Notice of Meeting

HEALTH AND ADULT SERVICES SELECT COMMITTEE

Wednesday, 1 March 2017 - 7:00 pm  
Committee Room 2, Town Hall, Barking

Members: Cllr Peter Chand (Lead Member); Cllr Linda Zanitchkhah (Deputy Lead Member); Cllr Sanchia Alasia, Cllr Abdul Aziz, Cllr Edna Fergus, Cllr Jane Jones, Cllr Eileen Keller, Cllr Hardial Singh Rai and Cllr Faraaz Shaukat

By Invitation: Cllr Maureen Worby (Agenda Item 4)

Date of publication: 21 February 2017  
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Chief Executive

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AGENDA

1. Apologies for Absence

2. Declaration of Members’ Interests

In accordance with the Council’s Constitution, Members are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. Minutes - To confirm as correct the minutes of the meeting held on 11 January 2017 (Pages 3 - 8)

4. Draft Report resulting from the Committee’s Scrutiny Review on Cancer Prevention, Awareness and Early Detection (Pages 9 - 55)

The Cabinet Member for Social Care and Health Integration has been invited to the meeting for her comments on the Draft Report.

5. Update on the matters covered at the last Joint Health Overview & Scrutiny Committee (Pages 57 - 59)

6. Work Programme (Page 61)

The following items were scheduled to be presented at today’s meeting; however, following discussions with the Leads for each item and the Chair of the Select
Committee, it was agreed that they would be re-scheduled for a future meeting:

- Update on Eye Care recommendations from Barking and Dagenham Clinical Commissioning Group;
- Health and Local Government Ombudsman report on failures in discharge from hospital; and
- Care Quality Commission’s re-inspection of BHRUT.

7. Any other public items which the Chair decides are urgent

8. To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.

Private Business

The public and press have a legal right to attend Council meetings such as the Health and Adult Services Select Committee, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). There are no such items at the time of preparing this agenda.

9. Any other confidential or exempt items which the Chair decides are urgent
Our Vision for Barking and Dagenham

One borough; one community; London’s growth opportunity

Our Priorities

Encouraging civic pride

- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

Enabling social responsibility

- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

Growing the borough

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough’s image to attract investment and business growth

Well run organisation

- A digital Council, with appropriate services delivered online
- Promote equalities in the workforce and community
- Implement a smarter working programme, making best use of accommodation and IT
- Allow Members and staff to work flexibly to support the community
- Continue to manage finances efficiently, looking for ways to make savings and generate income
- Be innovative in service delivery
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AGENDA ITEM 3

MINUTES OF
HEALTH AND ADULT SERVICES SELECT COMMITTEE

Wednesday, 11 January 2017
(7:00 - 8:05 pm)

Present: Cllr Peter Chand (Chair), Cllr Sanchia Alasia, Cllr Abdul Aziz, Cllr Jane Jones, Cllr Eileen Keller, Cllr Hardial Singh Rai and Cllr Faraaz Shaukat

27. Declaration of Members' Interests

There were no declarations of interest.

28. Minutes - To confirm as correct the minutes of the meeting held on 2 November 2016

The minutes of the meeting held on 2 November 2016 were confirmed as correct.

29. Review of Continuing Healthcare Packages

Rob Meaker, Director of Innovation (the DI) for Barking and Dagenham, Redbridge and Havering Clinical Commissioning Groups (BHRCCGs), delivered a presentation on BHRCCGs’ planned review of Continuing Healthcare Packages. The DI stated that:

- Continuing Healthcare (CHC) packages were NHS packages of care for those who had been assessed and identified as having a continuing healthcare need.
- BHRCCGs were in the process of reviewing CHC packages of people with learning difficulties with enhanced care needs (packages of over £1000).
- Historically, once a package was provided a reassessment may not have been carried out for some time (sometimes years) even though the initial assessment may have covered short-term care measures. The purpose of the review is to ensure that the packages are appropriate for the patient’s needs, which may have changed since they first became eligible to receive a CHC package.
- Barking and Dagenham CCG has employed a nurse assessor who is visiting everyone with a CHC package of over £1,000 in the borough. Once all patients have been reassessed anyone who has been identified as potentially needing a different package will have a full assessment by the CCG and the community learning disability team to assess their needs. Together they will use the ‘decision support tool’ to identify the most appropriate care package.
- 30 Barking and Dagenham residents had already been reviewed with ten people yet to be reviewed. 70 percent of those reviewed would have seen a change to their care package, not all of whom would receive a reduced package.
- If following the reassessment, the person was deemed not to require a CHC package, their needs would potentially be met by the Local Authority’s social care services, which may involve means testing. There was now a dispute resolution mechanism in place to ensure
that when there is a dispute as to whether the person’s needs should be met by a CHC package or social care services, a fair process was in place to resolve the matter. An independent chair for this was currently being recruited.

- In response to questions from members and officers, the DI stated that:
  - He did not have information with him as to how many of the 40 Barking and Dagenham residents reassessed had had their CHC package reduced or removed all together, however he would provide it.
  - The views of the individual’s family, their GP and other professionals involved in their care would be taken into account as part of the reassessment process. The decision would be made under a clear framework, after which a care plan would be developed with the family.
  - After the reassessment, the individual’s needs would be reviewed again in three months’ time and annually thereafter, which could potentially lead to a smaller or larger package of care depending on their circumstances. Members asked whether affordability for social care was not a factor in the reassessment and the individual would need to discuss this with social services.
  - People were aware of the appeal process and it was used regularly;
  - The CCG had a duty to acknowledge receipt of the appeal correspondence within a week and to make a decision within a month of receiving the appeal;
  - He was not certain of exactly which advocacy support service the CCG signposted people to, but he imagined that the social care service would provide advocacy support;
  - The assessment process takes up to 28 days but can take longer if it is deferred and if the CCG breached NHS England (NHSE) specifications on timeline, it would need to report this to them.
  - The decision on reassessment would be made by trained and experienced nurses, not managers.

The Council’s Strategic Director for Service Development and Integration (SDSDI) stated that it was the Council’s understanding that a multi-disciplinary team would make the initial decision following the reassessment, which would be subject to change by a CHC Panel. The DI stated this was an old process and the current process was that the initial reassessment would be checked by a ‘Quality Assurance Panel’ (QAP) which was comprised of experienced nurses.

Members expressed disappointment that the BHRCCG could not offer assurance that service users were being sign-posted to advocacy services. They also asked whether it was possible that an individual who had complex behavioural problems as part of their learning disability, whose behaviour was being managed by a CHC package, could have their package removed or reduced after a re-assessment because it would appear to the assessor that the person no longer had a need for the package, when in fact, a removal of the package would result in that person manifesting their behavioural problems again. The DI stated in response to the comments around advocacy that he was personally not aware of the advocacy service individuals were being sign posted to, but the CCG was.
In relation to an individual with complex behavioural problems, he would hope that the scenario described would not occur because the assessment would consider the consequences for the individual if the package was removed.

Members asked the DI how one would reconcile the fact that the decision of the nurse who meets with the individual and their family to undertake the initial reassessment, could be changed by the QAP, who although were experienced, did not meet the individual or their family. The DI stated that in most cases the QAP would not be overturning the nurse assessor’s decision, rather they would potentially be changing the particulars of the package recommended, such as the number of skilled nurses required to support the individual with a particular aspect of their health and wellbeing. He felt that this was the correct process as the nurses who formed the QAP were very skilled and experienced in this field of work.

Members asked whether there were leaflets explaining the right to appeal for people with learning difficulties who were having their CHC packages reviewed. The DI stated that there was no leaflet; however, there was a letter which was sent to the individual after the reassessment which included the decision, and the procedure for appealing. He stated that he would share the template letter with the Committee.

In response to a question from the Integrated Care Director of North East London Foundation Trust, the DI stated that so far, safeguarding issues had not arisen as a result of the historical delay in reviewing packages and that systems had been put in place to ensure reviews are done in a timely fashion in future because BHRCCGs acknowledged that delay was not beneficial to them as organisations and nor to the individual.

A member of the public suggested to the DI that people who were the subject of current and future reviews be advised that they could contact carers of Barking and Dagenham for support and advice, which the DI stated he would take on board.

