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

AGENDA – PART 1

1. WELCOME AND APOLOGIES

2. DECLARATION OF INTERESTS

Members are asked to declare any pecuniary, other pecuniary or non-pecuniary interests relating to items on the agenda.

3. HEALTH PROTECTION FORUM (HPF) / INFLUENZA UPDATE (6:20 - 6:50PM) (Pages 1 - 30)

To receive the report of the Director of Public Health 'Health Protection Forum Annual Report' on the functions and priorities of the HPF; and the Influenza Vaccination Update.

4. CANCER SCREENING UPDATE (6:50 - 7:20PM) (Pages 31 - 66)

To receive the report of the Executive Director of People Services in respect of the current situation of cancer in Enfield.

5. HOUSING AND HOMELESSNESS PRESENTATION (7:20 - 7:50PM)

Presentation to be received from Joanne Drew, Director of Housing and Regeneration.

6. SECTION 75 AGREEMENT - SERVICES FOR 0-19 YEAR OLDS (7:50 - 8:05PM)

To receive the report of the Director of Adult Social Care.

(SENT TO FOLLOW)

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

To receive the report of the Director of Public Health.

(TO FOLLOW)

REPORTS FOR INFORMATION

The following reports are for noting and support.

8. ENFIELD POVERTY AND INEQUALITY COMMISSION (Pages 67 - 72)

To receive an update on progress.

9. MINUTES OF THE MEETING HELD ON 20 MARCH 2019 (Pages 73 - 78)

To receive and agree the minutes of the meeting held on 20 March 2019.

10. HEALTH AND WELLBEING BOARD FORWARD PLAN

(TO FOLLOW)

11. DATES OF FUTURE MEETINGS

Dates of meetings for the 2019/20 municipal year:

Thursday 26 September 2019
Thursday 5 December 2019
Thursday 19 March 2020

Development Session to commence at 4:30pm.
Formal Board meeting to commence at 6:15pm.
Unless otherwise advised.
Venues to be confirmed.

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Agenda Item 3

MUNICIPAL YEAR 2019/20

Meeting Title:
HEALTH AND WELLBEING BOARD
Date: 20 June 2019

Contact officer: Dr Tha Han
Telephone number: 020 8379 1269
Email address:
Tha.Han@enfield.gov.uk

Agenda Item:

Subject: Health Protection Forum Annual Report

Report of: Stuart Lines, Director of Public Health

1. EXECUTIVE SUMMARY

Enfield Health Protection Forum is a partnership group with members from a wide range of stakeholders from statutory bodies and is chaired by a Consultant in Public Health deputised by the Director of Public Health (DPH).

Key partners include Public Health England (PHE), Enfield CCG, NHS England and local health care providers. There is also a close working relationship with the LBE Emergency Planning team.

The role of the Health Protection Forum (HPF) is to ensure, on behalf of the HWB, that adequate arrangements are in place for the surveillance, prevention, planning and response required to protect the public's health. The Health Protection Forum (HPF) facilitates positive relationships, ensuring that clearly defined roles and responsibilities are in place that underpin the local response to public health threats, outbreaks and major incidents, and when the roles cannot be made clear due to legislation, a joint effort is applied to meet the health protection needs of the local health and care sector. The HPF also discusses and helps resolve many emerging priorities identified by partner organisations.

This is the first annual report to be presented to Enfield Health and Wellbeing Board (HWB) by the Health Protection Forum. The purpose of this document is to provide a clear overview of the current health protection situation within Enfield highlighting any on-going challenges or issues.

This report has been written to a framework that was agreed by the forum members to reflect the most crucial parts of the standing items (Appendix 3) and to summarise the quarterly meetings since April 2018 against the following health protection areas:

- Communicable disease outbreaks and incidents
- Immunisation and vaccination
- Emergency planning
- Non-Infectious Environmental Hazards
- Healthcare and community acquired infection

- Others: screening programme, TB, HIV

The below are the priorities in the forward plan for 2019-20:

Immunisation and vaccination

- Promote flu vaccination and childhood immunisations
- Support the development and implementation of the immunisation improvement plan

Infection and disease outbreak control

- Health Protection Forum partners to continually look for opportunities of inter-disciplinary and multi-agency working which will bring system-wide improvements and management of infection.
- Tackling community-acquired infection working with LBE social care, care homes, NHSE providers and commissioners.

Reduce environmental hazards to health

- Monitor incidence data of environmental hazards to health and care systems system on appropriate long-term measures.

Business Continuity Plans to be flu pandemic ready

- Encourage and support partners organisations and LBE departments to have their respective Business Continuity Plans updated that is aligned to LB of Enfield's Multi-agency Influenza Pandemic Plan.

2. RECOMMENDATIONS

The Board is asked to note and comment on the functions and priorities of the HPF.

3. BACKGROUND

3.1 Health protection seeks to prevent or reduce the harm caused by communicable and non-communicable diseases and minimise the health impact from environmental hazards. This report is part of a locally agreed assurance process that was put in place following the 2012 Health and Social Care Act (Section 6C regulations)[i] where the Director of Public Health (DPH) provide assurance to the Health and Well-being Board (HWB) that the health of the residents in Enfield is being protected in a proactive and effective way by the stakeholder organisations.

3.2 Achieving success in health protection relies on strong working relationships at a local level. Enfield Health Protection Forum is a partnership arrangement with members from a wide range of stakeholders from statutory bodies and is chaired by a Consultant in Public Health deputised by the Director of Public Health (Appendix-2. Terms of Reference). The role of the Health Protection Forum (HPF) is to ensure, on behalf of the HWB, that adequate arrangements are in place for the surveillance, prevention, planning and response required to protect the public's health. The Health Protection Forum (HPF) facilitates positive relationship, ensuring that clearly defined roles and responsibilities are in place that underpin the local response to public health threats, outbreaks and major incidents, and when the roles cannot be made clear due to legislation, a joint effort is applied to meet the health protection needs of the local health and care sector. The HPF also discussed and resolved many emerging priorities identified by partner organisations.

This is the first annual report to be presented to Enfield Health and Wellbeing Board (HWB) by the Health Protection Forum. The purpose of this document is to provide a clear overview of the current health protection situation within Enfield highlighting any on-going challenges or issues.

Key partners include Public Health England (PHE), Enfield CCG, NHS England and local health care providers. There is also a close working relationship with LBE Emergency Planning.

Thanks to the cooperation and collaboration through the Forum, Enfield has been able to communicate all partners fairly quickly and control communicable diseases into a minimum, prevented measles outbreaks, maintain better cancer screening rates than STP average and London average, resolve issues around hospital discharges related to superbug carriers, close the gap in infection control skills in community care setting through a training and mitigating issues around food hygiene.

4. REPORT

4.1 This report has been written to a framework that was agreed by the forum members to reflect the most crucial parts of the standing items (Appendix 2) and to summarise the quarterly meetings since April 2018 against the following health protection areas:

- Communicable disease outbreaks and incidents
- Immunisation and vaccination
- Emergency planning
- Non-Infectious Environmental Hazards
- Healthcare and community acquired infection

- Others: screening programme, TB, HIV

4.2 The draft of the report (Appendix 1) was signed off by the forum in June 2019.

5.0 Recommendations

5.1 The Board is asked to note the contents of the report.

Appendix 1

Communicable disease outbreaks and control

Background

- PHE, in conjunction with LBE Environmental Health and Microbiology colleagues, continually monitor incidents of communicable diseases across the borough, neighbouring boroughs and at London and national levels. Where community outbreaks have been reported to PHE, 'situation reports' based on suspected cases of communicable diseases are produced and then shared with the relevant agencies. In many cases, if appropriate, laboratory confirmation follows.

- Over the year there have been various incidents in Enfield which have required effective inter-agency management to protect the public's health. Managing any outbreak or incident requires identifying the source of infection and implementing control measures to prevent further spread or recurrence. Examples include scarlet fever and chicken pox outbreaks in schools, influenza outbreaks in care home, norovirus outbreaks in care homes, sporadic cases of legionnaire's disease and measles cases in a community.

- Public Health team as part of assurance of the health protection role, work closely with North Central London Public Health England Infection Control team to support the investigation, and management of disease outbreaks.

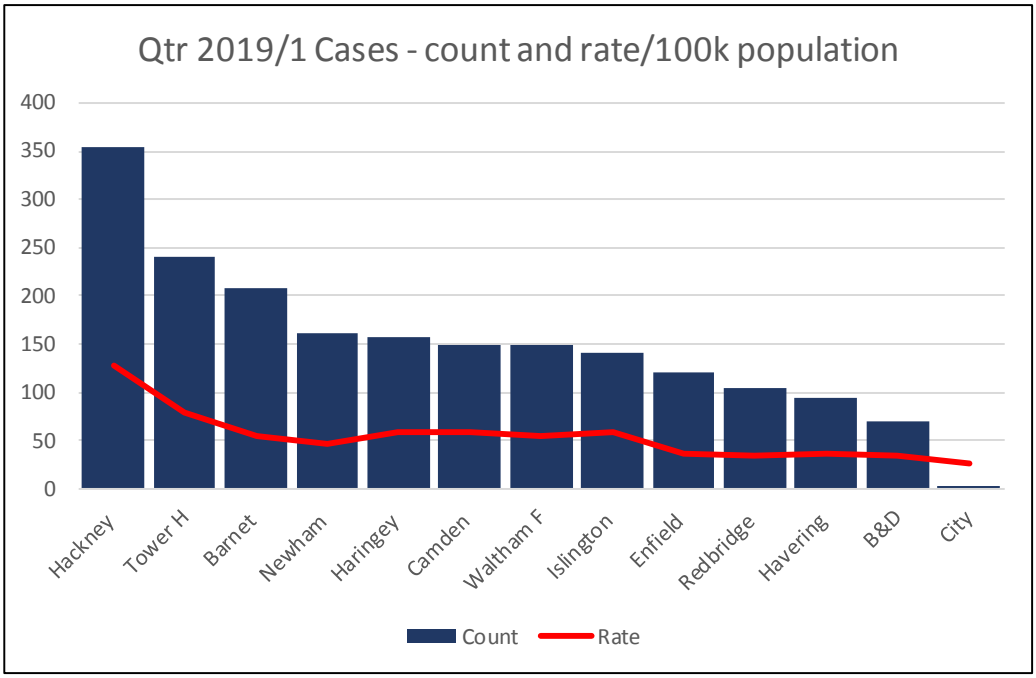


Figure. Notified Communicable Diseases Count and rate/100k population by Local Authority, Qtr 1, 2019

- At quarterly Health Protection Forum meetings, incidence of infectious disease and other outbreaks are discussed to give the borough the assurance that appropriate investigations have been undertaken and the public has been provided with adequate information on self-management and prevention of onward transmission of infections.

Concerns

- Measles outbreaks in neighbouring boroughs might spread into Enfield. (Appendix 8)

Action

- Opportunistic immunisation status check for all children at medical, childcare and school settings and promote immunisation.

Immunisation

Background

- NHSE commissions GPs and school nurses to deliver routine immunisation.
- Pertussis (Whooping cough) in the very young is a significant cause of illness and death. A temporary programme for the vaccination of pregnant women was introduced in October 2012 to protect infants against pertussis from birth until they are vaccinated at two months of age.
- People aged 65 years are eligible for a free pneumococcal vaccination (PPV), given once only
- A shingles vaccination has been developed which is designed to reduce the severity and length of a shingles episode, should it occur. People aged over 70 are most at risk from shingles and so a vaccination is offered at 70, with a catch-up cohort at 78 years old
- Flu vaccines need to be repeated every year by the at-risk population. Since 2018/19 flu season, front line health and care workers can have free flu vaccine at participating pharmacies.

Concerns

- Flu vaccine uptake among children in Enfield is the lowest in NCL (Appendix 7). There is evidence indicating parental resistance to flu vaccination in some sections of the community.
- Flu vaccination for at risk groups and older people is also low compared to London average.
- Staff flu vaccination rates at local NHS providers are not sustainable.
- None of the childhood immunisation coverage reaches the target needed to produce her immunity.
- MMR target is 95% but Enfield rates are around 80%. Neighbouring boroughs with similar low uptakes were experiencing numerous outbreaks, making local PHE unit to declare business continuity measures.

Action

- We will continue to promote flu vaccination from early September coordinated by NHS England.
- Develop action plan to improve flu and immunisation in the borough working with local stakeholders especially GPs.
- GPs are to be clearly made aware that MMR catchup can be given at any age and GPs will be remunerated.
- Engage with the public to support the NHSE commissioning role to improve immunisation, and rates of call and recall in communities where the uptake is low.
- Public health volunteered to run a local workshop and make a number of engagements with practice nurses, local partners and the public to promote

immunisation and to co-produce an immunisation improvement strategy for Enfield.

Emergency planning for Health and Healthcare

Background

- A wide range of events can cause health emergencies, including natural hazards, accidents, outbreaks of disease and terrorist attacks.
- Emergencies can be minor events that threaten the health and lives of local communities or major events that affect the whole population.
- An influenza pandemic is one of the acute viral illnesses that have the potential to become pandemic (worldwide spread of a new form of the disease) at any time and originate anywhere in the world.
- The Local Resilience Forum is the principal mechanism for the coordination of Multi-agency planning for all the emergencies at the local level. Its membership includes all Category 1 responders (such as emergency services, local authorities and health care institutions) which are subject to a range of civil protection duties under the Civil Contingencies Act 2004.
- The Director of Public Health is the lead for Enfield Multi-agency Influenza Pandemic Plan and will chair the Influenza Pandemic Committee. The governance of Enfield Multi-agency influenza pandemic plan can be seen in Figure 1.
- In Sept 2018, a multi-agency pandemic flu exercise was conducted (a 3-yearly event) to revise existing Enfield Multiagency Influenza Pandemic Plan.
- Public Health is encouraging partners organisations and LBE departments to have their respective Business Continuity Plans aligned to Multi-agency Influenza pandemic plan.
- London Association of Directors of Public Health held a workshop on mutual aid between London boroughs in emergencies e.g., Grenfell disaster.

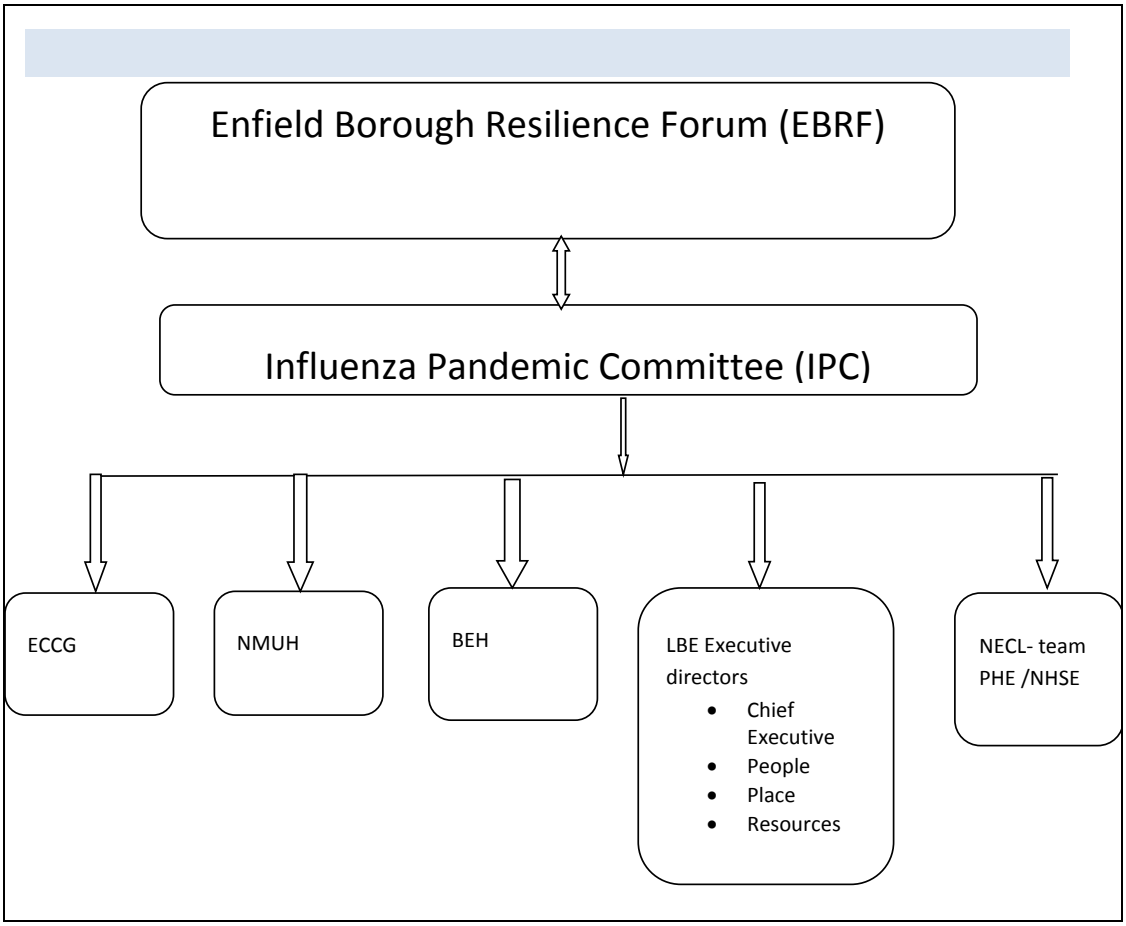


Figure-1 Enfield Influenza Pandemic and governance as part of EBRF

Concerns

- There is a concern that the business continuity plans of partner organisations are not coherent in terms of mutual aid and support.

Action

- Health Protection Forum will support the LBE department and partner agencies to develop a business continuity plan aligned to Enfield Multi-agency Influenza pandemic plan.

Non-infectious Environmental Health

Background

Air Quality is a major environmental risk to public health, contributing to cardiovascular disease, lung cancer and respiratory diseases. Enfield has a statutory duty to provide appropriate monitoring of air quality as per Air Quality Standards Regulations (2010). Evidence shows 36.9% of the Enfield population live in areas scoring in the worst 20% on the Access to Healthy Assets and Hazards (AHAH) Index, which includes access to green spaces and exposure to the air pollutants NO2, PM10s and SO2)[ii].

