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HEALTH AND WELLBEING BOARD

Thursday, 20 June 2019 at 6.15 pm
Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

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Please note meeting time

MEMBERSHIP

Cabinet Member for Health and Social Care – Councillor Alev Cazimoglu (Chair)
Leader of the Council – Councillor Nesil Caliskan
Cabinet Member for Public Health – Councillor Mahtab Uddin
Cabinet Member for Children's Services – Councillor Rick Jewell
Chair of the Local Clinical Commissioning Group – Dr Mo Abedi (Vice Chair)
Healthwatch Representative – Parin Bahl
Clinical Commissioning Group (CCG) Chief Officer – John Wardell / Rob Larkman
NHS England Representative – Dr Helene Brown
Director of Public Health – Stuart Lines
Director of Adult Social Care – Bindi Nagra
Executive Director People – Tony Theodoulou
CEO of Enfield Voluntary Action – Jo Ikhelef
Voluntary Sector Representatives: Vivien Giladi, Pamela Burke

Non-Voting Members

Royal Free London NHS Foundation Trust – Natalie Forrest
North Middlesex University Hospital NHS Trust – Maria Kane
Barnet, Enfield and Haringey Mental Health NHS Trust – Andrew Wright
Enfield Youth Parliament representative

TO FOLLOW 2 - AGENDA – PART 1

4. CANCER SCREENING UPDATE (6:50 - 7:20PM) (Pages 1 - 36)

To receive the report of the Executive Director of People Services in respect of the current situation of cancer in Enfield – UPDATED REPORT ATTACHED

7. HEALTH AND WELLBEING BOARD MEMBERSHIP / TERMS OF REFERENCE AMENDMENT (8:05 - 8:20PM) (Pages 37 - 40)

To receive the report of the Director of Public Health – FOR DISCUSSION – CURRENT TERMS OF REFERENCE ATTACHED.

(SENT TO FOLLOW)

10. HEALTH AND WELLBEING BOARD FORWARD PLAN (Pages 41 - 44)

(SENT TO FOLLOW)

Agenda Item 4

MUNICIPAL YEAR 2019/2020 - REPORT NO.

MEETING TITLE AND DATE **Health and Wellbeing Board** 20 Jun 2019	**Agenda - Part:** **Item:** **Subject: Current situation of cancer in Enfield** **Wards: All**
Executive Director of People Services	**Cabinet Member consulted:** **Cllr Mahtab Uddin**
Contact officer: Dr. Tha Han tha.han@enfield.gov.uk	**Approved by:** **Stuart Lines**

1. EXECUTIVE SUMMARY

Cancer is the biggest killer in Enfield and the second biggest contributor towards the life expectancy gap between the most deprived and the least deprived. The NHS long-term plan intends to improve the cancer survival of England as our current performance is behind many comparable European countries. Early detection of cancer, when the condition is more amenable to treatment, is central to the plan which aims to prevent tens of thousands of deaths each year.

In Enfield, Enfield CCG hosts the Enfield Cancer Action Group, where Enfield Public Health is a member, together with other major stakeholders such as GPs and Cancer Research UK. The group submitted grant application bids to the UCLH Cancer Collaborative who leads on Cancer Transformation in the Northeast and Northcentral London and was awarded £85,000 in total.

With this grant, Enfield CCG, London Borough of Enfield's Public Health team and Communications and Marketing team is running a year-long cancer awareness campaign supported by the voluntary care sector, community health champions and Healthwatch. Further funding could be secured through NCL Cancer Board who will manage cancer awareness and early diagnosis on behalf of the UCLH Cancer Collaborative.

This report is to provide a briefing on

- The scale of the impact of cancer (morbidity and mortality) in Enfield
- Inequalities in cancer in terms of incidence and survival
- Cancer prevention through awareness of cancer risk and early detection
- Cancer screening and changes in its delivery
- Other key processes to improve cancer care, and
- Work to improve early awareness of cancer.

Enfield main issues are:

- Inequalities: Cancer kills disproportionately those who live in the most deprived areas of Enfield. 22% more cancer deaths occur in the most deprived areas compared with the most affluent areas of Enfield. Incidentally adult smoking prevalence among routine and manual occupation groups were higher in Enfield compared with both London and England.

- Cancer survival:
  - Enfield has one-year survival and under-75 cancer mortality worse than neighbouring boroughs such as Barnet and Camden.

- Mortality: under 75 cancer mortality is better than London and England (all persons); but, male under 75 cancer mortality is slightly higher than compared with the London average.

- Cancer awareness: To update the knowledge from the last survey (2009/10), where only 30% of Enfield residents can recall a possible symptom of cancer, to assess the work done since then, and to form a baseline for further work this year, a new survey was carried out from January to April 2019 to inform a new campaign.

- Screening: Although better than neighbouring boroughs across all cancer screening indicators, opportunities are missed due to the lower uptake and coverage than National targets.

- Early diagnosis: Emergency presentations are as high as the England average.

- Waiting times: 2-week wait for referrals around 86% (below 93% target) but 62-day standard (71%) is much lower than 85% target. Patients on a prostate cancer pathway accounted for almost half of all breaches. Improvement actions are focused on streamlining pathways and increasing capacity.

- Patient experience: worse than England average in Enfield (RFL and NMUH)

- Population level outcomes can come from lung cancer, colorectal cancer, upper GI cancers and improvements in screening.

Grid of key cancer indicators at CCG and STP levels - March 2019

	One-year cancer survival	Under 75 cancer mortality	Patient experience	Bowel screening coverage (60-69)	Bowel screening uptake (60-69)	Bowel screening coverage (60-74)	Bowel screening uptake (60-74)	Breast screening coverage	Breast screening uptake	Cervical screening coverage	Emergency presentations	Two-Week Wait	62-day Standard	Incidence age-standardised rate	Early stage diagnosis	Cancers staged
North Central London STP	74.2	117.1	8.6	48.3	46.1	50.3	47.2	64.0	64.8	63.3	17.6	89.2	77.6	574.9	49.3	80.0
Barnet	76.4	103.1	8.5	48.9	47.3	50.9	48.5	67.6	67.6	63.0	13.7	90.3	80.3	542.8	47.6	76.9
Camden	74.6	104.3	8.6	45.0	42.0	47.6	43.8	53.0	44.7	54.6	18.2	89.9	89.5	531.8	49.2	76.8
Enfield	73.3	119.5	8.5	51.5	49.6	53.5	50.5	69.0	71.5	69.3	21.8	86.3	71.2	593.7	47.0	80.9
Haringey	71.3	129.4	8.5	47.5	44.6	49.3	45.7	63.1	63.2	66.2	20.9	87.8	65.4	607.8	55.8	84.0
Islington	73.0	146.1	8.8	45.9	43.3	47.3	43.6	60.6	59.4	62.8	11.5	91.9	82.6	636.9	49.1	83.0

Table 1. Key cancer indicators for NCL (Source: CADEAS, published March 2019)

2. RECOMMENDATIONS

The board is asked

2.1 To note the performance in early diagnosis of cancer, cancer screening and other cancer outcomes

2.2 To support the cancer awareness campaigns to improve cancer outcomes in Enfield, and to encourage the work to reduce inequalities in cancer morbidity and mortality.

3. BACKGROUND

Cancer is the biggest killer in Enfield and the second biggest reason behind the life expectancy gap between the most deprived and the least deprived. The NHS Long-term plan aims to improve the cancer survival performance of England because it is behind many European countries. Sir Mike Richards will soon report on cancer screening with an aim to improve its quality and falling uptake.

NHS England commissions cancer screening and cancer treatment, and Enfield CCG commissions cancer diagnosis. Enfield Public Health holds the assurance role for health protection such as cancer screening and prevention.

Cervical cancer screening is provided by local GPs and the providers of breast screening and bowel screening. NHS England also commissions Cancer Alliances to implement cancer transformation. The cancer board of the North Central partners in Health liaise closely with commissioners to improve cancer outcomes in North Central London.

In Enfield, Enfield CCG hosts the Enfield Cancer Action Group where Enfield Public Health is a member together with other major stakeholders such as GPs and Cancer Research UK. The group adopts a collaborative approach to improve all aspects of cancer outcomes in Enfield.

The NHS Long Term plan and an earlier Sir Mike Richard's report[1] (commissioned by Health Foundation) highlighted the lower survival from cancer in the UK than top European countries and in particular from lung cancer, oesophageogastric cancer and brain cancer. Nonetheless in England, **half of all patients diagnosed with cancer can now expect to survive for at least 10 years**.

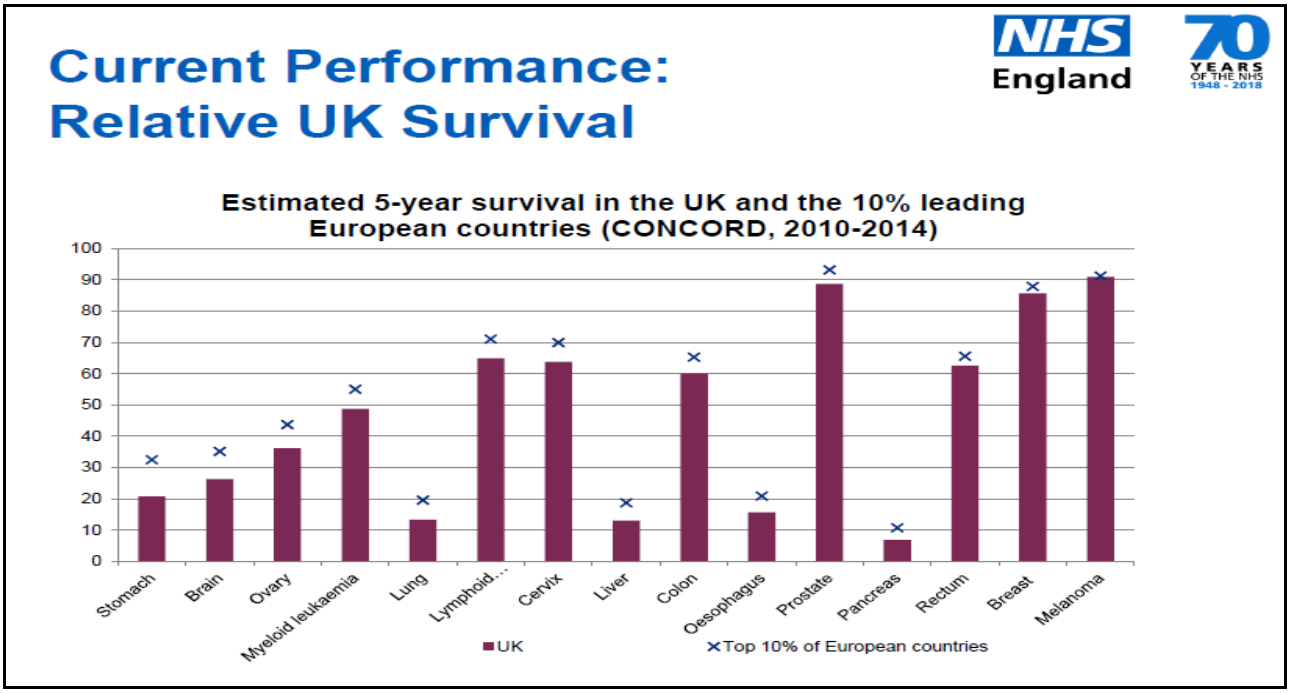


Figure 1. 5-year survival of cancer between UK and top European countries. Source: NHS England.

This report will provide a briefing on

- The scale of the impact of cancer (morbidity and mortality) in Enfield,
- Inequalities in cancer in terms of incidence and survival,
- Cancer prevention through awareness of cancer risk and early detection.
- Cancer screening and changes in its delivery,
- Other process outcomes related to cancer care.

[1] https://www.health.org.uk/publications/unfinished-business

- Work to improve early awareness of cancer

4.0 Report

4.1 What is cancer and what is the care pathway?

Cancer is a term covering a broad range of diseases of different organs in the body which differ in type and effect, but almost all of which have the three following characteristics:

- unregulated growth of abnormal cells (malignant growth) in affected areas;
- local 'invasion' from the primary source of this malignant growth whereby the immediately surrounding areas are destroyed and replaced by abnormal tissue;
- distant spread (or 'seeding') of the primary cancer to other parts of the body to produce 'secondary' cancers ('metastases'), usually by the lymphatic system and/or the blood.

The risk of cancer increases with age, genetic predisposition and environmental exposure (diet, air pollution, smoking, water pollution, alcohol, soil pollution, infections, radiation, lifestyle). Although there are advances in the knowledge of genetics and the use of it in cancer diagnosis and treatment, lifestyle remains the most modifiable risk for individuals, yet the awareness of the genetic risk helps them to manage further risks, and state players are may intervene on unhealthy diet and environment. Figure 2 below shows the attributable risk of leading lifestyle risk factors for cancer. **Smoking is the biggest lifestyle risk** and smoking prevalence has been reducing in Enfield, **but obesity is rising in Enfield.** (Appendix 1) Some viral infections such as HPV (warts) and hepatitis B and C can also cause cancer where there are vaccines to prevent HPV and hepatitis B.

