table>
<thead>
<tr>
<th>Ethnic Groups</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>Growth Rate over 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>206,248</td>
<td>204,841</td>
<td>203,298</td>
<td>202,091</td>
<td>200,876</td>
<td>199,238</td>
<td>-3.4%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>17,477</td>
<td>17,928</td>
<td>18,315</td>
<td>18,706</td>
<td>19,082</td>
<td>19,415</td>
<td>11.1%</td>
</tr>
<tr>
<td>Black African</td>
<td>17,201</td>
<td>17,674</td>
<td>18,077</td>
<td>18,483</td>
<td>18,841</td>
<td>19,093</td>
<td>11.0%</td>
</tr>
<tr>
<td>Black Other</td>
<td>7,480</td>
<td>7,753</td>
<td>7,987</td>
<td>8,216</td>
<td>8,427</td>
<td>8,603</td>
<td>15.0%</td>
</tr>
<tr>
<td>Indian</td>
<td>12,596</td>
<td>12,754</td>
<td>12,896</td>
<td>13,045</td>
<td>13,188</td>
<td>13,303</td>
<td>5.6%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>2,234</td>
<td>2,297</td>
<td>2,355</td>
<td>2,413</td>
<td>2,466</td>
<td>2,505</td>
<td>12.1%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>4,508</td>
<td>4,656</td>
<td>4,797</td>
<td>4,935</td>
<td>5,063</td>
<td>5,176</td>
<td>14.8%</td>
</tr>
<tr>
<td>Chinese</td>
<td>2,849</td>
<td>2,899</td>
<td>2,965</td>
<td>3,032</td>
<td>3,097</td>
<td>3,150</td>
<td>10.6%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>9,102</td>
<td>9,289</td>
<td>9,459</td>
<td>9,632</td>
<td>9,792</td>
<td>9,915</td>
<td>8.9%</td>
</tr>
<tr>
<td>Other</td>
<td>8,333</td>
<td>8,721</td>
<td>9,089</td>
<td>9,450</td>
<td>9,788</td>
<td>10,081</td>
<td>21.0%</td>
</tr>
<tr>
<td>All Groups</td>
<td>288,026</td>
<td>288,813</td>
<td>289,238</td>
<td>290,002</td>
<td>290,620</td>
<td>290,479</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

N.B. Different projections are used for ethnicity projections which result in different overall population figures.
In 2006 it was estimated that Enfield currently had 115,000 households and this is expected to rise to 139,000 by 2029, an increase of 20%.

5.18 Adult Social Care Services

This section sets out key data about social care services purchased or provided by Enfield Council. In addition there is a significant minority of people who purchase services directly without assistance from Enfield Council, but there is no coherent data available. It is estimated that almost half of the numbers of older people in care homes are not known to Enfield Council (some of whom will be non-Enfield residents). It is believed that relatively small numbers of people who have learning difficulties, physical disabilities or mental ill-health, purchase services directly without assistance.

NUMBERS OF PEOPLE RECEIVING CARE SERVICES

Of adult clients receiving services in 2008/9, 65.2% presented with physical disability/frailty, 14.5% with mental ill health and 7.5% with learning disability. Enfield supports a higher proportion of its adult population in each of these categories than the outer London average.
The total number of people receiving a service has increased by 14% compared with 2007/08. With Substance Misuse this has almost doubled (going from 15 to 29) and Mental Health saw an increase of 48%. The other client groups show much smaller increases: Physical Disability, Frailty and Sensory Impairment (7%) and Learning Disability (4%). Vulnerable People showed no significant change.

There has been an increase in absolute numbers of people with significant support needs (see table below).

### Change in Numbers of People Requiring Residential Care or an Intensive Level of Support at Home in the Three-Year Period to end of 2008/9 (Figure 2)

<table>
<thead>
<tr>
<th>Category</th>
<th>NET Gain/Loss</th>
<th>% Increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disability</td>
<td>+31</td>
<td>+5%</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>+57</td>
<td>+11%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>-16</td>
<td>-3%</td>
</tr>
<tr>
<td>Older People</td>
<td>+112</td>
<td>+3%</td>
</tr>
</tbody>
</table>

This growth in the numbers of people with a disability is reflected in the numbers of people receiving Disability Living Allowance. This is particularly noticeable for middle-aged adults in Enfield where the increase is higher than the average for London. The total numbers of claimants in Enfield has grown by 25% from 2002 to 2008, which is the same rate of growth for London overall. The growth in the 50-59 age group has been 22%, compared with the London average of 18%.