A report, together with the Air Quality Action Plan which provided information on the issues of air pollution faced in LB Enfield and how these problems are being addressed have been presented to security committee on 8th of Nov 2018[iii]. The report highlighted NO2 PM10 levels exceeded the annual mean objective along main roads in the Borough.

On the other hand, Enfield environmental health services are also concerned with aspects of the environment that can present a risk to health, such as poor housing, a

safe supply of food and water, the control of pests that can spread infection, poor air quality and environmental exposures. Hazards that the environment team tackle on a regular could be categorised into physical, chemical and biological.

Physical

- Noise leading to deafness
- Ionising radiation can cause intracellular ionisation
- Exposure to ultraviolet (UV) radiation carries an increased risk of skin cancers.

Chemical

- Dusts, gases and fumes such as tobacco smoke, ozone, ammonia, asbestos.

Biological

- Moulds, bacteria and viruses
- Non-infective (allergic) reaction to an agent, or other agents such as cholera, legionella, and faecal material from house dust mites.

The environmental health team as part of the borough HPF and working closely with wider public health team, has taken action to ensure that adequate measures are taken to prevent the infection from spreading amongst employees and the public.
In the last one year, the team has been involved in wide range of physical, chemical and biological risk to individual and population health in the borough. Examples below are some of the work that the environment team in partnership with Public health England and as part of the borough Health Protection been engaged with:

- A child under ten years of age was identified with elevated blood lead levels with the suspected source within the home. This required both food and housing officers to investigate the potential sources. It was established that there was no food sources or utensils within the home that could have contributed to the levels found. It was alleged that the child had consumed paint from timberwork in the property, it was established that that no paint containing lead was every used in the property. It was also confirmed that the water supply was not via lead pipes.

- Clusters of legionnaires disease infection required the team to visit potential locations and establish the safety procedures in place to demonstrate compliance with managing their systems.

- Investigation of a restaurant following a confirmed Salmonella case in order to locate the source and prevent an outbreak.

Concerns

- Air quality continues to be an issue for Enfield like everywhere else in London.

Actions

- The Health Protection Forum (HPF) working in partners with NHS providers and commissioners, voluntary sectors and schools will promote to increase awareness, knowledge and understanding of air quality and help everyone who lives, commutes or works in Enfield to reduce their own exposure as well as to improve air quality.
- Work with Public Health England, LBE environmental health team and NHSE providers to better control environmental risks to population health from physical, biological and chemical hazards.

Healthcare acquired Infections

Background

- Infection prevention and control is fundamental to stop the spread of communicable diseases.
- Infection control and Prevention is part of the Enfield CCGs Quality Strategy for 2017 to 2021. The CCG is working to reduce gram negative infections as well as Clostridium difficile. In the past year the CCG has developed an action plan that is focussed on the reduction of Clostridium difficile and Escherichia coli.
- As part of the national drive to reduce gram negative infections the CCG has worked with Acute and Community Providers to produce the action plan. The action plan required that Providers focus on as Escherichia coli as a mandatory infection to report.
- Work has also been undertaken on the introduction of catheter passports for patient being discharged from hospital. This initiative will help patients self-manage their catheters as well as aid better continuation of care between acute, community and primary care.
- The CCG is currently planning to work in collaboration with neighbouring CCGs to review ways of further reducing these infections in the community.

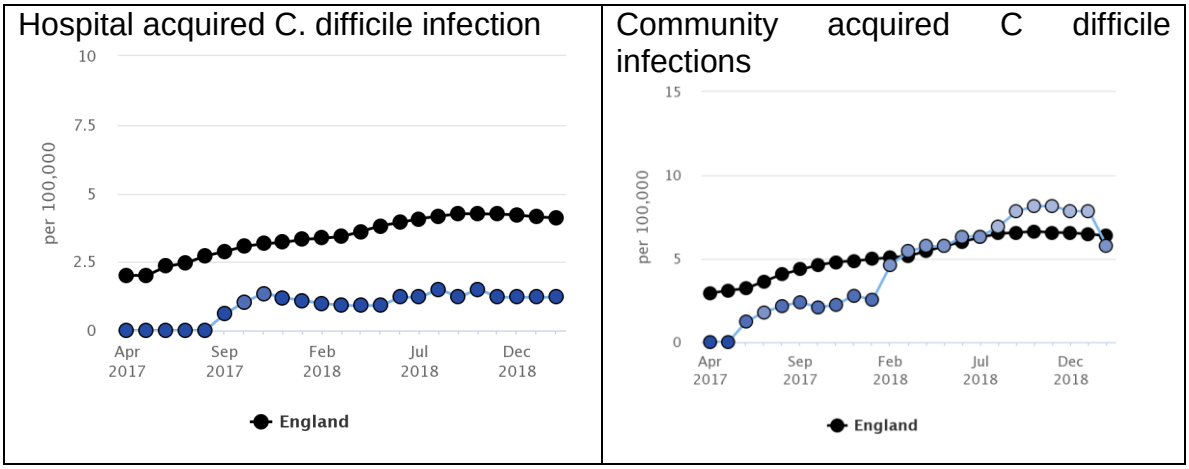


Figure 2. Healthcare acquired infections in Enfield.

Infection control in the community

- In 2017, public health, CCG and North Middlesex Hospital Infection control team carried out an audit of community acquired C.difficile infection and found the rate was increasing when the neighbouring county could maintain lower numbers. We learned from their best practice and organised infection control training for care home staff. We shared this good practice at PHE Conference 2018 (Appendix 4). This training needs repeated at least every other year because of the turnover of the staff in the sector and the apparent lack of commitment in the private care sector.
- An issue was raised by adult social care colleagues on the discharges with high risk of cross infection e.g., carbapenem-resistant Enterobacteriaceae (CRE). It's been agreed that Public Health England will give tailored guidance and advice to individual cases and ensure the standard operating protocol is adhered to by the NHS providers. Patients transferred from other hospitals and those who have been in hospitals the last 12 months will be screened for CRE when high risk for CRE; similar measures now in BEH, Barnet & Chase and NMUH.

Action

- Infection control training for community care should be repeated to limit community acquired C diff infections.

Others

Terms of Reference

The forum's terms of reference were revised and agreed at the November meeting.

Latent TB screening

- TB is a bacterial airborne infection that is associated with deprivation.
- TB often affects the lungs (pulmonary TB) but can also affect other parts of the body. Infection can be active or latent (latent TB can be reactivated in later years). The rate of TB has been decreasing since 2011 in the UK, albeit a very small reduction between 2015 and 2016; London has followed a similar pattern. The incidence of TB in Enfield lower than London average at 19 per 100,000 however, need to be tackled to reduce inequalities associated with these communicable diseases.
- As part of the Mayor and the GLA effort to support the national TB strategy, Enfield has joined the initiative for screening for latent TB infection. The programme targets people aged 16-35 with a connection to a defined list of high-risk countries and who have been in the UK for five years or less. It draws on best practice but, uniquely, screening, treatment and follow-up are all based in primary care.
- This innovative approach gives patients greater choice in treatment, significantly reduces cost and has boosted the numbers of patients being screened and treated. This cost-effective model also reduces the impact on hospital TB services, reducing waiting times for other high-risk TB patients.
- As well as identifying patients with latent TB, it has a potential for uncovering active TB patients that are asymptomatic and who may have otherwise presented late to the TB team.
- Enfield currently provides latent TB screening as package of universal offer to all eligible patients since Dec 2017.

BCG vaccine

Enfield like many parts of London experienced challenges related to BCG vaccine shortage. There have been several enquiries from parents and members of the public concerned about the lack of BCG vaccination for new born and the change in the processes to ensure the available new BCG vaccine is available those with highest risk. The forum worked closely with PHE North Central Team and North Middlesex University Hospital, in communicating the progress of changes and assuring the public.
But now the issue is resolving as the stock started to be replenished.

Anti-microbial resistance

Background

- Antibiotic resistance has been described as one of the biggest threats of modern times
- Over-reliance on antibiotics, and not taking antibiotics properly, is leading to bacteria becoming resistant
- Without effective antibiotics many common bacterial infections will become increasingly dangerous.
- Antibiotics cannot kill viruses – so will not work on viral infections such as colds or flu,
- One third of the public believe that antibiotics will treat coughs and colds and 1 in 5 people expect antibiotics when they visit their doctor
- Even many mild bacterial infections get better on their own, without using antibiotics.
- However, GPs commonly express concerns that they feel pressurised by patients asking for antibiotics, such as when people ask on behalf of a child
- Enfield CCG has encouraged appropriate prescribing of antibiotics in primary care in several ways during 2018/19. For example, an appropriate prescribing of antibiotics is included as a subject for discussion in the CCG practice visits and at locality GP meetings. In addition, antibiotic prescribing is included in Medicines Management Locality Commissioned Service (LCS) 2018-19 which encourages a reduction in prescribing and more appropriate choices of antibiotic.
- There is now joint prescribing guidance for infections across North Central London CCGs.
- Public health supported the communication to the public and GPs in antibiotic awareness and stewardship by providing leaflets and participating in seminars.
- Thanks to those joint efforts persistent over more than 5 years, the use of antibiotics in Enfield is in a decreasing trend. (Figure 3)

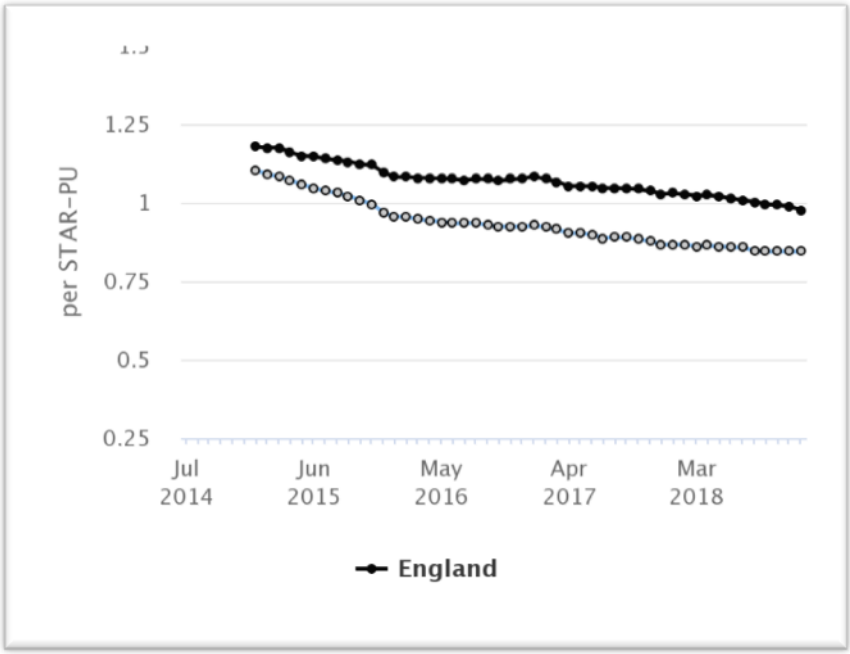


Figure 3. The rate of antibiotics uses in Enfield against England average. Source: PHE.

Anti-biotic awareness campaign

- This year's theme for antibiotic campaign is "Keep Antibiotics Working" (KAW) raises awareness of antibiotic resistance amongst the general which is to public to trust in doctors' advice when it comes to whether take an antibiotic or not.
- Enfield CCG has included information its twitter feeds, website and intranet referring to World Antibiotic Awareness Week aims to increase awareness of global antibiotic resistance and to encourage best practices among the general public, and health workers

Concerns

- High rate of accident and emergency attendance in the winter season including with flu like symptoms.

Action

- Work with schools and local parents and at-risk groups to plan antibiotic awareness campaign during before the onset of the flu season

HIV

Background

- HIV late diagnosis rate in Enfield is 57/100,000 higher than London average at 35/100,000.
- Public Health in the LB of Enfield is responsible for commissioning sexual health services (inc HIV testing). LBE also participates in the national HIV self-sampling service procured by PHE, while NHSE is responsible for HIV treatment.
- NHSE commissions HIV testing as part of antenatal screening. If HIV is detected, antivirals can be given to reduce the viral load to protect the health of the mother and reduce the risk of mother-to-child transmission.

Concerns

- Late diagnosis of HIV affects treatment outcomes.
- Some groups are at greater risk of HIV due to their social circumstances, lifestyle or language difficulty to access prevention, diagnostic and treatment services or to take treatment appropriately;

Action

- Continue with public awareness of late HIV diagnosis and tackle the stigma associated with HIV diagnosis.
- Continue to work with PHE and NHS England in London on achieving zero transmission of HIV in London.

Cancer Screening

- Cancer screening in Enfield is consistently above NCL averages across all indicators and London average although short of the England average and national target. This will be reported in great detail in the Cancer Report.
- Enfield PH has been granted funding for cancer awareness campaign and would like to work with voluntary care sector and CCG to implement the campaign over the next 18 months (Oct 2018- Mar 2020)

Priorities for Health Protection Forum (Forward Plan) 2019-20.

Immunisation and vaccination

- Promote vaccination for children, pregnant women, and older people
- Promote flu vaccination for those with medical conditions, pregnant women, eligible children and older people
- Support the development and implementation of the immunisation improvement plan

Infection and disease outbreak control

- Health Protection Forum partners to continually look for opportunities of inter-disciplinary and multi-agency working which will bring system-wide improvements and management of infection.
- Tackling community-acquired infection working with LBE social care, care homes, NHSE providers and commissioners.

Reduce environmental hazard to health

- Monitor incidence data of environmental hazard to health and care systems system on appropriate long-term measures.

Support Business continuity plans to be flu pandemic ready

- Encourage and support partners organisations and LBE departments to have their respective Business Continuity Plans updated that is aligned to Multi-agency Influenza Pandemic Plan.

Appendix 2. Health Protection Form (HPF) Terms of Reference

The forum's terms of reference were revised and agreed at the November meeting.

ENFIELD HEALTH PROTECTION FORUM (HPF)
TERMS OF REFRENCE

Introduction

Health protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation. As well as major programmes such as the national immunisation programmes and the provision of health services to diagnose and treat infectious diseases, health protection involves planning, surveillance and response to incidents and outbreaks[iv].
"The Health and Social Care Act 2012 states that Directors will also have a responsibility for the exercise of the local government health protection duty and provide public health advice to clinical commissioning groups. It also emphasises that successful health protection requires strong working relationships at the local level; the duty of NHS England (NHSE), Public Health England (PHE), Clinical Commissioning Groups (CCGs) and other agencies to cooperate in order to protect the population health[v].
Enfield Council is therefore required to work with local partners (NHS and private sector providers, Health and Social Care commissioners, local voluntary and statutory sector) to ensure that threats to health are understood and properly addressed. The local authority role in health protection planning is not a managerial but a leadership function. Public Health England, with its expertise and local health protection teams, has a critical role to play helping local authorities understand and respond to potential threats. The NHS will also continue to be a key partner in planning and securing the health services needed to protect health. NHS-funded providers can be required through contracts to share plans and appropriate information.
The Department of Health suggests that local authorities establish a local forum for health protection issues, chaired by the director of public health, to review plans and issues that need escalation.

Purpose

The purpose of the Enfield Health Protection Forum (HPF) is to:

- Provide assurance that safe and effective plans are in place to protect the health of the Enfield population health, including but not limited to communicable disease control, infection prevention and control, Emergency planning, sexual health, environmental health
- Support the Council's response to health protection emergencies, such as a flu pandemic and other incidents
- Provide oversight and interpretation of local uptake of national immunisation and screening programmes

Objectives

The objectives of the HPF are to:

- Provide a forum for assurance of organisational health protection plans and risk management, including plans for major outbreaks or incidents
- Ensure that sufficient plans are in place for major outbreaks such as Pandemic Flu
- Provide oversight and interpretation of local implementation of national immunisation and screening programmes
- Ensure Health Protection is incorporated into care sector across Enfield through active engagement and education.
- Advise the Enfield Health and Wellbeing Board on health protection matters as appropriate and when necessary
- Encourage in continuous quality improvement in air quality, measures to minimise drug-related harm, integrated services in place to prevent and control tuberculosis, etc.
- Provide the public health contribution to relevant local, regional and national health protection exercises as required.

The forum seeks assurance in the following ways:

- Collaborate with PHE to review all significant incidents / outbreaks to identify and share lessons learnt; and provide recommendations to commissioners / providers / partners regarding the strategic and operational management if these risks.
- Provoke evidence-based practice in all areas of health protection practice.
- Escalate major health protection concerns to the Director of Public Health, the Health and Wellbeing Board, Enfield CCG, NHS England, PHE and other bodies as appropriate
- Facilitate multi-agency task and finish groups and work collaboratively with partners as necessary
- Invite secondees to membership as necessary to the agenda, to deliver on key priorities within Task and Finish groups.

Scope

Issues that may be within the scope and interest of the HPF are, but not restricted to:

1. Infectious diseases in the community
2. Healthcare acquired infections, including hospital acquired infections
3. Environmental hazards
4. Immunisation programmes
5. Sexually transmitted infections, including HIV
6. Blood borne viruses
7. National screening programmes
8. Tuberculosis
9. Pandemic influenza
10. Excess seasonal mortality

Issues that are specifically out of the scope of the committee include:

1. Health services emergency planning arrangements and response, including CBRN, LRF
2. Business continuity
3. “Business as usual” events, such as winter planning

Membership

Chair –Consultant in Public Health with Health Protection role
Coordinator – Public Health Strategist/ Officer
Membership includes the representative from the following teams in Enfield council due to their crucial roles contributing towards health protection

- Commissioner of sexual health services
- Representative from public health children and young people
- Representative from Environmental Health
- Representative from Enfield Borough Resilience Forum (EBRF)
- Representative Adult social care
- LBE Communications team (when required)

Local Statutory bodies

- Enfield Clinical Commissioning Group (ECCG) lead for infection control
- ECCG representative for TB and primary care
- Screening Commissioner, NHS England
- Immunisation commissioner / PH representative who attended the meeting at NHSE
- CCDC or representative from NENCL HP team, Public Health England
- Infection control lead from North Middlesex University Hospital
- Infection control lead from Royal Free London FT
- Infection control lead from BEH Mental Health Trust

Accountability

- The HPF will be accountable to the Health and Wellbeing Board and will provide the Board with an annual summary report on Enfield's health protection issues, and reports on other issues as necessary.
- The HPF will also provide information to Health Scrutiny Committee as required

Frequency of meetings

- The HPF will meet quarterly and will be convened when necessary throughout the year.