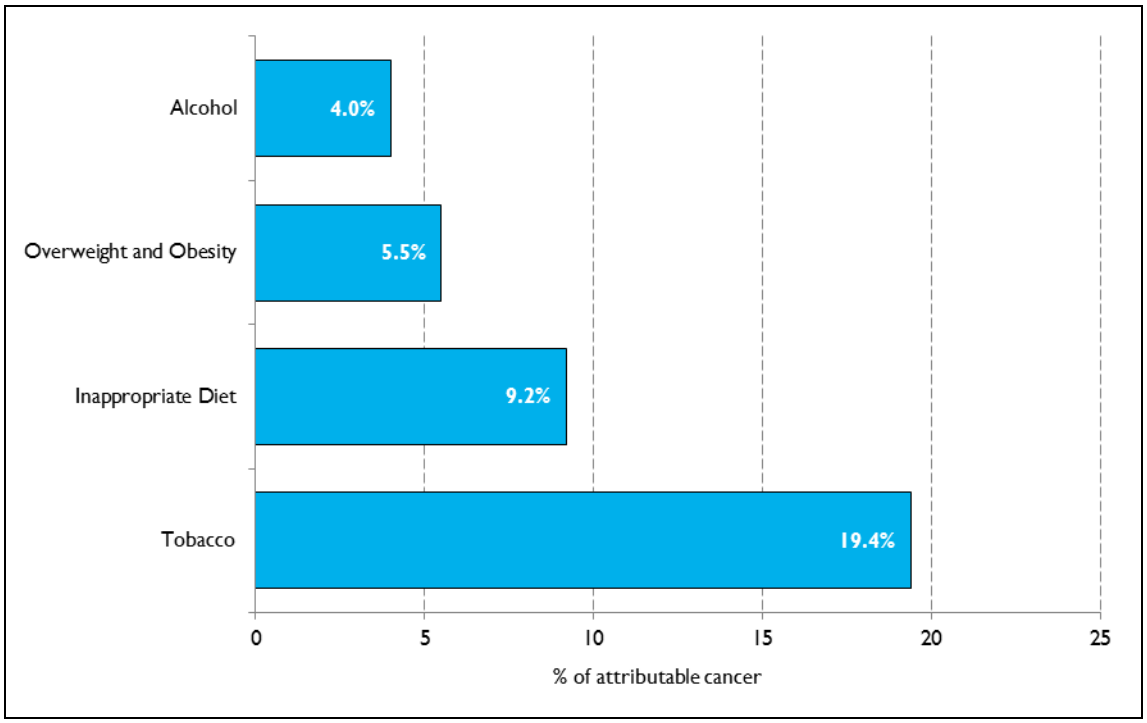


Figure 2. The Proportion of Cancers in the UK Attributable to Different Lifestyle Exposures. Source: Parkin et al. (2011)

Medical advances allow cancer to be treated and cure some cancers. Usually early diagnosis results in improved outcomes. Three cancers can be screened at a National level: breast, bowel and cervical. Screening of lung cancer is being piloted.

For other cancers not in the screening programme **symptom awareness** is key (risk awareness and assessment for prostate cancer) so that patients present to GPs early. GPs refer suspicious cases to specific clinicians if symptoms point to a particular cancer or multidisciplinary diagnostic centres for vague symptoms. NHS England applies waiting time standards for cancer diagnostics and first treatments. Cancer charities and NHS work together to support cancer patients so they can have the best quality of life possible during treatment and living with cancer. **In Enfield, over 8,000 residents are living with cancer.** Healthy lifestyle relevant to the cancer and treatment is key in maintaining wellbeing for the patients living with cancer.

4.2 Cancer burden (morbidity and mortality)

4.2.1 Prevalence

With better diagnosis and better treatment, **the number of residents living with cancer is increasing**, and their holistic care and their need to take part as independent citizens must be supported. **The prevalence of cancer is increasing** and 2.5% of Enfield population (8,371 people, 3815 male, 4556 female) are living with cancer in 2015, of which 4,631 (55%) have been living with cancer for more than 5 years.

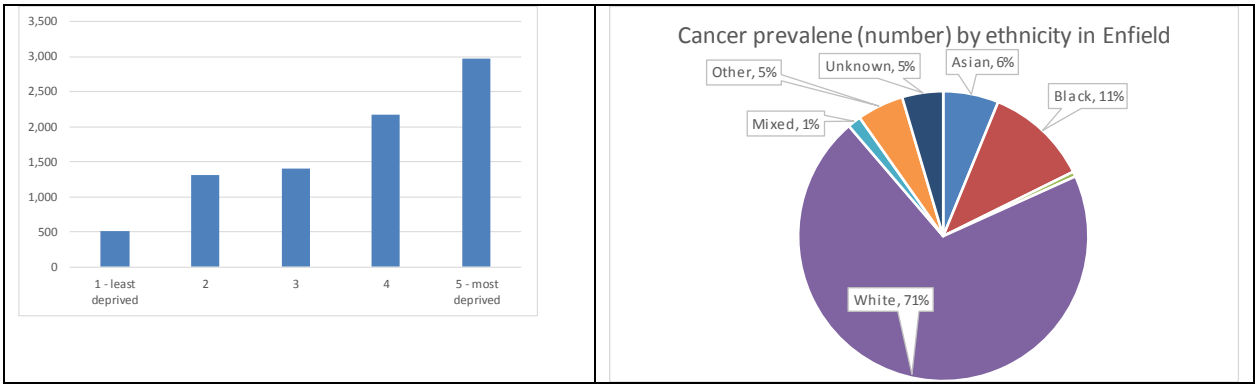


Figure 3. Cancer prevalence (number) in Enfield by deprivation and ethnicity. Source: TCST/ Macmillan/ PHE.

4.2.2 Mortality

In general, Under-75 cancer mortality from cancer in Enfield was similar to, or better than, the England average. However, our neighbouring boroughs such as Barnet and Haringey perform better.

Indicator	Period	Enfield		London	England
Mortality		Count	Value	Value	Value
4.05i - Under 75 mortality rate from cancer (Persons)	2015-17	816	123.1	123.6	134.6
4.05i - Under 75 mortality rate from cancer (Male)	2015-17	454	145.3	140	149.6
4.05i - Under 75 mortality rate from cancer (Female)	2015-17	362	103.2	109.3	120.7
4.05ii - Under 75 mortality rate from cancer considered preventable (Persons)	2015-17	471	71	71.6	78
4.05ii - Under 75 mortality rate from cancer considered preventable (Male)	2015-17	252	81.5	79.4	84.1
4.05ii - Under 75 mortality rate from cancer considered preventable (Female)	2015-17	219	61.7	64.8	72.3
Cancer deaths (%), Persons, Aged 0 - 64 years	2016	126	37.40 %	36.70 %	37.00 %
Cancer deaths (%), Persons, Aged 65 - 74 years	2016	133	44.90 %	42.60 %	44.10 %
Cancer deaths (%), Persons, Aged 75 - 84 years.	2016	171	31.10 %	31.10 %	31.20 %
Cancer deaths (%), Persons, Aged 85 years and over.	2016	131	15.90	16.70	15.60

			%	%	%
Cancer deaths (%), Persons, All Ages.	2016	561	28.00 %	28.70 %	28.00 %
Deaths from lung cancer	2015 - 17	314	45.6	51.5	56.3
Deaths from oral cancer	2015 - 17	39	5.1	4.8	4.6
DiUPR - Cancer (%), Persons, All Ages.	2016	175	31.20 %	35.60 %	44.50 %
Under 75 mortality from colorectal cancer	2015 - 17	69	10.7	10.9	12
Under 75 Mortality rate from breast cancer	2015 - 17	62	16.7	20.1	20.6
Rate of deaths from Cancer among people aged 65 years and over	2015 - 17	1,298	998	1011.3	1105.7

Table 2. Cancer mortality indicators. Source: PHE.

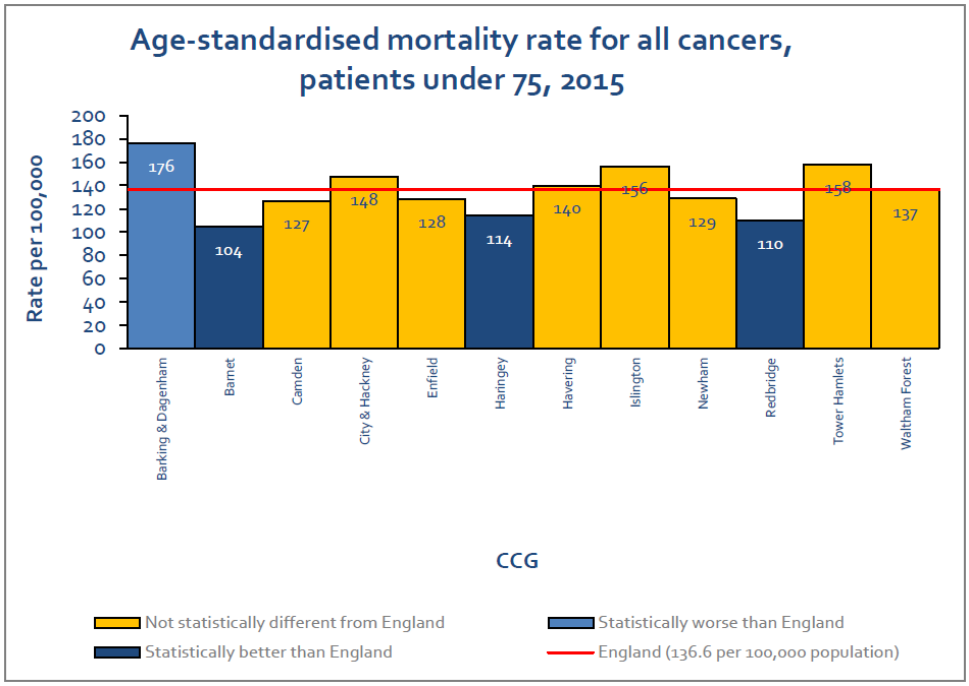


Figure 4. Under 75 mortality from cancer (age-standardised). Source: CADEAS

4.3.1 Cancer incidence

Cancer incidence represents new cases of cancer in a year. Breast, prostate, lung and colorectal cancers are the major cancers (Figure 5) for North Central London. The proportion of diagnoses made at early stages (stages 1 and 2) for overall cancers (Figure 6) was better than the England average. Lung cancer (Figure 7) is a cancer with high incidence yet **half of the cases are known at a very late stage** (Stage 4). Colorectal (bowel) cancer (Figure 8) also has substantial proportion of late diagnosis where screening could improve the situation.

Enfield's achievement on early diagnosis of lung cancer and colorectal cancer is below many other CCGs and NCL averages (Figures 7,8).

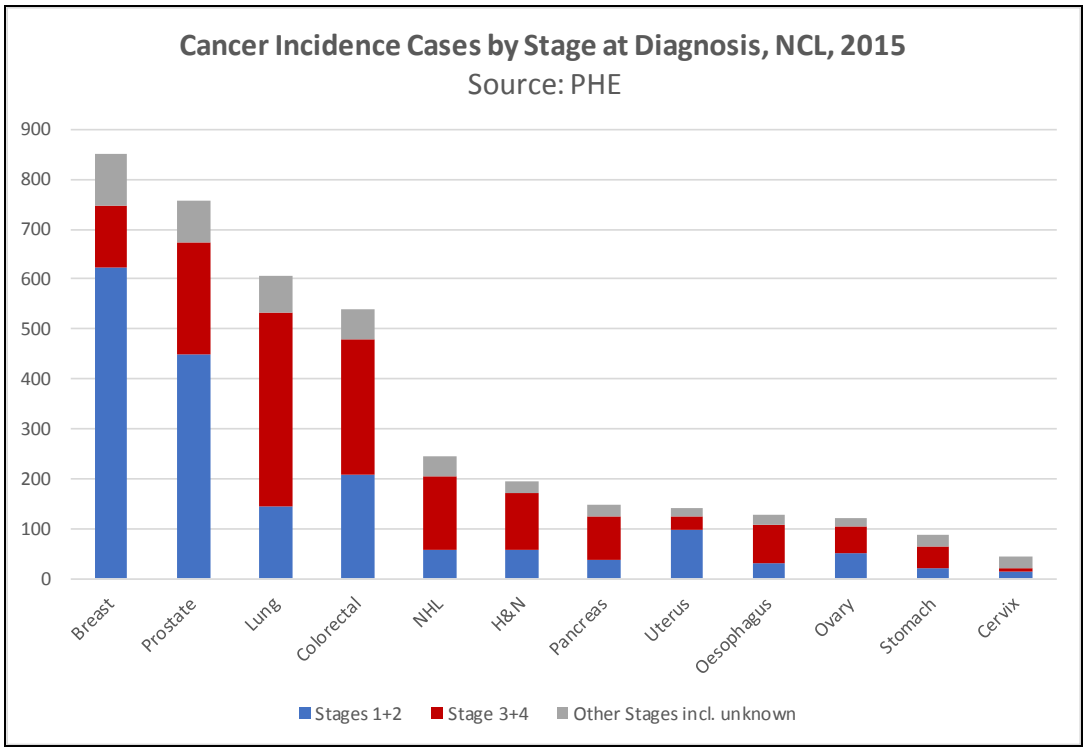


Figure 5. Cancers by incidence and stage at diagnosis, NCL.

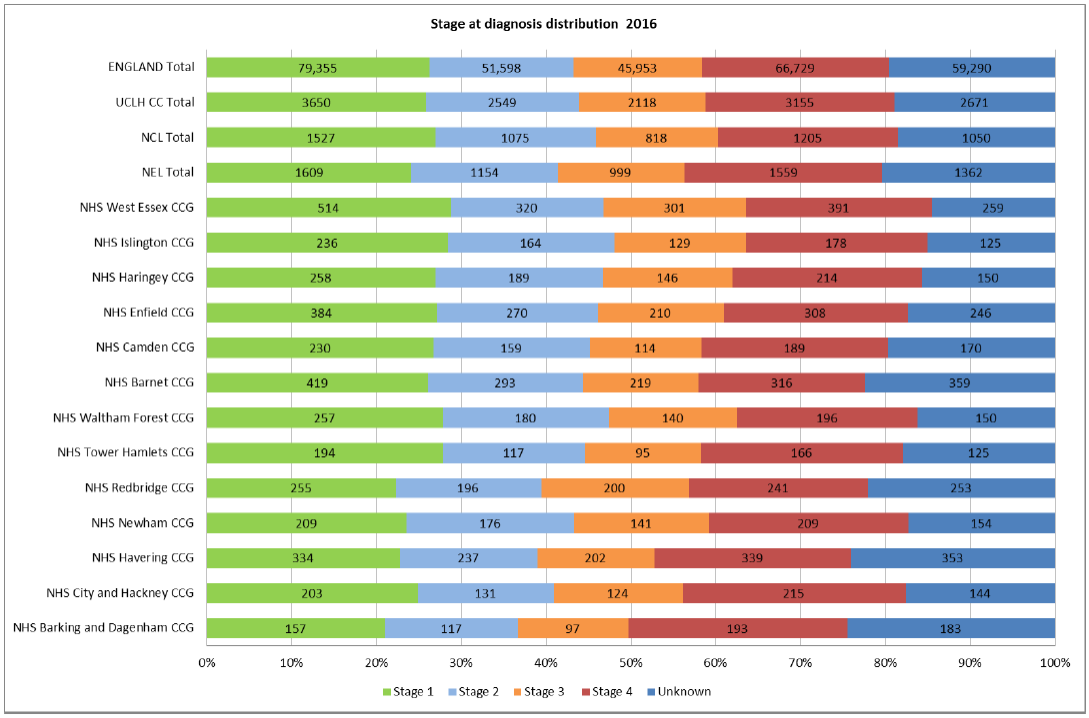


Fig 6. Stage at diagnosis, all tumours, NCL, 2016. Source: NCIN.