30. Localising Healthy Lifestyle Services

The Council’s Consultant in Public Health (CPH) delivered a presentation on the Localising Healthy Lifestyle Services Project Development and the Mayesbrook ward Park Pilot. Members noted:

- The aims of the project;
- Overview of the service;
- Key achievements and milestones of the pilot;
- Key elements of the service model
- Next steps.

The PHC stated that evaluation of the project would take place in March 2017, after which it would be decided to what extent the project would be rolled out in other wards.

Members asked who was meeting the cost of the pilot and who would be meeting the cost if the project was rolled out further. The CPH stated that there is no additional cost, other than the project manager cost, as the services covered are already provided by the lifestyle service. The cost of
the project manager was being met by the Public Health grant and that as part of the pilot, project workers were reviewing how to make the project more cost-effective for the potential future roll out of the service.

Members asked how members of the public would find out about the pilot and get involved. The CPH stated that people would get referred through a number of community routes e.g. GP, leisure services and schools, for example through the child weight management scheme. An important part of the service is also outreach into the local community and part of the reason for basing the pilot in parks was so that the service would be much more accessible to the public who could enquire about the service directly.

Members asked whether the project was designed in a way that would meet the needs of the diverse communities in the borough. CPH stated that it was fundamental to the project that it would attract members of all communities and providing services in the community parks would help with this, and furthermore, the community health champions, who were a core part of the project, were volunteers from the community itself, which meant that they would encourage a diverse group of people to take part.

The local Healthwatch representative asked how the Council would know whether the pilot was effective. The PHC stated that project workers already had some baseline information from a feedback event, which they were using to develop a set of indicators that would help them measure what local people thought about the pilot and its effectiveness in encouraging them to become more active and, eat more fruit and vegetables, for example. A member of the public who was also a community health champion stated that the community health champions were also looking to gather feedback on their role, which would help with the overall evaluation of the pilot.

31. Update on System Wide Health Integration: the Sustainability and Transformation Plan and the Accountable Care Organisation Devolution Pilot

The Council’s Commissioning Director for Adult’s Care and Support (CDACS) presented a report which updated the Committee on system wide health integration initiatives; the Sustainability and Transformation Plan (STP) and the Accountable Care Organisation (ACO) Devolution Pilot.

Members noted that the STP is a new planning framework for NHS services which is intended to be a local blueprint for delivering the ambitions NHS bodies have for a transformed, more cost-efficient health service. This Committee had received a presentation at its meeting on 19 July 2016 where members were informed that the boroughs of Barking and Dagenham, Havering and Redbridge (BHR) had agreed to run a pilot to develop an ACO, where primary and secondary care would be more closely integrated and patient pathways redesigned. It was explained that for BHR, the detail of the local contribution to the STP for north east London (NEL) has been developed through the established programme to draft a business case for an ACO.

The CDACS went on to summarise the extensive work that had been carried out since then to form a Strategic Outline Case (SOC) for an ACO. Following this, the SOC had recommended a new model of service delivery
supported by more effective joint strategic commissioning arrangements; however, made it clear for reasons detailed in the report, that the BHR system does not support a direct move to an ACO. Therefore, the work on developing the ACO Business Case as part of the health devolution pilot has not progressed as anticipated and a new organisational form for delivering health and social care across the BHR area would not be forthcoming in the near future. There has been a shift in language from an ACO to an Accountable Care Partnership (ACP), reflecting this. The CDACS assured members that while a new organisational form in the shape of an ACO would not happen soon, the work undertaken represents significant progress in terms of developing approaches for integration for BHR and understanding the needs of the local population.

The CDACS explained the structures being put in place to develop and deliver this work which included a strong emphasis on a locality based delivery model, built around the key principle of organisations working together to manage common resources and designed to radically alter the way that residents access health and wellbeing services across BHR. He stated that for Barking & Dagenham, the work to develop the detail underpinning the STP is still being taken forward jointly with Havering and Redbridge through the work around devolution via an ACP.

Members noted the work described in the report to develop the STP, the organisations involved, its vision and the priorities it would deliver.

The SDSDI explained that there has been significant national concern about transparency and local political legitimacy of the STP process. There have been ongoing concerns expressed by local authorities across NEL, and particularly by BHR at the level of engagement of local authorities in the STP process. Although the basis of the BHR contribution to the STP is work that has been shaped through good engagement across BHR, the pace and complexity of reinterpreting this at NEL level has meant that local authorities have had limited engagement in the final product. She added that NHSE does not require that local authorities ‘sign off’ the plan, which is a disappointing step in a plan which is intended to address whole system functioning. There has been an effort made by the NEL STP team to address concerns of local authorities, which has been appreciated, but there are fundamental flaws in the process that remain a concern.

Members noted the other concerns described in the report, shared by some partners in the NEL system, which were discussed at the Health and Wellbeing Board meeting on 22 November 2016.

The SDSDI stated that early thinking about governance of the STP has been shared with councils, and in response the Leaders of BHR councils have written to their counterparts in the other NEL boroughs making a suggestion of an alternative approach which gives greater prominence to the system-level governance arrangements over a cumbersome all-NEL tier of governance. A key principle for all BHR partners, is that decision making should lie at the local system and borough level as a starting point, with decisions and approaches taken at a NEL level where this is necessary. There is a concern that as the STP grows, more decisions will flow towards the NEL-level, and early sight of the governance options has reinforced this concern.

Members noted the next steps for moving forward with the STP which
included the positive step of local joint work by local Healthwatch organisations to gather and understand the views of local people to ensure engagement is relevant to local needs. Officers stated that the Health and Wellbeing Board would be kept updated on the progress of the STP and that they would be also happy to attend future meetings of the HASSC for this purpose.

32. Work Programme

The latest version of the Work Programme was agreed.

Minutes agreed as a true record.

Chair: ………………………………..

Date: ………………………………..
HEALTH AND ADULT SERVICES SELECT COMMITTEE

1 March 2017

Title: The Cancer Prevention, Awareness, and Early Detection Scrutiny Review

Report of the Director of Public Health

Open Report

For Decision

Report Author: Sue Lloyd, Public Health Consultant & Masuma Ahmed, Democratic Services Officer

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Accountable Divisional Director: Matthew Cole, Director of Public Health

Accountable Director: Anne Bristow, Strategic Director, Service Development and Integration

Summary:
The Health and Adult Services Select Committee (HASSC), has undertaken an in-depth scrutiny review of awareness and early diagnosis. The findings of the Review, in line with the terms of reference and work plan, are in the report.

Recommendations of HASSC as an outcome of the scrutiny review are key to changes leading to improved cancer outcomes in Barking and Dagenham. This paper focuses on recommendations that the members of HASSC may want to consider.

Recommendation(s)
The HASSC is recommended to review the report, and discuss and agree recommendations based on the report.

Reason(s)
The topic of Cancer Prevention, Awareness and Early Detection relates to the Council’s priority to ‘Enable Social Responsibility’ and the objectives to ‘protect the most vulnerable, keeping adults and children healthy and safe’ and ‘ensure everyone can access good quality healthcare when they need it’.

1. Introduction and Background

1.1 Every year each of the Council’s Select Committees agrees a work programme which lists the areas it wishes to scrutinise in the current municipal year. As well as one-off agenda items, the work programme often includes a more-in depth investigation into an area of concern that is relevant to the committee’s remit, which usually involves members attending sessions outside of the standard evening meetings scheduled for the year.
1.2 For 2016/17, the HASSC agreed Cancer would be the topic on which to undertake a scrutiny review due to the scale of the issue locally, and the serious implications on public health. It was felt that an in-depth review into this topic adds value.

2. Proposal and Issues

2.1 From the evidence Members will want to consider recommendations that support HASSC to hold providers and commissioners in the borough to account:

- Improve lifestyle in Barking and Dagenham, particularly smoking and being a healthy weight.
- Increase confidence to seek help early by increasing knowledge and awareness of signs and symptoms of cancer in:
  - Residents, particularly Black-African residents
  - healthcare staff
  - other staff who are customer-facing
- Assure that screening uptake is increased, bowel, breast and cervical, through screening services being appropriately commissioned.
- Assure that screening services are accessible to residents.
- Assure that primary care staff who are key to early diagnosis are facilitating screening of residents, and have appropriate skills and knowledge to ensure timely access to the local cancer pathways and early diagnosis.

