The London Borough of Enfield: Health Needs, Inequalities and ICS Priorities

The Centre for Population Health January 2026

Introduction

This summary provides an integrated overview of The London Borough of Enfield's population, health needs, inequalities and systemwide priorities. It brings together demographic analysis, deprivation patterns, health outcomes, and strategic priorities aligned with the Integrated Care System to support evidence-based planning across health, social care and community partners.

The pack has been created by the Centre for Population Health using the best possible publicly available resources to provide a borough-by-borough outline for participants and supporters of the NWL and NCL Population Health Management Leadership Programme (see References Section at the end of this pack). The aim of this pack is to help create a shared understanding about the local area, population needs and to highlight some good examples to help inform discussions about improving population health and equity across West and North London. Information provided in this pack should be supplemented with local insights through conversations with communities and partners, and latest non-public datasets to ensure the best possible information is being used to inform decision making for this.

Enfield JSNA 2026 – Summary

Enfield's population is 327,434, with modest 0.3% growth over ten years and recent slight decline.

Life expectancy exceeds national averages, yet deprived neighbourhoods experience seven-year shorter lives and poorer health.

Over 30% of children live in poverty, with eastern Enfield among England's most deprived 2% areas.

Borough is highly diverse, with 69% identifying as non-White British and over 120 languages spoken locally.

Chronic disease burden is high, including 8.4% diabetes prevalence and significant obesity across childhood and adulthood.

Strong community assets and ICS partnerships support targeted interventions across Start Well, Live Well, and Age Well.

Borough Overview

Enfield covers 82.2 km², stretching from dense Edmonton neighbourhoods to affluent, greener north-western residential areas.

Population density is 40.5 persons per hectare, significantly lower than London's 57.8 persons per hectare average.

Population growth has stagnated, with a net decline of 580 residents between 2023 and 2024 due to outward migration.

Only 31.3% identify as White British, reflecting large Turkish, Greek, Somali, and Eastern European communities borough-wide.

Life expectancy is 80.5 years for men and 84.7 for women, masking stark internal east–west inequalities.

Deprived Edmonton wards rank among England's most disadvantaged 2%, contrasting sharply with affluent western neighbourhoods.

Population Characteristics and Demographics

Children under 20 represent 28% of residents, with 7.6% aged 0–4, exceeding London's 6.6% average.

Working-age adults (20–64) form 60% of residents, though only 21% are aged 20–34, below London's 27%.

Older adults aged 65+ comprise 14.7% of residents, projected to rise to 16% by 2025 due to ageing trends.

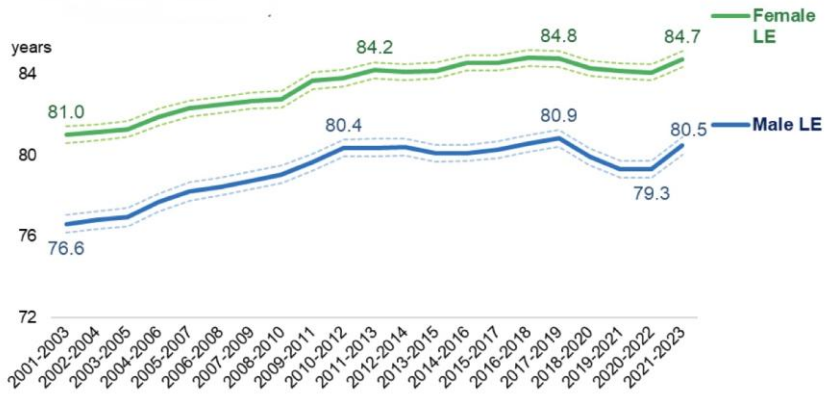
Ethnic diversity is high, with 18.6% identifying as Other White and 18% identifying as Black ethnic groups.

Over 40% speak a primary language other than English, with 9% of households lacking an English-proficient adult.

Population churn is significant, with 36% of residents living at a different address one year earlier.

Life Expectancy & Healthy Life Expectancy Inequalities

- Residents in most deprived areas live seven years shorter than those in affluent western neighbourhoods.
- Healthy life expectancy gap is fifteen years, with deprived communities experiencing earlier onset of long-term illness.
- One in twenty residents reports bad or very bad health, concentrated heavily in Edmonton and eastern wards.
- COVID-19 caused sharp declines in life expectancy between 2018 and 2020, with partial recovery by 2023.
- Poorer neighbourhoods experience higher rates of chronic disease, disability, and premature mortality across adulthood.
- Ethnic minority communities face additional barriers, including language, cultural norms, and lower screening uptake.



Enfield: Male and Female Life Expectancies at birth (in years)

Chronic Disease and Long-Term Conditions

Adult diabetes prevalence is 8.4%, exceeding London and national averages, especially affecting South Asian communities.

Hypertension and cardiovascular risks are elevated, with poorer control in deprived GP practices across eastern Enfield.

Childhood obesity at Reception age is 25.5%, the fourth highest in London, signalling early metabolic risk.