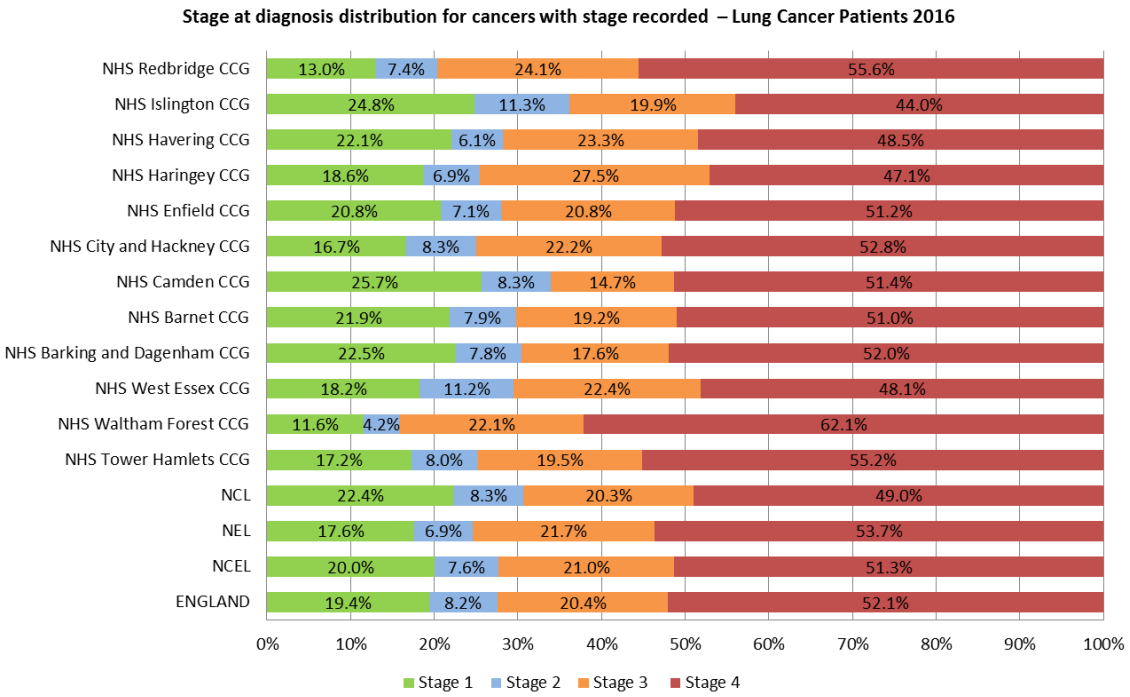


Figure 7. Lung cancer and stages at diagnosis by CCG, Source NCIN.

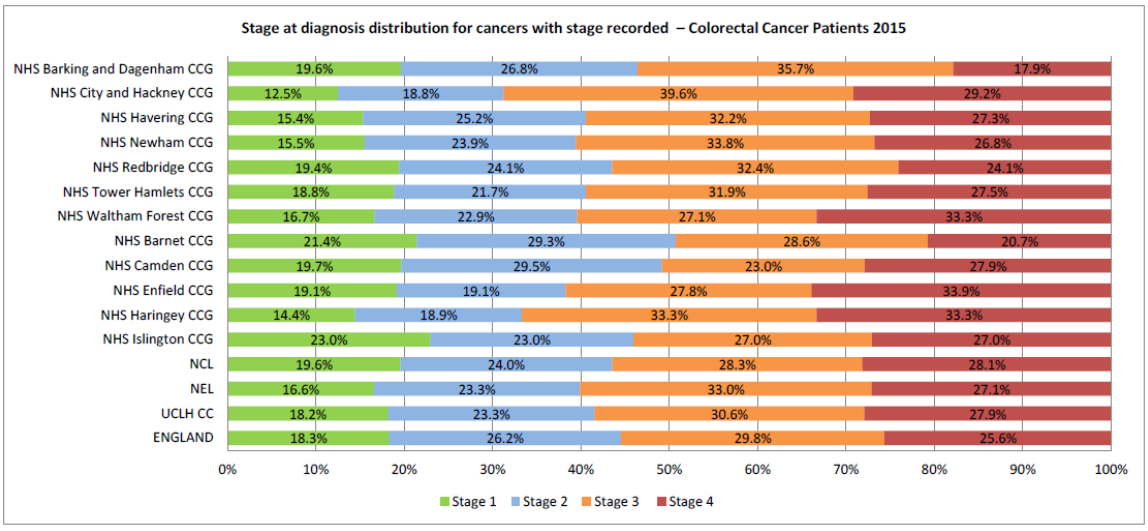


Figure 8. Colorectal (bowel) cancer and stages at diagnosis by CCG, Source NCIN.

4.3.2 Inequalities in cancer occurrence (incidence)

Cancer incidence in Enfield is higher than Barnet, Camden and Haringey (Figure 9). In England, the incidence varies with ethnicity, deprivation, age and other demographics (Appendix 2). This knowledge is key in improving cancer prevention and early diagnosis where specific campaigns for symptom awareness and help-seeking behaviour can be streamlined.

- Deprivation is linked to increased incidence of cancer incidence in all ethnicities, the gradient is more pronounced among Black and Asian people
- Age: most tumours are diagnosed after age 60; brain, breast, colorectal, H&N, kidney, liver, lung, melanoma, myeloma, NHL, prostate and ovarian earlier between 40-50; and cervical, Hodgkin's, leukaemia, testis in younger ages.
- Usually, the incidence across all tumour types show the following pattern:
    - non-White male > White male,
    - White female > non-White female

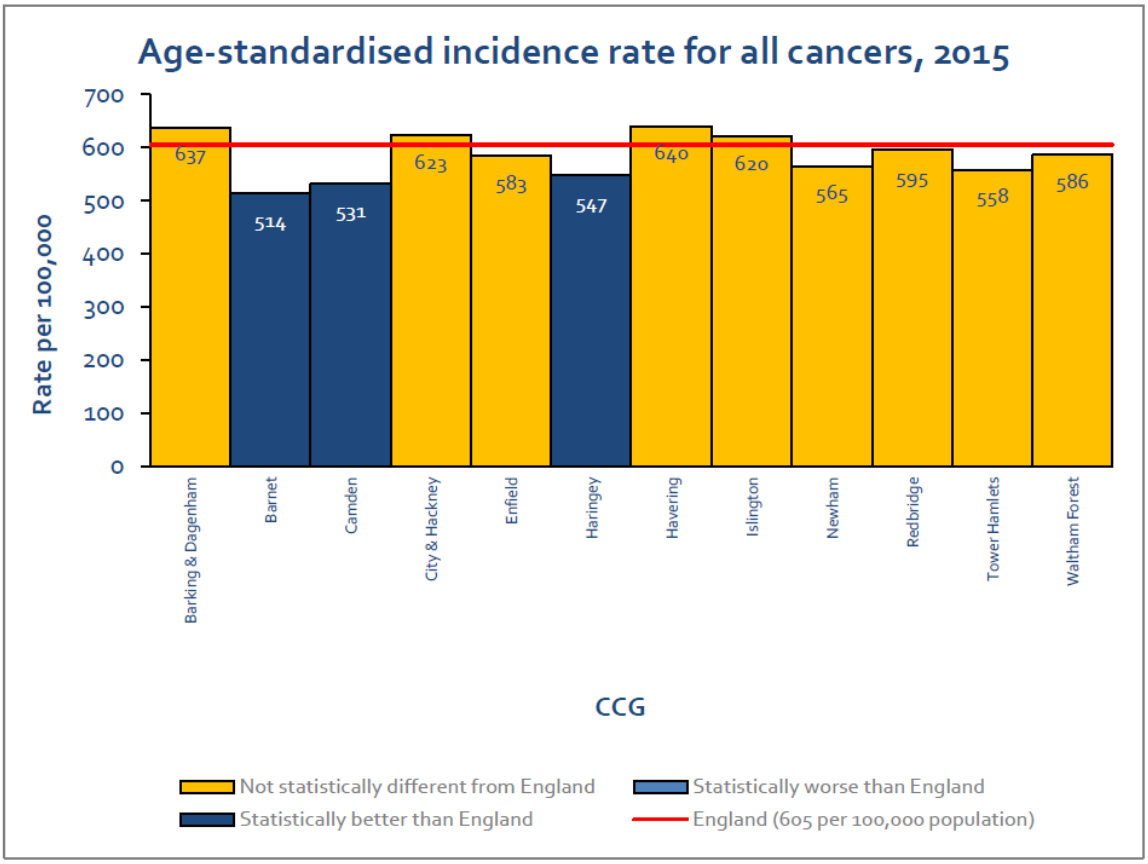


Figure 9. Age-standardised incidence rate for all cancers, 2015. Source: CADEAS.

4.4 Early diagnosis of cancer

Early cancer diagnosis depends on a multitude of factors such as the risk and symptom awareness by the patients, availability and accessibility of screening programmes, patients' consultation with their own GP, referrals to the relevant pathway, presentation at emergency and secondary care diagnostics. In Enfield, although **overall early diagnosis of cancer is better than the England average and cancer screening is better than the London average**, the early diagnosis of lung cancer and colorectal cancer has large room to improve together with the coverage across all three cancers in the screening programme.

Indicator	Period	Enfield		London	England
		Count	Value	Value	Value
2.19 - Cancer diagnosed at early stage (experimental statistics)	2016	559	54.60%	51.90%	52.60%
2.20i - Cancer screening coverage - breast cancer	2018	22,869	72.10%	69.3%*	74.9%*
2.20ii - Cancer screening coverage - cervical cancer	2018	68,090	68.80%	64.7%*	71.4%*
2.20iii - Cancer screening coverage - bowel cancer	2018	20,014	53.20%	50.2%*	59.0%*
Cervical cancer registrations rate / 100,000	2011 - 13	42	9.9	8	9.6
Oral cancer registrations	2014 - 16	99	13.4	14.7	14.7
Oesophageal cancer registrations	2014 - 16	83	12.6	12.4	15.6
Lung cancer registrations	2014 - 16	480	73.2	75.7	78.6

Table 3. Cancer diagnosis indicators. Source: PHE Fingertips

4.4.1 Symptom awareness

More than 300,000 new cancers are diagnosed annually in the UK, across over 200 different cancer types. The best way of tackling any cancer is for patients to receive an early diagnosis. If cancer is caught at an early stage, before the disease has spread, treatment is more likely to be successful.

In Enfield, the awareness of cancer has been a concern. In 2009/10, the Cancer Awareness Measure (CAM) Survey found that **only 30% of people surveyed in Enfield could recall a single symptom of cancer**.

This was when [among the 22 boroughs that took part] Richmond achieved the highest percentage of respondents being able to recall a symptom of cancer (67%).[2]

More importantly, awareness was particularly lower in males, younger people and those from lower socioeconomic status (SES) groups or ethnic minorities.[3] Every year since 2014, a cancer awareness campaign was run by LBE Public Health for different major cancers (Appendices 5 to 8). Thus, it was hoped that the awareness of cancer would have improved over this time. Therefore, Enfield Cancer Action Group submitted funding applications to the UCLH Cancer Alliance who granted £85,000 to assess these annual campaigns and for a further targeted campaign to boost early awareness and screening.

A survey based on CAM was codesigned with Healthwatch, CRUK, voluntary sector and Enfield CCG, and was run by LBE between January and March 2019 (Appendices 3 and 4). This will be further discussed below in Section 4.13.

4.4.2 Cancer Screening Programme

Screening for three cancers (breast, bowel and uterine cervix) contributes to 4% of the new cancer diagnoses in London. In England, this figure is 6%. Cancer screening coverage of London across all indicators is worse than England figures. Although Enfield's cancer screening indicators are the best in North Central London, they are still below England averages.

For cervical cancer screening, the gap in coverage is mostly due to younger age women (25-49). Since cervical cancer screening is done at local GPs, local support and investment can improve cervical screening. Although Enfield CCG are not the assigned commissioner for screening, they commissioned extended hours primary care centres to provide cervical cancer screening so that it is more accessible for working age women. If the capacity can be added to screen an average of 10 women per year per practice for cervical cancer, in 5 years, the gap can potentially be closed (Table 4c).

A new and improved test kit (FIT) for bowel cancer screening is being rolled out this year (Appendix 9). The roll-out of a once-only bowel scope for those age 55 and above that will complement the bowel screening is delayed for Enfield due to the capacity at Chase Farm Hospital.