2.2 An action plan will be written from the recommendations and the accountable organisation/agency/board engaged on behalf of the population of Barking and Dagenham. Accountable organisations/agencies/boards include the Health and Wellbeing Board; Barking and Dagenham, Havering, and Redbridge CCG; NHS England; and other partners.

3. Title and Terms of Reference

3.1 Due to restrictions on time and resources, the focus of the review has been on factors that may help prevent cancer and increase early detection. The title of the Scrutiny Review is “Cancer Prevention, Awareness and Early Detection” and the following three key questions formed the Terms of Reference for the scrutiny review:

1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?
2. What is the reason that residents are less likely to respond to requests to screen for cancer than in other London boroughs?
3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London boroughs?

4. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?

4.2 In summary, the reasons why residents are more likely to develop cancer and less likely to survive are, that they tend to have less healthy lifestyles, and are less
aware of cancer signs and symptoms. This means that cancer is more likely to develop and less likely to be identified early.

4.3 Lifestyle accounts for 4 out of 10 preventable deaths from cancer and, for many reasons, residents of Barking and Dagenham have less healthy lifestyles than in many other London boroughs. (Report sections 4.1 – 4.7, 7). This suggests that more action is needed to improve lifestyle in the borough.

4.4 As well as residents often having less healthy lifestyles, the evidence indicates that people in the borough are also less likely to be aware of the signs and symptoms of cancer when these do occur. (Report section 7). This suggests that more action is needed to raise awareness so that residents are more aware of signs and symptoms of cancer.

4.5 Rates of diagnosis of cancer through emergency routes in Barking and Dagenham are decreasing but are higher than the England average. To improve this situation, it is essential that we have improved screening rates (see 5) and effective routes to diagnosis (see 6).

5. What is the reason that residents are less likely to respond to requests to screen for cancer than in other London boroughs?

5.2 In summary, there are many reasons why residents are less likely to present for screening, and to an extent the reason depends on the type of screening, and may be as simple as the resident not understanding the importance of being screened. In the review, we address breast and bowel screening. The reasons why residents do not always respond are presented below (also see, Section 7 for the report):

5.2.1 Emotional – residents worry, or are scared about what the screening might find.

5.2.2 Cultural – residents are not always able to understand the information that they are sent. For some residents, the process of screening can be culturally offensive, one example is bowel screening, as residents need to handle their own faeces.

5.2.3 Practical – difficulty in making an appointment with the GP surgery can be barrier as can be getting to a surgery appointment, or to a screening unit.

5.3 These findings suggest that more action is needed to be assured that the providers of screening services communicate effectively, and regularly, with residents in Barking and Dagenham, using appropriate languages and cultural approaches. The service commissioners can most effectively facilitate this approach, BHR CCG.

5.4 Assurance can also be provided, from NHSE, through the Director of Public Health’s, Health Protection, assurance process.

6. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London Boroughs?

6.2 In summary, Barking and Dagenham residents are not as knowledgeable about signs and symptoms of cancer as people in other London boroughs. We know that in 2009 residents in Barking and Dagenham were less aware of common signs and symptoms of cancer, such as lumps and swellings; and even less aware of less common symptoms like a long-term cough.

6.3 A small survey of residents in 2016 found that awareness of signs and symptoms amongst residents has improved slightly but the question still stands, why to
residents present so often, with cancer, at the accident and emergency department?

6.4 These findings suggest that more action is needed to assure improved uptake of screening (see 5); to support people to be aware of signs and symptoms through campaigns and face-to-face activities; to be assured that the ability of those working in primary care to recognise signs and symptoms is being maintained and enhanced; to be assured that healthcare staff facilitate timely access to the local cancer pathways; to be assured of the ability of healthcare staff, who are not routinely in touch with people who develop cancer, to recognise potential signs and symptoms and to signpost to services.

7. **Cancer survival**

7.2 Members learnt that cancer is a serious disease that can impact on life in the short term, because of treatment, and in the long term, because of disability. They were also assured that the risk of cancer can be reduced through changes in lifestyle; and the worst consequences of cancer can be reduced through early diagnosis and treatment. (Case study: report p35).

8. **Reading List**

8.1 Officers and members will draw on the following papers throughout the review to inform the report and assist with producing recommendations:

Achieving World Class Cancer Outcomes: A strategy for England


9. **Financial Implications**

Implications completed by: (name and title of senior Finance Officer)

9.1 (This section only to be completed by a senior Finance Officer (i.e. the Corporate Director, Divisional Director, or Group Manager)

10. **Legal Implications**

Implications completed by: (name and title of senior Legal Officer)

10.1 (This section only to be completed by a senior Legal Officer (i.e. Head of Legal, Legal Group Manager or Senior Lawyer)
Background Papers Used in the Preparation of the Report:
None.

List of appendices:

HASSC DRAFT Cancer Scrutiny Report
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Report of the
Health and Adult Services
Select Committee:
Cancer Prevention, Awareness and Early Detection:
Scrutiny Review 2016/17

Contact:
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Lead Member’s Foreword

The Health and Adults Services Select Committee (HASSC) is a scrutiny committee made up of local councillors who want to help improve health and social care outcomes for the borough’s residents by working with the Council and its partners to improve services and hold decision makers to account.

In 2016/17, as the Chair of the Committee, I oversaw an in-depth review into Cancer awareness and treatment services. We chose to review this area as we felt that the fear of having cancer was the main barrier for people to discuss this with their GP, which could mean that many people were missing out on early diagnosis of this diseases, such as breast, lung or prostate cancer.

We were concerned that there needed to be more public awareness around the importance of early intervention to ensure that care services are accessed in a timely manner to have the best possible outcome for our residents.

One of our residents shared her story of surviving cancer. I found her story of survival uplifting and you can read it for yourself on page 35 of this review.

Her journey was a mixed picture, she felt unwell for a long period but didn’t really follow it up with her GP.

Her message was loud and clear, eat well, exercise, drink in moderation and if you smoke, try to stop or get some help!

I also want all our residents to feel comfortable talking about cancer. Talking about cancer means we can share positive messages and encourage early diagnosis through understanding signs and symptoms. Currently many of our residents don’t know the signs and symptoms of cancer, and without knowing these it’s more difficult for our residents go to get help when they need it.

Leading a full and active life after a cancer diagnosis is most likely if the cancer is diagnosed early. I want to support residents to take up invitations to be screened and to assure them that it is the right thing to do.

I will be pushing for screening letters to be sent to groups that fall into the at-risk band.
It is very important that we have an awareness road show that goes into churches, temples, mosques and local schools.

All the evidence points to a ‘healthy lifestyle’ protecting against cancer, and this report points us toward making a change and making the healthy choice the easy choice.

Smoking is the leading cause of cancer in the borough, and I believe that the time has come to talk openly about how smoking is causing lung cancer in Barking and Dagenham. Sadly, a resident of Barking and Dagenham is one and a third times more likely to develop lung cancer than people in other parts of England.

I believe that residents can live healthily given the right environment. This means that Barking and Dagenham must become a place where the healthy choice is the easy choice. It must be a place where eating healthily and being active is normal from the start, and families who are overweight or obese are supported to address their problems.

This is easy to say, but much harder to achieve.

So, this review is very welcome and very necessary. It sets out a series of principles, ideas and actions that will support residents to become more aware of signs and symptoms of cancer and to recognise the importance of early diagnosis. This will help to focus and drive the work of all the borough’s health and social care partners. Please take the time to read it.

Councillor Peter Chand
Lead Member, Health & Adult Services Select Committee 2016/17 – 2017/18
Members of the HASSC 2016/17

The HASSC members who carried out this Review were:

Councillor P Chand (Lead Member)  
Councillor L Zanitchkhah (Deputy Lead Member)  
Councillor S Alasia

Councillor Edna Fergus  
Councillor A Aziz

Councillor E Keller  
Councillor J Jones

Councillor F Shaukat  
Councillor H S Rai
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Executive Summary

Members learnt that cancer is a serious disease that can impact on life in the short term, because of treatment, and also in the long term, because of disability as a result of the cancer. They were also assured that the risk of cancer and the worst consequences of cancer can be reduced.

4 out of 10 avoidable deaths in England are a result of cancer (ONS).

1 in 2 people will be diagnosed with cancer during their life (CRUK).

Over 2 million people are living with and beyond cancer in the UK (4 million by 2030) (Macmillan).