Long-term illness affects 17% of residents, with higher rates among older adults and deprived neighbourhoods.

Black African and Caribbean communities experience higher hypertension, stroke, and diabetes complications.

Ageing population growth increases demand for frailty, dementia, and complex multimorbidity support services.

Child Health, Obesity and Early Years Inequalities

Over 30% of children live in poverty, with highest concentrations in Edmonton and Ponders End neighbourhoods.

One in four Reception-age children is overweight or obese, reflecting early dietary and environmental inequalities.

High birth rates in early 2010s created large child cohorts, though under-5 population declined 5% since 2015.

Breastfeeding, immunisation, and early development outcomes vary significantly across ethnic and socio-economic groups.

Overcrowding affects 16% of households, disproportionately impacting children's health, sleep, and developmental outcomes.

Lone-parent households (11.8%) face higher financial stress, increasing risk of poor child health and wellbeing.

Mental Health, Social Isolation and Vulnerable Populations

Mental health needs increased post-pandemic, with deprivation strongly linked to anxiety, depression, and poor wellbeing.

Older adults face high isolation, with 36.8% of residents aged 65+ living alone, increasing frailty and risk.

Migrant communities experience language barriers, trauma histories, and reduced access to mental health services.

High population churn disrupts continuity of care, particularly for families in temporary accommodation or resettlement.

Refugee and asylum-seeking households require tailored support addressing trauma, housing instability, and integration.

Economic insecurity, unemployment, and low qualifications contribute to chronic stress and poorer mental health outcomes.

Deprivation & Its Impact on Health

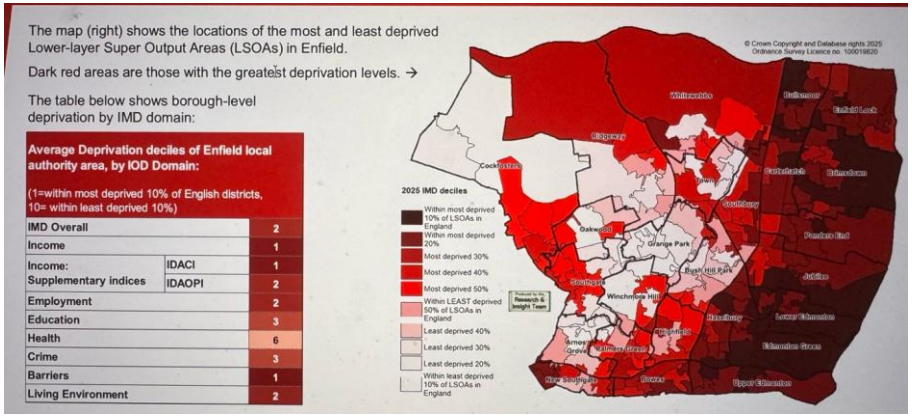
- Eastern Enfield neighbourhoods, including Edmonton, rank among England's most deprived 2% by IMD 2019 indicators.
- Child poverty affects 55.5% of children in income-deprived households, one of London's highest borough-level rates.
- Overcrowding affects 16% of households, especially larger migrant families living in small terraced homes or flats.
- Median household income is £41,100, the 10th lowest in London, with significant east–west income disparities.
- Education inequality persists, with 22.5% of adults having no qualifications, well above the London average.
- Housing affordability pressures drive outward migration, contributing to population decline and service instability.16

The map (right) shows the locations of the most and least deprived Lower-layer Super Output Areas (LSOAs) in Enfield.

Dark red areas are those with the greatest deprivation levels. →

The table below shows borough-level deprivation by IMD domain:

Average Deprivation deciles of Enfield local authority area, by IOD Domain: (1=within most deprived 10% of English districts, 10= within least deprived 10%)		
IMD Overall		2
Income		1
Income: Supplementary indices	IDACI	1
	IDAOPI	2
Employment		2
Education		3
Health		6
Crime		3
Barriers		1
Living Environment		2



Key Priorities Overview

CENTRE FOR POPULATION HEALTH
www.centreforpopulationhealth.co.uk

- Give Every Child the Best Start in Life (Early Years and Family Support)
- Support the Wellbeing of Children and Young People (School-Age and Adolescents)
- Promote Healthy Lifestyles and Prevent Long-Term Conditions in Adults
- Improve Management of Long-Term Conditions and Reduce Health Inequalities
- Support Mental Health and Wellbeing for All Adults
- Independent Ageing (Older People's Health)
- Tackle Deprivation and Its Health Consequences
- Ensure Equitable Access to High-Quality Health and Care Services
- Empower Communities and Promote Health Literacy
- Strengthen Health Protection and Emergency Preparedness

Priority 1: Give Every Child the Best Start in Life (Early Years and Family Support)

- Over 55% of children live in income-deprived households, driving early developmental gaps and reduced school readiness.
- Only 65% achieve good development in some wards, compared with 80% in more affluent neighbourhoods.
- 5.4% of pregnant women smoke at delivery, above London's 4.6%, increasing low-birthweight and perinatal complications.
- Infant mortality is 4.2 per 1,000, with 8.8% low-birthweight births in Edmonton Green versus 6% elsewhere.
- Breastfeeding at 6–8 weeks is 65%, with significantly lower rates among white working-class and Turkish communities.
- Immunisation coverage for MMR1 is ~82%, below the 90% target, leaving toddlers vulnerable to preventable diseases.