Quoracy

- For the Committee to be quorate, there must be 50% attendance, which must include the Chair or their deputy. This is because the forum will require to form or act as a task and finish group of specific priorities e.g., immunisation improvement.

Agenda items

Agreed standing agenda item subject to amendment are the following

- Communicable disease patterns, outbreaks and incidents
- National Immunisation and screening programmes
- Tuberculosis
- HIV and Sexual Health
- Emergency planning
- Non-Infectious Environmental Hazards (NIEH)

- Healthcare acquired infection / infection control (acute and community)
- PHE update

Reviews

This term of reference is subject to annual review by the HPF.

Appendix 3. Standing Agenda template

1. **AGENDA**
    a. Welcome and apologies
    b. Urgent updates
    c. Minutes of the previous meeting
    d. Standing items
        i. Outbreaks and incidents – (PHE and providers)
        ii. Immunisation – (CCG and providers/ NHSE commissioner)
        iii. TB – (ECCG)
        iv. HIV and Sexual Health (Commissioner/ Provider)
        v. Emergency planning (LBE- EPO)
        vi. Non-Infectious Environmental Hazards (LBE EHO)
        vii. Healthcare acquired infection / infection control (acute and community) (ECCG, ASC and providers)
2. **Any other business**
3. **Date and time of next meetings**

Appendix 4. Poster at PHE Conference 2018

Public Health England

Protecting and improving the nation's health

Infection control training for the staff in care homes and domiciliary care in a London borough: the need and the how.

ENFIELD Council

Alka Maru[1], Gosaye Fida[2] and Tha Han[2]

1. NENCL Health Protection team; 2. Public Health team, London Borough of Enfield

INTRODUCTION

Care home residents share living space, food and equipment; and many of them are vulnerable hosts for infections, making care homes a good ground for infection outbreaks, that can result in high morbidity and some mortality. One London borough of over 340,000 population has an abundance of care homes. It experienced a rising *Clostridium difficile* infections (CDI) in the community, which was indicating a potential of outbreaks especially gastrointestinal. Local Health Protection Forum identified a need in concerted effort to prevent infections in care settings, and put forward **an action plan** to address this by offering training for frontline staff working in care and nursing homes as well as those providing domiciliary care. The objectives were to improve the level of infection control knowledge and skills required to respond to infections, not limited to CDI, and to nurture a culture of planning and preparation towards prevention of infections in the community care setting. This article summarises the principles of outbreak prevention, preparedness, local collaboration and ownership, sharing our experience in working with a local system and practical steps in achieving an effective delivery.

METHODS

The multi-agency local working group produced a case and proposed an action plan to Health Protection Forum, where many local stakeholders were members, and to the Quality and Safety Committee of the local CCG. The action plan put forward was agreed by both groups and it was implemented by a multi-agency working group consisting of Public Health England North Central London infection control team, local authority Public Health team and local CCG safeguarding team. CCG team invited care homes and domiciliary care providers by email citing the importance and urgency to attend the infection control training. The training was delivered by the NENCL PHE, co-designing the syllabus with local CCG and Public Health to suit the needs of the audience, and using the knowledge on local epidemiological situation. There was a formative assessment to understand the existing knowledge of the attendees and their background. The training aimed to empower to tackle common infections in care settings; and it consisted of basic infection control training that also covered immunisation, chest infections, MRSA, UTI and E coli septicaemia, gastroenteritis outbreak training, and influenza preparedness training. Training sessions were effectively delivered before the winter starts, local information was collected from the delegates and the training was evaluated.

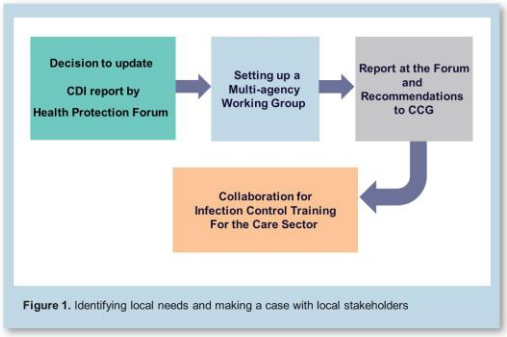


Figure 1. Identifying local needs and making a case with local stakeholders

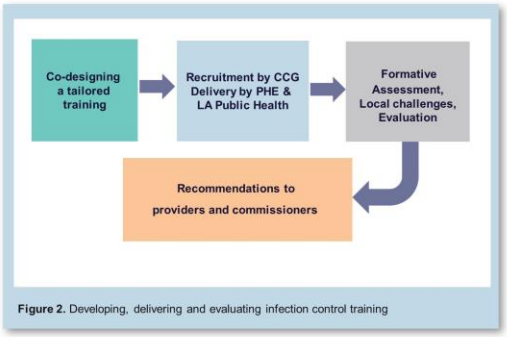


Figure 2. Developing, delivering and evaluating infection control training

RESULTS

138 enrolled for the training and 116 (84%) members of staff from the 12 local nursing homes, 80 local residential homes and domiciliary care providers attended the training. They were from a range of professional backgrounds.

The training was also an opportunity to learn from the delegates the gaps and challenges in local infection control practices. The lack of knowledge and lack of facilities usually form a barrier in adhering to waste disposal standards.

We found that occupational health engagement could improve the attitude towards infection control including flu vaccine uptake, the prevention of the spread of blood borne infections and the knowledge on some first response such as in the case of needle stick injury.

- The email communication followed by another email message and a telephone reminder by CCG safeguarding team was effective in recruiting delegates within a short time.
- The training was evaluated at the end of the sessions. On the whole, feedback from the delegates was very positive. 97% of the attended strongly agreed training met their expectations. Positive feedback from comments included "Fantastic knowledge I have learned a lot today" and "I know we will take all the training we have gained today and continue to keep our residents safe".
- Recommendations were made to providers and commissioners to improve access to occupational health, PPE and waste disposal facilities, and further commitment to infection control training tailored to local needs.

DISCUSSION

By identifying the scale of a serious infection in the community and by working with local stakeholders in a local Health Protection Forum and a local Clinical Commissioning Group, we secured the leadership commitment and the support of local stakeholders.

It is key to tailor the training that has a balance between the education needs of frontline staff providing care for vulnerable adults and the time they will have to take out of the usual business.

Delivering interactive training to diverse workforce also allowed us to identify some of the challenges in maintaining infection control standards in the local care setting which enabled us to make recommendation to the commissioners and providers.

CONCLUSIONS

- With increasing aging population who are vulnerable to infection, the problem of infections will remain a top priority in preventing avoidable illnesses, hospital admissions and escalation of social care need.
- The impact of infections is not limited to individuals affected but also to the families, carers and wider health and care system.
- With high staff turnover, the large size of the care sector in the local borough, and the comparatively higher community CDI than neighbouring CCG areas, this London borough needs to continue surveillance and management of infections in care settings to avoid what is easily avoidable and to help older people live healthily and longer.
- Half-day training in infection control, offered every 6 months, can be more acceptable by employers and front-line staff.

ACKNOWLEDGEMENTS

The authors would like to thank the members of the local Health Protection Forum, the Quality and Safety Committee of the CCG, safeguarding team of the CCG, Infection Control team of the North Middlesex University Hospital and the care sector managers for their contribution in reviewing CDI rates and subsequent infection control training.

REFERENCES

1. Prevention and control of infection in care homes – an information resource. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214929/Care-home-resource-18-February-2013.pdf
2. https://www.nice.org.uk/guidance/qs61

Appendix 5. School nursing immunisation poster

Enfield School Aged Immunisation Team

Enfield has a dedicated school aged immunisation team made up of professionals who are highly skilled and experienced in giving vaccinations to children and young people – in school and community settings. The team deliver the school immunisation programme in Enfield. The team work in partnership with schools, including state, independent, academies, special schools and pupil referral units and offer community clinics for young people who are educated at home.

The current routine school immunisation schedule is:

Years Reception, 1, 2, 3, 4, 5

Fluenz (to reduce influenza rates) - this is a nasal spray-not an injection

Year 8 HPV (to reduce cervical cancer rates)-FOR GIRLS ONLY - an injection into the upper arm. This will be 2 injections approximately 6-12 months apart

Year 9 Meningitis ACWY (to reduce incidents of 4 strains of meningitis)

along with Revaxis (to reduce incidents of diphtheria, tetanus, polio) 2 injections, 1 in either arm at the same appointment

Enfield Children's Immunisation Team, Forest Primary Care Centre, 308A Hertford Road, Edmonton N9 7HD

Email: beh-tr.enfieldimmunisationteam@nhs.net

Telephone: 0208 702 4829 / 0208 702 3700

Service Open Hours: 09.00 – 16.00 hrs. Monday – Friday.

Enfield Health
Supporting Physical and Mental Health in Enfield

August 2018

Appendix 6. One of the staff flu vaccine campaign posters 2018/19.

Do you work in Enfield Social Care?

You have more choice for getting your free flu jab

STAY WELL THIS WINTER

This year all Enfield Council staff can have a free flu jab at Well Pharmacy branches in Enfield.

If you work in the **social care sector (adults or children)** you have even more choice to get a free flu jab. See the list of pharmacies inside for details.

Protect yourself, your loved ones and others. To get a free flu jab, show your Council badge and tell the pharmacy your Team.

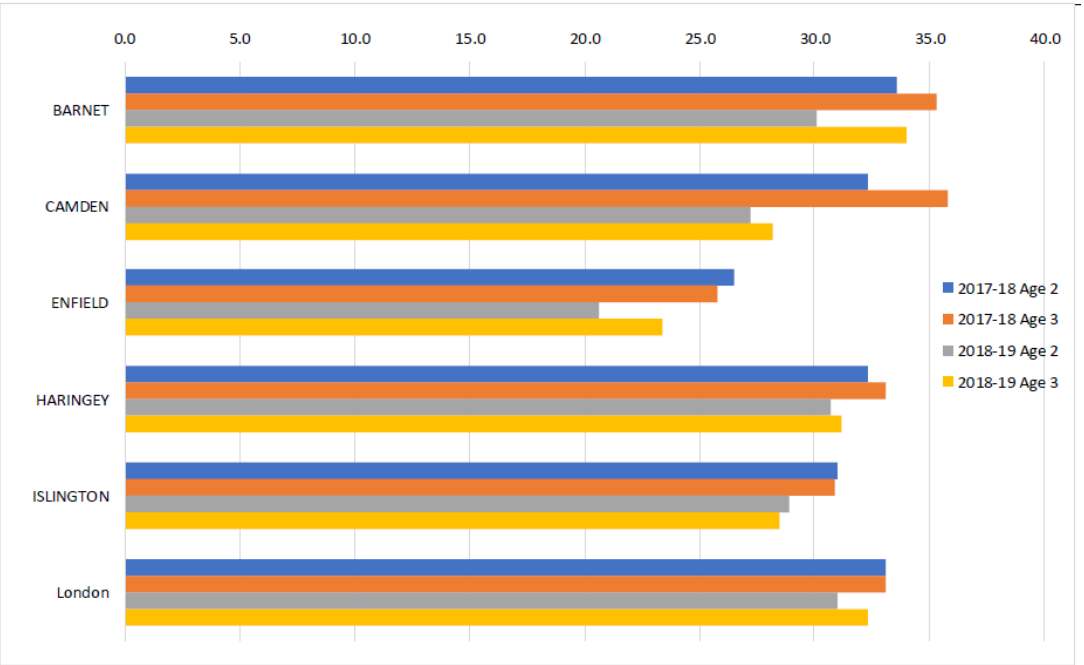
Please also tell the clients that you look after and their carers that they also qualify for free flu jabs.

Catch it. Bin it. Kill it.
Stop the spread of flu germs. Use a tissue and wash your hands thoroughly.

www.enfield.gov.uk/HealthyEnfield

ENFIELD Council

Appendix 7. Flu vaccine uptake at GPs for 2-3 year-olds. NCL. Source: NHS England.



Appendix 8. Measles cases Oct 2018 to May 2019.

Confirmed and probable cases (only) notified by month and LA 01/10/2018 – 31/05/2019, NENCL HPT

LA	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Total
B&D			1						1
Barnet		1		1	2	7	16	7	7	41
Camden		2		1		1	5	2	2	13
Enfield		5	5				3	4	5	22
Hackney		9	42	49	62	79	40	18	10	309
Haringey		16	5	7	15	5	7	4	5	64
Havering										0
Islington							1	6	2	9
Newham							2		2	4
Redbridge							1		1	2
Tower Hamlets							4	1		5
Waltham Forest		3	4	1		1		3	3	15
Total		**36**	**57**	**59**	**79**	**93**	**79**	**45**	**37**	**485**

[i] http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

[ii] Public Health England. https://fingertips.phe.org.uk/search/air#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/93074/age/1/sex/4

[iii] https://governance.enfield.gov.uk/ieListDocuments.aspx?CId=115&MID=10163#AI42188

[iv] Department of Health (2012). Public Health in Local Government

[v] NHS Standard Contract 2017/2019 (may 2018 version) can be found at: https://www.england.nhs.uk/wp-content/uploads/2018/05/2-nhs-standard-contract-2017-19-particulars-service-conditions-may-2018.pdf

vi. Health and Social Care Act 2012. Protection of Public Health. https://www.england.nhs.uk/wp-content/uploads/2018/05/2-nhs-standard-contract-2017-19-particulars-service-conditions-may-2018.pdf

MUNICIPAL YEAR 2019/2020 - REPORT NO.

MEETING TITLE AND DATE **Health and Wellbeing Board**	**Agenda - Part:**	**Item:**
	Subject: Influenza vaccination update **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

Influenza (flu) and its complications form a key factor in NHS winter pressures impacting on those who become ill, the NHS services that provide direct care, and on the wider health and social care system that supports people in at-risk groups

Vaccination is the best method for the prevention and control of influenza and vaccination can reduce illness and lessen severity of infection[1].

This report is to provides an update on

- Seasonal influenza vaccination for children, pregnant women, over 65 age groups and the high-risk group
- Seasonal flu uptake by frontline (%) in frontline health and care workers staff

The uptake of flu vaccine by staff needs to be sustained and the lower uptake among the nurses need to be investigated and mitigated.

The uptakes of the influenza vaccine by pregnant women and children in Enfield were among the lowest in London. The public attitude towards the vaccine and awareness of its benefits are crucial in childhood flu vaccination uptake.

The uptakes of flu vaccine among those with medical conditions and older people were also low.

Currently, the local flu vaccine campaigns were run by the LBE with small resources. A coordinated stronger campaign by key organisations is required to improve the uptake of flu vaccines from the very low rates.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4362519/

2. RECOMMENDATIONS

The board is asked

2.1 To note the performance in influenza vaccination in Enfield in comparison to London and England.

2.2 To encourage HWB members to actively work towards improving the influenza vaccine uptake under National immunisation programme, and to support the work to sustain the staff flu vaccine uptake.

3. BACKGROUND

Influenza is an acute viral infection of the respiratory tract characterised by a fever, chills, headache, muscle and joint pain, and fatigue. The risk of serious illness or complications from flu is greater in children under six months of age, older people, pregnant women and those with underlying health conditions and can therefore have a significant impact at population level[2].

Flu is a key factor in NHS winter pressures impacting on those who become ill, the NHS services that provide direct care, and on the wider health and social care system that supports people in at-risk groups

Vaccination is the best method for the prevention and control of influenza and vaccination can reduce illness and lessen severity of infection[3].

In England in 2018/19, influenza vaccine uptake was ***slightly lower*** than that seen the previous season for 65+ year olds, those aged 6 months to under 65 years of age with 1 or more underlying clinical risk factors, and pregnant women. Influenza vaccine uptake in Health Care Workers (HCWs) ***increased*** compared to the previous season.

Priority groups for flu vaccination are[4]:

- People aged 65 years of over (including those becoming age 65 years by 31 March 2018)
- People aged from six months to less than 65 years of age with a medical condition
- All pregnant women (including those women who become pregnant during the flu season)
- All children in reception class and school years 1, 2, 3 and 4 (aged 4-5 to 8-9 years old)

[2] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/09/phe-sw-flu-review-2017-18.pdf
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4362519/

- People living in long-stay residential care homes or other long-stay care facilities

4. Report

4.1 Health and Care Front-line staff flu vaccination

Health and social care workers who have regular close contact with patients, residents and clients are likely to have more exposure to infection and can further spread the infection to their family and people they care for. Influenza is very infectious, but immunisation is highly effective in working-age adults.

Immunisation is therefore recommended for staff directly involved in social care, especially for staff in nursing and care homes that look after older people. Staff immunisation can reduce the transmission of influenza to vulnerable residents, some of whom may have impaired immunity and thus reduced protection from any influenza vaccine they have received themselves [5].

All the major NHS providers commissioned by Enfield CCG and the council have been making good progress in vaccinating frontline staff.

However, within staff group flu vaccination, the uptake by qualified nurses was much lower than doctors, other qualified clinical staff and support (management and administrative) staff. vary. The staff flu uptake at Royal Free London was lower than London average.

	All Frontline Healthcare Workers	All Doctors	Qualified Nurses (including GP Practice Nurses)	All other professionally qualified clinical staff	All support staff
Barnet Enfield and Haringey (BEH)	58.8%	61.9%	51.2%	56.4%	69.6%
North Middlesex hospital	70.4%	87.3%	46.5%	100%	92.0%
Royal Free	49.4%	50.3%	46.3%	55.6%	49.1%
London region	49.7%	53.9%	50.5%	49.3%	47.4%

Table-1 Seasonal Flu Vaccine Uptake (Frontline Healthcare Workers), 1 September 2018 to 28 February 2019

4.2 Council staff flu vaccine uptake

NHSE has commissioned local pharmacies to offer frontline line care workers flu vaccination_ free of charge. LBE actively promoted staff flu vaccination for all staff and frontline care workers https://new.enfield.gov.uk/news-and-events/flu-jab-does-the-job/

[5] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/09/care-home-toolkit-18-19.pdf

Although the data were not available for the uptake of flu vaccination at local pharmacists, we received the data from Wells pharmacy on the flu vaccine uptake by other members of staff, including those who work in schools.

219 members of staff accessed Wells pharmacy for flu vaccination in 2018/19 winter. The number could have been much higher had the stock not been depleted.