More services are provided to people in the older age ranges, as seen in the bar-chart below. Equipment and Adaptations is the service received by more people than any other service, followed by Home Help (this service is usually...
described as home care – the term home help is used in the return to the Department of Health, from which this data was taken). It should be noted that some people who live at home will be receiving more than one service.

Number of Services Provided by Age Group 2008/09 (Figure 1)

![Image of a bar chart showing the number of services provided by age group.]

BALANCE OF CARE BETWEEN RESIDENTIAL AND COMMUNITY BASED SERVICES

The balance of care between residential and community based services in Enfield has improved as more people are helped to maintain their independence in the community for longer. The table below shows how Enfield compared with Outer London Boroughs at the end of 2008/9 for residential care.

(Figure 2)
Within residential services for older people there has been a net decrease but with a more significant increase within that of people requiring residential and nursing services for dementia, increasing from 221 to 295 over the last 3 years, an increase of 33%.

The provision overall of community based services is similar to the outer London average, with the exception of provision of equipment and adaptations, where Enfield exceeds the average (49.6% Enfield, 36.9% Outer London).

The numbers of new homecare clients in the 45-64 age band are progressively increasing (see Figure 4). It is likely that this trend will continue as the population projection (see page 151) shows that the age groups that will grow the most between 2007 and 2012 are the ages 45-54.

(Figure 4)

A total of 137 people with a physical disability received Home Care or Direct Payments for the first time in 2008/9. There has been a significant increase of 21% over the last year, and there are indications that this is a rising trend as the increase from 2006/7 to 2008/9 is 13%.

The number of people choosing to buy their own services through direct payment increased between 07/08 and 08/09 by 32.7%.

Enfield exceeds the outer London average in the provision of services for carers generally but lags behind in the provision of direct payments for carers. Although the numbers of people being funded in this way is relatively low.
TYPES OF NEED

There is considerable diversity in the types of conditions experienced by people who receive services. The most common conditions are set out in the table below. There is some consistency over the three-year period, but thereafter there are significant variations from year-to-year with some conditions e.g. there were 13 people with cancer in 2006/7 but only 6 the following year.

Disability/Condition of New Service Users Ages 18-64, from 2006/07 – 2008/09 (Figure 5)
GEOGRAPHICAL PATTERN

The next table shows a fairly consistent pattern of provision of services within each ward, with one notable exception. Generally there are more people in residential care than nursing home care, but that ratio is reversed in Chase, Southgate and Upper Edmonton.

Number of Services Provided by Ward* 2008/09 (Figure 6)

*It should be noted that not all wards have the same number of people. The population sizes range from 11,605 to 15,103 with an average (mean) size of 13,026.62. See www.enfield-observatory.org.uk/stats/stats.asp click ‘people’ and follow link to ward profile.
The numbers of people receiving services (purchased or provided by Enfield Council) is not in line with the size of the populations of each ward. Figure 7 shows that there is a degree of consistency with the numbers of older people (75% of service recipients are older people), but there are significant variations. The following wards have a significantly higher proportion of service recipients to older people: Chase, Edmonton Green, Enfield Lock, Lower Edmonton and Ponders End. Wards with a significantly lower proportion are: Bush Hill Park, Cockfosters, Grange, Highlands, Southgate and Southgate Green.

**Numbers of Adults Receiving Services at end of 08/09 compared with the Projected Numbers of People aged 75+ in 2009 (Figure 7)**
SAFEGUARDING

Key data in relation to the safeguarding of adults is as follows:

- 370 Safeguarding Adults Alerts received in the Council in the year April 2008/09. Was 315 in 2007/08.
- Alerts on persons over 65 years comprised 70% of the annual total.
- 72 Alerts related to people with a Learning Difficulty (19.5%).
- Females were the largest percentage of the Alert subject group (64.9%).
- The majority of Alerts received related to Financial Abuse and to Physical Abuse categories (54%). Previous year, that had been 49%.
- Over a third of Alerts on Older People were on Financial Abuse (34%).
- 83% of Alerts related to white UK and to other white groups.
- 44% of perpetrators of abuse were family members/friends/careers.
- 84% of SA Alerts received had an agreed multi-agency strategy in place within five days to deal with the abuse reported.
- Most Alerts were raised by the following groups, in this order - Council staff, independent care providers, hospital staff, and community professionals.

The rise in the number of ‘Alerts’ to the Council (from 315 in 2007/08, to 370 in 2008/09) can be attributed to a greater awareness of the service and its purpose and function by professionals mainly. These groups have constituted the most active referrers. Greater public awareness of safeguarding issues undertaken in late 2008 and early 2009 may lead to a continued rise in ‘Alerts’.