Priority 1 – Actions

Increase early maternity booking by targeting communities with late attendance, including Turkish and Somali groups.

Expand stop-smoking support using voucher incentives for high-risk mothers in areas with elevated smoking prevalence.

Strengthen breastfeeding support by deploying culturally matched peer supporters in low-uptake communities.

Ensure all mandated Health Visiting contacts reach families, with additional visits for young parents in deprived wards.

Raise immunisation uptake through monthly evening clinics in Family Hubs and libraries across Edmonton and Enfield Highway.

Increase 2-year-old childcare uptake from 68% to 90% by simplifying applications and targeting families in temporary accommodation.

Priority 2 – Support the Wellbeing of Children and Young People (School-Age and Adolescents)

28% of Year 6 children are obese and 41.7% overweight/obese, among the highest rates in London.

Obesity exceeds 30% in deprived school clusters compared with ~13% in affluent areas, doubling inequality.

Only 53% of children meet activity guidelines, with lowest participation in Edmonton and Ponders End schools.

CAMHS referrals increased ~20% in 2021/22, with one in six young people experiencing probable mental disorders.

Self-harm admissions among 10–24 year-olds reached ~275 per 100,000, indicating significant unmet emotional need.

Around 30% of 15-year-olds have tried vaping, with rising regular use of high-nicotine disposable devices.

Priority 2 – Actions

Priority 3 – Promote Healthy Lifestyles and Prevent Long-Term Conditions in Adults

59.7% of adults are overweight or obese, exceeding London's 55.9% and increasing chronic disease risk.

Adult diabetes prevalence is 8.4%, above the national ~7%, driven by excess weight and dietary inequalities.

13.5% of adults smoke, higher than London's 11.7%, with elevated rates among Turkish and Eastern European men.

23% of adults binge drink on heaviest drinking days, contributing to rising alcohol-related hospital admissions.

Hypertension affects an estimated 28% of adults, with poorer control in deprived GP practices.

Under-75 mortality is ~329 per 100k, with ~75 per 100k from cardiovascular disease, much of it preventable.

Priority 3 – Actions

- Target smoking cessation in high-prevalence communities, reducing borough smoking toward London's 11.7% benchmark.
- Expand weight-management programmes to address 59.7% adult excess weight, prioritising deprived eastern wards.
- Increase physical activity through active travel promotion and expanded community exercise programmes post-pandemic.
- Boost NHS Health Check uptake to identify undiagnosed hypertension among the 28% estimated with high blood pressure.
- Promote cancer screening through culturally tailored outreach in communities with low uptake and higher mortality.
- Reduce alcohol-related admissions by expanding brief interventions and targeted support for binge-drinking adults.

Priority 4 – Improve Management of Long-Term Conditions and Reduce Health Inequalities

Many residents live with multiple long-term conditions requiring coordinated, proactive management to prevent deterioration.

Poor disease control leads to emergency admissions, reduced quality of life, and increased pressure on services.

Inequalities persist, with disadvantaged communities experiencing poorer outcomes and inconsistent clinical support.

Fragmented pathways cause missed reviews, delayed medication optimisation, and limited continuity for complex patients.

People with serious mental illness face significant physical health gaps requiring integrated, sustained support.

Growing multimorbidity demands stronger primary care capacity and consistent evidence-based interventions.

Priority 4 – Actions

Standardise	Standardise long-term condition pathways across practices to ensure consistent reviews and proactive follow-up.
Expand	Expand multidisciplinary teams coordinating medical, social, and community support for complex patients.
Strengthen	Strengthen diabetes, respiratory, and cardiovascular management through structured education and personalised care plans.
Improve	Improve physical health checks for people with serious mental illness through integrated clinics and coordinated follow-up.
Increase	Increase access to rehabilitation programmes supporting recovery, self-management, and reduced deterioration risk.
Enhance	Enhance digital tools enabling residents to monitor conditions and access timely clinical advice.

Priority 5 - Support Mental Health and Wellbeing for All Adults

Adult mental health needs continue rising, affecting employment, relationships, and overall community wellbeing.

Economic pressures, housing insecurity, and debt significantly increase stress and risk of mental health decline.

People with severe mental illness experience poorer physical health outcomes and require holistic support.

Loneliness and isolation remain widespread, particularly among older adults, carers, and residents living alone.

Stigma and cultural barriers prevent many adults from seeking timely help or recognising early symptoms.

Service capacity challenges create delays, increasing risk of crisis escalation for vulnerable residents.