4.3 Adults vaccination at GPs: over 65, those with medical conditions and pregnant women

Adult flu vaccination at Enfield GPs were significantly below National averages and Enfield's pregnant women uptake is one of the three lowest in London.

- 64.8% of GP registered patients aged 65 years and over in Enfield received the vaccine in the stated period, compared to 72.0% nationally.

- 40.7% of those in the 6 months to under 65 years at-risk[1] category received the vaccine in the stated period, compared to 48.0% nationally

- 28.9% of pregnant women received the vaccine in the stated period, compared to 45.2% nationally

The three London CCGs with the highest proportions of those aged 65 years and over who received the vaccine were Tower Hamlets (70.8%), Bromley (69.8%) and Sutton (68.8%), whereas the three CCGs with the lowest proportions were Hammersmith & Fulham (56.5%), Kensington & Chelsea (57.8%) and Westminster (58.8%).

The three London CCGs with the highest proportions of those in the 6 months to under 65 years at-risk category who received the vaccine were Tower Hamlets (50.6%), Newham (49.6%) and Harrow (48.8%), whereas the three CCGs with the lowest proportions were Hammersmith & Fulham (32.3%), Bexley (36.9%) and Richmond upon Thames (38.0%).

The three London CCGs with the highest proportions of pregnant women who received the vaccine were Wandsworth (46.8%), Tower Hamlets (45.9%) and Kingston upon Thames (45.1%), whereas the three CCGs with the lowest proportions were **Enfield** (28.9%), Hackney (31.3%) and Hounslow (32.3%).

Table 2a. Percentage of GP Patients Vaccinated Against Influenza[a]

	Aged 65 and over	Clinical at risk[b]	All pregnant women
Enfield	64.8%	40.7%	28.9%
London	65.4%	44.4%	41.0%
England	72.0%	48.0%	45.2%

[a]1 September 2018 to 28 February 2019, [B] Clinically at risk patients, aged 6 months to under 65 years old.
Source: https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-winter-2018-to-2019

4.4 Children flu vaccination

4.4.1 Children flu vaccination in GP practices

Children flu vaccination was given in primary care (for 2-3-year-olds) and in schools (reception to Year-5). Children flu vaccination in primary care in Enfield is one of the three lowest in London.

21.6% of 2-year olds and 24.4% of 3-year olds received the vaccine in the stated period, compared to 43.8% and 45.9% respectively across England as a whole. The three London CCGs with the highest proportions of 2-year olds who received the vaccine were Kingston upon Thames (43.4%), Bromley (43.3%) and Wandsworth (40.3%), whereas the three CCGs with the lowest proportions were **Enfield** (21.6%), Hackney (22.3%), and Westminster (24.6%)

The three London CCGs with the highest proportions of 3-year olds who received the vaccine were Bromley (46.8%), Kingston upon Thames (44.4%) and Richmond upon Thames and Wandsworth (both 39.7%), whereas the three CCGs with the lowest proportions were Hackney (23.6%), **Enfield** (24.4%) and Westminster (24.7%)

Table 2b. Percentage of Children (GP patients) Vaccinated Against Influenza[a]

	Aged 2 years	Aged 3 years	All 2 and 3 year olds
Enfield	21.6%	24.4%	23.0%
London	31.8%	33.0%	32.4%
England	43.8%	45.9%	44.9%

[a]1 September 2018 to 28 February 2019

Source: https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-winter-2018-to-2019

4.4.2 Children flu vaccination in schools

Similarly, children flu vaccination in schools were also lower than London and England averages, but better than Tower Hamlets that had the lowest overall uptake in the Country across all primary school years.

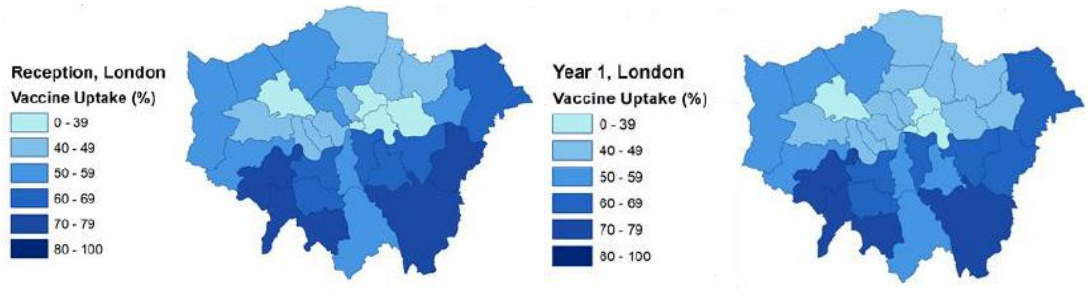
Table 3. Percentage of Children in School Vaccinated against Influenza: Reception to Year 5[a]

	Reception	Year 1	Year 2	Year 3	Year 4	Year 5
Enfield	47.9%	46.0%	43.7%	42.1%	39.0%	35.9%
London[b]	53.7%	52.7%	50.2%	48.9%	46.5%	44.6%
England	64.3%	63.6%	61.5%	60.4%	58.3%	56.5%

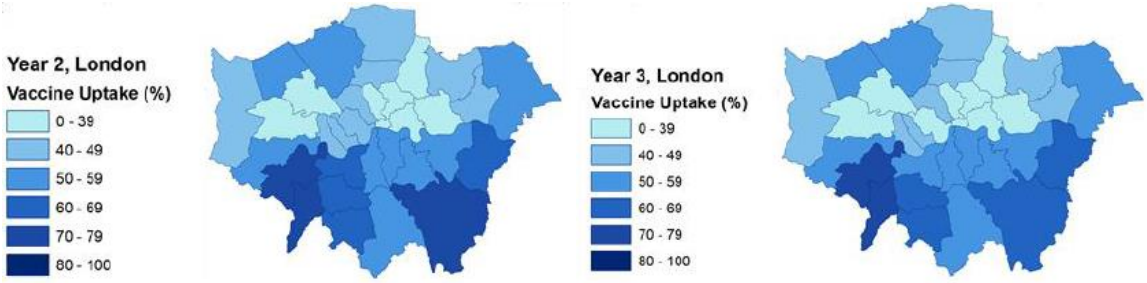
[a]1 September 2018 to 31 January 2019, [b] London PHE centre

Source: https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-children-of-primary-school-age-winter-2018-to-2019

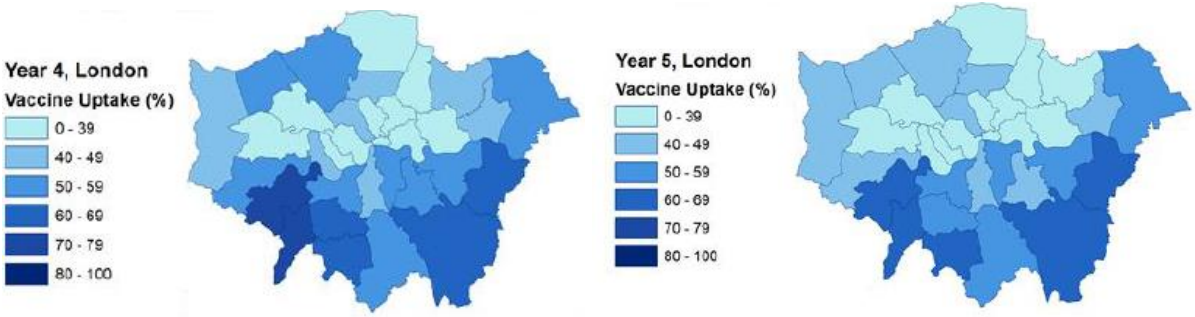
Figure-1 Vaccine uptake (%) in school years reception and 1, 01/09/18 and 31/01/19



Vaccine uptake (%) in school years 2 and 3, 01/09/18 and 31/01/19



Vaccine uptake (%) in school years 4 and 5, 01/09/18 and 31/01/19



5. **ALTERNATIVE OPTIONS CONSIDERED**
Not applicable.

6. **REASONS FOR RECOMMENDATIONS**
The improvement in flu immunisation uptake rates in Enfield will improve unnecessary illness among the vulnerable residents (children, pregnant women, those with medical conditions and older people) and avoid burden on GPs, A&E and other health services.

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
Health and Social care Act 2012 mandated local authorities to assure health protection where cancer screening forms one.

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.

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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**.

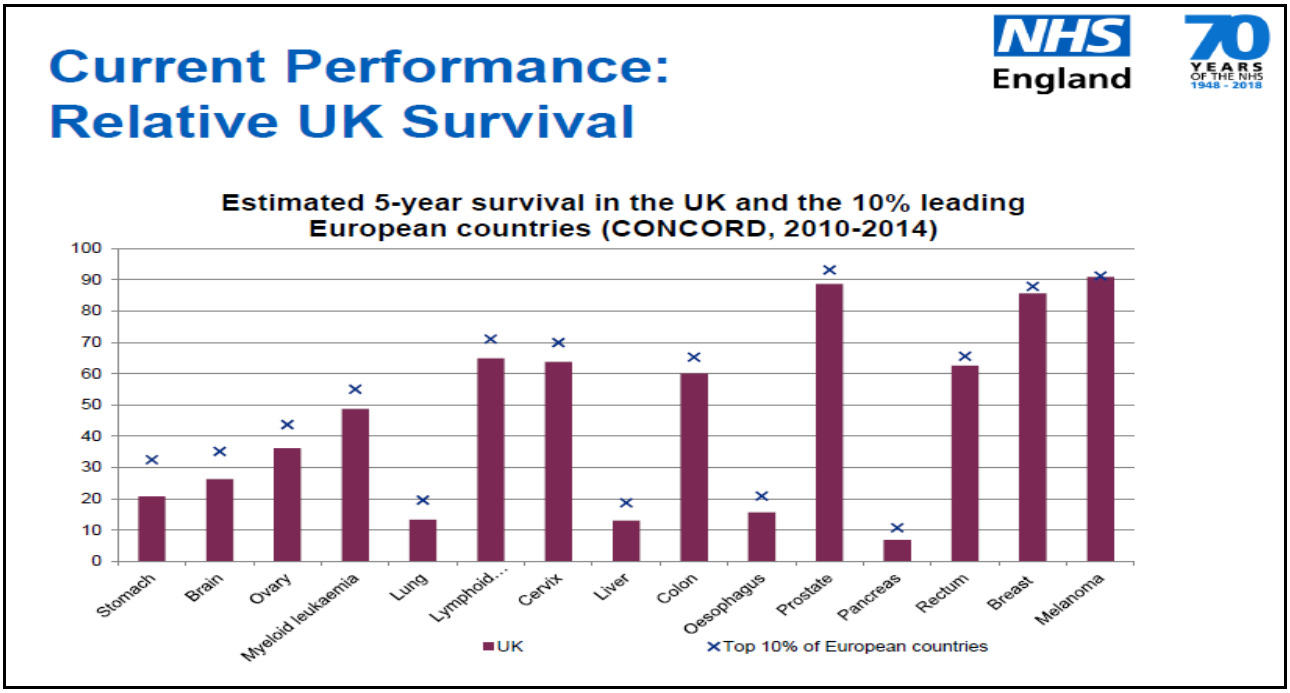


Figure 1. 5-year survival of cancer between UK and top European countries. Source: NHS England.

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.

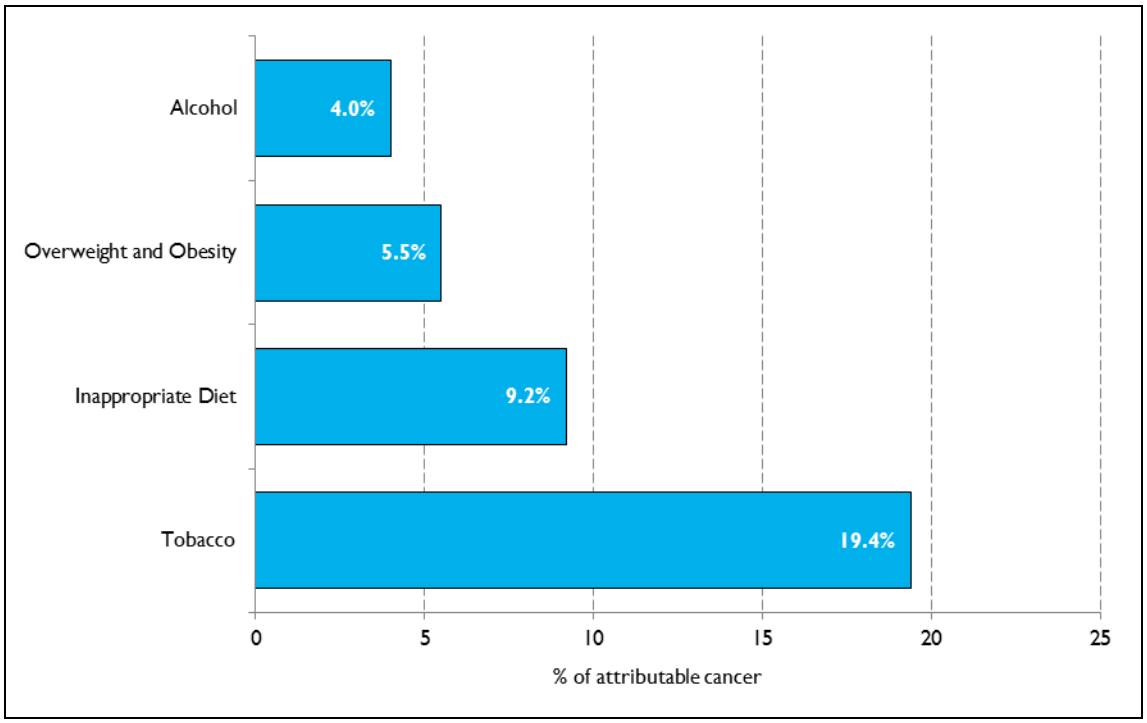


Figure 2. The Proportion of Cancers in the UK Attributable to Different Lifestyle Exposures. Source: Parkin et al. (2011)

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.

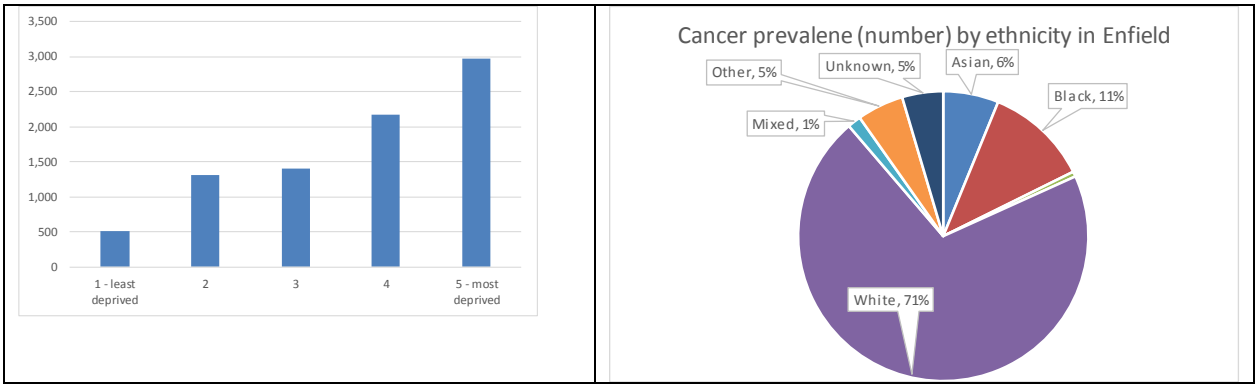


Figure 3. Cancer prevalence (number) in Enfield by deprivation and ethnicity. Source: TCST/ Macmillan/ PHE.

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.

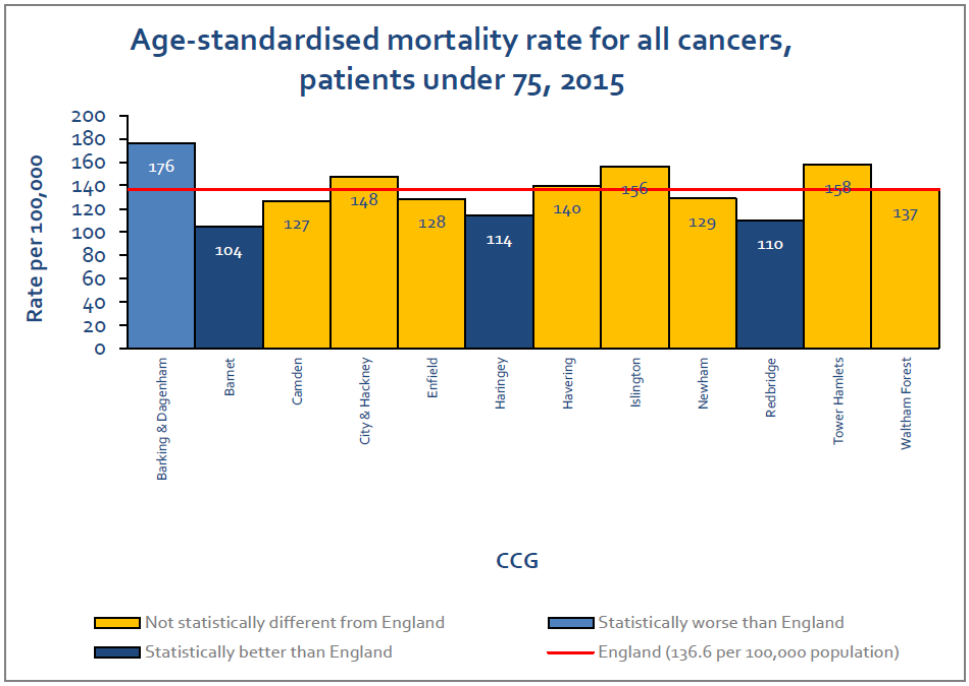


Figure 4. Under 75 mortality from cancer (age-standardised). Source: CADEAS

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).