Through extensive scrutiny of lifestyle and early awareness of cancer in the borough members were able to make recommendations on how improvements can be made for residents.

The England Independent Cancer Taskforce\(^1\) established 4 priorities for improving cancer outcomes

1. A radical upgrade in prevention and public health – focus on reducing smoking and obesity
2. Achieving earlier diagnosis
3. Patient experience on a par with clinical effectiveness and safety
4. Transformation in support for people living with and beyond cancer

The LBBD Scrutiny Committee decided to focus on the first 2 priorities:

A radical upgrade in prevention and public health – focus on reducing smoking and obesity

Achieving earlier diagnosis

Based on the 2 priorities the Taskforce recommended 6 evidence-based outcomes:

1. Adult smoking rates should fall to approx. 1 in 10
2. 3 out of every 4 screening opportunities offered should be taken up
3. Approximately 6 out of 10 people should be surviving 10 years or more after a cancer diagnosis
4. More than 7 out of 10 people should be surviving for 1 year
5. The cancer waiting time standard of 2 weeks, 31 days and 62 days to be achieved
6. 95% of people to have a definitive cancer diagnosis within 4 weeks, and 50% within 2 weeks.

Barking and Dagenham are performing less well than we could be as a borough on some of these indicators, particularly 2 in 10 people in the borough smoke and less than 2 of every people invited attend screening.

Figure X
At the Talk Cancer workshop Members learnt that both lifestyle and awareness are important factors in cancer prevention and survival.

**Lifestyle**
Lifestyle factors that we can control include smoking, how much alcohol we drink, what we eat, how heavy we are, how much exercise we get, and how long we expose our unprotected bodies to the sun.

Smoking is most important preventable cause of cancer in Barking and Dagenham.

Being overweight can cause 13 types of cancer and Barking and Dagenham has one of the highest numbers of overweight and obese adults in any of the London boroughs.

Members also learnt that the lifestyle clearly has a big impact on residents’ risk of developing cancer but other factors are in play and we mustn’t forget about them. These include:

- Air pollution and radon gas
- Infections and HPV
- Hormones, for example HRT
- Risk factors in the work place e.g. exposure to asbestos, chemicals and gases
- Genes
- Age

**Screening and early diagnosis**
Members learnt that if a cancer diagnosis is made early it is better than if it is made late. A resident who is diagnosed with Stage 1 or Stage 2 cancer is more likely to survive one or five years, then someone diagnosed at Stage 4.

One way to find a cancer early is through screening, another is through recognising signs and symptoms.

Screening programmes available to residents include breast screening, bowel screening and cervical screening. Uptake of screening programmes is lower than the London average, and there is room to support an increase in uptake.

The research done with the Cancer Awareness Measure found that residents in Barking and Dagenham were less likely to recognise signs and symptoms of cancer compared to residents in other London boroughs.
From the report on the pilot for healthy lifestyle services members learnt that through the Mayesbrook Park pilot a number of health champions have been trained to talk to the public, and particularly to people from their own ethnic group about cancer, lifestyle and screening. These people now have the skills and knowledge to increase awareness.

From the resident’s experience Members learnt that there are 4 barriers to early diagnosis, and these barriers can be reduced with effective partnership working.

**Barriers to early cancer diagnosis**

1. **Emotional**
   - Too worried about what the doctor might find
   - Too embarrassed
   - Difficulty in talking about the symptoms
   - Too scared

2. **Cultural**
   - Language barriers
   - Other cultural barriers

3. **Practical**
   - Difficulty in making an appointment
   - Other things to worry about
   - Difficult to arrange transport

4. **Service**
   - Worry about wasting the doctor’s time
## 1. Background to the Review

*Why did the Health and Adult Services Select Committee (HASSC) choose to undertake an in-depth review on Cancer Prevention, Awareness and Early Detection?*

1.1 The Council’s scrutiny committees decide what topic to undertake an in-depth review on based on the ‘PAPER’ criteria. The section below explains why according to this criteria ‘Cancer Prevention, Awareness and Early Detection’ was a good topic to review.

<table>
<thead>
<tr>
<th>P - PUBLIC INTEREST</th>
<th>A - ABILITY TO CHANGE</th>
<th>P - PERFORMANCE</th>
<th>E - EXTENT OF THE ISSUE</th>
<th>R - REPLICATION</th>
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<tr>
<td>The residents of Barking and Dagenham are more likely to develop cancer and less likely to survive than residents in other London boroughs and England. Overall, the borough has the lowest net survival amongst London and West Essex Clinical Commissioning Groups (CCGs).</td>
<td>More than 40% of all cancers are linked to behaviour and environmental exposures which could be avoided or reduced. Factors that also contribute to poor outcomes in Barking and Dagenham include poor awareness of the signs and symptoms, and late detection and diagnosis. Members considered that there was potential to improve people’s knowledge around signs and symptoms of cancer.</td>
<td>As well as ranking the lowest out of 33 CCGs for net survival, 1 in every 4 cancers is diagnosed in the Accident and Emergency department. This is high compared to London and England.</td>
<td>As of the end of 2010, around 3,600 people in B&amp;D were living with and beyond cancer up to 20 years after diagnosis. This could rise to an estimated 7,000 by 2030. People living with cancer can have complex and varied needs which require holistic support.</td>
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2. Scoping & Methodology

2.1 This section outlines the scope of the Review which includes the areas the HASSC wished to explore and the different methods the HASSC used to collate evidence for potential recommendations.

Terms of Reference

2.2. Having received a scoping report at its meeting on 7 September 2016, the HASSC agreed that the Terms of Reference for this Review should be:

1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?
2. What is the reason that residents are less likely to respond to requests to screen for cancer than in other London boroughs?
3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London boroughs?

As there are over 200 types of cancer the HASSC agreed to focus on the four most prevalent cancers in the borough which are cancers of the lung, breast, bowel and prostate. These are also the four most common cancers nationally.

Overview of Methodology

2.3 The review gathered evidence during the Committee’s meetings held between 7 September 2016 and 11 January 2017. Details of stakeholders and their contributions to this review are outlined below.

Presentation – National and Local Context on Cancer Awareness and Early Diagnosis

2.4 On 7 September and 2 November 2016 Public Health delivered presentations which considered:

- The national challenge
- Cancer Taskforce Strategy priorities and ambition for 2020
- Barking and Dagenham cancer numbers
- Prevention and early diagnosis
- Barking and Dagenham – what are the problems and what is happening to overcome them.
Talk Cancer Workshop

2.5 Nurses from Cancer Research UK delivered an engaging workshop on 12 October 2016 to members of the HASSC as well as community health champions which raised awareness of the risk factors for cancer and the signs and symptoms.

Report on the Pilot for Healthy Lifestyle Services

2.6 At the HASSC meeting of 11 January 2017 members considered a report on a pilot project for Healthy Lifestyle Services in the borough and how such services could help raise awareness of cancer and its prevention locally.

A Resident’s Journey

2.7 On 2 February 2017 members of the HASSC met with a resident who previously had cancer to hear about the resident’s journey and take her views into consideration as part of this review.

Submissions

2.8 During the review xxxx, and xxxx submitted statements to the HASSC expressing views about current provision, pathways and potential areas for service improvement.

Research

2.9 During the Review Council Officers considered the following pieces of evidence: NOTE: to be extended.

3. Introduction – Understanding Cancer

What is cancer?

3.1 There are more than 200 different types of cancer, and each is diagnosed and treated in a particular way.

One common fact about cancers is that all cancers begin in cells. Our bodies are made up of more than a hundred million million (100,000,000,000,000) cells. Cancer starts with uncontrolled changes in one cell or a small group of cells.

Usually we have just the right number of each type of cell. This is because cells produce signals to control how much and how often the cells divide. If any of these signals are faulty or missing, cells may start to grow and multiply too much and form a lump called a tumour. Where the cancer starts is called the primary tumour.

Some types of cancer, called leukaemia, start from blood cells. They don't form solid tumours. Instead, the cancer cells build up in the blood and sometimes the bone marrow.

A Typical Cell

Source: Cancer Research UK

Source: www.nhs.uk
The Impact of Cancer

3.2 Cancer is a serious disease that can impact on life in the short term, because of treatment, and also in the long term, because of disability as a result of the cancer.