	Bowel	Bowel	Breast	Breast	Cervical	Cervical
	Uptake (60-74)	Coverage (60-74)	Uptake (50-70)	Coverage (50-70)	Coverage (25-49)	Coverage (50-64)
London	47.4%	50.4%	64.8%	65.6%	62.3%	74.3%
North East & Central London	46.5%	49.5%	63.3%	62.6%	61.4%	75.2%
NHS BARNET CCG	48.7%	51.0%	67.4%	67.4%	59.6%	72.2%
NHS CAMDEN CCG	43.7%	47.6%	44.1%	46.9%	51.5%	68.9%
NHS ENFIELD CCG	50.4%	53.5%	71.1%	69.0%	66.0%	77.5%
NHS HARINGEY CCG	45.7%	49.5%	63.0%	62.6%	62.9%	75.9%
NHS ISLINGTON CCG	43.4%	47.5%	58.3%	59.8%	60.2%	73.4%

[2] Page 28. https://www.healthylondon.org/wp-content/uploads/2017/10/NHS-Enfield-CCG-Summary_v3.6.pdf

[3] https://www.cancerresearchuk.org/sites/default/files/bjc_awareness_in_britain_0.pdf

	Number screened					
	Bowel	Bowel	Breast	Breast	Cervical	Cervical
	Uptake (60-74)	Coverage (60-74)	Uptake (50-70)	Coverage (50-70)	Coverage (25-49)	Coverage (25-49)
London	245,584	499,658	218,830	623,615	1,322,564	1,322,564
North East & Central London	89,255	175,903	66,634	216,804	509,845	509,845
NHS BARNET CCG	12,497	25,487	7,299	30,369	51,211	51,211
NHS CAMDEN CCG	5,256	11,287	1,904	10,401	34,887	34,887
NHS ENFIELD CCG	10,047	20,640	8,914	25,849	43,021	43,021
NHS HARINGEY CCG	7,180	15,008	7,821	20,016	45,695	45,695
NHS ISLINGTON CCG	4,708	10,175	4,165	13,024	39,980	39,980

	Gap analysis (rate per year)					
	Bowel	Bowel	Breast	Breast	Cervical	Cervical
	Uptake (60-74)	Coverage (60-74)	Uptake (50-70)	Coverage (50-70)	Coverage (25-49)	Coverage (50-64)
London	65,016	94,980	51144.4	137,008	107,734	7,382
North East & Central London	25,884	37,364	17,553	60,446	44,071	2,279
NHS BARNET CCG	2,900	4,518	1,366	5,679	5,005	473
NHS CAMDEN CCG	1,967	2,927	1,548	7,351	5,519	338
NHS ENFIELD CCG	1,908	2,494	1,123	4,104	2,617	129
NHS HARINGEY CCG	2,255	3,195	2,117	5,554	3,548	184
NHS ISLINGTON CCG	1,794	2,687	1,552	4,394	3,749	200

Table 4 a,b,c. Screening Programmes Summary to Jun-18. Source: UCLH/ NHS England, Jan 2019.

4.5 Evidence of What Works in Population Awareness and Screening Uptake:

Evidence found the following measures work in improving cancer awareness and cancer screening:

- ‘Be Clear on Cancer’ and Multi-faceted campaign (community peer education, pharmacy, multi-media campaign and GP education) led to increase in awareness of cancer symptoms.

- A GP endorsement statement added to invitation letters was noted to have the greatest effect. Pre-screening reminder letters and enhanced reminders sent to those who “DNA” (did not attend) are also beneficial.

- Although low cancer symptom awareness was found to be associated with poor cancer survival for all cancers combined, awareness is only one step towards improving survival. There should be well connected pathways to diagnosis, treatment and care.

- CAM survey: Socioeconomically deprived groups and ethnic minority groups reported delay seeking medical assistance due to “fear”/ “fatalism.” CRUK Road shows reduced, in short-term, fears related to cancer presentation and treatment.

- Sending patients with higher risk questionnaires about their symptoms, via their GP also promoted help-seeking.

4.6 2-week wait referrals:

Although an “average GP” finds just under 8 new cases of cancer a year from 8,000 appointments a year, it is known that GPs can usually spot eighty per cent of cancers after two visits, making GPs a crucial node in the cancer diagnosis pathway.[4] [5]

Early diagnosis of a disease may mean more effective treatment and better outcomes. For this reason, where there is a possibility that symptoms could indicate cancer, people are referred urgently to see a specialist (on what is called a ‘two-week pathway’).

The great majority of people referred this way do not have cancer, but it is important to see a specialist as soon as possible to confirm or exclude a cancer diagnosis.

If an individual presents to a GP, or a GP finds signs and symptoms that could be related a cancer, the GP refers urgently to hospital for an urgent appointment to be seen by a specialist within two weeks. Enfield’s achievement for two-week wait standard is slightly below England average but its conversion rate (6.3%) was one of the highest in NCL (Table 5).

CCG	2WW referral (indirectly age-sex standardised ratio)	2WW referrals resulting in a diagnosis of cancer		
	Value	Value	Lower confidence interval	Upper confidence interval
NHS Barnet	98.8	5.5	2.9	11.1
NHS Camden	140.0	3.6	1.9	7.8
NHS Enfield	98.2	6.3	3.3	12.1
NHS Haringey	96.0	6.0	3.1	11.8
NHS Islington	121.3	4.7	2.5	9.2
England	**100.0**	**7.6**	**7.6**	**7.6**

Table 5. Age-standardised 2 week wait referral rate and conversion by CCG - 2016/17. Source: PHE Fingertips.

4.7 Multidisciplinary diagnostic centres (MDCs)

Multidisciplinary diagnostic centres are for patients referred by their GP because of non-specific symptoms that potentially could indicate cancer. These patients need to access appropriate tests quickly to improve early diagnosis which cannot happen under a single specialist. This project is part of the national Accelerate, Coordinate, Evaluate (ACE) Programme jointly funded by Cancer Research UK, Macmillan Cancer Support and NHS England.

For patients with **vague symptoms** such as abdominal pain, weight loss or painless jaundice, it can be difficult to refer them to the most appropriate tests quickly through two-week wait referral to a specific specialist. To cater for these patients and to further support early diagnosis, multidisciplinary diagnostic centres are designed to offer rapid diagnosis to patients. Thanks to the MDCs, pancreatic cancer, liver cancer and lung cancer can be diagnosed earlier.

4.8 Emergency presentation

Cancer can present when complications arise or rarely when another separate condition is investigated in an emergency setting [such as a persistent chest infection]. It cannot be a positive patient experience to receive a cancer diagnosis in an emergency especially when it is in a late stage. Effective screening programme, GP referrals and MDCs can avoid a large proportion of emergency presentations.

[4] https://www.nice.org.uk/news/feature/helping-gps-make-an-early-diagnosis-of-cancer
[5] https://www.dur.ac.uk/research/news/item/?itemno=16667

Enfield's rate of emergency presentation of cancer (18%) is slightly better than England average. Barnet, Camden and Islington perform better than Enfield in this rate.

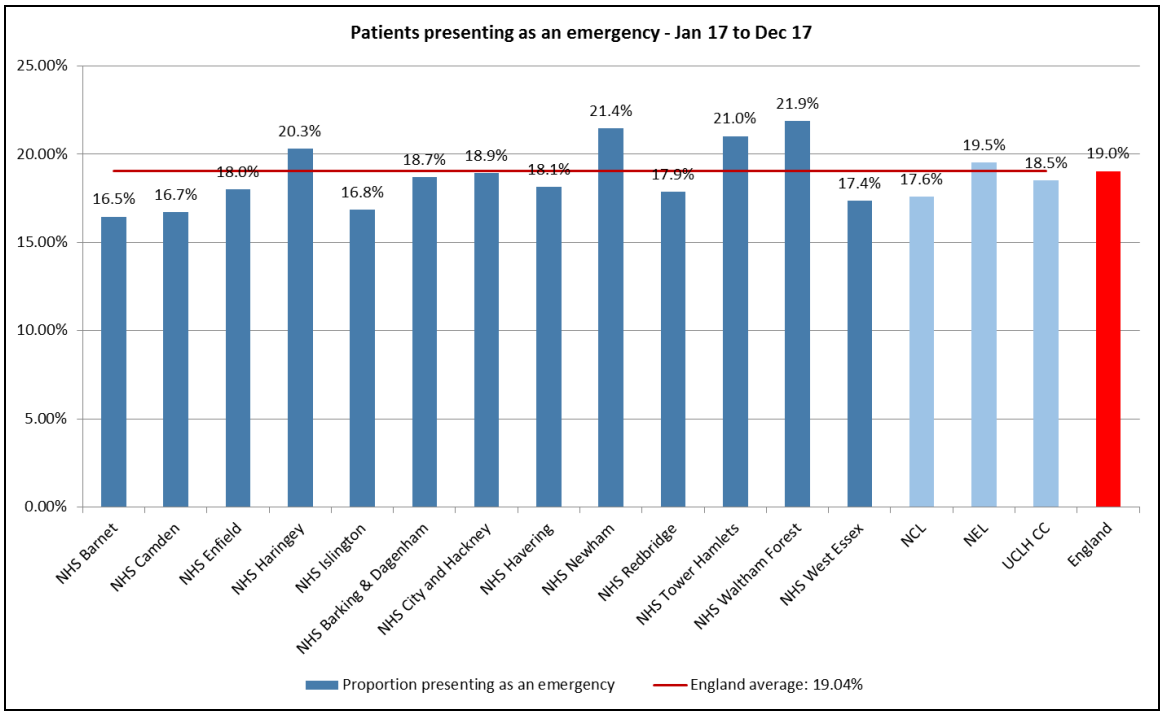


Figure 10. Proportion of cancer diagnosis through emergency presentation. Source: CADEAS.

4.9 Investigation and treatment standards

There are eight NHS Constitutional targets for Cancer waiting times. These are based on the principles that all patients should receive high quality care without any unnecessary delay and that patients can expect to be treated at the right time and according to their clinical priority.

The most important one is the 62-day standard which is the demands that a cancer patient begins first definitive treatment following urgent GP referral for a suspected cancer within that period.

The delivery of these standards is dependent upon partnership working by acute trusts across North Central London and North East London. This is because Trusts provide different elements of the care pathways depending upon their specialist expertise and diagnostic service provision.

In December 2018, NCL providers achieved aggregate performance of 76% against the 85% 62-day cancer diagnostic standard, another improvement on previous months (+2% October & November 2018) and 24 breaches from target.

The under-achievement was largely attributable to delays with the prostate, head and neck and colorectal cancer pathways. Inter-Trust Transfer delays also accounted for more than half of all breaches. These shared pathways make up 30% of all NCL pathways compared to an average of 20% for the rest of London.

Improvement actions focused on streamlining pathways and increasing capacity are being progressed at provider and sector level, overseen by the newly established Task and Finish Group for North Central London STP.

Although not all cancers warrant similar waiting times, having those standards maintain the capacity in the system to be responsive.

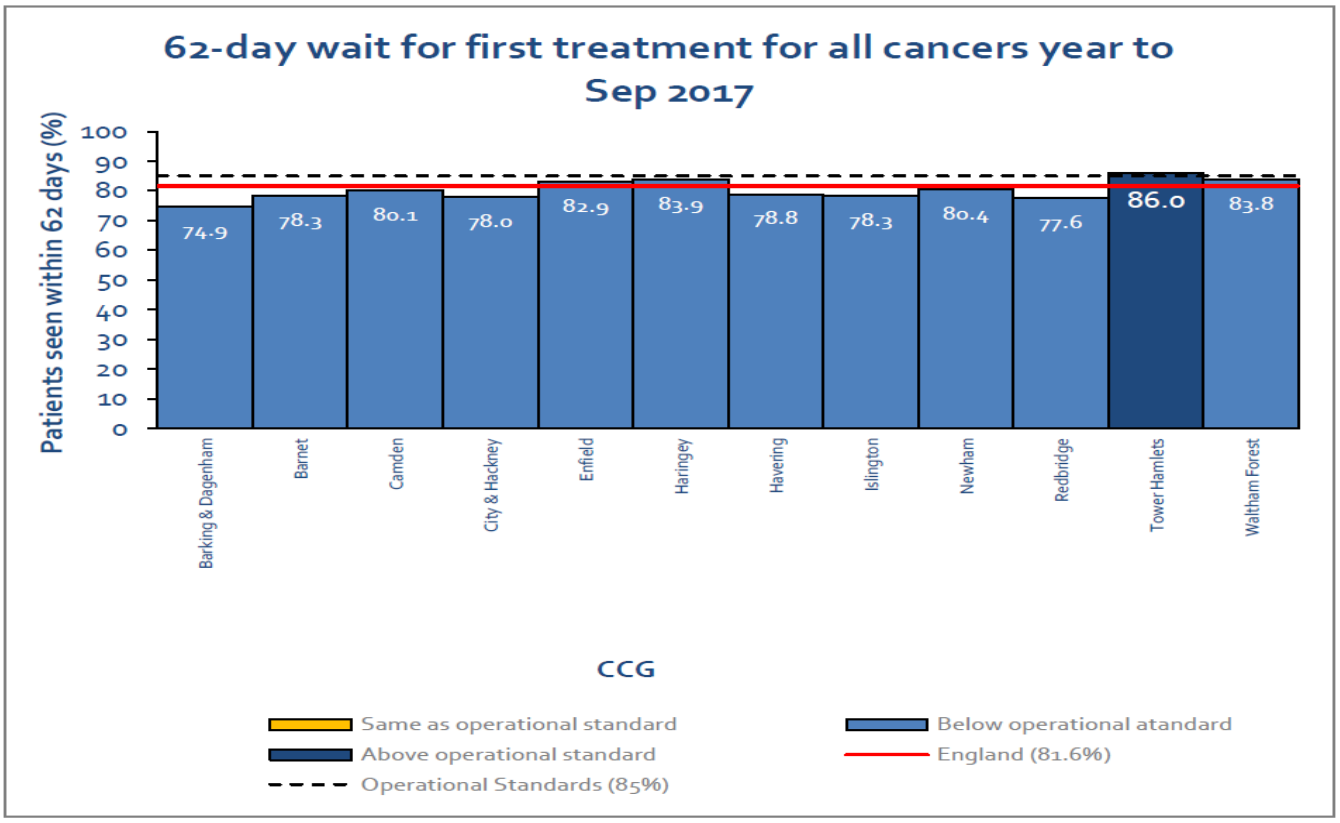


Fig 11. 62-day wait for first treatment for all cancers. Source: CADEAS.