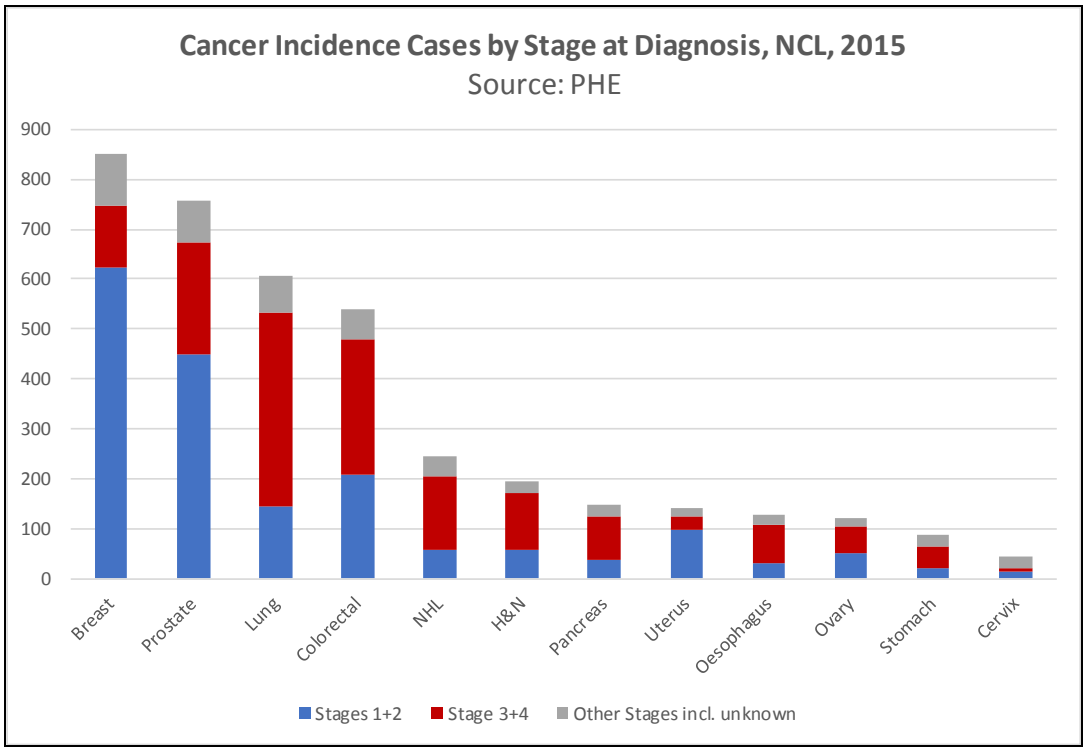


Figure 5. Cancers by incidence and stage at diagnosis, NCL.

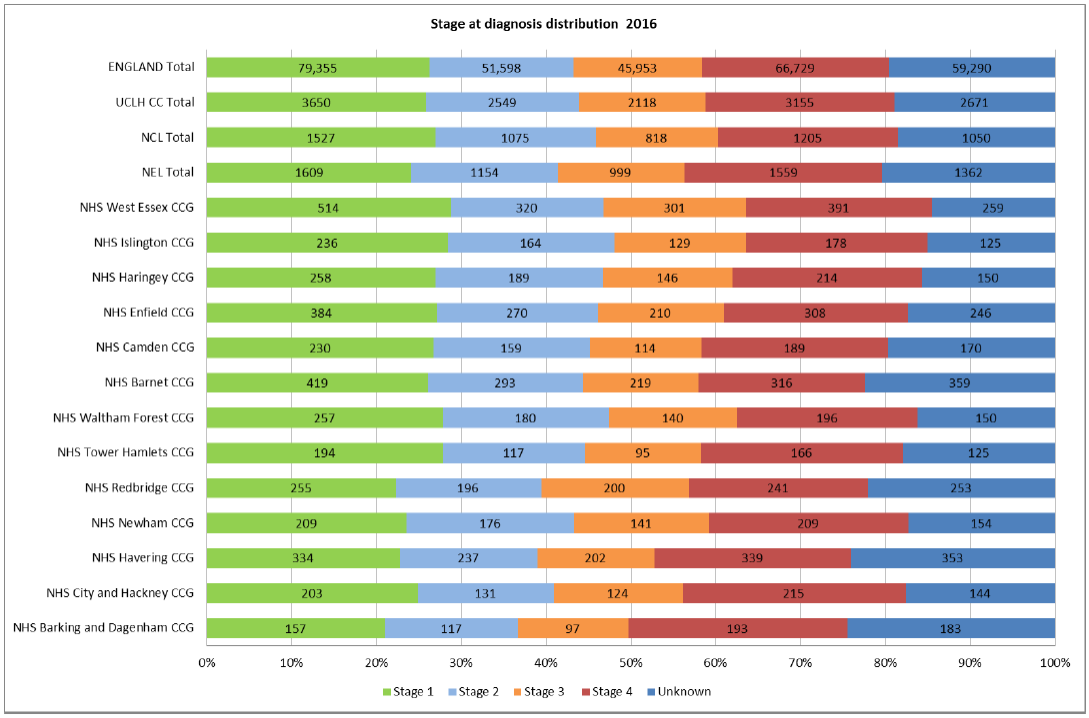


Fig 6. Stage at diagnosis, all tumours, NCL, 2016. Source: NCIN.

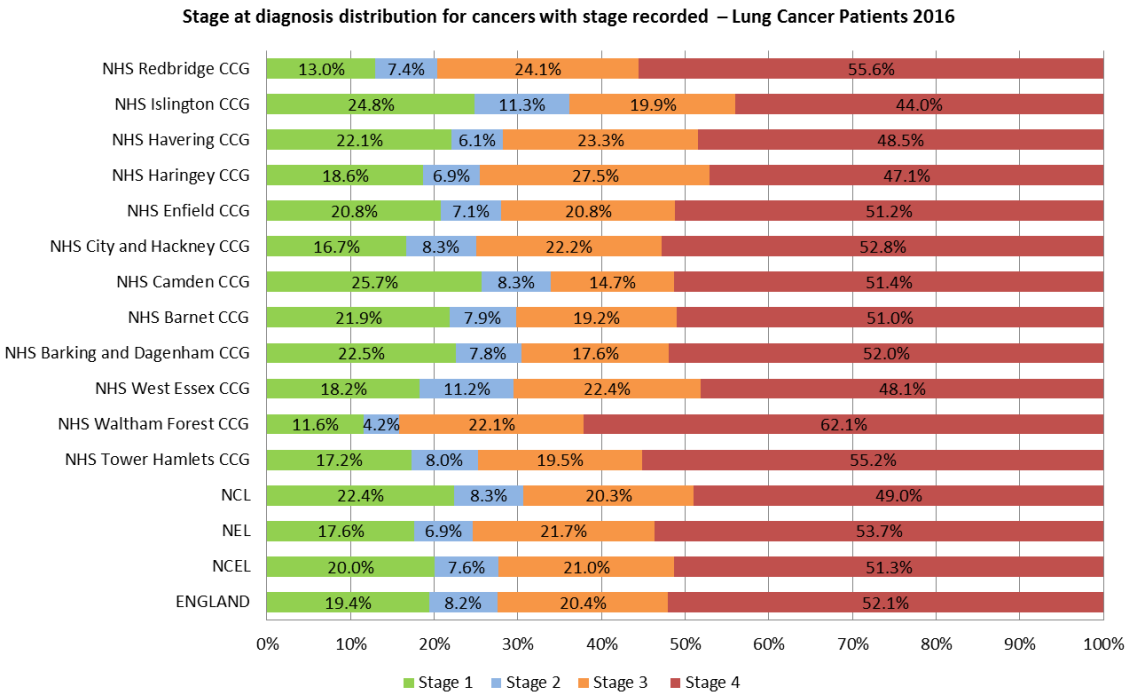


Figure 7. Lung cancer and stages at diagnosis by CCG, Source NCIN.

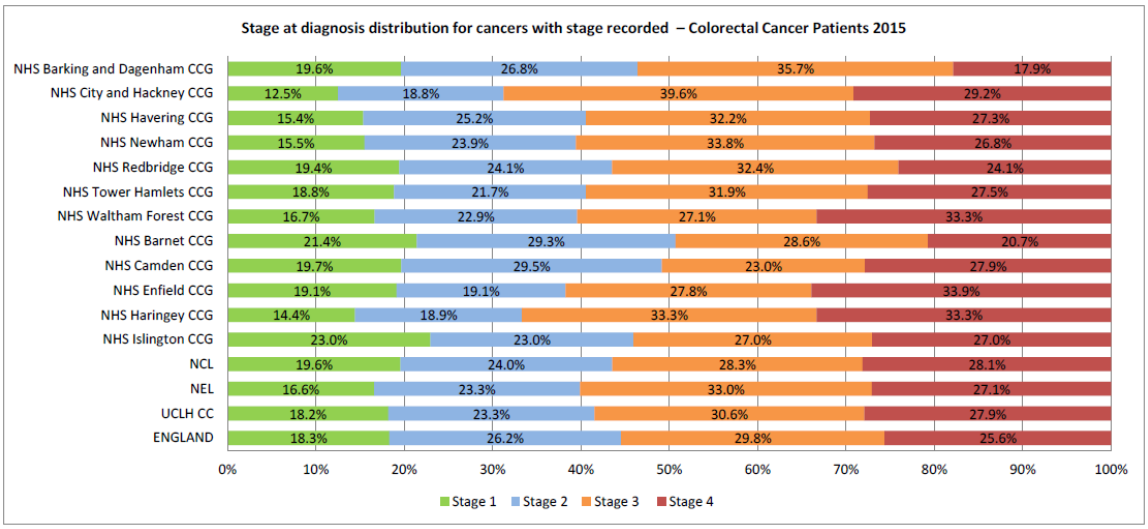


Figure 8. Colorectal (bowel) cancer and stages at diagnosis by CCG, Source NCIN.

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

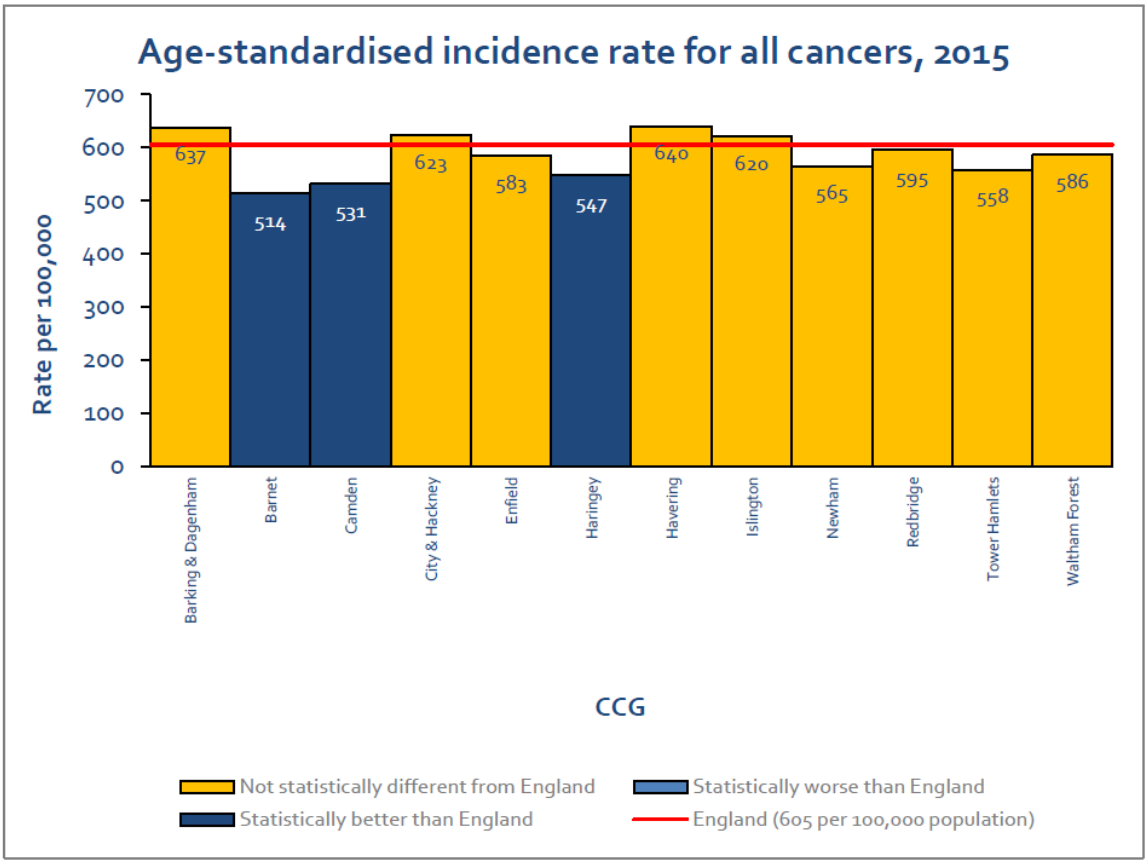


Figure 9. Age-standardised incidence rate for all cancers, 2015. Source: CADEAS.

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.

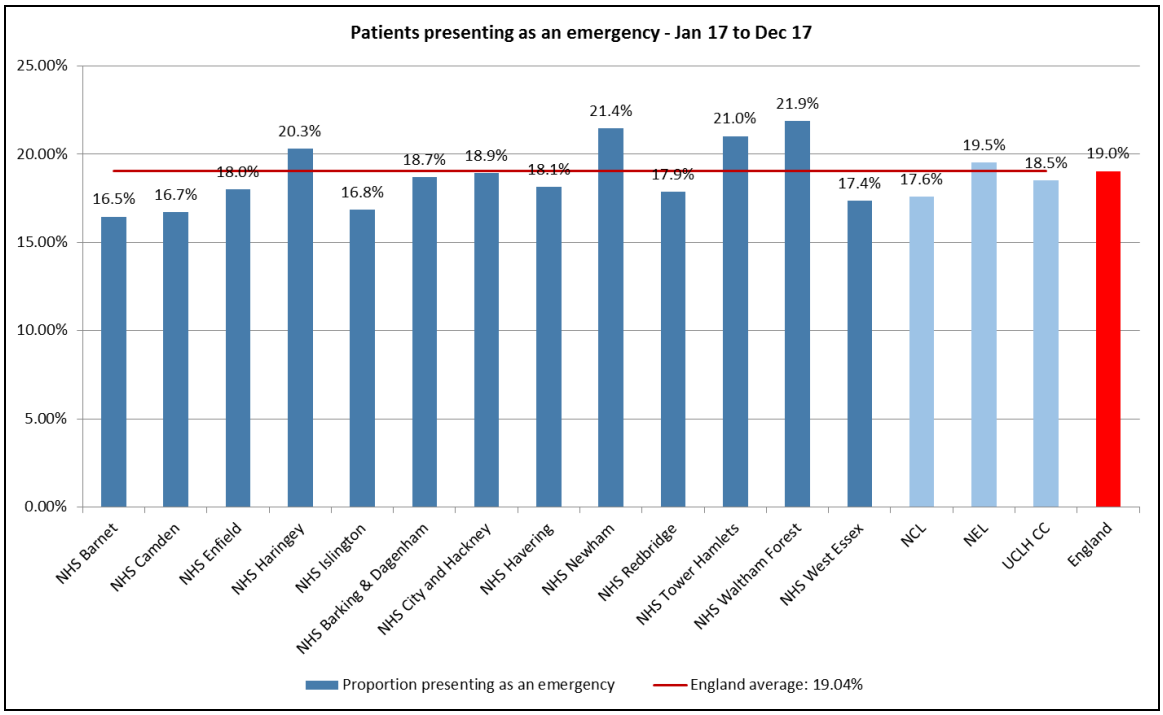


Figure 10. Proportion of cancer diagnosis through emergency presentation. Source: CADEAS.

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.

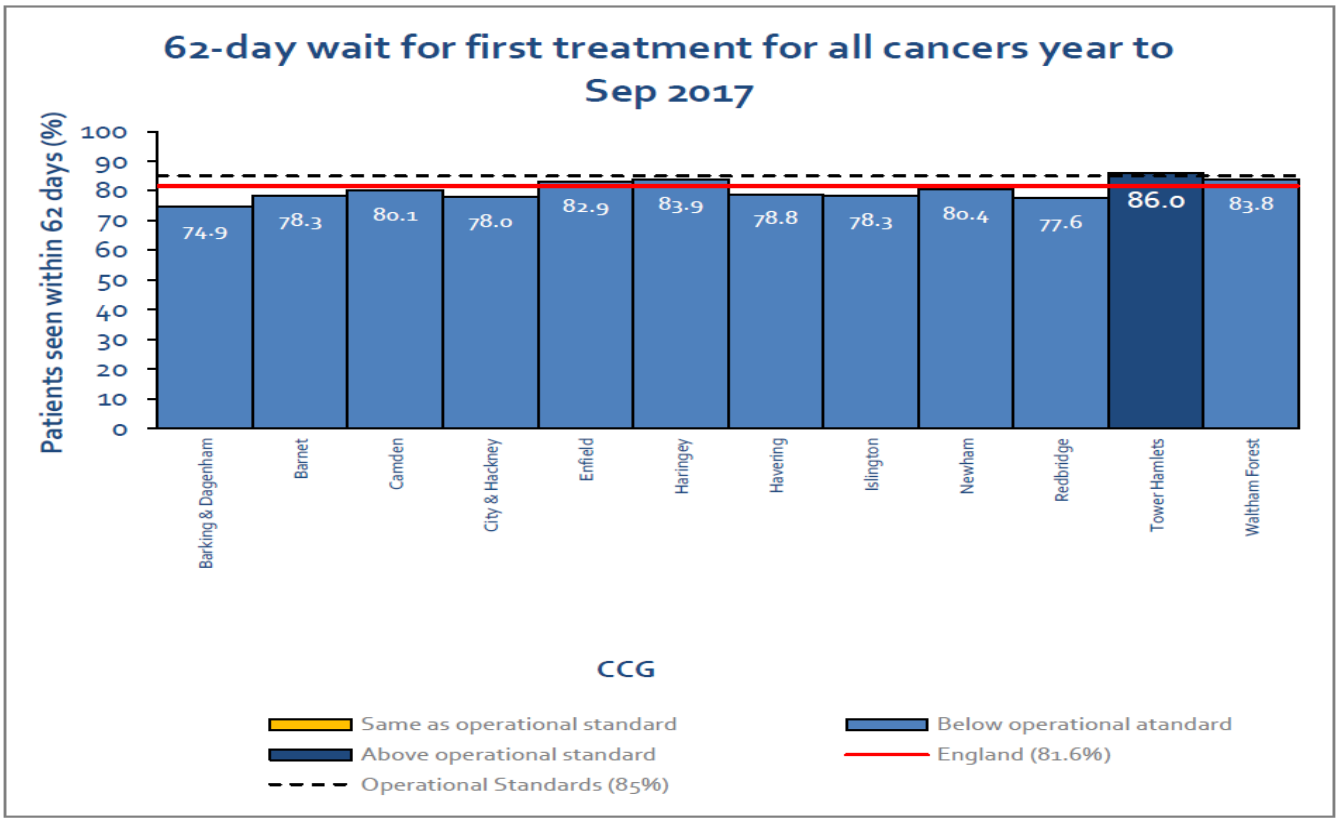


Fig 11. 62-day wait for first treatment for all cancers. Source: CADEAS.