3.3 Cancer and the worst consequences of cancer are also preventable. We look at prevention and early awareness in section 4, of this report.

3.4 Cancer that is found early is more easily treated than if it is found late. We look at early detection in section 5, of this report.

3.5 The consequences of cancer and its treatment may mean that people are unable to take part in activities that had been a normal part of their life before, such as going to school or college, shopping, working, socialising, being physically active, going on holiday and enjoying sexual intimacy. This leads to a significant knock-on effect on family and friends, which in turn may cause breakdown of relationships, mental health problems and further isolation.²

Common Signs and Symptoms of Cancer

3.6 The common signs and symptoms of cancer are:

- A lump in your breast
- Coughing, chest pain and breathlessness
- Changes in bowel habits
- Bleeding
- Unexplained weight loss
- Any changes that you don't recognise in your body.

Source: [www.nhs.uk](http://www.nhs.uk) and [www.cancerresearchuk.org](http://www.cancerresearchuk.org)

How is Cancer Treated?

3.7 Common treatments for cancer include:

- Surgery
- Radiotherapy
- Chemotherapy

Cancer taskforce

The England Independent Cancer Taskforce\(^3\) established 4 priorities for improving cancer outcomes

1. A radical upgrade in prevention and public health – focus on reducing smoking and obesity
2. Achieving earlier diagnosis
3. Patient experience on a par with clinical effectiveness and safety
4. Transformation in support for people living with and beyond cancer

The LBBD scrutiny committee decided to focus on the first 2 priorities:

A radical upgrade in prevention and public health – focus on reducing smoking and obesity

![](image)

Achieving earlier diagnosis

Based on the 2 priorities the Taskforce recommended 6 evidence-based outcomes:

1. Adult smoking rates should fall to approx. 1 in 10
2. 3 out of every 4 screening opportunities offered should be taken up
3. Approximately 6 out of 10 people should be surviving 10 years or more after a cancer diagnosis
4. More than 7 out of 10 people should be surviving for 1 year
5. The cancer waiting time standard of 2 weeks, 31 days and 62 days to be achieved
6. 95% of people to have a definitive cancer diagnosis within 4 weeks, and 50% within 2 weeks.

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Barking and Dagenham are performing less well than we could be as a borough on some of these indicators, particularly 2 in 10 people in the borough smoke and less than 2 of every people invited attend screening.

Figure X

4. Risk Factors for Cancer

LBBD officers spent the afternoon of the 12 October 2016 taking part in a ‘Talk Cancer workshop’ run by Cancer Research UK. It was an excellent opportunity to hear experts in the field talk about some of the myths around cancer and to present the facts about incidence, diagnosis and treatment, in a very positive and encouraging way. All the attendees found the session, which was presented in an interesting and enjoyable way, very helpful in increasing their knowledge and actually changing their thoughts about cancer from a negative to a more positive way…

Pre-workshop word association  Post-workshop word association

The session busted a number of common cancer myths, and gave an excellent insight into just how important a healthy lifestyle is to preventing cancer.
4.1 Cancer specialists estimate that 4 out of 10 cancer cases could be prevented largely through lifestyle changes. Many people believe that getting cancer is purely down to genes, fate, or bad luck. However, as members discovered on the Talk Cancer session in October 2016, our risk depends on a combination of genes, age, environment, and lifestyle, the last two factors we are more able to control.

Lifestyle factors that we can control include smoking, how much alcohol we drink, what we eat, how heavy we are, how much exercise we get, and how long we expose our unprotected bodies to the sun.

4.2 Smoking

Smoking remains the most important preventable cause of cancer Barking and Dagenham. Smoking has a long history of being linked to lung cancer, having been identified by Dr Richard Doll in the 1950s. Research in recent times has now also identified that smoking increases the risk of developing cancer in many other areas of the body including breast, bowel, stomach, bladder, prostate and cervix. It is in fact fair to say that there isn’t a part of the body that the damaging effects of smoking do not reach.

4.3 Alcohol consumption

According to recent research from Sheffield University alcohol related cancers will cause about 135,000 deaths over the next 20 years, unless people radically change their drinking habits.

The majority of alcohol-related cancer deaths are expected to be from cancers of the oesophagus, bowel, mouth and throat, breast and liver.

Advice on safe alcohol consumption has varied over the years and has not provided the necessary clarity for the public, part of the difficulty being that moderation, rather than total abstinence has been the message.
4.4 Diet

Diet can directly affect cancer risk. Some foods, such as processed and red meat and salt-preserved foods, can increase the risk of developing cancer; whilst others, such as fruits, vegetables and foods high in vitamins, minerals and fibre, can reduce the risk.

Eating a healthy, balanced diet also helps maintain a healthy body weight, which is important, because obesity is the second biggest preventable cause of cancer after smoking. However in areas of deprivation like Barking and Dagenham it can be harder to afford a healthy diet and money will go further in buying sugary, refined food than buying fruit and vegetables.

4.5 Weight

Research shows that many types of cancer are more common in people who are overweight or obese. This is essentially because fat cells affect the level of hormones and proteins in the body. These chemical messengers can then cause cells to change and divide abnormally, and so becoming cancerous.

Being overweight or obese can cause 13 types of cancer. The list includes 2 of the most common types of cancer that affect people in Barking and Dagenham, breast and bowel and 3 of the hardest to treat – pancreatic, oesophageal and gallbladder cancer.

Excess fat around the belly is particularly linked to cancer of the bowel and breast.

Source: Active People Survey, Sport England 2012

4.6 Exercise

Around 3,400 cases of cancer in the UK each year could be prevented by keeping active.

Being inactive and sedentary lifestyles can increase the risk of cancer. The risk of getting bowel, and breast cancer could be reduced if people increased their physical activity.

Physical activity can help people manage their weight and therefore decrease the cancer risks that are linked to excess weight.
Physical activity helps food move through the bowel and so reduces the amount of time the toxins from digestion are in contact with the lining of the bowel.

Physical activity also helps control levels of inflammation in the bowel, which if repetitive can lead to cells multiplying more frequently than usual as they attempt to repair the damage. There is then more risk that this excess cell multiplication can turn cancerous.

*Source: Active People Survey, Sport England. 2012*

### 4.7 Exposure to the sun (solar radiation)

Overexposure to ultraviolet (UV) light from the sun, during leisure or work, or sunbeds is the main cause of skin cancer.

Melanoma is the most serious type of skin cancer and in the UK more than 8 in 10 cases could be prevented through enjoying the sun safely and avoiding sunburn.

There are 2 main types of UV rays that damage our skin. Both types can cause skin cancer:

- **UVB** is responsible for the majority of sunburns.
- **UVA** penetrates deeper into the skin. It ages the skin, but contributes much less towards sunburn.

Sunbeds give off UVA and UVB, but the mixture of the two is usually different to natural sunlight and the UV is often much stronger.

Sunburn is a clear sign that the DNA in your skin cells has been damaged by too much UV radiation. Getting painful sunburn, just once every 2 years, can triple your risk of melanoma skin cancer.

*Source: [http://www.cancerresearchuk.org](http://www.cancerresearchuk.org)*

### 4.8 Other factors?

Members learnt that the lifestyle clearly has a big impact on residents’ risk of developing cancer but other factors are in play and we mustn’t forget about them. These include:

- Air pollution and radon gas
- Infections and HPV
5. The Importance of early diagnosis

5.1 Stages of cancer development

While no-one wants to be diagnosed with cancer Members learnt that if a cancer diagnosis is made early it is better than if it is made late. A resident who is diagnosed with Stage 1 or Stage 2 cancer is more likely to survive one or five years, then someone diagnosed at Stage 4.

Staging is important because cancers that are smaller and not entangled with healthy cells are harder to find but easier to treat. These cancers are generally stage 1 and stage 2 cancers.

Cancer grows and as it grows it gets bigger and entangled with other, healthy cells. Staging is a way of describing how big a cancer is and whether it has spread into surrounding tissues.

5.2 National cancer screening programmes and uptake

Screening is a positive way of finding cancers early so that they can be treated.

There are 3 national cancer screening programmes, bowel, breast and cervical cancer. Screening can help detect cancer before the person has symptoms or has become aware of any. People should still be alert to signs and changes as described earlier in section 3 as cancer can develop between screening rounds. However, attending screening is a good way to save lives by finding cancer at an early stage.
The earlier cancer is detected in a person and is treated, the longer his or her survival after diagnosis is likely to be. People need to be registered with a GP with an up to date address to receive screening invitations.