4.10 One-year cancer survival

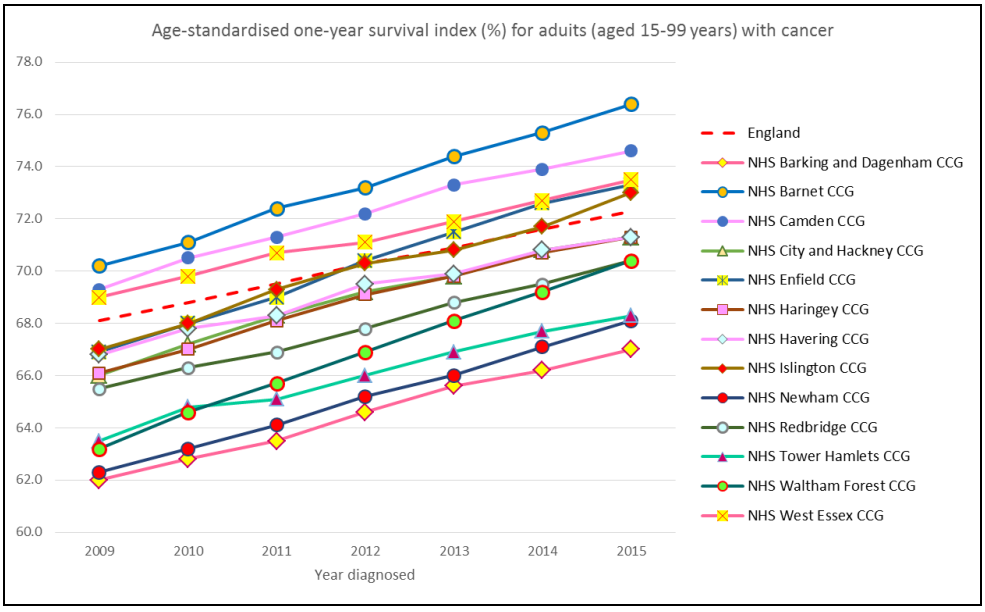


Figure 12. One-year survival for adults with cancer by CCG. Source: CADEAS.

One-year survival is said to be an outcome related to early diagnosis and effective clinical care. Enfield's 1-yr survival rates have improved above the England average after 2012 (Figure 12) but continues to be below the Barnet and Camden rates. This could probably be due to the differences in risk factors in those populations. Although the 1-year survival rates of **breast cancer** and overall cancers in Enfield are better than most NCL CCGs

and are improving, the 1-year survival rates of **colorectal and lung cancer** in Enfield **are worse than those in Barnet, Camden and Islington** (Figures. 14, 15).

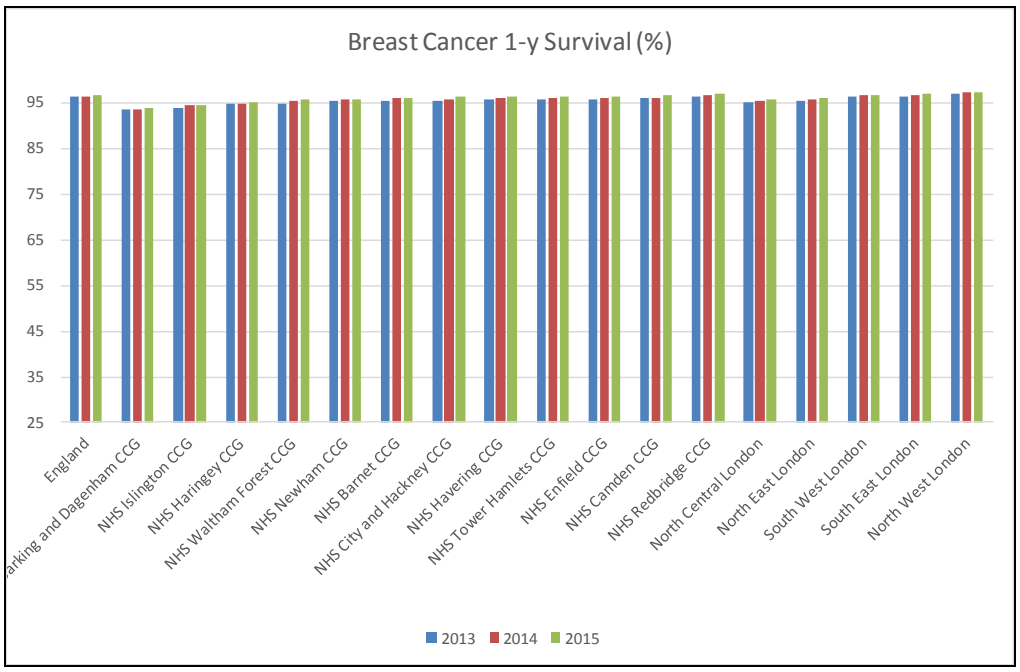


Figure 13. One-year survival for breast cancer by CCG. Source: CADEAS.

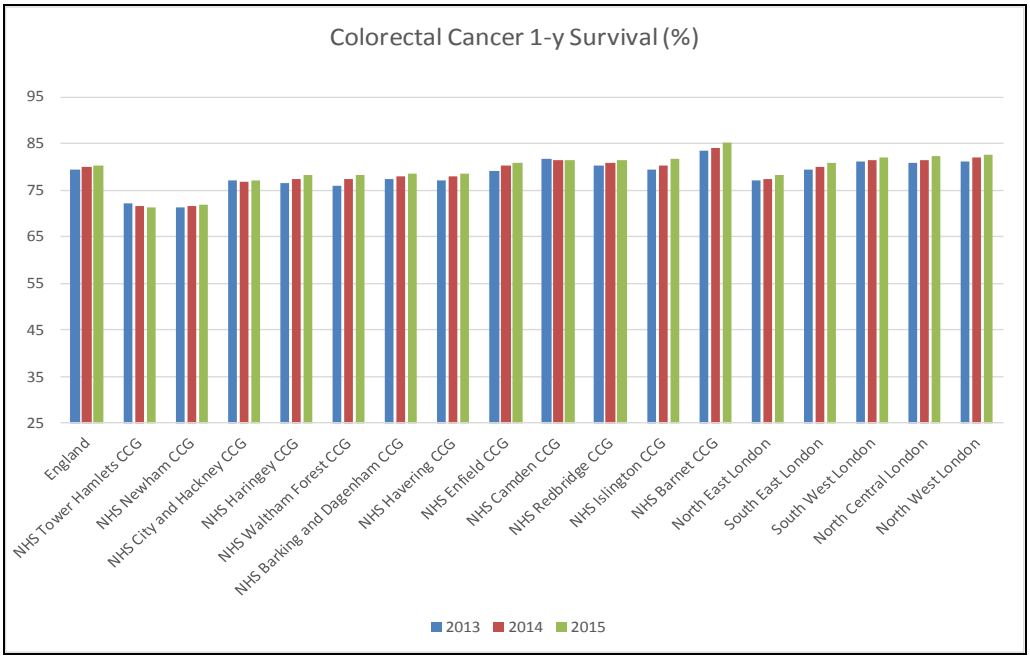


Figure 14. One-year survival for colorectal (bowel) cancer by CCG. Source: CADEAS.

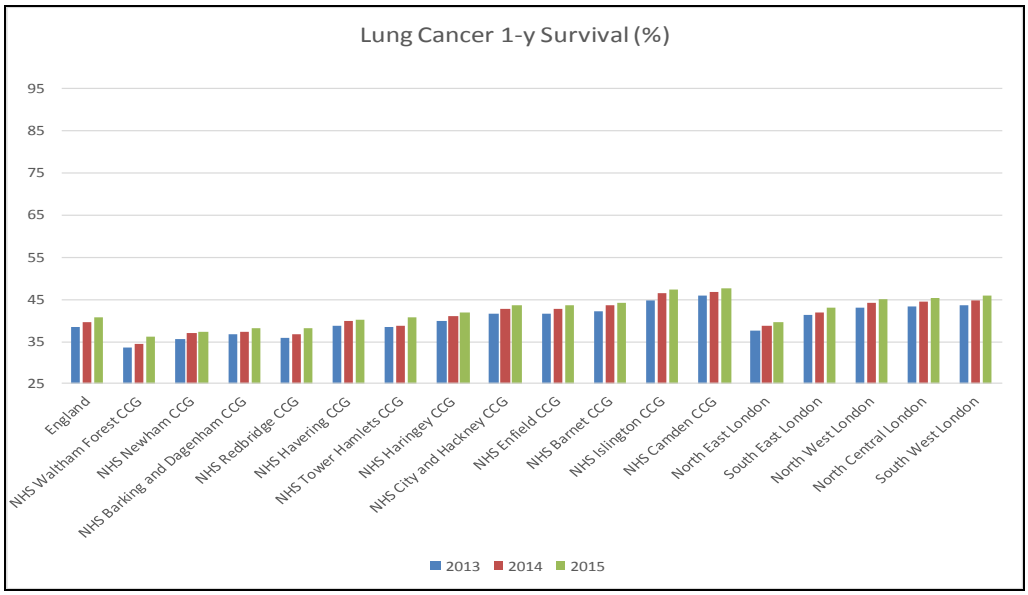


Figure 15. One-year survival for lung cancer by CCG. Source: CADEAS.

4.11 5-y survival

The data are not available at CCG level. However 5-y (Figure 16) and 10-y survival (Figure 17) rates have been improving in NCL, converging with England average.

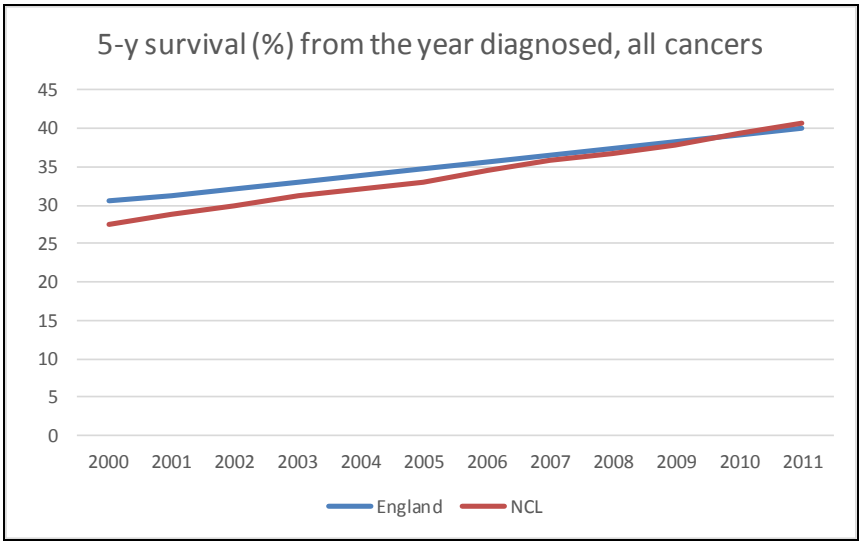


Fig 16. 5-year survival from all cancers. Source: TCST/PHE

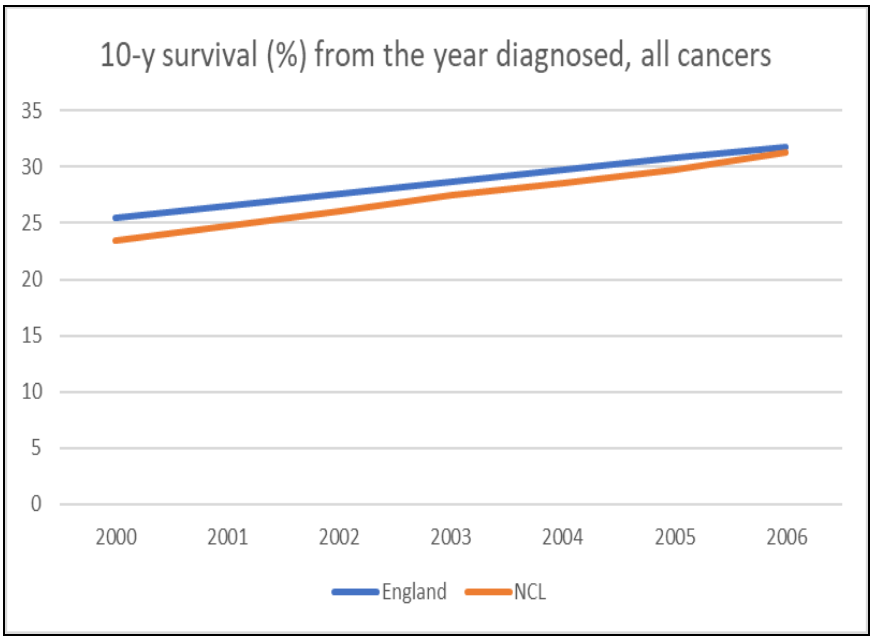


Fig 17. 10-year survival from all cancers. Source: TCST/PHE .

4.12 Patient experience

The National Cancer Patient Experience Survey (NCPES) has been run since 2010. In 2017 the patient reported experience of Enfield was worse than that of NCL and England averages.