4.10 One-year cancer survival

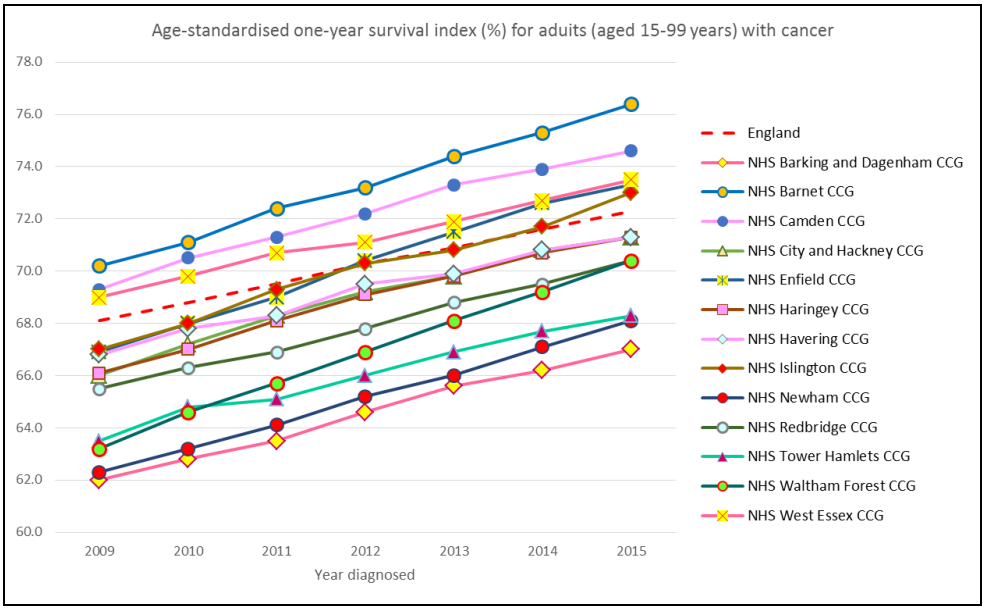


Figure 12. One-year survival for adults with cancer by CCG. Source: CADEAS.

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).

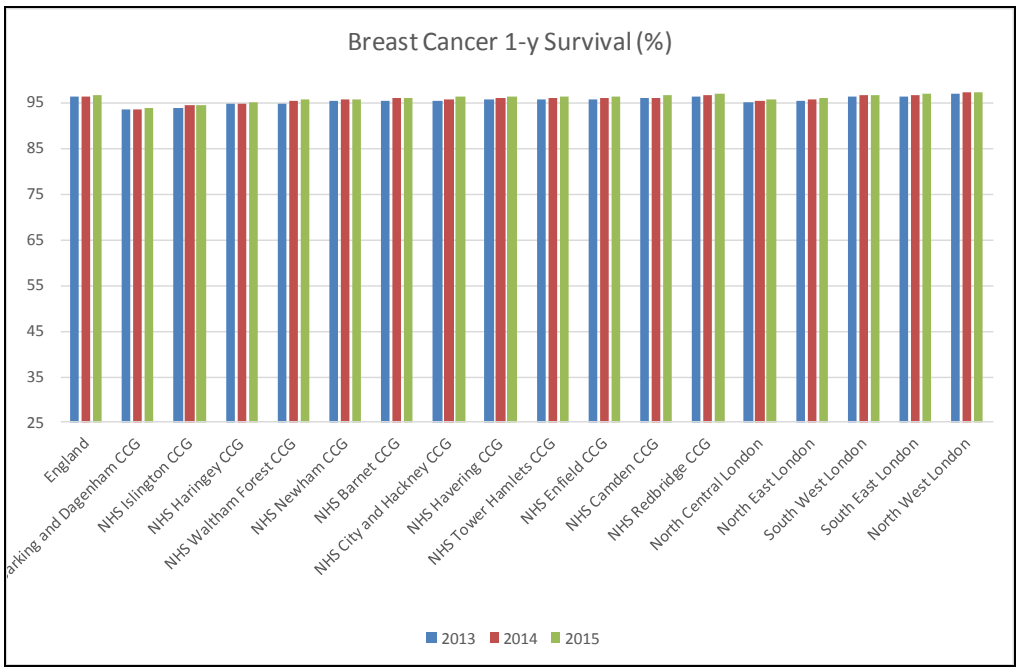


Figure 13. One-year survival for breast cancer by CCG. Source: CADEAS.

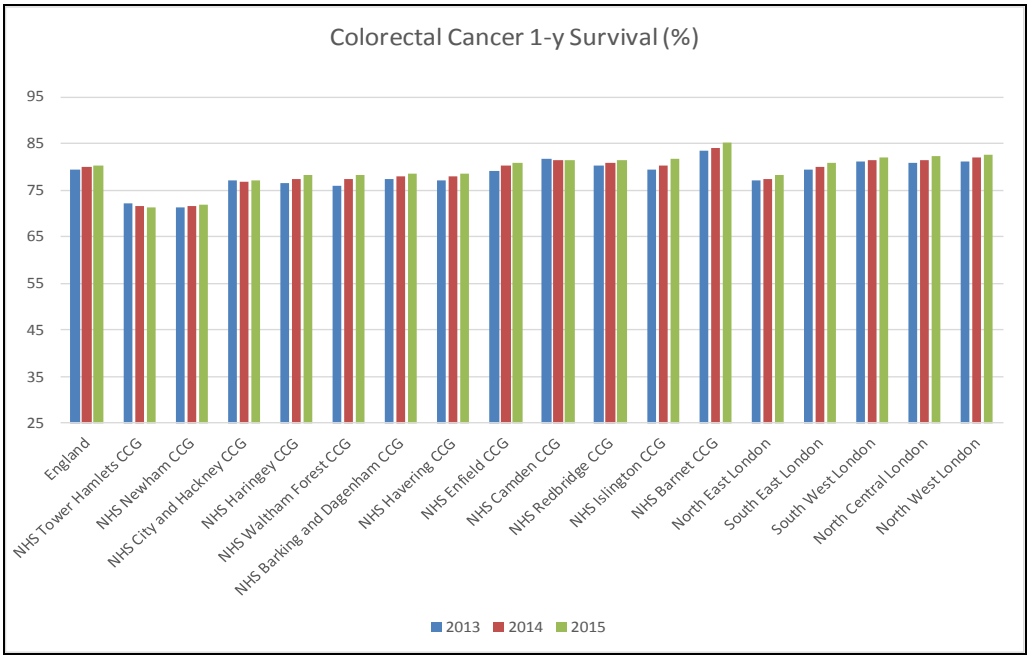


Figure 14. One-year survival for colorectal (bowel) cancer by CCG. Source: CADEAS.

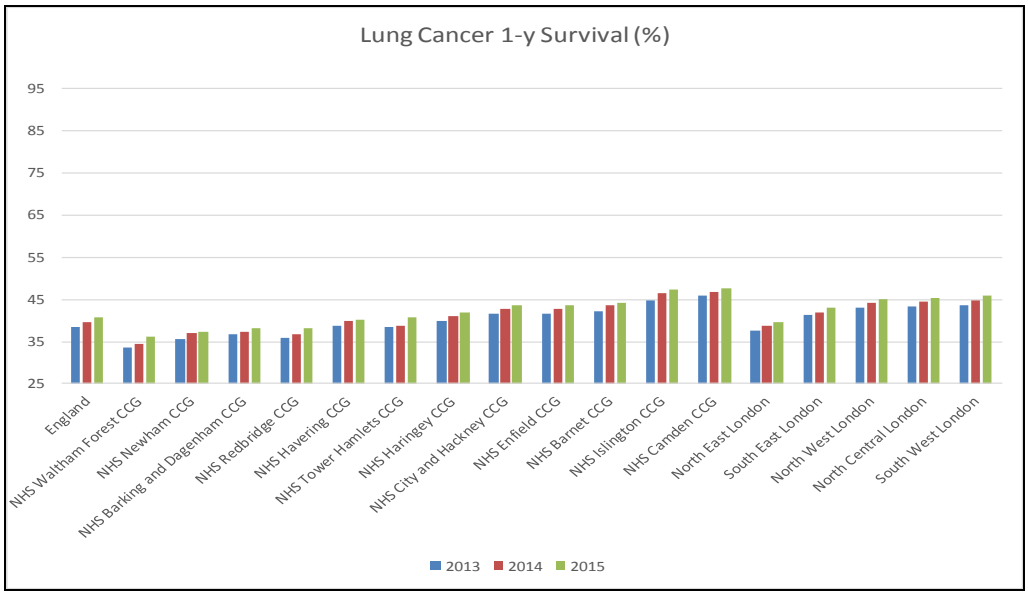


Figure 15. One-year survival for lung cancer by CCG. Source: CADEAS.

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.

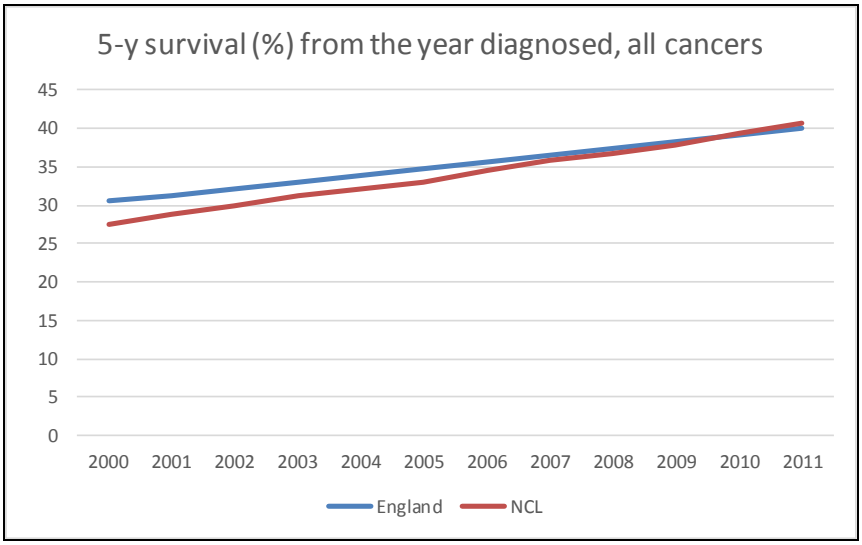


Fig 16. 5-year survival from all cancers. Source: TCST/PHE

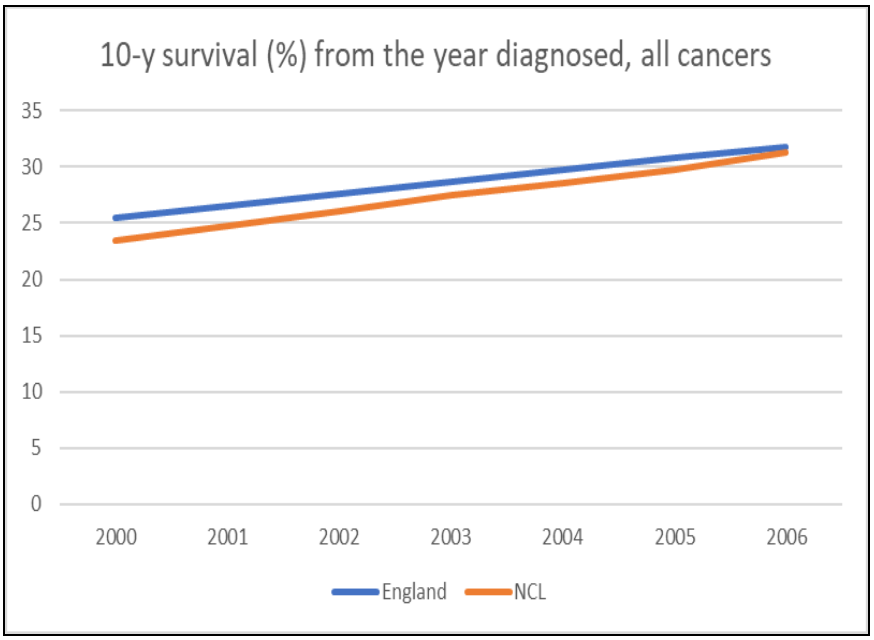


Fig 17. 10-year survival from all cancers. Source: TCST/PHE .

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.

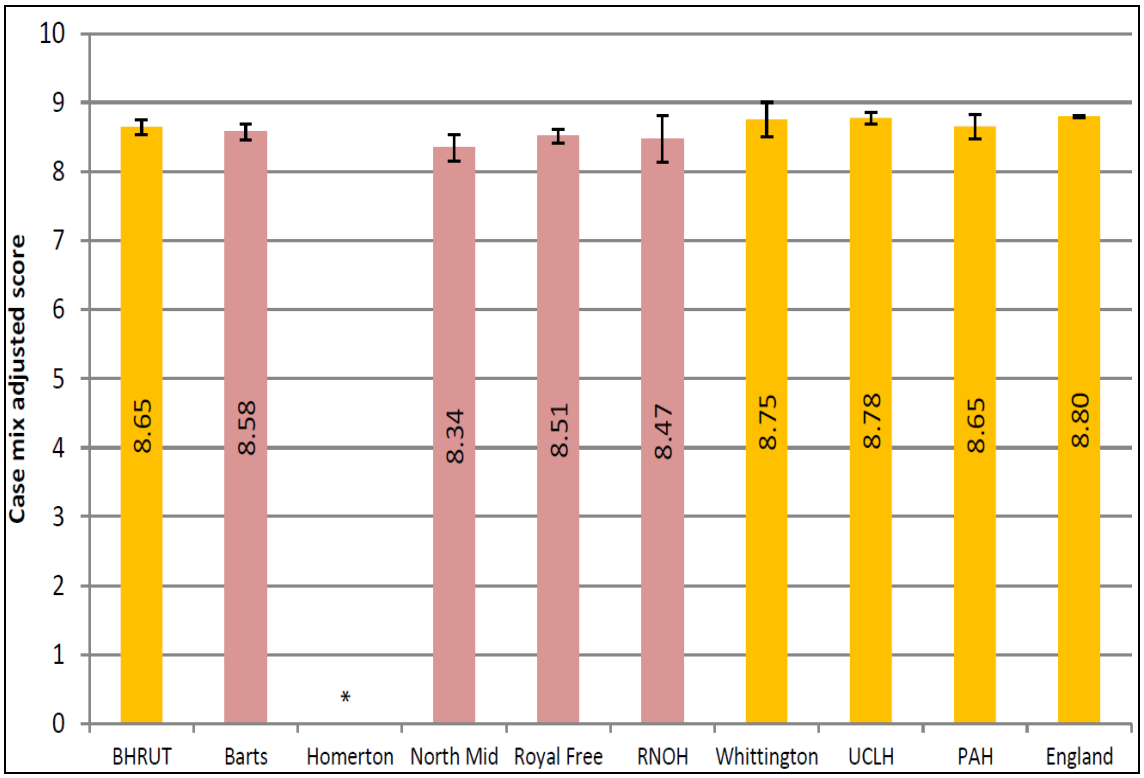


Fig 18. Case mix-adjusted patient experience scores; Q59. Overall, how would rate your care? (NCPES, 2017)

	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)

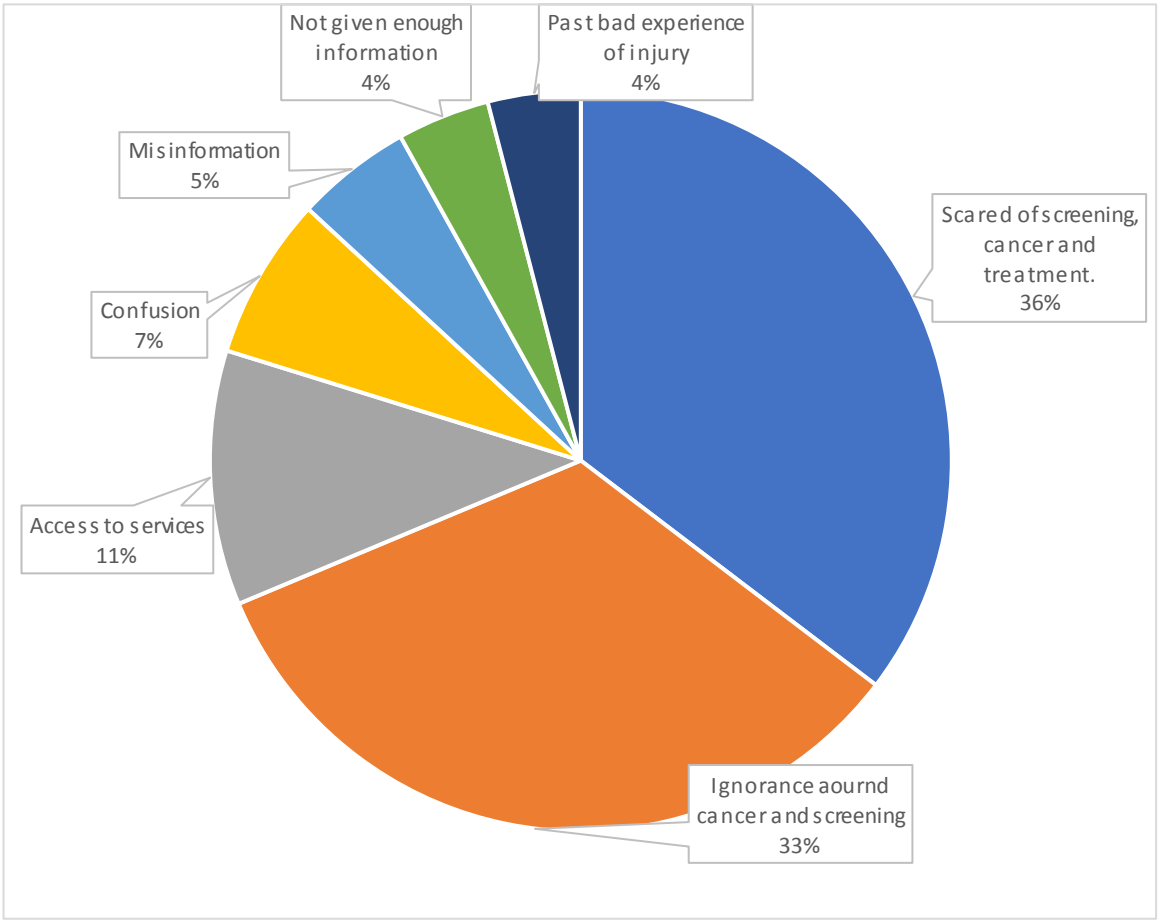


Figure 19. The causes behind not wanting to take part in cancer screening.