5.19 Older People

Older people (those aged 50 and over) number just over 80,000 in Enfield – about 29% of the total population. A little over half of those are of state pension age. Enfield has a high proportion of older people compared to the London average though not to the national average. Ethnic diversity will increase in this population group, over the next 5 years, with some of the fastest projected increases in some eastern wards.

About 20% of older people claim disability related benefits. The number is increasing broadly in line with the national average. There is a clear correlation with poverty.

The 2005 mid-year estimate put the total population of state pension retirement age at 43,900 (about 16% of the total population). This was higher than the London average of 13.8% but lower than the England average of 18.6%.

At the 2001 census, 36% of those aged 65 and over were living alone. The Census figures showed less than 2% of residents as living in communal establishments although the proportion naturally rises with age – to about 21% of the 90+ group.
5.20 Falls

In 2007/8, 850 Enfield residents aged 50 and over were admitted to hospital due to an accidental fall. This is approximately 1 in every 100 residents aged 50 and over. On average women over 50 were 1.5 times more likely to be admitted following an accidental fall than men over 50. The likelihood of admission due to a fall within a 1 year period rises significantly at ages 80 and over, to 1 in every 25 for a resident in their 80s and 1 in every 10 for a resident in their 90s.

In 2007/8, the total cost to the NHS of admissions due to accidental falls, for residents aged 50 and over was £2,461,191.23. (That is a cost per head of £9 for every resident in Enfield).

Within Enfield the highest rates of admissions for falls were in the wards of Ponders End (15.1 per 1,000) and Grange (13.6 per 1,000), the lowest rate was seen in Bowes (3.4 per 1,000).

Enfield’s rate of admissions due to a fall has generally been lower than London or national averages.

5.21 Seasonal Influenza Vaccination

Influenza (flu) is an acute, highly infectious viral infection of the respiratory tract. The disease is characterised by the sudden onset of fever, chills, aches and extreme tiredness; other common symptoms include a dry cough, sore throat and stuffy nose. Currently available flu vaccines give 70-80% protection against flu, which lasts about one year. As antibody levels may take up to 14 days to reach protective levels after immunisation, we start to vaccinate from September so that people are protected before the flu season can take hold.

The objective of the flu immunisation programme is to protect those who are most at risk of serious illness or death should they develop flu; those aged 65 or over, and those over 6 months with an underlying clinical condition.

Uptake of the influenza vaccine in the over 65 age group improved from 71.7% in 2007/8 to 72.9% in 2008/9. Vaccination coverage in groups at risk is also significantly improving at 78% on average versus 42% in 2007/8.

<table>
<thead>
<tr>
<th>Number immunized &lt;65 as at risk due to:</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with Chronic Heart Disease</td>
<td>77.9</td>
</tr>
<tr>
<td>Patients with Chronic Respiratory Disease</td>
<td>86.1</td>
</tr>
<tr>
<td>Patients with Chronic Renal Disease</td>
<td>76.5</td>
</tr>
<tr>
<td>Patients with Chronic Liver Disease</td>
<td>98.6</td>
</tr>
<tr>
<td>Patients with Diabetes</td>
<td>118</td>
</tr>
<tr>
<td>Patients with Immunosuppression</td>
<td>50.7</td>
</tr>
<tr>
<td>Patients with Stroke/TIA</td>
<td>70.9</td>
</tr>
<tr>
<td>Patients with Chronic Degenerative Neurological Disease or MS</td>
<td>45.5</td>
</tr>
</tbody>
</table>
Comparator data shows that we vaccinated a higher percentage of those aged 65 and over than the average reported across London.

All GP practices vaccinate for flu in Enfield, we also have a specialist nurse-led housebound service that vaccinates those people who can’t attend their GP. Community sessions were also put on to encourage vaccination.

The 2009-10 programme is now underway. The following recommendations come from evaluation of the past season:

- Provide feedback to GPs of their practice uptake compared to others within the borough.
- Work with those practices reporting lower uptakes to identify any barriers in the process.
- Undertake a list clean to create a more accurate denominator.
- Heighten public awareness through communication.
- Consider best use of community sessions.

5.22 End of Life Care

The definition of palliative care is the active total care of patients with life-limiting disease, and their families, by a multi-professional team. There is increased recognition of the need for high standard palliative care provision by GPs and primary care teams. (Quality and Outcomes Framework (QOF) guidance for GMS Contract 2008/9: Delivering investment in general practice).