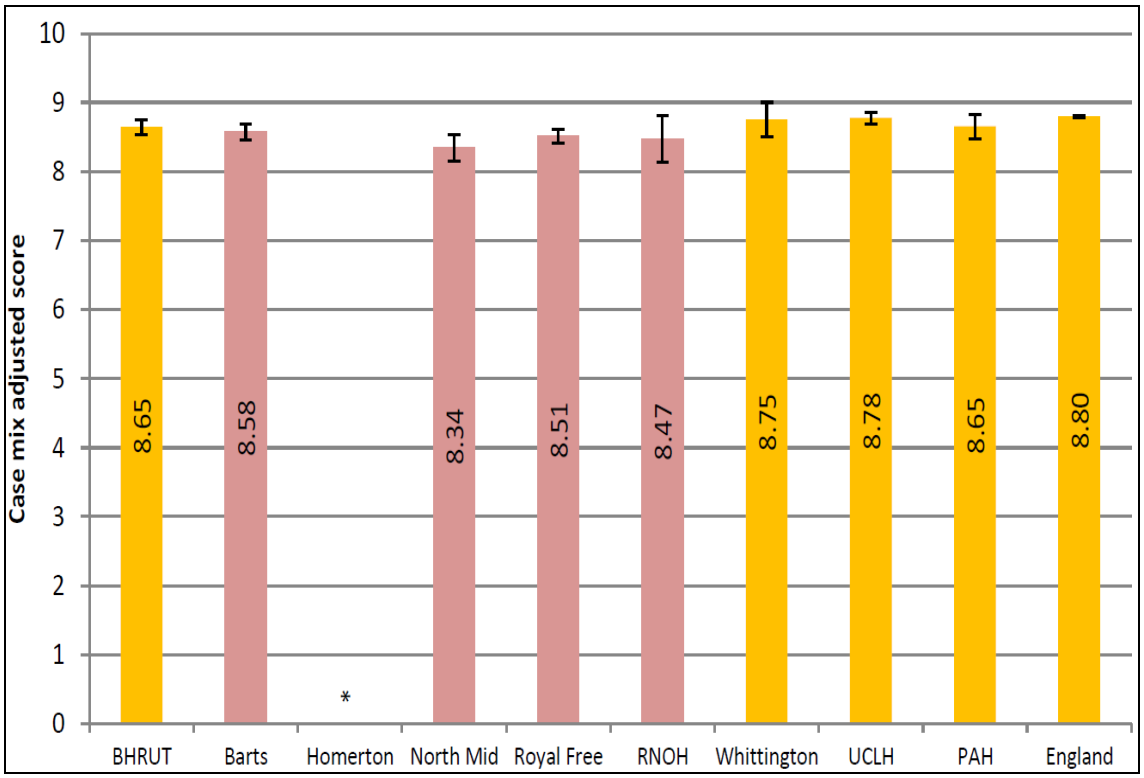


Fig 18. Case mix-adjusted patient experience scores; Q59. Overall, how would rate your care? (NCPES, 2017)

	Barnet			Camden			Enfield			Haringey			Islington		
	2017	2016	2015	2017	2016	2015	2017	2016	2015	2017	2016	2015	2017	2016	2015
Rating of overall care	8.5	8.6	8.5	8.6	8.6	8.8	8.5	8.5	8.5	8.5	8.6	8.5	8.8	8.7	8.8
% of respondents who said															
definitely involved as much as they wanted to be in decisions about their care and treatment	76.0%	77.6%	75.1%	76.9%	70.1%	75.5%	77.0%	69.3%	72.7%	76.4%	71.2%	76.6%	75.2%	78.2%	76.9%
were given the name of a Clinical Nurse Specialist who would support them through their treatment	90.7%	90.5%	89.3%	93.9%	92.4%	96.3%	92.1%	91.9%	91.2%	91.8%	90.4%	89.9%	95.5%	95.7%	92.3%
when asked how easy or difficult it had been to contact their Clinical Nurse Specialist respondents said that it had been 'quite easy' or 'very easy'	79.2%	86.6%	79.8%	73.4%	79.1%	75.3%	77.2%	85.1%	87.3%	81.3%	89.6%	85.1%	84.4%	80.1%	83.0%
that, overall, they were always treated with dignity and respect they were in hospital	86.1%	91.5%	84.8%	84.8%	86.3%	88.3%	86.2%	81.8%	84.8%	83.2%	84.7%	82.4%	89.6%	83.7%	81.4%
hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital	90.9%	90.0%	93.0%	91.9%	92.2%	92.9%	91.6%	94.1%	91.8%	95.0%	90.7%	90.6%	95.3%	94.1%	92.2%

Table 6. North Central London STP Area: National Cancer Patient Experience Survey 2017

4.13 Work in Enfield to improve early diagnosis of cancer

The cancer awareness survey by CRUK in 2009/10 found only 30% of Enfield residents were aware of a single cancer symptom. Every year since 2013, a cancer awareness campaign is conducted jointly by LBE communication team and public health team with the cooperation of the cancer action group hosted by Enfield CCG. Due to the limitation in resources, we did not manage to evaluate until this year. However, incidental findings from the lung cancer audit showed Enfield patients with lung cancer presented less in emergency, knew their diagnosis early and survived longer (Appendix 11).

In 2018, to respond to steep reduction in cervical cancer uptake among women age 25-49, Enfield CCG commissions extended access primary care hubs to carry out cervical screening despite that the commissioning responsibility lies with NHS England.

In late 2018, the cancer action group submitted grant application bids to UCLH Cancer Collaborative which leads on Cancer Transformation in the Northeast and Northcentral London. Enfield was awarded £85,000 in total. With this grant, Enfield CCG, London Borough of Enfield's Public Health team and Communications and Marketing team are running a year-long cancer awareness campaign supported by the voluntary care sector, community health champions and Healthwatch. The first step of the campaign is to assess the state of awareness through a survey.

Enfield were a pathfinder in the region to repeat the survey. A survey (Appendix 4) was codesigned by Healthwatch, CRUK, Public Health, local GP and Enfield CCG, and was conducted between the middle of February until the end of March 2019 using questions adapted from the standard CAM questionnaire. A tailored version was produced for those with learning disabilities.

Two voluntary sector organisations, digital campaign groups and health champions were commissioned to support community engagement work to enable equitable survey participation. Publicity (Appendix 3) was sent in advance via all social media and electronic communications (e.g., e-newsletter – sent to 6,009 subscribers) by the local authority and the CCG communication teams.

The first 350 responses were analysed to establish the representation of different sections of the borough. Street marketing campaigns and household mailshots were undertaken in March to reach ethnic minorities and younger men who were identified as poor responders. In six weeks, we recruited over 1,600 participants and were able to improve participation.

The analysis of the survey will be used to design a year-long, multi-faceted cancer awareness campaign from the 1st of July 2019. Some preliminary results of the survey can bee seen below. Less than 10% said they would not take part in cancer screening programme. Many reasons related to poor awareness around cancer and screening, fear of cancer and treatment and inadequate information around screening appointment (Figure 19) were said to be the causes of not wanting to take part in cancer screening. Their main source of health information was said to be face-to-face communication. (Figure 20)

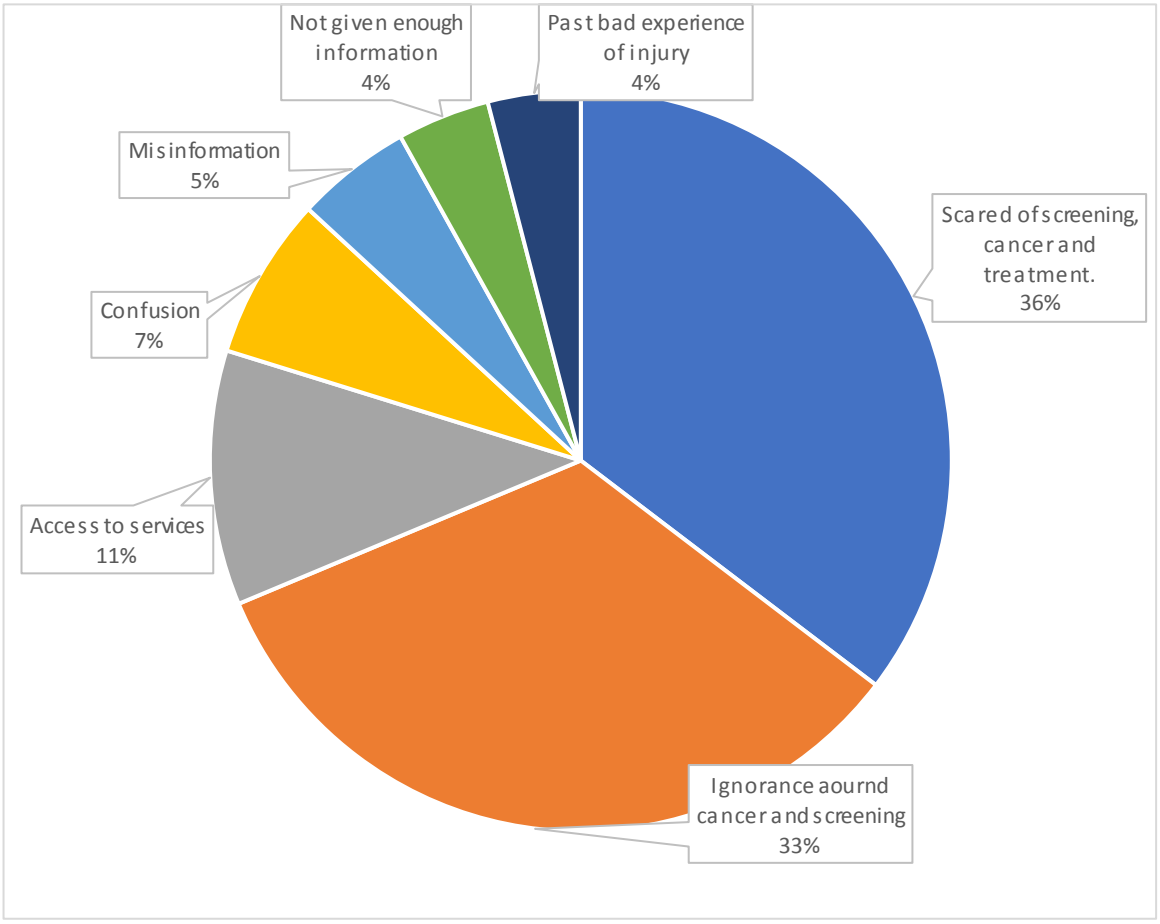


Figure 19. The causes behind not wanting to take part in cancer screening.

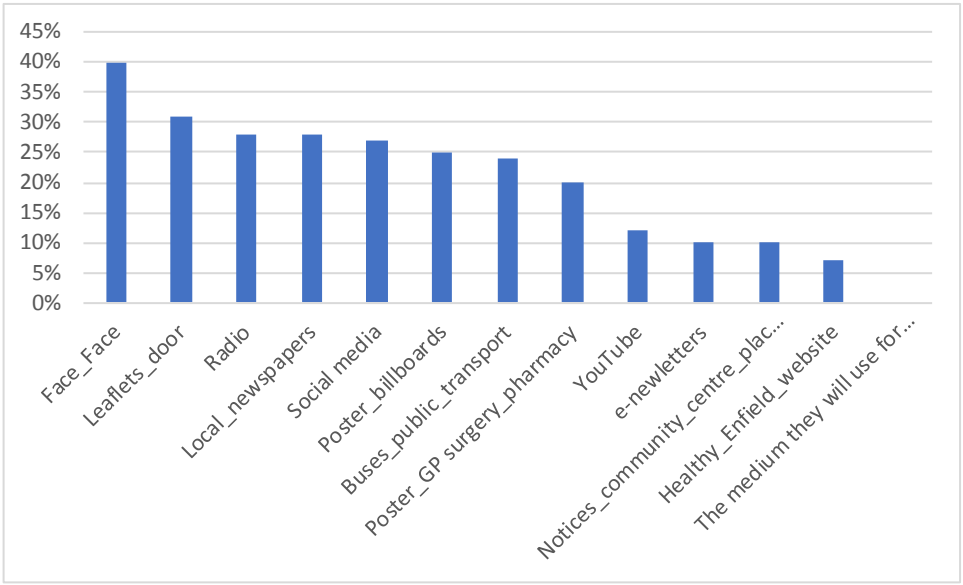


Figure 20. Popular channel of information by those who do not want to take part in cancer screening

4.14 Other Activities and changes affecting Enfield

Enfield is one of the recruiting sites for a pilot screening for lung cancer using low-dose CT scan based at UCLH. The pilot will screen 50,000 people aged over age 50-77 with a smoking history (ex- or current smokers) for lung

cancer using low-dose CT scan. UCLH are asking Enfield GPs to refer patients to the screening pilot and Enfield patients can ask their GPs if they think they are eligible.

A new test called FIT (faecal immunochemical test) will be rolled out during this year to replace current bowel cancer screening kit across North Central London. The new kit is easier to use and is more sensitive so it is hoped that the uptake could improve, and more early diagnosis could be made, thus saving more lives. The test will also free up some endoscopy capacity and reduce waiting times as GPs can use it to exclude cancer before referring a patient to endoscopy for bowel cancer.

The Planning Guidance for the cancer alliances for 2019/20 includes 4 key delivery priorities: sustainable operational performance, screening and early diagnosis and personalised care. Under screening and early diagnosis, the performance management will measure screening uptake for bowel and breast screening and coverage for cervical screening, number of targeted lung health checks and low dose CT scans, the establishment of diagnostic centres, number of patients diagnosed and average time to diagnosis.

5. **ALTERNATIVE OPTIONS CONSIDERED**

N/A

6. **REASONS FOR RECOMMENDATIONS**

7. **COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS**

7.1 Financial Implications

Not directly from the report.

7.2 Legal Implications

The Health and Social care Act 2012 mandated local authorities to assure health protection where cancer screening is a part.

8. **KEY RISKS**

Cancer is the first cause of mortality in Enfield and it is important for the cancer patients to live well with cancer for longer.

9. **IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY**

a. Enabling people to be safe, independent and well and delivering high quality health and care services
b. Creating stronger, healthier communities
c. Reducing health inequalities – narrowing the gap in life expectancy
d. Promoting healthy lifestyles

10. **EQUALITIES IMPACT IMPLICATIONS**

If the facts in the report are considered well in local health and care, health inequalities will be reduced.