**Bowel cancer**

Bowel screening is offered every 2 years to people between the ages of 60 and 74, however those over the age of 74 can request a screening kit. The screening can detect cancer at an early stage and also help cancer from developing in the first place.

**Breast cancer screening**

Breast cancer uses a test called mammography which involves taking x-rays of the breast; it can help find cancers early when they are too small to see or feel. Tiny breast cancers, at Stages 1 or 2, are usually easier to treat than larger ones. Screening is offered to women between the ages of 50 and 70, though again, people over the age of 70 can request a screening. There are also pilots to increase the age range for screening so that it is between 47 – 73 years. Current evidence suggests that breast screening reduces the number of deaths from breast cancer by about 1,300 a year in the UK.

**Prostate cancer screening**

Diagnosis of prostate cancer is by a GP through recognising signs and symptoms and sending a resident for further tests. This depends on the resident recognising the potential signs and symptoms.

There is no national screening programme for prostate cancer because we don’t have a reliable enough test to use.

**Lung cancer screening**

Diagnosis of lung cancer is by a GP recognising signs and symptoms and sending a resident for further tests. Of course, again this depends on the resident recognising the potential signs and symptoms first.
There is no screening programme for lung cancer because there isn’t a practical way to screen a population for this condition.

5.3 Emergency cancer presentation

Emergency presentation of cancer often happens late at Stages 3&4. Diagnosing cancers early is important and members learnt that residents of Barking and Dagenham are less likely to recognise signs and symptoms of cancer. When a patient is diagnosed as an emergency, this can mean their cancer has progressed to stage 3 and 4 and this is harder to treat.

6. The Incidence of Lung, Bowel, Breast and Prostate Cancers

6.1 This section compares the incidence of the four most common cancers in Barking and Dagenham against national rates.

Lung Cancer – the National Picture

6.2 Most lung cancers are diagnosed at a late stage and it is more common in those living in the most deprived areas.

Lung cancer is the third most common cancer in the UK, 46,000 new cases were diagnosed in 2014. Incident rates are highest in the 85-89 age group, but 44% are diagnosed in people aged 75 and over.

Lung Cancer – the Local Picture

6.3 A resident of Barking and Dagenham is one and a third times more likely to develop lung cancer than people in other parts of England. The incidence of lung cancer in Barking and Dagenham is higher than the national average, which is in keeping with the fact that it is the 3rd most deprived borough in London and that smoking rates are higher than London and the average.

However, after treatment a resident is more likely to survive up to 1 year. The 1 year survival rates at 37.6% are better than England (35.4%)

Breast Cancer – the National Picture

CRUK Local stats site The 2013 European age standardised rate for 2012-14 is 109.9 per 100,000 where the England average is 79.8.
6.4 Breast cancer is the most common cancer in the UK, and the commonest cause of cancer in women, with 150 cases diagnosed every day. Most breast cancers are diagnosed at an early stage, but incident rates are expected to rise by 2% up to 20135.

Incident rates are highest in people 85 years and over, but 1 in 2 breast cancers are diagnosed in women aged 65+.

There is increasing evidence that black African and black Caribbean women have a high risk of particular types of breast cancer and are more likely to get breast cancer in an aggressive form (‘triple negative cancer’) and so have a much worse prognosis. The survival rate for women aged 15-64 years after both one and three years is significantly lower in black African/Caribbean women than in white women.\(^5\)

**Breast Cancer – the Local Picture**

6.5 A resident in Barking and Dagenham is less likely to develop breast cancer than a person living in the rest of England. This is in keeping with the fact that it is less common in the most deprived areas and in the Asian and black females.

Once diagnosed a resident likely to survive to one year, and this is good news. In Barking and Dagenham 9 out of 10 people survive to one year, across England this is also 9 of 10 people.

It is, however, important to note that there is slightly lower than expected uptake of breast cancer screening, the relatively high numbers of people of Black ethnic origin in the population.

Breast cancer screening uptake in Barking and Dagenham (2015) was 6 out of 10 (60%) people invited compared to England 7 out of 10 (73%).

**Bowel Cancer – the National Picture**

6.6 Bowel cancer is more common in males living in deprived areas and most bowel cases are diagnosed at a late stage.

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Bowel cancer is the 4th most common cancer in the UK, with 110 cases diagnosed every day.

Over the last decade, bowel cancer incidence rates have increased by a twentieth (5%) in the UK. The increase is greater in females where rates have increased by 6%, than in males where rates have increased by 3%.

**Bowel Cancer – the Local Picture**

6.7 A resident in Barking and Dagenham is slightly more likely to develop bowel cancer than a person living in the rest of England.

Residents are less likely to send their screening kits back for testing than in England generally. Until recently screening uptake rate was 4 of 10 in the 60-69 year age group, across England it was 6 of 10.

Barking and Dagenham is now seeing 5 of 10 people sending off kits. This has happened since the start of a local scheme to increase uptake.

Once diagnosed a resident is equally likely to survive 1 year as other people living in England.

**Prostate Cancer – the National Picture**

6.8 Prostate cancer is the most common cancer in males, with 130 cases being diagnosed every day.

One in every two cases are diagnosed each year in men aged 70+ and the numbers diagnosed have more than doubled since the 1970s, probably because of improved diagnostic testing. The numbers of cases of prostate cancer are higher in Black men than other ethnic groups. Prostate cancer is three times more common in Black ethnic groups.⁶

**Prostate Cancer – the Local Picture**

6.9 A resident of Barking and Dagenham has the same chance of developing prostate cancer as someone in another area of London.

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However, a person who does develop prostate cancer is sadly, more likely to die.

6.10 Barking and Dagenham has a has larger than average young population of men of Black African and Caribbean ethnic origin and the number of cases of prostate cancer is likely to rise in the future. For this reason, it is important to raise awareness of the signs and symptoms.

7. Why is the incidence of lung, breast, bowel, and prostate cancers higher in Barking and Dagenham?

In this section we explore the reasons why the incidence of lung, bowel and prostate cancer is higher in the borough than the England average.

Lifestyle Influences

7.1 As previously mentioned 4 out of 10 cancers could be prevented by healthier lifestyles. So a decision to smoke and continue smoking, for example will increase a person’s risk of developing cancer. Also choosing not to do anything about being overweight, exercising and eating more healthily, a person is also increasing their risk.

However the ability to choose to live a healthy lifestyle is harder and more limited if you are poor than if you are more affluent. You may feel unable to afford healthy food, which is more expensive than unhealthy, more refined food and you may feel unable to afford to belong to a club that will encourage you to exercise. In fact, you may feel depressed and lacking in motivation anyway and find it hard to break a habitual cycle of

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7 Mortality rates for prostate cancer are higher than the England average – 52.4 per 100,000 as opposed to 45.9. This follows logically from the higher incidence rate.
unhealthy behaviours, unless there is access to the means to change and which won’t cost money.

Lifestyle influences: In LBBD

4 in 10 cancers can be avoided through lifestyle modifications

Smoking

Smoking prevalence in Barking and Dagenham is 18.4% and higher than the London average (14%) and the national (16.3%). The numbers of smokers in Barking and Dagenham have steadily been going down as have the national averages, particularly since the 2007 smoking ban in public places. However, we know that there are certain pockets of the population where smoking prevalence is above the averages that are cited. This is because the poorer the area, the higher the prevalence of smoking. In these communities and amongst the unskilled and manual working groups smoking remains an acceptable, social activity. Stop smoking services have attempted through various targeting strategies, to actively engage these resistant smokers in quitting attempts with some degree of success. However it is difficult and intensive work to break down these barriers and support the breaking of habits that are long established and often perpetuated through family and friendship networks.
Alcohol

In Barking and Dagenham, it is estimated that 14.2% of the population binge drink at least one day a week which is not as high as the national average of 20.1%

However with poor rates of other healthy lifestyles and poorer outcomes on cancer compared to national and London averages, we should not be complacent about Barking and Dagenham’s statistics and should aim to bring about a decrease in drinking levels.

Diet

Food access, particularly to healthy food is a problem in some areas of Barking and Dagenham. The borough also has a high number of takeaway food outlets particularly in residential areas and intake of fruit and vegetables is low with 4 in 10 people eating fruit and vegetables every day compared to 5.5 in 10 across England. It is clear that these things impact on the healthy weight of people in the borough.