The PCT has commissioned services from three independent hospice providers that offer the best possible care in a safe and supportive environment. The hospices specialise in helping people with life-limiting illness including cancer, motor neurone disease, heart disease and renal failure. The three hospices including PCT investment are:

- North London Hospice £324,000
- Marie Curie – Edenhall £105,000
- St Joseph’s – Hackney £168,000

We are working with PCT colleagues across NCL Sector to agree a common tariff for inpatient admission. This will enable a more equitable investment in more services. As these hospices are registered charities, they are dependent on the generosity of the public to fund services (2008/9 Operating Plan, NHS Enfield).
Enfield primary care practices are assessed and awarded QOF points on the basis of being able to produce a complete register of patients in need of palliative care/support irrespective of age, and on the basis of having regular (at least quarterly) multidisciplinary case review meetings where all patients on the palliative care register are discussed. The graph shows that the majority of wards scored the full QOF score of 6. Four wards scored 4.5 on QOF and these have varying percentages of prevalence. There are two wards that achieved a QOF score of just 3. The wards to focus on are those that have both high prevalence and low QOF scores, such as Southgate Green, Southbury, Palmers Green and Southgate.
Identifies what the local response to the JSNA needs to achieve. Refers to the development of a strategy called ‘Improving Health and Wellbeing in Enfield’ and identifies the type of response needed from commissioners. Outlines the planned development of the JSNA in future years making reference to how an evaluation of this year’s process will inform this plan. Invites comments.

Evaluating responses to the JSNA

The new framework for the independent assessment of local public services in England, the Comprehensive Area Assessment (CAA) will assess whether local partnerships are achieving their aims for their area. The JSNA is one of the key documents that inspectorates will draw evidence from in addition to the local self-assessment. The CAA guidance states that it will focus on:

- joint working between councils and their partners in delivering the area’s priorities, as agreed in the local area agreement (LAA) and sustainable community strategies
- how the quality of people’s lives is improved.

The JSNA is also key to achieving 2 of the 11 competencies for World Class Commissioning, on which PCTs are assessed:

a) working collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
b) managing knowledge and undertaking robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements

Joint Strategic Response

The Director of Health and Adult Social Care and the Chief Executive of NHS Enfield have commissioned the development of a strategy entitled ‘Improving Health and Wellbeing in Enfield’ to respond to the priority needs set out in the JSNA. The vision for this strategy is as follows:

“Our vision is for a healthier Enfield, where everyone is able to benefit from improvements in health and wellbeing. We want to reduce health inequalities in Enfield and for its people to have a healthier, happier and longer life. We want Enfield to be a healthy and happy place to live, work, raise a family and retire in.”
The objectives of this strategy are to be delivered through integrated commissioning arrangements within and across the Enfield Strategic Partnership. The diagram below (reproduced from the above document) shows the relationship between this strategy, the JSNA and other key strategic initiatives.

 Commissioners’ Responses

Each of the member organisations of the Enfield Strategic Partnership with commissioning responsibilities will also wish to identify how their particular commissioning plans and service developments will be informed by the JSNA.

Some examples of initial responses are as follows:

a) HEALTH AND ADULT SOCIAL CARE

The JSNA will inform the development of joint health and social care commissioning strategies. It will facilitate an integrated health and social care response to improving health outcomes and enable a stronger focus on commissioning services that will reduce inequalities and improve people’s quality of life.
The JSNA provides a robust evidence base that describes the characteristics of the local population and will allow commissioners to identify the current areas of highest need, and how these are likely to change in the future. It will enable commissioners to work together with key partners to coordinate their planning so that services are better placed to meet these current and future needs.

Local stakeholders and partners will be involved in the development of commissioning strategies to ensure that there is meaningful input in to local decision making. Involvement could be through membership of project boards, participation in reference groups, or attendance at consultation meetings. As well as informing the development of commissioning strategies, the information that is gathered during this process will in turn feed back into further iterations of the JSNA.

b) CHILDREN’S TRUST

Children’s Trust commissioning activity has been designed to support the priorities currently identified within the Local Area Agreement and the Borough’s Children and Young People’s Plan, as well as NHS Enfield’s Strategic and Operating Plans.

An overarching Children’s Trust Commissioning Strategy has been developed which covers the period 2009 to 2012. This is supported by a number of individual commissioning strategies covering Looked After Children, Disabled Children, Youth Support Services, CAMHS, Substance Misuse and Preventive Services. The information available through the JSNA will inform the ongoing reviews of these strategies and will be incorporated into all future commissioning strategies and Children and Young People’s Plans.

Many current services support the JSNA priorities, providing support and interventions to children and young people and to their families and in this way a holistic approach addresses both immediate and longer-term need, providing diversionary activities while attempting to break the cycle of deprivation.