Priority 5 – Actions

Expand	Expand talking therapies and culturally adapted support, ensuring timely access for diverse communities.
Develop	Develop integrated community mental health hubs offering multidisciplinary support for complex needs.
Strengthen	Strengthen crisis prevention through safe spaces, rapid response pathways, and coordinated support.
Scale	Scale social prescribing and community connection programmes to reduce loneliness and improve resilience.
Provide	Provide targeted support for carers, new parents, unemployed adults, and residents with long-term conditions.
Deliver	Deliver borough-wide mental health literacy campaigns to reduce stigma and encourage help-seeking.

Priority 6 – Independent Ageing (Older People's Health)

The growing older population requires coordinated support to maintain independence and quality of life.

Frailty and falls significantly increase hospital admissions, disability, and loss of independence.

Dementia prevalence is rising, requiring early diagnosis and strong support for families and carers.

Loneliness harms physical and mental health, especially for older adults living alone or bereaved.

Multiple long-term conditions create complex needs requiring integrated, proactive care approaches.

Poor housing, fuel poverty, and sensory impairments increase vulnerability to illness and accidents.

Priority 6 – Actions

Expand	Expand falls prevention programmes, strength and balance classes, and home safety assessments.
Implement	Implement integrated frailty pathways, virtual wards, and enhanced care home support.
Improve	Improve dementia diagnosis, post-diagnostic support, and dementia-friendly community initiatives.
Scale	Scale befriending, social prescribing, and intergenerational programmes to reduce loneliness.
Increase	Increase vaccination, screening, and sensory health checks for older residents.
Strengthen	Strengthen rehabilitation and reablement services supporting recovery and safe discharge.

Priority 7 – Tackle Deprivation and Its Health Consequences

High deprivation drives poorer health outcomes and persistent inequalities across neighbourhoods.

Overcrowding, damp housing, and temporary accommodation worsen respiratory health and child development.

Poverty limits access to healthy food, physical activity, education, and stable employment.

Community safety concerns and trauma undermine wellbeing and opportunities for young people.

Environmental inequalities expose deprived communities to pollution and fewer green spaces.

Economic insecurity increases stress, mental illness, and reliance on crisis services.

Priority 7 – Actions

Embed	• Embed Health in All Policies to ensure planning and regeneration reduce health inequalities.
Improve	• Improve housing quality through inspections, fuel poverty support, and targeted interventions.
Strengthen	• Strengthen employment, skills, and financial wellbeing support through local partnerships.
Expand	• Expand violence-reduction programmes and trauma-informed mentoring for at-risk youth.
Enhance	• Enhance environmental health through air quality action and green space investment.
Support	• Support community resilience with programmes addressing poverty and social isolation.

Priority 8 – Ensure Equitable Access to High-Quality Health and Care Services

Unequal access to primary care limits early intervention and worsens health outcomes.

High A&E demand reflects gaps in urgent care pathways and same-day access.

Language, cultural, and digital barriers prevent residents from navigating services effectively.

Fragmentation between health and social care causes delays and poor experiences.

Digital exclusion risks widening inequalities as services move online.

Population growth increases pressure on facilities and workforce capacity.

Priority 8 – Actions

Expand	Expand primary care capacity through workforce growth and extended hours.
Improve	Improve urgent care pathways through NHS 111 integration and same-day access.
Strengthen	Strengthen language support, cultural competence, and translated materials.
Integrate	Integrate health and social care through shared records and joint MDTs.
Balance	Balance digital innovation with inclusion and non-digital alternatives.
Plan	Plan new facilities and workforce pipelines to meet future demand.

Priority 9 – Empower Communities and Promote Health Literacy

Low health literacy contributes to poor self-management and avoidable emergency use.

Community trust influences uptake of vaccines, screening, and lifestyle programmes.

Voluntary and faith groups deliver culturally relevant health messages and support.

Behaviour change is stronger when communities co-design solutions.

Misinformation undermines public health efforts and increases risk during crises.

Empowered communities build resilience and reduce isolation.

Priority 9 – Actions

Priority 5.10 – Strengthen Health Protection and Emergency Preparedness

COVID-19 exposed vulnerabilities and highlighted need for rapid public health response.

Low immunisation and screening uptake increase outbreak and late diagnosis risks.

Infectious diseases require ongoing surveillance and targeted community engagement.

Antimicrobial resistance threatens effective treatment and requires strong stewardship.

Environmental hazards and climate change increase risks for vulnerable residents.

Emergency preparedness ensures effective response to major incidents.

Priority 10 – Actions

Increase	Increase vaccination uptake through targeted outreach and multilingual reminders.
Strengthen	Strengthen outbreak response capacity with trained teams and rapid diagnostics.
Boost	Boost screening uptake with community ambassadors and mobile units.
Enhance	Enhance antimicrobial stewardship and infection prevention across all settings.
Develop	Develop multi-agency emergency plans for heatwaves, floods, and major incidents.
Maintain	Maintain community readiness through volunteer networks and rapid mobilisation.