Weight

1 in 4 reception children and 1 in 3 year 6 children are overweight or obese (2014/15) This prevalence sets Barking and Dagenham as the 5th highest prevalence of excess weight in reception (26.6%) in London, above the London and National prevalence of 23% and 22.5% respectively. Barking and Dagenham also has the 3rd highest prevalence of excess weight in year 6 (42.2%) in London, above the London and National prevalence of 37.6% and 33.5% respectively.

Nationally 64.6% of adults nationally are overweight, in Barking and Dagenham this figure is 68.4% and is the highest of all the London boroughs.

Exercise

Physical activity of adults in Barking and Dagenham is low (46.4%), with less than one in two residents taking 150 minutes of physical activity per week. The England average is 6 out of 10 people doing this amount of activity.
A Healthy Weight Strategy for Barking and Dagenham to address lifestyle issues in the borough, such as diet and physical activity was approved by the Health and Wellbeing Board in September 2016 [https://www.lbdd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/health-and-wellbeing-strategy/81738-2/](https://www.lbdd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/health-and-wellbeing-strategy/81738-2/)

**Recommendation**

Support the actions linked to the vision and ‘to do’s of the borough’s Healthy Weight Strategy

- Barking and Dagenham to be a place where residents can make a change to help enable them to achieve or maintain a healthy weight

1. Enable families and individuals to take responsibility for achieving and maintaining a healthy weight.

2. Make an active lifestyle and healthy eating the easier choice.

3. Address causes that put particular groups of families and individuals at a greater risk of obesity.

4. Ensure the built and natural environment support families and individuals to be more healthy and active.

**Exposure to sun**

Residents are exposed to the sun particularly during heatwaves. The borough takes an active role in advising residents particularly those at high risk.

Some occupations, including people who work on highways for LBBD, need protection when exposed to the sun.

**The Cancer Awareness Measure**

Members learnt that in 2009/2010 residents were asked a number of questions as part of national research to find out if people could
recognise signs and symptoms of cancer. This research used the Cancer Awareness Measure (CAM). This survey found that while people are generally aware that smoking can cause cancer only 1 in 3 residents of Barking and Dagenham were aware that a persistent cough can be sign of cancer.

Similarly 1 in 3 residents could not recall any other sign or symptom of cancer including:

- An unexplained lump or swelling
- Persistent unexplained pain
- Unexplained bleeding
- A persistent change in bowel habits

At the same time, across England 2 in 3 residents could recall a classic cancer symptom.

Local information, from a small number of residents who answered a questionnaire, suggests that in 2016 4 in 5 residents know that an unexplained lump or swelling could be a sign of cancer.

In the same survey we found that 3 in 5 residents were aware that a persistent cough, persistent change in bowel habit or change in appearance of a mole is a sign or symptom of cancer.

Less residents were aware of other signs and symptoms e.g. persistent difficulty in swallowing; a sore that does not heal; a persistent unexplained pain.

Awareness of the signs of cancer is also lower in men, teens and ethnic groups.
Other barriers

7.2 Cancer and improving awareness and early intervention is the topic of this review. Through the review process Members found that there are a number of barriers to getting diagnosed. These can be emotional, cultural, practical and service-based barriers.

**Emotional**
Cancer is a concerning topic and some people find it very difficult to talk about, they may be embarrassed, concerned with what the doctor might find or simply not quite know how to bring the topic up with the doctor.

**Cultural**
Difficulty in talking about cancer may also be a cultural issue, for some residents English is not a first language. There may also be cases where individuals are not taking tests e.g. bowel cancer screening because handing faeces is culturally offensive.

**Practical**
Both for screening and diagnosis residents need to tackle practical issues such as making an appointment, and arranging or taking transport. These issues can disproportionality affect people from vulnerable groups in the community including people from minority ethnic groups, people with mental health issues, people living with learning disabilities and people living with physical disabilities.

**Service**
Sometimes residents simply worry that they are wasting the doctor’s time with their concerns.

<table>
<thead>
<tr>
<th>Emotional</th>
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<tr>
<td>Too worried about what the doctor might find</td>
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<tr>
<td>Too embarrassed</td>
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<tr>
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</tbody>
</table>
Cultural
Language barriers
Other cultural barriers

Practical
Difficulty in making an appointment
Other things to worry about
Difficult to arrange transport

Service
Worry about wasting the doctor’s time

In general Barking and Dagenham residents are more likely to have emotional barriers to seeking diagnosis rather than practical barriers. However vulnerable groups may need additional support to overcome barriers.

Screening uptake

Residents of Barking and Dagenham have access to the three cancer screening programmes, breast, bowel and cervical. The uptake of cervical screening is 70.2% slightly worse than the England average of 73.5%.

Breast cancer screening

The uptake of breast cancer screening in the borough is decreasing. In 2012 the offer was taken up by 64% of those offered. In 2014/15 this had decreased to 60%. One barrier to attending has been that there is no breast screening unit in the borough.

There is considerable variation in uptake by patients across GP practices. Some GP practices in the borough have an uptake that is higher than 64%, others needs support and have an uptake that is considerably lower than 64%.
Bowel cancer screening

The uptake of bowel cancer screening in the borough is low and steady. In 2012 the offer was taken up by 43% of those offered. In 2014/15 this was still 43%. One barrier to taking the test has been lack of awareness of the test and cultural objections to handling faeces.

Uptake of bowel screening has recently increased to 51.73% after the introduction of a local enhanced services agreement with GP practices.

There remains considerable variation in uptake by patients across GP practices with some practices achieving an uptake of 53.7% and others 31%.

Figure X Changes in breast and bowel cancer screening uptake 2012 – 2015.

The Cancer Strategy for England\(^8\) recommends that NHS England work with other arm’s length bodies to develop a cancer dashboard of metrics at the

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CCG and provider level. It is proposed that this dashboard includes information on screening uptake across GP practices.

7.3 Emergency diagnosis results in poorer outcomes for residents. As an outcome of all the factors that are outlined in this section residents of Barking and Dagenham the number of cancers diagnosed at a later stage, Stages 3 and 4, in the borough is higher than is usual in England.

The chances of a resident surviving for one year after a cancer is diagnosed at accident and emergency is significantly lower than all other routes to diagnosis because this generally correlates with late stage diagnosis. The impact of this can be demonstrated by looking at the rates of survival when cancer is diagnosed at different stages. For example, in bowel cancer, an early diagnosis usually means 9 out of 10 residents will survival for 5 years or longer, whereas a late diagnosis often results in less than 1 in 20 surviving five years or longer.

For breast cancer early diagnosis results in 9 out of 10 residents surviving 5 years or longer, but late diagnosis means only 1 in 10 surviving five years or longer.

Nearly 1 in every 4 (22.8%) cancer diagnosis in Barking and Dagenham are made through emergency routes, as compared to the England average which is 1 in every 5 (20.1%) of cancer diagnoses.

Presenting late for cancer diagnosis leads to poor outcomes for residents. Sadly, residents who are diagnosed with cancer in the borough
are more likely to be diagnosed late and therefore not to survive one year, Figure X.

**Figure X** all age group, age-standardised mortality rate per 100,000 by tumour group, LBBD and England, 2013

Source: LCI-PHE and MCS
Mary’s story

Mary told members that she had suffered with lung cancer which later spread to her brain, and how, after successful treatment, she is now leading a full and active life.

Mary explained that she before her lung cancer diagnosis, she had had a cough for about three weeks but that at the time this did not seem relevant to her because her main concern was severe joint pains. She was an ex-smoker but at the time of her diagnosis she had not been smoking for over 8 years. She had also lost weight. The joint pain, her main concern, was unusual for her and so she went to her GP. A test result showed a high marker for cancer in her liver and an X-ray later confirmed that there was a mass in her lung. Queen’s was initially not able to confirm a cancer diagnosis despite undertaking a bronchoscopy and PET scan due the positioning of the mass in her lung. Eventually she was referred to a consultant in Barts and three weeks later she had an operation to remove the cancer.