Background Papers

Appendix 1. Cancer risk factors in Enfield

Indicator	Period	Enfield		London	
		Count	Value	Value	Value
Hepatitis C detection rate/100,000	2016	98	32.1	-	19.7
Incidence of malignant melanoma per 100,000 all ages	2010 - 12	88	12.5	14.8	23.3
2.12 - Percentage of adults (aged 18+) classified as overweight or obese	2016/17	-	61.40%	55.20%	61.30%
Smoking Prevalence in adults (18+) - current smokers (APS)	2017	37,077	14.90%	14.60%	14.90%
3.03xii - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old)	2017/18	1,414	75.70%	81.00%	86.90%
<80%80% to 90%≥90%					
Smoking Prevalence in adults in routine and manual occupations (18-64) - current smokers (APS)	2017	-	26.30%	24.70%	25.70%
Smoking prevalence in adults (18-64) - socio-economic gap in current smokers (APS)	2017	-	2.21	2.15	2.44
Smoking prevalence in adults (18+) - current smokers (GPPS)	2017/18	-	17.00%	15.60%	14.70%
Attitudes to smoking in 15 year olds - 'smoking causes harm to others' (WAY survey)	2014/15	-	87.90%	90.00%	90.90%
Incidence rate of alcohol-related cancer (Persons)	2014 - 16	255	34.69	35.03	37.98
Incidence rate of alcohol-related cancer (Male)	2014 - 16	115	34.83	35.57	39.3
Incidence rate of alcohol-related cancer (Female)	2014 - 16	145	34.81	34.91	37.15

Appendix 2. Cancer incidence and ethnic predisposition

Tumour	*Higher incidence groups*
Lung	**Chinese (M), White**
Liver, Pancreas	**Black, White, Chinese (F), Mixed (F)**
Colorectal	**Black, Chinese, White**
Breast	**White (F), Black (F)**
Oesophagus, cervix	**White, Chinese**
Stomach	**Black, Mixed (M)**
Prostate	**Black (M), Mixed (M)**
Bladder	**White**
Uterine	**Asian (F), Black (F)**
Lymphomas	**Black (M)**
Leukaemia	**Asian (F)**
Brain	**White**
Head & Neck	**Asian (F), White**
Myeloma	**Black, Asian (M), White, Mixed**

Appendix 3. Cancer Awareness Survey Poster 2018:

Appendix 4. Cancer Awareness Survey Questionnaire

Cancer Awareness Survey 2019

Please complete this survey by 11th March 2019

Please click 'Next' to continue

Thank you in advance for taking the time to complete this survey. The survey will inform us about how aware Enfield's residents are of potential cancer symptoms. This will then help us to inform residents in a better way about the symptoms to look out for and how to reduce the risk of cancer.

Spotting cancer early means treatment is more likely to be successful.

The project is being delivered through Enfield Council and Enfield Clinical Commissioning Group's Cancer Action Group, whose members include Cancer Research UK, Macmillan and the Public Health Team at Enfield Council. We also take advice and support from Enfield Healthwatch.

For more information on cancer screening please visit:
https://new.enfield.gov.uk/healthandwellbeing/healthy-enfield/healthyyou/cancer-screening-2/

The survey will take around 5 to 10 minutes to complete.

Q1 First, we will ask what you know about the warning signs of cancers. **Please name up to 3 warning signs of cancer:**

Q2 Do you think the following could be a sign of cancer? **Please tick one per row:**

	Yes, it could be	No, it could not be	Don't know / not sure
A lump or swelling you don't know why it has appeared	☐	☐	☐
Pain that won't go away and can't be explained	☐	☐	☐
Unexplained bleeding	☐	☐	☐
A cough that lasts longer than 3 weeks	☐	☐	☐
Persistent change in toilet habits	☐	☐	☐
Difficulty swallowing that doesn't get better	☐	☐	☐
A mole that has changed in colour or size	☐	☐	☐
A sore which does not heal	☐	☐	☐
Unexplained weight loss	☐	☐	☐

Q3 Now you will be asked what you know about the causes of cancer. What things do you think affect a person's chance of developing cancer? **Please name up to 3 causes of cancer:**

Q4 Do you think the following can increase a person's risk of developing cancer. **Please tick one per row:**

	Yes, it could be	No, it could not be	Don't know / not sure
You smoking or another person smoking	☐	☐	☐
Not eating enough fruits or vegetables	☐	☐	☐
Being overweight	☐	☐	☐
Having a close family member with cancer	☐	☐	☐
Drinking alcohol	☐	☐	☐
Eating too much red or processed meat	☐	☐	☐
Being older	☐	☐	☐
Having had genital warts around you	☐	☐	☐

Q5 Cancer screening is to test apparently healthy people for signs of a cancer. Usually you would be invited to take the test without asking for it. **Please name which three cancers are in the screening programme in England?**

Q6 If you are invited for cancer screening, will you take it?

☐ Yes

☐ No

If not, please state the reason here?

Q7 If you have a family member who is invited for cancer screening, would you encourage them to take it?

- [ ] Yes
- [ ] No

If not, please say why not?

Q8 Where would you like to see / hear information on cancer in a local campaign?

Please choose 3 from the list below:

- [ ] Face to Face
- [ ] Leaflets through your door
- [ ] Posters / billboards
- [ ] Radio
- [ ] Social Media (Facebook, Twitter etc)
- [ ] You Tube
- [ ] Local newspapers and magazines
- [ ] Council e-Newsletters
- [ ] Healthy Enfield website
- [ ] Posters at your GP surgery or pharmacy
- [ ] Notices at community centres, places of worship etc On buses / public transport

To enable us to better understand your views please answer the following questions. Any information you provide will be managed, stored and used in accordance with the Data Protection Act 1998.

About You

Q9 How old are you?

--Click Here--

- Under 18 years of age
- 18 - 24
- 25 - 34
- 35 - 44
- 45 - 54
- 55 - 60
- 61- 64
- 65 years of age or over
- Prefer not to say

Q10 Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

--Click Here--

- Yes, limited a lot
- Yes, limited a little
- No
- Prefer not to say

Q11 Which languages do you speak?

Q12 How would you describe your ethnic origin?

--Click Here--

English / Welsh / Scottish / Northern Irish / British
Irish
Greek
Greek Cypriot
Turkish
Turkish Cypriot
Italian
Russian
Polish
Prefer not to say
Gypsy / Irish Traveller
Romany
Other Eastern European
White and Black African
White and Black Caribbean
White and Asian
Mixed European
Indian
Pakistani
Other
Sri Lankan
Chinese
Caribbean
Ghanaian
Somali
Nigerian
Arab
Kurdish
Bangladeshi

Q13 In which postal district do you live?

--Click Here--

EN1
EN2
EN3
EN4
EN8
N9
N11
N13
N14
N18
N21
N22
Prefer not to say
Other

If other please specify:

Q14 Are you male or female?

--Click Here--

- Male
- Female
- Transgender
- Prefer to self describe
- Prefer not to say

If you prefer to self describe, please provide details below

If you would like to read about ways to cut your risk of Cancer please visit the Cancer Research UK website: www.cancerresearchuk.org/ www.cancerresearchuk.org/about-cancer/causes-of-cancer.org

Thank you for taking the time to tell us your views

After you click 'Submit', you will be taken to the Enfield Website Homepage

Appendix 5. Cervical screening campaign 2018

IT'S TOO IMPORTANT TO FORGET

BOOK YOUR APPOINTMENT FOR YOUR CERVICAL SCREENING TEST TODAY

Healthy Enfield

We're making it easier for you to have your cervical screening test at a time and location that's convenient for you.

WHAT IS THE TEST?

It is a quick procedure that looks for abnormal cells on the cervix. This test could potentially save lives.

WHO CAN ACCESS THE SERVICE?

Book an appointment if you have received an invitation letter for cervical screening and you're registered with an Enfield GP practice.

HOW DO I BOOK AN APPOINTMENT?

You can book an appointment directly with a GP/practice nurse at your usual surgery during their opening hours.

OR

To book an appointment at any one of the primary care access hubs call the service directly on **03000 333 666**. Hub appointments can also be booked via your GP practice.

HUB OPENING TIMES:

6.30pm - 8pm weekdays
8am - 8pm Saturdays and public holidays

HUB LOCATIONS:

Evergreen Primary Care Centre
1 Smythe Close
Edmonton N9 0TW

Carlton House Surgery
28 Tenniswood Road
Enfield EN1 3LL

The Woodberry Practice
1 Woodberry Avenue
Winchmore Hill N21 3LE

Cervical cancer screening tests save lives

www.enfield.gov.uk/healthyenfield

NHS Enfield Clinical Commissioning Group

ENFIELD Council

Appendix 6. Be clear on cancer symptoms, 2016

Appendix 7. Breast and bowel cancer screening, 2015.

NHS
Cancer Screening Programmes

NHS Breast Cancer Screening Programme

All women aged 50-70 are invited to breast screening every three years.

It's too important to forget.

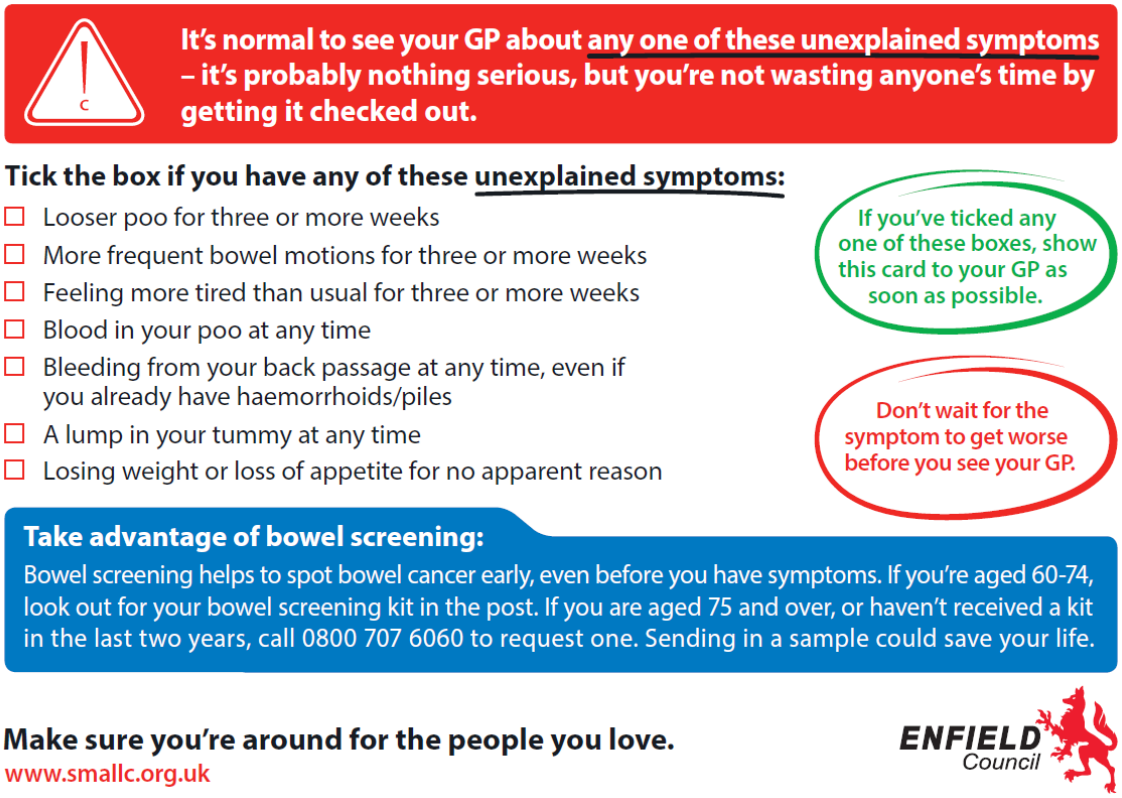
If you've missed your appointment telephone the North London Breast Screening Service on 020 8951 4045 and you will be offered another appointment.

NHS Bowel Cancer Screening Programme

If you are aged **60-74** and registered with a GP, you will automatically be sent a test kit every two years.

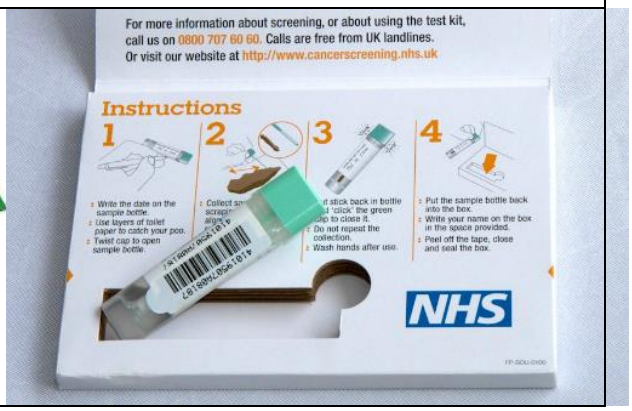
Aged 75 or over you can request a kit by calling Freephone 0800 707 60 60.

Appendix 8. Small C Bowel Cancer Campaign June 2014



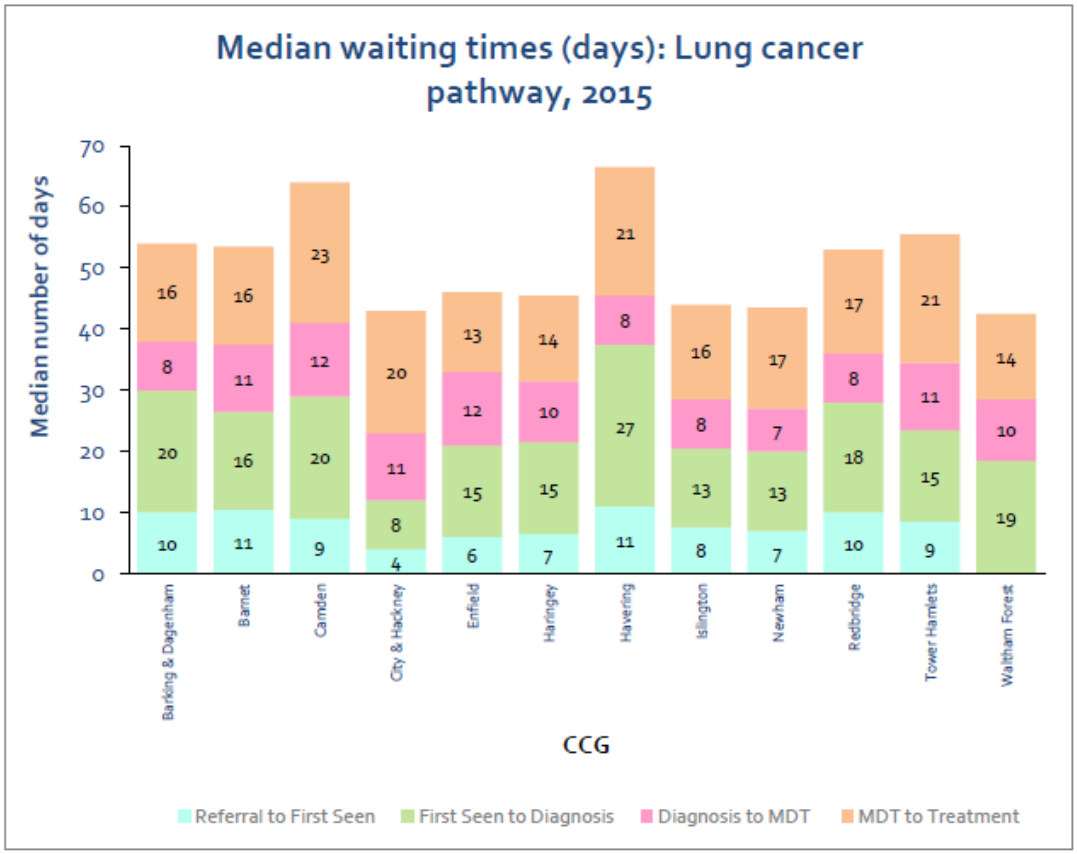
Appendix. Breast cancer and Stoptober Campaign, October 2013.