Best Practice Examples from Enfield

Family Hubs: A One-Stop Shop for Early Years Support

Community Advice Hub: Linking Health with Social Support at the Hospital Front Door

Community Food Pantries and Co-ops: Tackling Food Poverty and Nutrition

"Smart Living" Digital Inclusion for Older Adults: Combating Isolation and Enabling Independence

The Sanctuary Crisis Hub: Safe Haven for Mental Health Support

Family Hubs – Description

Five Family Hubs established across Edmonton, Enfield Highway, Ponders End, Carterhatch and De Bohun between 2022–2025.

Provide integrated early years support for families from pregnancy to age 19, including midwifery and health visiting.

Offer parenting programmes, infant feeding support, speech and language sessions, youth mentoring and SEND support.

Located deliberately in high-need wards where under-5 deprivation exceeds 40% and school readiness is lowest.

Over 9,800 families registered across the hub network, with 3,200 attending at least one session monthly.

Operate a “no wrong door” model ensuring families receive coordinated support regardless of presenting issue.

Family Hubs – Why It's a Best Practice

Co-locating NHS, Council and VCS professionals reduces fragmentation and improves access for families with complex needs.

Hubs increase early identification of developmental delays; 27% more children referred for early speech support in 2024.

Engagement is significantly higher in deprived wards; attendance rates doubled compared with previous children's centre model.

Breastfeeding support delivered to over 1,400 mothers annually, improving continuation rates in hub catchment areas.

Hubs reduce escalation to statutory services; early help assessments decreased by 18% in hub-served neighbourhoods.

Strong community ownership and culturally tailored support improve engagement among Turkish, Somali and Eastern European families.

Family Hubs – Key Lessons for Intervention Planning

- Locating hubs in trusted community spaces increases uptake; school-based hubs saw 40% higher attendance than standalone sites.
- Weekly multidisciplinary huddles improve coordination, reducing referral delays from an average of 21 days to 5 days.
- Practical design features such as pram storage, sensory rooms and flexible drop-ins significantly improve accessibility.
- Shared outcomes across NHS and Council teams ensure alignment, particularly around immunisation, breastfeeding and school readiness.
- Sustaining hubs requires blended funding; Enfield successfully transitioned 62% of roles into core budgets by 2025.
- Real-time data dashboards allow targeted outreach, increasing engagement among families previously not accessing services.

Family Hubs – Evaluation Results

93% of parents reported improved wellbeing or parenting confidence; 88% reported improved child development outcomes.

Breastfeeding continuation at 6–8 weeks increased by 5 percentage points in hub areas compared with borough average.

1,200 children attended early language groups, with 64% showing measurable improvement in communication milestones.

480 families avoided escalation to statutory social care due to timely early help interventions delivered through hubs.

72% of families attending hubs reported reduced isolation and stronger peer support networks.

Recognised nationally in the DfE 2025 Family Hubs Model Framework as an exemplar of integrated early years practice.

Community Advice Hub – Description

Located in the atrium of North Middlesex University Hospital, serving Enfield and Haringey residents since 2021.

Provides welfare, housing, debt, carer support, fuel poverty advice and crisis intervention for anyone attending hospital.

Staffed by Citizens Advice, Council Welfare Team, Enfield Carers Centre and VCS partners on a rotating schedule.

Supports patients presenting with social needs affecting health, including homelessness, debt, food insecurity and benefits issues.

Integrated into discharge pathways; ward staff refer patients whose social needs delay safe discharge.

Over 1,200 residents supported annually, addressing more than 2,500 issues across income, housing and wellbeing.

Community Advice Hub – Why It's a Best Practice

Addresses social determinants at the point of crisis; 41% of users present with issues directly affecting health outcomes.

Reduces pressure on A&E; frequent attenders supported by the hub saw a 30% reduction in re-attendance within six months.

Provides multi-issue support; average client presents with three separate problems requiring coordinated intervention.

Leverages trust in the NHS; 62% of users said they would not have sought help elsewhere.

Prevents homelessness; at least 50 evictions avoided annually through rapid intervention and landlord negotiation.

Recognised nationally with a 2022 HSJ High Commendation for Place-Based Partnership Working.

Community Advice Hub – Key Lessons for Intervention Planning

- Locating support in hospitals captures residents who would not access community services due to stigma or complexity.
- Clinician awareness is essential; embedding hub referrals in discharge checklists increased referrals by 48%.
- Joint training on safeguarding, data sharing and mental health first aid ensures consistent, high-quality support.
- Strong governance and shared protocols build trust across agencies, enabling seamless handovers and coordinated care.
- Flexibility is crucial; during cost-of-living peaks, fuel poverty specialists were added to meet rising demand.
- Model is scalable; Enfield is piloting satellite hubs in GP practices based on hospital success.