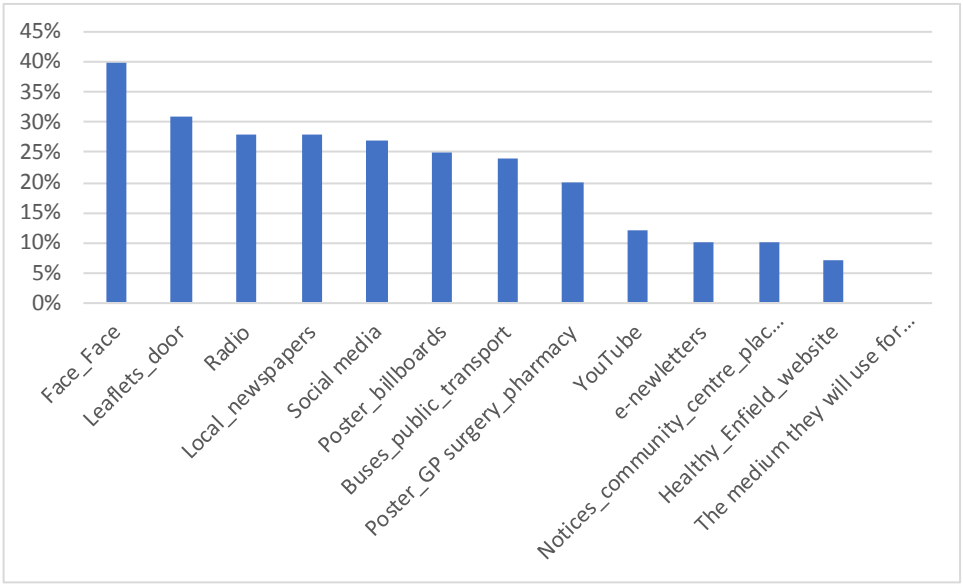


Figure 20. Popular channel of information by those who do not want to take part in cancer screening

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

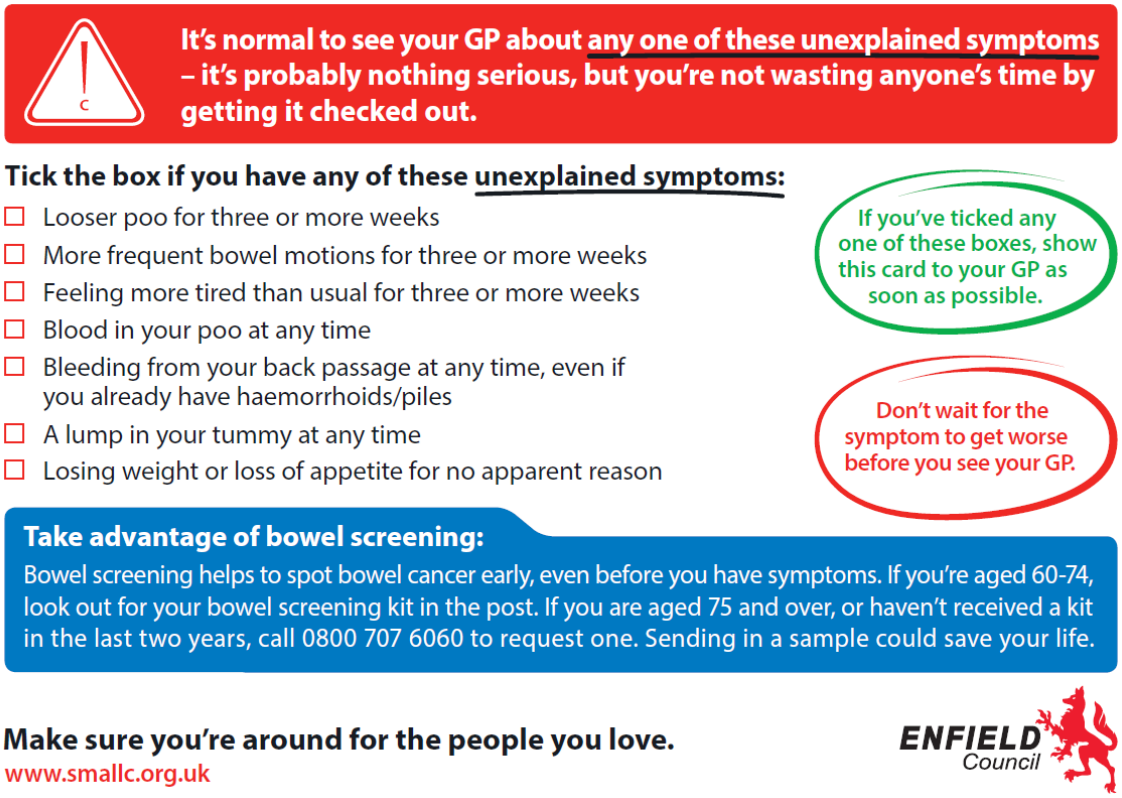
NHS Enfield Clinical Commissioning Group

ENFIELD Council

Appendix 6. Be clear on cancer symptoms, 2016

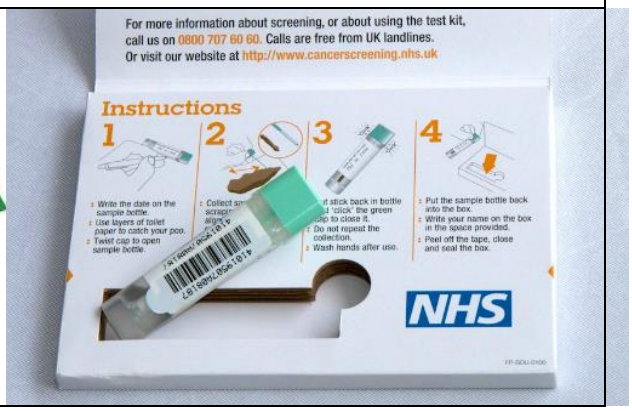
Appendix 7. Breast and bowel cancer screening, 2015.

Appendix 8. Small C Bowel Cancer Campaign June 2014



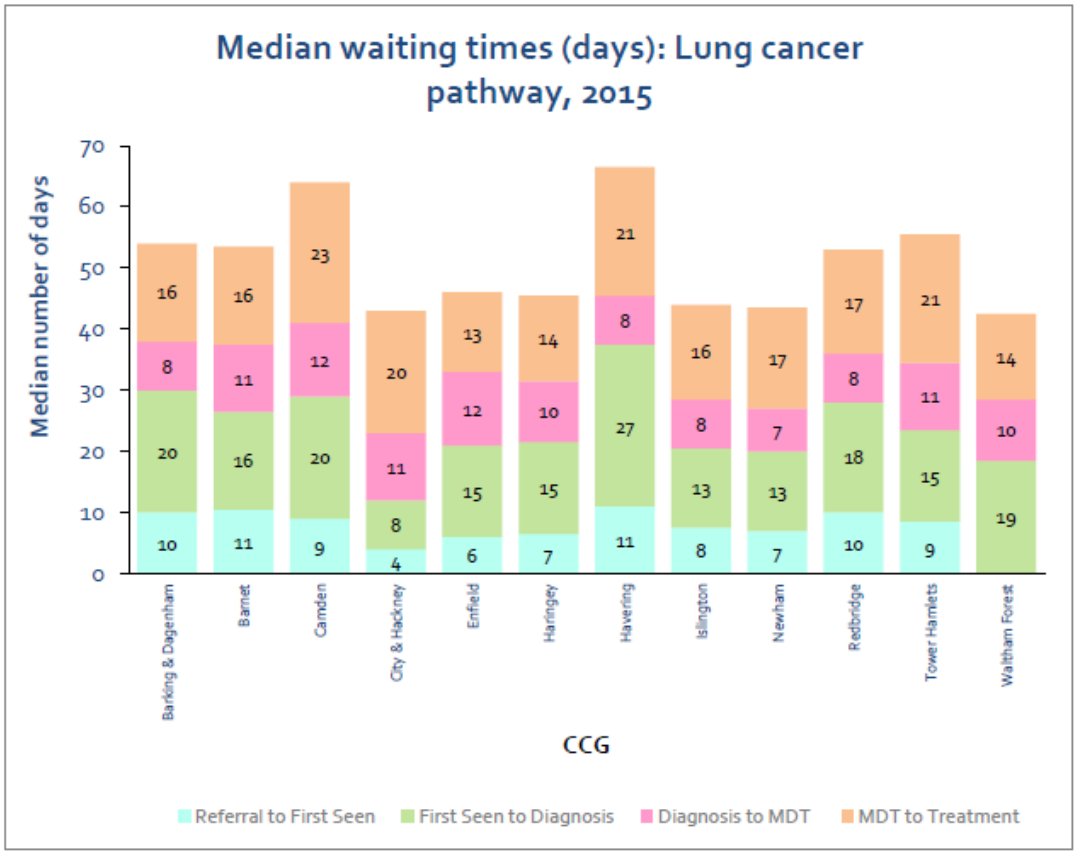
Appendix. Breast cancer and Stoptober Campaign, October 2013.

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

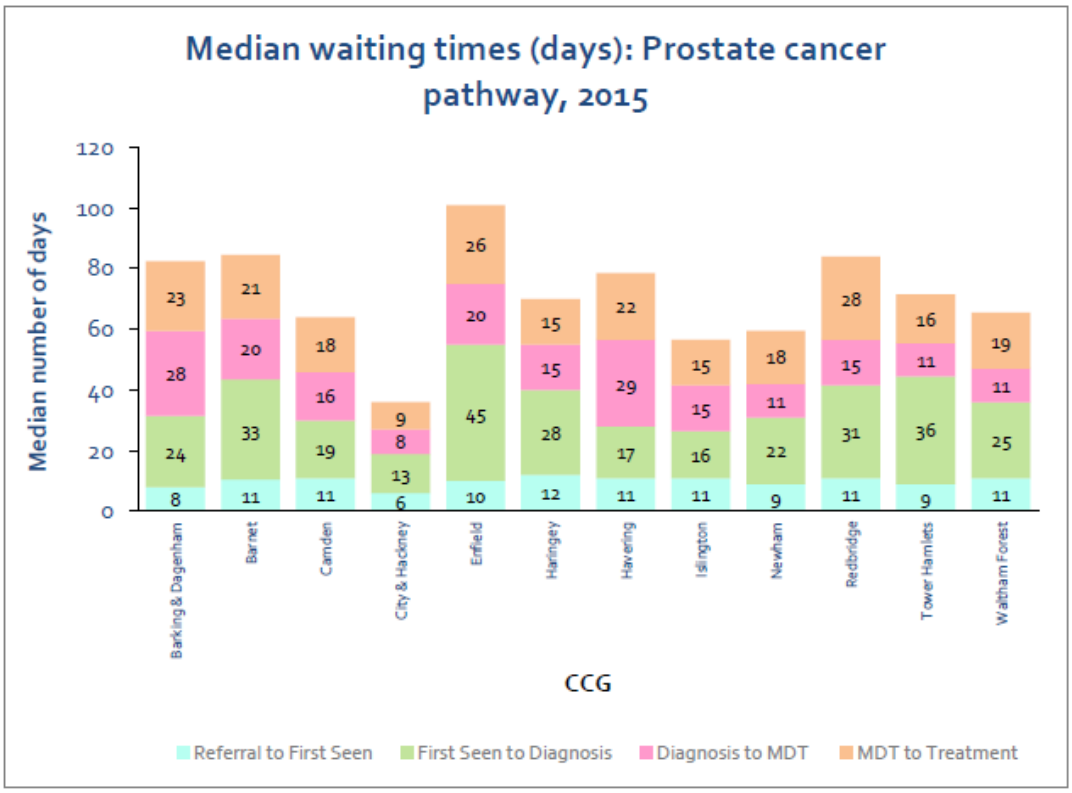
Guaiac Faecal Occult Blood Test (gFOBT)	Faecal Immunochemical Test (FIT)
	

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

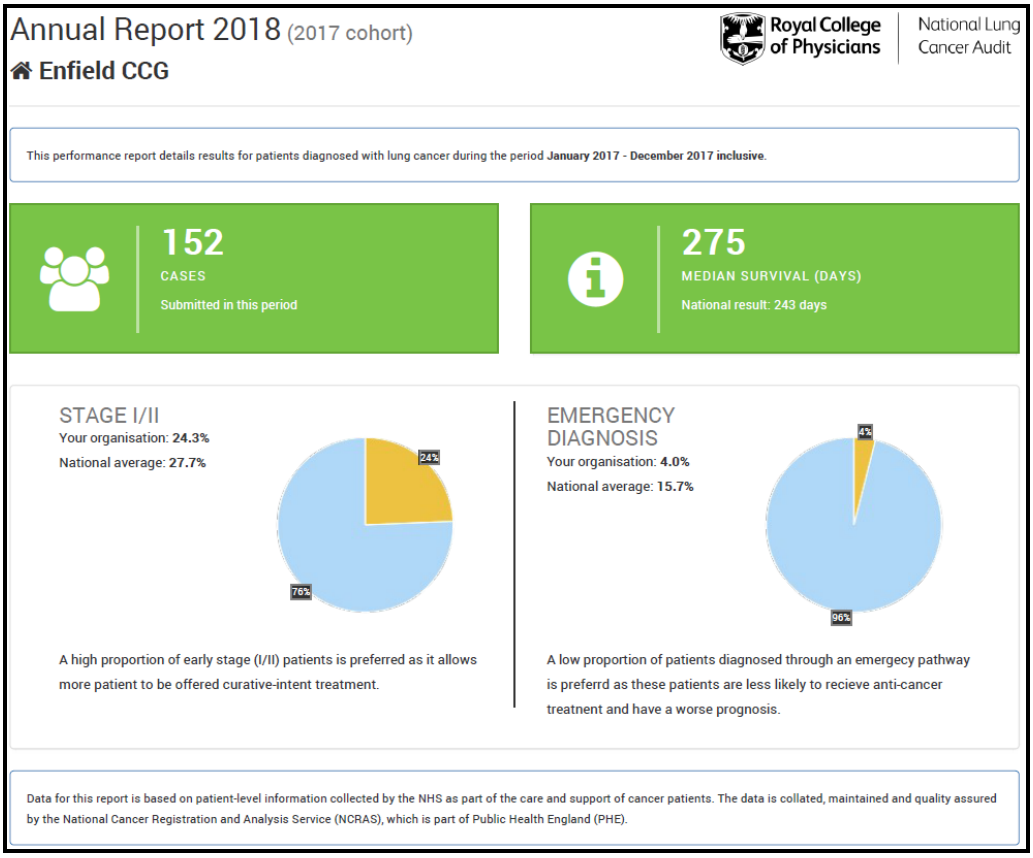
Median waiting times: Lung cancer pathway



Median waiting times: Prostate cancer pathway



Appendix 11. Lung cancer audit results for Enfield



Agenda Item 8

To: Health and Wellbeing Board
From: Shaun Rogan, Head of Corporate Strategy

Date: 12 June 2019

BRIEFING

Update on the Enfield Poverty and Inequality Commission (EPIC)

Background

As a key pledge of the Labour Group election manifesto of 2018, it was agreed that an independently delivered and time-limited commission be established to better understand the forces driving poverty and inequality in the borough and point the way to potential local solutions.

Following several months of preliminary research and engagement with specialist partners, a fit for purpose commissioning spec was issued in March 2019 to recruit an independent partner to deliver the Commission. Bids were assessed by three council officers, who unanimously agreed in April 2019 that the Smith Institute be commissioned to deliver the project.

The Smith Institute are a leading independent, not for profit, public policy think tank with a wealth of experience in running Commissions. This has included delivering bespoke work including for councils and non-governmental organisations, such as the Living Wage Foundation and Trust for London. The Institute has extensive experience conducting in depth research on social policy matters and recently published an authoritative study on poverty affecting outer London and social justice.

Purpose of the Commission and scope

Poverty and inequality affect thousands of people in Enfield, reducing their quality of life and limiting their opportunities. Tackling poverty and inequality is a priority for Enfield Council and matters not just for those affected but all residents.

The Commission is studying three inter-connecting strands of interest, with each considering the impact of protected characteristics on outcomes.

These are:

- **Living** – In Enfield, to what extent does who we are and where we live affect our life chances and the services we can access?

- **Learning** – Do challenges or barriers exist which prevent local people from accessing opportunities to excel through education and training?

- **Earning –** How can local people currently on low (net) incomes be supported to secure long-term economic prosperity?

By aiming to base our study on these three areas that can be easily identified by local people as relevant and engaging we hope that we can get to the heart of the matter with those people we most need to hear from on terms that enable them to speak to us effectively.

Identifying and recruiting Commissioners

The process of identifying and recruiting potential partners commenced in early 2019 and moved quickly to finalisation following the recruitment of the Smith Institute as partner facilitator.

This has been a highly successful effort and we have a very strong panel in place that can give us the maximum chance of success. The Panel is being independently chaired by Baroness Tyler of Enfield who as well as being born and raised in Enfield has a huge wealth of relevant experience to bring to the table. Baroness Tyler is being supported by a panel of Commissioners that balance national and regional expert knowledge with a strong local representation that bring the focus firmly inside our borough.

Chair

Baroness Claire Tyler of Enfield

Commissioners

- **Greg Beales -** Director of Communications, Policy & Campaigns, Shelter
- **Pamela Burke -** Chief Executive, Enfield Carers Centre
- **Sam Gurney -** Regional Secretary, TUC
- **Jill Harrison -** Chief Executive, Citizens Advice Enfield
- **Jinjer Kandola -** Chief Executive, Barnet, Enfield and Haringey Mental Health Trust (BEHMHT)
- **Daniella Lang –** Headteacher, Brimsdown Primary School
- **Monty Meth MBE –** President, Enfield Over 50's Forum
- **Laura Payne -** Project Manager, 4in 10 London Child Poverty Network
- **Dr Susan Tranter -** Chief Executive and Executive Headteacher, Edmonton County Secondary School
- **Dr Andrew Whittaker -** Associate Professor, London South Bank University

Further consideration is currently being given to extend local presentation to the core Panel.