Appendix 9. A new method for bowel screening (FIT testing) vs old method (gFOBT)

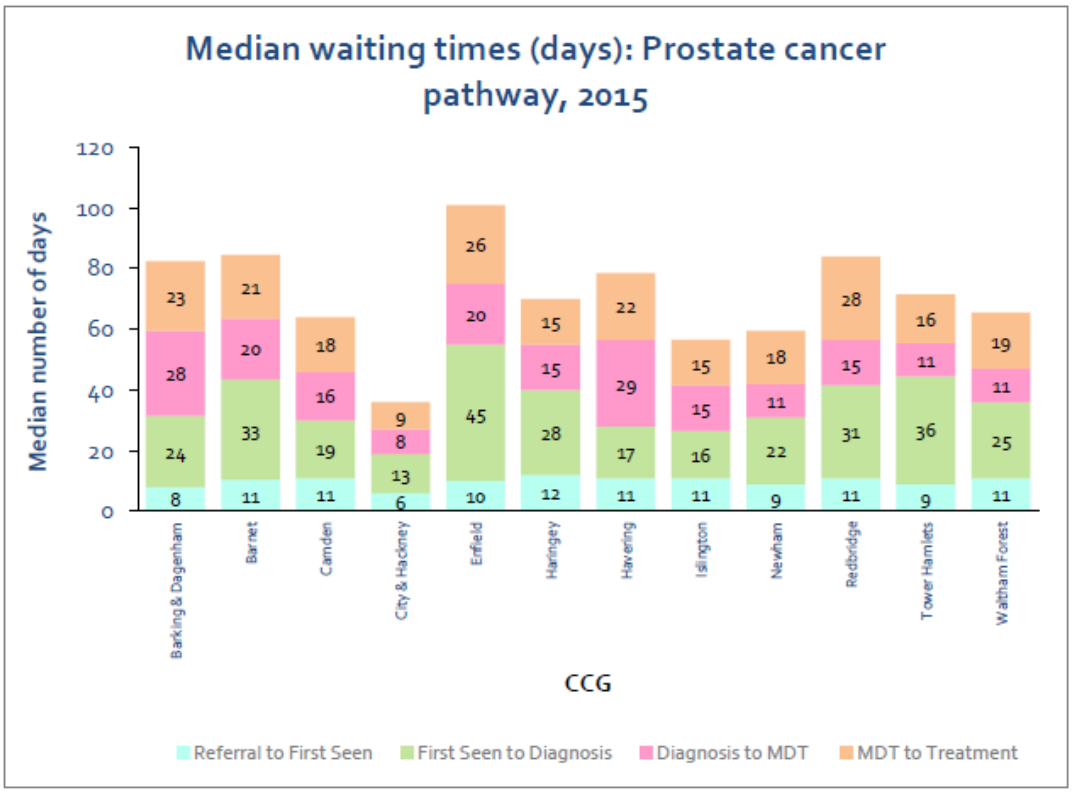
Guaiac Faecal Occult Blood Test (gFOBT)	Faecal Immunochemical Test (FIT)
	

Appendix 10. Median waiting times of lung cancer and prostate cancer pathways

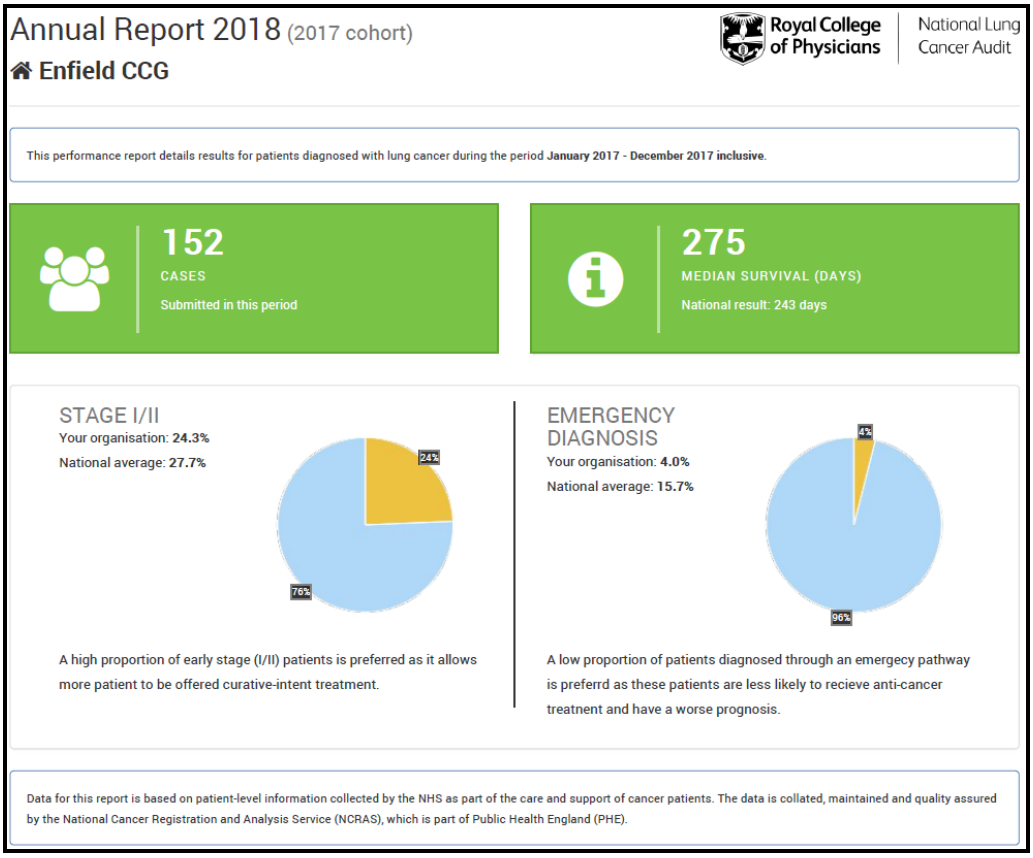
Median waiting times: Lung cancer pathway



Median waiting times: Prostate cancer pathway



Appendix 11. Lung cancer audit results for Enfield



HEALTH AND WELLBEING BOARD – CURRENT TERMS OF REFERENCE

Agreed at full Council July 2018.

10. HEALTH AND WELLBEING BOARD

Appointed by: Council

Proportionality: Does not apply

Membership:

4 members of the Council as below:

- Chair - Leader of the Council or their appointed representative
- Cabinet Member with responsibilities for Health and Social Care
- Cabinet Member with responsibilities for Education, Children's Services
- Cabinet Member with responsibilities for Public Health

Plus

- Vice Chair - Chair of the local Clinical Commissioning Group (CCG)
- HealthWatch Representative
- CCG Chief Officer
- Director of Public Health
- Director of Adult Social Care
- Director of Children's Service
- Elected Representative(s) of the Third Sector (Term of office 3 years)
- Representative from Enfield Voluntary Action

Non Voting Members

- Director of Planning from the Royal Free London NHS Foundation Trust
- Chief Executive from the North Middlesex University Hospital NHS Trust
- Director of Strategic Development from the Barnet, Enfield and Haringey Mental Health NHS Trust
- Enfield Youth Parliament Representatives x 2
- Strong & Safer Communities Board representative
- Enfield Strategic Partnership representative

Substitute Members

Each EHWB member can nominate a substitute member to be permitted to attend in the following circumstances:

(a) To take the place of an ordinary member on the EHWB where that member will be absent for the whole of the meeting. Such an appointment would apply for the entire meeting, including where the meeting is reconvened after any adjournment; or

(b) Where an ordinary member of the EHWB is prevented from attending and

participating in a meeting due to any disclosable interest they may have in an issue or complaint to be considered. In these cases the substitute appointment would only apply to the consideration of the relevant item on the agenda.

The EHWB member who wishes to appoint a substitute member must notify Democratic Services, prior to the beginning of the relevant meeting of the intended.

Additional members may be appointed to the EHWB by the agreement of all current members and Council. Non statutory membership will be reviewed by the EHWB annually.

The membership must be drawn from: As set out above

Chair and Vice-Chair appointed by:

The Chair will be either the Leader of the Council or their appointed representative. The Vice-Chair will be the Chair of the Enfield Clinical Commissioning Group.

Public / Private meeting: Public

Substitutes: Each EHWB member can nominate a substitute member to be permitted to attend as set out in Membership above.

Quorum:

The quorum for the EHWB shall be at least 4 full members or one quarter of the full membership, to include a representative from the Clinical Commissioning Group, and a councillor.

Frequency:

Each year there will be 4 formal meetings of the EHWB as well as any other additional extraordinary Board meetings and between 2-4 development sessions as called by the Board.

Terms of Reference:

Key functions of the Board

● The preparation of the Joint Strategic Needs Assessment (JSNA), Pharmaceutical Needs Assessment (PNA) and Joint Health and Wellbeing Strategy (JHWS)

● Promoting greater integration and partnership between the NHS and local government to improve local health outcomes and reduce inequalities

● Supporting closer working between commissioners of health-related services to improve services for the local population.

Management and administration

The Director of Public Health will be the lead officer for the EHWB supported by the Strategic Partnerships Manager or their representative who will be in attendance at all Board meetings.

The EHWB will be administrated by Enfield Council Democratic Services.

Sub-committees and groups and the Health Improvement Partnership

The EHWB is to appoint sub-committees to discharge their functions in accordance with section 102 of the 1972 Local Government Act.

All sub-committees will have their Terms of Reference and membership approved by the EHWB and will operate in accordance with the requirements of the Board, and be focused on activity that is in line with the Terms of Reference and remit of the EHWB.

The key sub-committee is the Health Improvement Partnership (HIP), which operates to support the work and delivery of the EHWB. Its membership will consist of representatives of each of the Board members.

Supporting groups include the JSNA Steering Group, the JHWBS task & finish group and working groups to support the delivery of key work streams.

Voting

Each full member of the Board shall have one vote and decisions will be made by a simple majority. The Chair will have the casting vote.

Conduct of Business of the Health and Wellbeing Board

(i) EHWB meetings will generally be open to the public and other councillors except where they are discussing confidential and exempt information. This will need to be in accordance with the requirements of the Local Government Act 1972 as amended.

(ii) Members of the EHWB will be entitled to receive a minimum of five clear working days' notice of such meetings, unless the meeting is convened at shorter notice due to urgency.

(iii) Any member of the Council may attend open meetings of the EHWB and speak at the discretion of the Chair.

(iv) Agendas and notice of meetings: There will be formal agendas and reports which will be circulated at least five working days in advance of meetings.

(v) Exempt and confidential items**:** There will be provision for exempt or confidential agenda items and reports where the principles of the relevant access to information provisions of the Local Government Act 1972 (as

amended) apply.

(vi) Reports**:** Reports for the EHWB will usually be prepared by the relevant officer or EHWB member.

(vii) Reports will be presented by the appropriate EHWB member, and must include advice from relevant officers, including finance and legal implications and reasons for the recommendations.

(viii) Officer advice**:** Officer advice will be stated fully and clearly within reports to the EHWB Board.

(ix) Templates**:** Formal reports to the EHWB will need to be submitted with the EHWB template, completed in accordance with the Council's report writing guidance.

(x) Minutes of decisions made at EH&WB meetings**:** Minutes will be made public within 10 working days of each meeting.

HWB Forward Plan Update.

Session	Notes
20th March 2019 Development Session Postponed	
20th March 2019 HWB - Proposed Agenda CCG Finance Update – CCG Loneliness and Social Isolation Scrutiny Workstream Review of 2014-19 JHWS Strategy – MLT Feedback on Successor JHWBS Consultation – SL/HP **Reports** VCS Representative Appointment – NN/MLT NHS Long-Term Plan North Central London Paediatric Asthma Plan Duncan Selbie Visit – SL LGA – update - MLT Minutes Health and Wellbeing Forward Plan [Below]	
May 2019 HWB – Proposed Agenda HPF/Influenza TFG Update – Report Dr Tha Han 2019 – 2024 JHWS sign off - Stuart Lines / Harriet Potemkin LBE HiAP implementation plans	

Future Development Session Topics	**Notes**
Metrics against JHWS? For future	Gayan
Better understanding of PHOF and Life Expectancy for instance. Healthy Life Expectancy -	
Community Pharmacy -	
LBE HiAP implementation plans	
Mental wellbeing – mental Mr Staurt Right.	This one
Mental health and Employment -	This one – Suzy Francis.
Life Course material as well.	This one
Formal Boards Agenda Items	
Regular Updates on HWBS	
Serious Youth Violence – Potentially Joint SSCB Session	
Screening and Immunisations	
Oral Health	
Social Prescription Activities	
Community Development	
Integration / ICSs / Population Health Management	
Long-term conditions	
MECC	
A Public Health Approach to… • Sexual Health • Youth Violence • Gangs • Pollution • Substance misuse	
Housing	
Poverty	
NCL Prevention workstream	
Suicide Prevention Strategy	

Healthy Streets	
Loneliness & Social Isolation	

Other considerations

How can we encourage an active speaking within HWB environment?

Give different members of the board the responsibility to lead certain meetings.

[Labour manifesto] Council Plan – one-year on.

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