Community Advice Hub – Evaluation Results

- £500,000 in unclaimed benefits and grants secured for residents annually, improving financial stability and reducing stress.
- 1,200 individuals supported, with 2,500 issues resolved, including 600 housing problems and 400 debt cases.
- 30% reduction in unplanned readmissions among hub users compared with their previous six-month history.
- 100+ hospital staff accessed support during COVID-19 and cost-of-living pressures, improving wellbeing and retention.
- 92% of users reported improved ability to manage their circumstances after receiving support.
- Service feedback highlights compassion, accessibility and practical problem-solving as key strengths.

Community Food Pantries and Co-ops – Description

Three Community Food Pantries located in Edmonton Green Library, Enfield Highway and Upper Edmonton.

Provide weekly access to £15–£20 worth of nutritious food for a £4.50 membership fee.

Stock sourced from FareShare, supermarkets and local suppliers, prioritising fresh produce and culturally appropriate foods.

Community Food Co-ops launched in 2025 in partnership with Cooperation Town, enabling collective bulk purchasing.

Pantries integrated with Community Hubs, offering welfare advice, debt support and employment guidance.

Over 1,800 households supported annually, distributing more than 250 tonnes of food across high-need wards.

Community Food Pantries and Co-ops – Why It's a Best Practice

- Directly addresses food insecurity; 1 in 5 Enfield households struggled to afford food in 2022.
- Improves diet quality; pantry users increased fruit and vegetable intake by an average of two portions daily.
- Reduces stigma; membership model promotes dignity, choice and agency rather than emergency food handouts.
- Tackles root causes; 40% of pantry users referred to debt, welfare or employment support services.
- Strengthens community cohesion; pantries serve as social spaces reducing isolation and building peer networks.
- Reduces food waste; redistributes surplus stock, preventing more than 100 tonnes of food from landfill annually.

Community Food Pantries & Co-ops – Key Lessons for Intervention Planning

Locating pantries in libraries and community centres increases accessibility and reduces stigma for vulnerable households.

Strong partnerships with supermarkets and FareShare ensure consistent supply of nutritious, culturally appropriate foods.

Embedding public health expertise improves nutritional standards and strengthens evaluation of health outcomes.

Community-led co-ops enhance sustainability by empowering residents to shape and manage local food initiatives.

Flexible membership options reduce waste and meet diverse household needs, including single-person households.

Integrating food support with welfare advice addresses underlying causes, enabling families to move towards independence.

Community Food Pantries and Co-ops – Evaluation Results

- 1,800 households supported annually, with 250 tonnes of food distributed across Edmonton and Enfield Highway.
- 64% of users reported improved diet quality and reduced reliance on ultra-processed foods.
- 40% of pantry members accessed additional support, including debt advice, fuel vouchers and employment programmes.
- Co-ops demonstrated strong community ownership, with 70% of members participating in decision-making.
- Public Health monitoring showed improved children's nutrition and increased Healthy Start vitamin uptake.
- Reduced pressure on crisis food aid services by offering sustainable, preventative alternatives.

Smart Living Digital Inclusion – Description

Smart Living programme delivered across libraries, community centres and sheltered housing schemes in Edmonton, Palmers Green and Southgate.

Supports older adults to develop digital skills enabling independence, safety, social connection and access to services.

Provides training on smartphones, tablets, NHS App, online banking, video calling and digital safety.

Delivered by digital champions, volunteers and community navigators offering personalised one-to-one coaching.

Home-based support available for housebound residents requiring help with devices, connectivity or accessibility needs.

Over 1,500 older adults engaged since 2023, with 600 completing structured digital skills programmes.

Smart Living Digital Inclusion – Why It's a Best Practice

Tackles digital exclusion; 32% of Enfield residents aged 65+ lack basic digital skills needed for daily tasks.

Reduces loneliness; 68% of participants reported increased social contact through video calling and messaging tools.

Improves access to health services; 72% of learners successfully used the NHS App independently after training.

Enhances independence; participants reported greater confidence managing finances, appointments and online shopping.

Community-based delivery ensures culturally sensitive support for diverse older populations across the borough.

Strengthens resilience by equipping residents with skills needed to navigate an increasingly digital society.

Smart Living Digital Inclusion – Key Lessons for Intervention Planning

- Digital inclusion must be personalised; older adults require patient, tailored support to build confidence and skills.
- Trusted community venues significantly increase participation among digitally anxious or socially isolated older adults.
- Partnerships with telecom providers and device donors help overcome affordability barriers for low-income households.
- Ongoing support is essential; follow-up sessions maintain confidence and prevent digital regression.
- Embedding digital skills within wider wellbeing programmes increases engagement and reinforces practical relevance.
- Monitoring digital uptake helps target support to residents most at risk of isolation or service exclusion.

Smart Living Digital Inclusion – Evaluation Results

1,500 older adults engaged, with 600 completing structured training and 400 receiving home-based support.

72% successfully used the NHS App independently, improving access to prescriptions, appointments and health records.

68% reported reduced loneliness and increased social contact through digital communication tools.

55% reported improved confidence managing online banking, utilities and essential household tasks.

Digital champions observed significant increases in confidence among residents previously unable to use smartphones.