Independent Facilitators

- **Joe Caluori -** Deputy Director, The Smith Institute
- **Paul Hunter -** Director, The Smith Institute

Enfield Council Officers in Support

- **Victoria Adnan –** Policy Development Officer
- **Harriet Potemkin –** Strategy and Policy Hub Manager
- **Shaun Rogan -** Head of Strategy, Partnerships, Engagement & Consultation

You can read short biographies on each of the Commission members in Appendix 1.

Launching the Commission

Supported by The Smith Institute, the Commission launched the call for evidence publicly at the first Commission meeting on the 7th June 2019. The launch was framed by an initiation document that included existing data, to set out the key challenges for residents living, learning and earning in Enfield. The first Commission meeting also included short presentations from senior internal lead officers on the challenges facing the local authority as it seeks to help people live, learn and earn.

Next steps

A comprehensive engagement programme is now being finalised. The Commission will engage directly with local people and organisations to better understand how poverty and inequality affects the lives of residents in the Borough. This will be done through a range of meetings, events, focus groups and interviews with people and organisations in the local community. This engagement programme will be led by the Smith Institute with support from Enfield Council.

As poverty and inequality are the focus of this Commission, engagement activities will target those communities and groups that suffer the worst impacts. This may mean that we spend more time in more deprived Wards and with organisations who serve the poorest citizens. In order to be as comprehensive as possible the Commission will ensure the voices of groups commonly perceived as ‘hard to reach’, such as young people, socially isolated adults and the elderly are heard. The Commission will approach this by engaging with these groups through local organisations or services with whom harder to reach groups have a pre-existing relationship.

The Commission is also gathering evidence submission via a dedicated email address (epic@enfield.gov.uk) and in writing via comment boxes at the four hub libraries (Enfield Town, Edmonton Green, Palmers Green, and Ordnance Road Unity Hub). The boxes will remain in place for the duration of the call for evidence (until 30th September 2019).

The Commission will meet periodically over the life cycle of the work to deliberate on evidence gathered and give further direction to The Smith Institute as it continues is engagement and analysis work before drafting the final report.

Crucially, the Commission will produce a set of actionable recommendations for the final report, that are shaped by the views of Enfield residents, to make life on low incomes in the borough better (living), extend opportunity (learning) and to increase incomes (earning).

A further update will be presented to the Health and Wellbeing Board at the next meeting.

Commission Timeline

The Commission will be delivered, between June and December 2019, with the following key milestones:

First Commission meeting / launch of call for evidence	7 June 2019
Engagement program begins	w/c 10 June
Member engagement	*TBC*
Second Commission meeting	w/c 22 July
Third Commission meeting	w/c 9 September
Close of call for evidence / analysis of submissions	w/c 7 October
Deliberative Workshop	w/c 7 October
Draft report supplied	w/c 21 October
Editing and final report sign off	w/c 4 November
Final Commission meeting	w/c 18 November
Launch of report and press call	Mid-December

The final report will be published in mid-December 2019. It is intended that the work of the Commission will also influence wider strategy development and service delivery in the borough. As well as contribute to broader political discourse concerning the impact of poverty and inequality on communities in the UK.

Appendix 1

Enfield Poverty and Inequality Commission: List of confirmed panel members (May 2019)

Chair

Baroness Tyler of Enfield
Claire Tyler was nominated as a Liberal Democrat Peer in November 2010 and from February 2011 has sat in the House of Lords as Baroness Tyler of Enfield. She served as the Chair of CAFCASS (The Children and Family Court Advisory and Support Service) from March 2012 to March 2018. Between 2007 and 2012 Claire was the Chief Executive Officer of Relate, the UK's leading relationship support agency. She currently chairs the "Make Every Adult Matter" coalition of charities and serves on the board of Social Work England. Claire is also the current President of the NCB (National Children's Bureau).

Commissioners

Greg Beales - Director of Communications, Policy & Campaigns Shelter
Greg joined Shelter in 2017 and has previously worked as Director of Strategy & Planning at the Labour Party, as a Senior Policy Advisor at Downing Street and as National Performance Director for the NHS.

Pamela Burke - Chief Executive, Enfield Carers Centre
Pamela is Chief Executive at Enfield Carers Centre. This is a major local charity providing information, advice, training and other support services to people looking after someone living in Enfield, and who has an illness, disability or substance misuse issue.

Sam Gurney – Regional Secretary, TUC
Sam Gurney was appointed as Regional Secretary for the Trades Union Congress London, East and South East Region in January 2018. Prior to this he was acting head of the TUC's Equality and Strategy department. His Previous roles at the TUC include; Senior Strategy and Development Officer and Policy Officer in the International Department. He was a member of the Governing Body of the UN International Labour Organisation 2009-2017. Before he joined the TUC in 2003, he was a Regional Organiser for GMB union London Region and an Assistant National Organiser at Connect.

Jill Harrison, Chief Executive – Citizens Advice Enfield
Jill is the Chief Executive at Citizens Advice Enfield. This is a charity that offers free, accessible, quality advice to anyone who lives in Enfield. This includes help with all housing, employment, benefits, debts or immigration issues.

Jinjer Kandola, Chief Executive - Barnet, Enfield and Haringey Mental Health Trust (BEHMHT)
Jinjer is the Chief Executive of Barnet, Enfield and Haringey Mental Health Trust (BEHMHT). Jinjer joined the organisation in July 2018 and has a wealth of

knowledge, with over 18 years of senior level experience across both mental and physical healthcare. Jinjer was the first Asian woman to be awarded Human Resources Director of the Year, is the first Punjabi CEO in the NHS and is one of only five NHS CEOs from a BAME background.

Daniella Lang, Headteacher - Brimsdown Primary School
Since being appointed as Headteacher at Brimsdown Primary School in Enfield, Daniella has overseen a programme of improvement that has transformed performance and the working environment. Over the space of two years, by taking an innovative approach to staff wellbeing and team development, Daniella and her staff have elevated Brimsdown Primary from a school Ofsted rated as 'requires improvement' to one that is recognised as being 'good with 3 outstanding elements'.

Monty Meth MBE, President, Enfield Borough Over 50s Forum
Monty is a former journalist and is now President of the Over 50s Forum, one of the largest organisations of its kind in the country with a diverse subscribing membership of 6,000. The Forum campaigns on a wide variety of national and local issues in seeking to influence decision-makers on matters such as health, local transport and universal benefits. It provides a wide range of activities aimed at keeping older people active in mind and body and combatting loneliness and social isolation.

Laura Payne - Project Manager, 4in 10 London Child Poverty Network
Laura has over ten years of experience campaigning on issues of poverty and disadvantage faced by children in the UK. Laura has worked previously with Barnardo's as the Head of Campaigns, where her work included campaigns on child sexual exploitation and care leaver accommodation, and for the End Child Poverty campaign.

Dr Susan Tranter, Chief Executive and Executive Headteacher - Edmonton County Secondary School
Dr Susan Tranter was appointed to the Child Safeguarding Practice Review Panel in June 2018 and is a member of the DfE National Child safeguarding practice panel. Susan is Executive Head Teacher of Edmonton County Schools and Chief Executive of Edmonton Academy Trust. Susan is also a member of the Mayor of London's Office for Policing and Crime Strategy Group, and a member of the Audit and Risk Committee of the Office of the Children's Commissioner.

Dr Andrew Whittaker, Associate Professor, London South Bank University
Dr Andrew Whittaker is Associate Professor and Head of the Risk Resilience and Expert Decision Making (RRED) research group. His current research focuses on the risks faced by young people in London and he recently published a report on the link between poverty and the evolution of gangs in the London Borough of Waltham Forest, "From Postcodes to Profit" (2018). He has acted as an external reviewer for the Parliamentary Office for Science and Technology on gang related topics and his research has been featured on BBC TV and Radio 4.

MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON WEDNESDAY, 20 MARCH 2019

MEMBERSHIP

PRESENT Yasemin Brett, Achilleas Georgiou, Parin Bahl (Chair of Enfield Health Watch), Stuart Lines (Director of Public Health), Bindi Nagra (Director of Adult Social Care), Pamela Burke (Voluntary Sector), Jo Ikhelef (CEO of Enfield Voluntary Action), Natalie Forrest (Chief Executive, Chase Farm Hospital, Royal Free Group) and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust)

ABSENT Alev Cazimoglu (Cabinet Member for Health & Social Care), Nesil Caliskan (Leader of the Council), Mo Abedi (Enfield Clinical Commissioning Group Medical Director), John Wardell (Clinical Commissioning Group (CCG) Chief Officer), Dr Helene Brown (NHS England Representative), Tony Theodoulou (Executive Director of Children's Services), Vivien Giladi (Voluntary Sector) and Maria Kane (Chief Executive North Middlesex University Hospital NHS Trust)

OFFICERS: Dr Glenn Stewart (Assistant Director, Public Health), Mark Tickner (Senior Public Health Strategist), Harriet Potemkin (Strategy, Partnerships, Engagement & Consultation) and Niki Nicolaou (Voluntary Sector Manager) Jane Creer (Secretary)

Also Attending: Peppa Aubyn (representing Enfield CCG), Richard Gourlay (representing North Middlesex University Hospital NHS Trust), Councillor Derek Levy (Chair of Overview and Scrutiny Committee), Patricia Mecinska (Chief Executive of Healthwatch Enfield)

1
WELCOME AND APOLOGIES

Councillor Yasemin Brett, chairing the meeting in the absence of the Chair and Vice Chair, welcomed everyone to the meeting. Apologies for absence were received from Councillor Alev Cazimoglu, Councillor Nesil Caliskan, Dr Mo Abedi, John Wardell, Dr Helene Brown, Tony Theodoulou, Maria Kane and Vivien Giladi. Enfield CCG was represented by Peppa Aubyn, and North Middlesex University Hospital NHS Trust by Richard Gourlay.

2
DECLARATION OF INTERESTS

There were no declarations of interest in respect of any items on the agenda.

3
LONELINESS AND SOCIAL ISOLATION SCRUTINY WORK STREAM REPORT AND RECOMMENDATIONS

RECEIVED the final report of the Loneliness and Social Isolation Scrutiny Workstream, and presentation by Councillor Derek Levy, workstream chair.

NOTED the presentation highlighted the following:
• Loneliness and social isolation was recognised as a major problem.
• Local government and its partners were primarily enablers and facilitators of measures, many of which could be done at low or no cost.
• Though a major public health issue, this was a strategic issue that cut across departments. It could be particularly factored into spatial planning.
• The impact on a range of age groups was highlighted, and the importance of many parts of the Council to understand the issue.
• There was a need to think thematically and to change the culture of the way we operate.
• We can make a difference, and save resources and money in the long term.

IN RESPONSE comments and questions included:
1. The Chair recommended that all partners could encourage their staff into volunteering schemes.
2. Jo Ikhelef expressed complete support for the report and the recommendations. She would like to engage further with Recommendation 1.3 in particular, having experienced difficulties in utilising existing buildings for community use. Such barriers should be overcome. The Chair advised this should be a future item for Health and Wellbeing Board discussion, with Mark Bradbury and Councillor Oykener to be invited.

   ACTION: Public Health Team
3. In response to Richard Gourlay confirming NMUH support and queries about the coordination, it was advised that this was currently an early stage but a structure would be put in place operationally.
4. Bindi Nagra confirmed in respect of Recommendation 1.6 the database on the Council website, the My Life resource directory, listed over 400 activities and could be searched by location. Councillor Levy highlighted the importance of communication of this information, and that not everyone had access to a computer. Niki Nicolaou also held information on all voluntary organisations, but there could be transportation issues in reaching venues and that there may be a charge for some activities.
5. Stuart Lines highlighted the parallels with the Health in All Policies approach. It was important to emphasize the link between mental health and physical health. Understanding of the issues would allow them to be addressed. The Make Every Contact Count initiative could also be used to signpost people onto groups and activities.
6. Parin Bahl welcomed the report and thanked the workstream for raising awareness, and hoped they would take the community with them. A bigger

communication plan was required, involving local people in designing. She would be happy to give assistance.

7. The Chair thanked Councillor Levy for attending, and that members were welcome to contact him.

AGREED that Health and Wellbeing Board noted the recommendations put forward in the review and noted the responses provided by Directors and Executive Directors in Appendix A.

4

JOINT HEALTH AND WELLBEING STRATEGY (JHWBS) : REVIEW OF 2014-19 JHWBS / FEEDBACK FROM SUCCESSOR JHWBS CONSULTATION / PROGRESS UPDATE ON THE NEW JHWBS 2019 - 2022

RECEIVED the report of Stuart Lines (Director of Public Health).

NOTED

Public Health officers' introduction of the report highlighted:

- The previous JHWBS had been reviewed. There had been some improvements, such as reduction in teenage conception rates, but performance was difficult to measure in many areas.
- The successive strategy would need more specific focus and have more detailed and measurable outcomes and action plans.
- The 2019 – 2022 strategy was based on discussions with Board Members since the summer, and on public consultation, including a community event.
- There had been broad support for the vision.
- Members were encouraged to provide feedback and comments.
- Patricia Mecinska highlighted the report by Healthwatch Enfield set out from page 77 in the agenda pack, and that the organisation had been keen to be involved and had utilised their annual conference for conversation and feedback with the community. The re-focused priorities were welcomed, as well as the strong recommendation that mental health had more focus in the new strategy.

IN RESPONSE comments and questions were received, including:

1. There had not been resistance expressed to expanding smoking bans, and Bindi Nagra recommended that measures to introduce more no-smoking areas would receive support, and that bold ideas should be discussed and convention challenged. A number of potential actions were discussed for being smoke-free.
2. In response to a query on how the strategy linked with the Local Plan, for example to encourage exercise, it was confirmed that the Board had an input into the Local Plan, and that a health assessment was being carried out in respect of the Meridian Water development. There was also a proposal that Board membership be expanded to include representatives for Housing, Regeneration and Planning.

3. Parin Bahl's comments that the strategy included priorities which had the support of local people, and which came from data and evidence.
4. Members emphasised the need for joined up thinking and that recommendations had to work practically for people. The strategy could appear simple, but this was a transformational opportunity for the Council and its partners.
5. In respect of increasing activity, the participation in Park Run was discussed, and introduction of Junior Park Run, as well as encouraging more schools to participate in 'daily mile' or running initiatives. Distance markers along routes to / from stations or bus stops or parks were also suggested. It was important to make physical activity part of everyday life, and without financial cost.
6. Patricia Mecinska's comment that people had knowledge about what to do to be healthier. The biggest challenge was going to be changing people's habits. Many solutions of what could practically be done were cheap or free, and would help alleviate social isolation, such as gym buddy systems, first timer sessions and group activities. There was a role for commissioners to communicate to the grass roots. As employers there was a role to give staff time to exercise and to offer healthy food choices. She requested that work continued with local residents in order to make a meaningful difference. A number of those people engaging wanted to know more and could be kept informed via a newsletter.
7. The next steps were set out. Harriet Potemkin would provide all partners with an action plan template to gather specific measurable outcomes to be actioned over the next 12 months. It was suggested that a HWBB development session should be convened before the end of April. The final version of the strategy would be submitted to the Board for approval in May.

ACTION: Public Health Team / Harriet Potemkin

AGREED that Health and Wellbeing Board considered the results of the public consultation and:

(1) provided feedback on the draft strategy narrative and suggested any changes;

(2) provided a commitment to action from their organisation in relation to the priority areas. These commitments would then be included in the strategy action plan.

5

VOLUNTARY SECTOR REPRESENTATIVE APPOINTMENT / SELECTION PROCESS

NOTED that Pamela Burke was welcomed as the new Voluntary Sector representative, along with the re-appointment of Vivien Giladi. Thanks were recorded to previous representative Litsa Worrall for her contribution to the Health and Wellbeing Board.

6
MEMBERSHIP OF HEALTH AND WELLBEING BOARD

NOTED the update from Stuart Lines, Director of Public Health, that a change in the Board's terms of reference was being considered to reflect the wider remit of health and wellbeing, and to potentially include representatives of Housing and Regeneration and others as Board members. There may also be an overlap with Enfield Strategic Partnership. The issues would be discussed further with the Chair and a future report made to the Board.

7
VISIT TO BOROUGH BY DUNCAN SELBIE (CHIEF EXECUTIVE, PUBLIC HEALTH ENGLAND)

NOTED the update from Stuart Lines, Director of Public Health, that the Chief Executive of Public Health England had a very positive visit to Enfield last month. The work going on in Enfield and the challenges faced by the borough were set out to him.

8
PROPOSED LGA INTEGRATION WORK WITH BOARD

RECEIVED the report of the Director of Public Health.

NOTED
1. Mark Tickner, Senior Public Health Strategist provided an update regarding the facilitation of a joint workshop with the Local Government Association (LGA).
2. Harriet Potemkin's suggestion that the workshop may potentially be used to create the JHWBS action plan.
3. Members raised concerns in respect of NHS long term plans and integrated care systems; the potential loss of localism, and the importance of Health and Wellbeing Board involvement. It was advised that plans were at an early stage, but the concerns would be fed back to the CCG Chief Officer and a statement requested to Board Members and a discussion at the next Board meeting. It was suggested that the LGA workshop event should focus on Integration.

ACTION: Mark Tickner / CCG

9
LOCAL GOVERNMENT ASSOCIATION HEALTH AND WELLBEING SYSTEM BULLETIN

RECEIVED the LGA Health and Wellbeing System Bulletin for information.

10
MINUTES OF THE MEETING HELD ON 6 DECEMBER 2018

AGREED the minutes of the meeting held on 6 December 2018.

11
INFORMATION BULLETIN

To be sent to follow.

ACTION: Mark Tickner

12
HEALTH AND WELLBEING BOARD FORWARD PLAN

To be sent to follow.

ACTION: Mark Tickner

13
DATES OF FUTURE MEETINGS

NOTED the dates of future meetings for the 2019/20 municipal year would be agreed at Annual Council on 8 May 2019.