The robust needs data in the JSNA reflects the views of a wide range of stakeholders and this will enhance the participatory basis on which our commissioning is founded.

c) NHS ENFIELD

NHS Enfield commissioners have welcomed the JSNA as a key information and strategic resource which will be used, coming as it does at the beginning of the commissioning business cycle, to assess whether a change in strategic direction is needed for commissioned services. It will directly inform the assessment of existing projects to identify whether the appropriate health outcomes are being achieved.
In particular it will be central to informing the Enfield contribution to the development of the Enfield Primary Care strategy, in terms of assessing the health needs of each locality. It has already proved valuable in the identification of priority services and care pathways to be resourced in local poly systems. An example is its use in the development of a framework for decision making about which services could be situated in the Evergreen polyclinic centre, which will be designed to meet the health needs of Edmonton patients.

**Developing the JSNA Process**

The current JSNA provides a good overview of what is important, based on the evidence that is available. But as would be expected for such an ambitious process being undertaken for the first time, there are lessons to be learned from both our local experience and the experiences of other localities.

The JSNA is intended to be an ongoing process of understanding local needs and establishing agreed priorities, so a rolling programme for improving the content will be developed.

Much of the evidence of need is only partial. There are things we would like to know, but the data is not readily available or where there is data there is insufficient detail to provide the level of analysis that would be useful. For example it would be useful to develop a much better understanding of the differences that exist at a local level (e.g. council wards), so that links between deprivation factors can be better understood. Some of the existing priorities were based on strongly held beliefs about what was important, rather than hard evidence. So an important next step will be to improve the assessment of need as follows:

- addressing the gaps in our knowledge
- providing more ward-based analysis
- providing evidence to substantiate strongly held professional beliefs

It is certain that the ongoing developments in health and social care – to increase choice and independence and to transform the way that health and social care needs are met, will ensure that the conversation about wellbeing that we have started with Enfield residents through this JSNA will grow and increasingly allow the involvement of more of our residents, including some of those whose voices are seldom heard. But we also must make sure that we keep up the conversation about the bigger picture and also involve users of other services which contribute to health and wellbeing, like leisure and sports provision.

We will want to more effectively draw upon the expertise of front-line staff and those working in the third sector, as well as other people who have local experience and knowledge such as Councillors. The Enfield LINk will increasingly be important participants in the JSNA process, in helping to provide evidence of the views of local people about what is not working well.
There will be challenges in being able to assemble convincing evidence to support changes to the way services are to be provided that are likely to have an effective impact on many of the priority needs. Some of the priority needs identified are problems that do not have solutions where the evidence of what works is clear e.g. in reducing obesity. Nevertheless decisions will need to be made about allocating resources if a reduction in the scale of those needs is to be achieved. For some priority needs there are even greater challenges of intervening where there is a known association but causality is uncertain e.g. it is well known that there is an association between poverty and above average infant mortality, but causality is less well understood and is likely to be complex – particularly in those parts of the borough where the rate of infant mortality is relatively high.

As the process of evidence-based joint commissioning develops there will be feedback from those with an interest in and responsibilities for the three key determinants of priority needs: evidence of need, evidence of the views and aspirations of local people and evidence of what works. As the evidence in the JSNA starts to be applied, some of it will be found useful and some of it may not be useful, or insufficiently robust.

Fig 1. Three-year Review Cycle

To manage the issues identified above it is intended that there will be a three-year programme with the following elements:

A) annually:
   - address gaps (in selected priority areas)
   - consider emerging issues (and add new Priority Needs where relevant)
   - review basic data
• map, shape and take note of consultations of residents that are initiated by the Council and NHS Enfield

B) every other year:
• engage with vulnerable groups about priorities, including a review of the impact of their involvement
• evaluate impact on commissioning

C) in three years time:
• review the Priority Needs

**Evaluation of the JSNA Process**

The future development of the JSNA will be informed by an evaluation of the process that has taken place over the last year to produce the current JSNA. This will be published in early 2010.

Any views that you would like to express will be gratefully received. You can either use the format on the next page or simply send in your comments, ideally by March 31st 2010.
WHAT DO YOU THINK?

Please send your comments to:
Felicity Cox, Health and Adult Social Care, 6th Floor, Civic Centre or email felicitymargaret.cox@enfield.gov.uk

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<th>Usefulness</th>
<th>Improvements</th>
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<td>2. Consulting the People of Enfield and Involving Stakeholders</td>
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<td>5. Health and Wellbeing Data for Enfield</td>
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<td>6. Implementing and Developing the JSNA</td>
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Name: 
Position: 
Organisation (where relevant): 
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