Community venues reported increased engagement from older adults returning for additional learning and social activities.

Sanctuary Crisis Hub – Description

Sanctuary Crisis Hub provides a safe, calming space for residents experiencing mental health crisis or acute distress.

Located in Edmonton Green, operating extended hours including evenings and weekends for maximum accessibility.

Staffed by mental health practitioners, peer supporters and VCS partners trained in trauma-informed care.

Offers immediate emotional support, de-escalation, safety planning and practical guidance without appointment.

Provides onward referrals to crisis teams, talking therapies, housing support and community mental health services.

Supported over 2,200 residents since 2022, with 900 attending multiple times for early help before escalation.

Sanctuary Crisis Hub – Why It's a Best Practice

CENTRE FOR POPULATION HEALTH
www.centreforpopulationhealth.co.uk

Reduces pressure on A&E; 38% of users would otherwise have presented to emergency departments during crisis.

Provides compassionate, non-clinical support that validates experiences and stabilises emotional distress safely.

Peer support model increases trust and engagement among individuals reluctant to access formal mental health services.

Trauma-informed approach ensures residents feel safe, respected and empowered during moments of acute vulnerability.

Strengthens crisis pathways by enabling rapid referrals and coordinated follow-up with mental health teams.

Encourages earlier help-seeking, reducing escalation into severe crisis requiring emergency or inpatient care.

Sanctuary Crisis Hub – Key Lessons for Intervention Planning

CENTRE FOR POPULATION HEALTH
www.centreforpopulationhealth.co.uk

Crisis alternatives must be welcoming, non-clinical and staffed by individuals skilled in trauma-informed de-escalation.

Strong partnerships with NHS crisis teams ensure seamless referrals and continuity of support after initial contact.

Peer support workers provide unique value, improving engagement and reducing fear of mental health services.

Flexible opening hours are essential to meet needs during evenings, weekends and periods of heightened distress.

Community-based locations reduce stigma and increase accessibility for residents hesitant to approach clinical settings.

Continuous feedback from service users helps refine the environment, support offer and follow-up pathways.

Sanctuary Crisis Hub – Evaluation Results

2,200 residents supported since 2022, with 900 returning for early help before crisis escalation.

A&E attendances reduced by 32% among individuals using the hub during mental health crisis episodes.

84% of users reported feeling safer, calmer and more supported compared with previous emergency department experiences.

Rapid referrals improved continuity of care, reducing repeat crisis presentations by 28% within six months.

Staff observed improved de-escalation outcomes, with fewer incidents requiring police or emergency intervention.

Positive feedback highlighted the hub's welcoming environment, compassionate staff and non-judgmental approach.

Alignment with ICS Priorities and National Strategies

Enfield's priorities mirror NCL ICS focus on early years, prevention, inequalities and integrated community-based care.

Local actions directly support ICS ambitions to reduce life expectancy gaps and improve Healthy Life Expectancy borough-wide.

Strong alignment with Core20PLUS5, particularly maternity equity, SMI care, hypertension control and early cancer detection.

Enfield's prevention programmes operationalise NHS Long Term Plan commitments on obesity, digital access and mental health.

Local initiatives reflect London Health Inequalities Strategy aims around healthy children, healthy minds and healthy communities.

Enfield's approach embodies OHID and DHSC priorities on prevention, levelling-up health and reducing structural inequalities.

System Recommendations

Adopt	Adopt a formal Health in All Policies approach ensuring every major decision undergoes structured health impact consideration.
Ring	Ring-fence prevention budgets and increase upstream investment annually to reduce long-term acute and social care pressures.
Strengthen	Strengthen shared data systems enabling real-time population health management and targeted interventions across localities.
Expand	Expand community co-production, embedding resident voices in design, delivery and evaluation of all priority programmes.
Develop	Develop integrated multidisciplinary neighbourhood teams delivering coordinated, “no wrong door” support for complex needs.
Invest in	Invest in workforce development, ensuring staff are trained in trauma-informed, culturally competent and preventative practice.

Implications for Enfield, the ICS and the Wider Public Health System

Enfield's approach demonstrates how local innovation can directly advance ICS outcomes on inequalities and population health.

Strong alignment enables shared funding opportunities, particularly for prevention, crisis alternatives and community-based models.

Integrated working across borough partners strengthens resilience and reduces duplication across health, social care and VCS sectors.

Data-driven targeting supports ICS ambitions to narrow gaps for Core20PLUS5 and other high-risk inclusion groups.

Community-centred design enhances trust, improving uptake of screening, immunisation and lifestyle interventions across populations.

Enfield's models provide scalable templates for ICS-wide adoption, particularly hubs, co-production and integrated neighbourhood teams.

What This Means for the Borough and ICS

A whole-system, preventative approach is essential to reduce widening inequalities and improve long-term population outcomes.

Collaboration across NHS, Council and VCS partners must deepen to address complex, multi-factorial health determinants effectively.

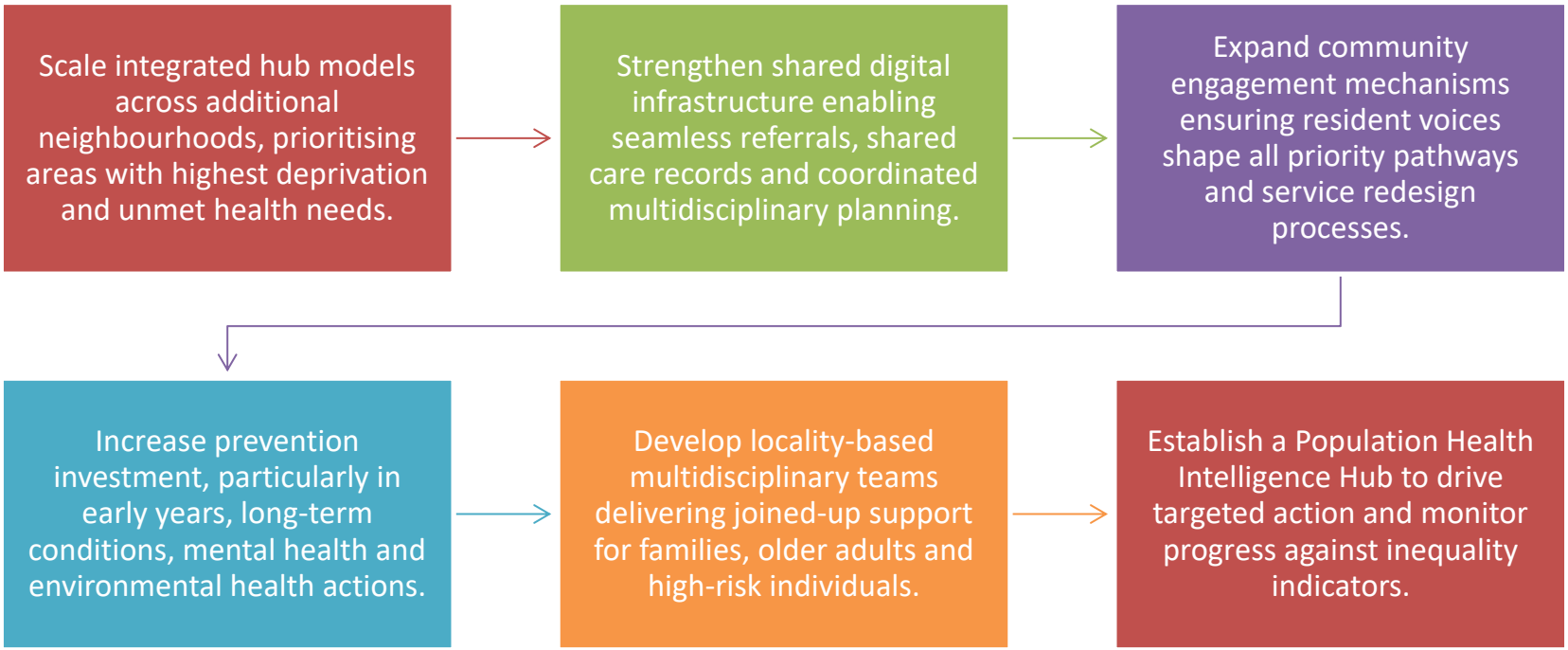
Targeted investment in deprived wards remains critical to narrowing East–West life expectancy and wellbeing disparities.

Integrated models like hubs and multidisciplinary teams should become standard practice across all neighbourhoods.

Data and insight must drive decision-making, ensuring resources reach communities with highest unmet need.

Community empowerment is central, requiring sustained engagement, trust-building and culturally tailored service design.

Next Steps for the London Borough of Enfield and the ICS



Recommendations

Embed Health in All Policies across Council and ICS structures to ensure health impacts shape all major decisions.

Protect and expand prevention budgets, recognising long-term savings from early intervention and upstream investment.

Build integrated neighbourhood teams delivering coordinated, holistic support for residents with complex or multiple needs.

Strengthen data sharing and analytics to identify risk, target interventions and monitor inequality reduction effectively.

Deepen community co-production, ensuring services reflect lived experience and cultural needs across diverse groups.

Prioritise equity by directing resources to deprived wards and inclusion groups consistent with Core20PLUS5 principles.

Closing Reflections

Enfield's strategy demonstrates that meaningful progress requires whole-system collaboration grounded in shared purpose and trust.

Community partnership is essential; residents must be active co-designers, not passive recipients, of health improvement efforts.

Prevention must remain central, with investment protected despite financial pressures to avoid future crisis-driven costs.

Equity must guide every decision, ensuring targeted support reaches communities experiencing the greatest disadvantage.

Integrated, data-driven models offer the strongest route to sustainable improvements in health, wellbeing and service efficiency.

Enfield is well-positioned to lead within the ICS, offering scalable models aligned with national and London-wide priorities.