Following on after her treatment for lung cancer, at around March/ April, Mary noticed that one side of her mouth had dropped so visited her GP again. He initially suspected Bell’s Palsy but sent her for tests to be sure, and it was after this that she found out that she had a tumour in her brain. Mary started treatment at King George’s Hospital in the chemo unit which is both small and comfortable. It was very positive that there was cancer nurse who she could contact. She could leave a message and the nurse was good at ringing her back.

Mary shared that her faith played an important part in her emotional state while she had cancer and still does. She went to a retreat in Bristol with her sister which she found very helpful, her she learnt more about cancer and the importance of diet in preventing cancer. She felt her immune system was very poor prior to her developing cancer as she kept getting infections. She personally felt that this may have had part to play in her developing the tumour.

To help other people she felt there are a lot of messages already out in the borough about diet and other lifestyle changes; however, these are not linked to cancer. Local services could be more explicit in their messages about the link between lifestyle and cancer but it is important to do this in a positive way by emphasising that it is preventative. Mary also felt the reason people in the borough don’t always attend screening is perhaps down to fear so she considered it is important to explain to people what cancer is and that it can be beaten more easily if it is caught early.

HASSC took from Mary’s story:

1. It is important to raise awareness of signs and symptoms of cancer.
2. It is important that residents have access to local services for both diagnosis and treatment.
3. It is important to ensure easy access to screening
4. It is important to promote the message that even if one does develop cancer that early treatment can lead to
8. What is Working Well and What more can be done?

We may want to use submissions here from local stakeholders – Dr Rai??

Have emailed Kanika and asked for some anecdotal/observations from her work with patients

What is working well?

The Mayesbrook Park pilot is an exciting piece of local work designed to increase awareness of healthy lifestyles, including signs and symptoms of cancer. This piece of work is particularly exciting because, through community engagement, many of our local residents are involved. Some are involved as community champions, and in this role have been trained to engage with their own community, whether that be an ethnic community, a faith community of simply their neighbours. If this piece of work evaluates well it will be rolled out across the borough.

Barking and Dagenham health partners have also been successful in introducing positive change through communities, GP practices and St Georges and Queen’s Hospitals.

8.1 In the community

• Local slant on NHS awareness campaigns.
• Using social media and posters E.g. Be Clear on Cancer
• Some community talks to local groups
• Physical activity schemes for cancer patients

8.2 In GP practices

• A Cancer Research Facilitator is in post to support primary care to develop skills and knowledge in cancer awareness and treatment
• Practice visits by MacMillan GPs and primary care facilitator
• Local Enhanced Scheme from bowel cancer screening.
• GP education programme to increase awareness of common and vague signs and symptoms of cancer
• Education programme for practice staff to support patient care locally
• Improved patient awareness of signs and symptoms of cancer, particularly within hard to reach groups
• Work plan to increase the uptake of screening services
8.3 St Georges and Queen’s Hospitals
- Audit of emergency department presentations of cancer to identify potential opportunities for early diagnosis and improved patient experience.

8.4 Across Barking & Dagenham, Havering and Redbridge
- Collaborative working with secondary care clinicians to develop direct access diagnostic pathways

What more can be done?

8.5 Support action to increase community awareness of importance of lifestyle. Building on the Mayesbrook project work and the community engagement, if successful, consideration should be given to rolling out this approach to wards across Barking and Dagenham.

8.6 Introduce targeted social media campaigns linked to the national be Clear on Cancer NAEDI campaigns. With the aim of increasing uptake of screening and awareness of signs and symptoms.
- Including encouraging attendance at the Cancer Research UK roadshow
- A targeted approach to increase screening in vulnerable groups e.g. increasing the uptake of bowel screening in people with learning disabilities should be put in place. (ELF)
- A targeted approach to increasing awareness and the uptake of screening in LBBD staff and other staff in the workplace can be encouraged through the London Work Place Health initiative.

8.7 Support action to increase screening, particularly bowel screening
- Support and encourage local residents to register with a GP practice
- Encourage health partners to put in place actions that are known to improve uptake of screening
  - Phone reminders
  - Case note reminders
  - Local enhanced services agreements

8.8 Support staff to skills in talking about cancer to residents, particularly community health champions, Community Solutions, social care and health staff.
- Encourage awareness training including on-line (making Every Contact Count (MECC))
8.9 **Further strengthen partnership with health providers to provide a consistent approach to awareness and early intervention role of health providers:**

- Strengthen links through the North East London Cancer Commissioning Board
- Strengthen local public health contracts through specifications that include a requirement to increase awareness and early intervention in cancer.

9. **Conclusions, Recommendations and next steps**

9.1 This report will be submitted to xxxx, who will decide whether to agree the recommendations. If the recommendations are accepted, xxx will be asked to draw up an action plan describing how the recommendations will be implemented. In six months’ time, the HASSC will request a monitoring report explaining the progress of the implementation of the recommendations and whether anything could be said of the early impact they have had.
The HASSC would like to extend its thanks to the following for contributing to this Review:

Officer Support for this Review

Members also thank the following Council officers for their support during this Review:

- Sue Lloyd: Public Health Consultant
- Mary Knower, Public Health Strategist
- Masuma Ahmed: Democratic Services Officer
Cancer Myths

Stress causes cancer
Some people think that stress can cause cancer but the evidence for this is poor. Stressful events can alter the levels of hormones in the body and affect the immune system but there is no evidence that these changes could lead to cancer. Stressful situations can make some people more likely to take up unhealthy behaviours such as smoking, overeating and drinking alcohol. We know these behaviours increase the risk of developing cancer.

Mobile phones cause cancer
So far, the scientific evidence shows that it’s unlikely that mobile phones could increase the risk of cancer, but we do not know enough to completely rule out a risk. The use of mobile phones has skyrocketed since the 1990’s. If mobile phones increase the incidence of brain cancer, increasingly people should be developing this disease. In the UK, the incidence of brain cancer has been constant for years.
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HEALTH AND ADULT SERVICES SELECT COMMITTEE

1 March 2017

Joint Health Overview and Scrutiny Committee: Update

Report of the Director of Law and Governance

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<tr>
<td><strong>Report Author:</strong> Masuma Ahmed, Democratic Services Officer</td>
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<td><strong>Accountable Divisional Director:</strong> Fiona Taylor, Director of Law and Governance</td>
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<td><strong>Accountable Director:</strong> Chris Naylor, Chief Executive</td>
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Summary:

This report updates the Health and Adult Services Select Committee (HASSC) on the issues that were discussed at the last meeting of the Joint Health Overview and Scrutiny Committee (JHOSC), held on 17 January 2017 at Redbridge Town Hall.

Recommendations

The HASSC is recommended to note the update.

Reason

To keep the HASSC updated on issues discussed at JHOSC meetings.

1. Introduction and background

1.1 The Outer North East London JHOSC is a discretionary joint committee made up of three health scrutiny members of the following local authorities to scrutinise health matters that cross local authority boundaries:

- Barking & Dagenham
- Havering
- Redbridge and
- Waltham Forest.

(The Essex County Council Health Overview and Scrutiny Committee is permitted to appoint one member to the JHOSC).

1.2 As agreed by the HASSC at the meeting on 9 June 2016, the London Borough of Barking and Dagenham’s representatives on the JHOSC for 2016/17 are Councillors Chand, Zanitchkhah and Jones.

1.3 Four JHOSC meetings are usually held per municipal year and are chaired and hosted by each constituent authority on a rota basis. This report covers the matters that were discussed at the third meeting of this municipal year, on 17 January. The final meeting of this municipal year has been scheduled for 4.00pm on 18 April 2017 at Waltham Forest Town Hall.
2. Matters discussed at the last meeting of the JHOSC

2.1 The last JHOSC meeting was held on 17 January 2017 Redbridge Town Hall and was chaired by Councillor Dev Sharma. An outline of the matters discussed at the meeting is provided below.

2.2 Sustainability and Transformation Plan

2.2.1 The JHOSC was addressed by two representatives from the Save Our NHS group who raised a number of concerns regarding the North-East London Sustainability and Transformation Plan (STP). These related to the prospective closure of the A&E department at King George Hospital (KGH), as well as the closure of acute beds there. Concerns were also raised around what was viewed as ‘secrecy’, lack of democratic accountability and public engagement around the STP, and the feeling that key financial details were being withheld. Further concerns were raised that the STP would be devastating for the local area where a lot of new housing had been proposed but no details around where new health facilities would be located, and that GP surgeries were forming into larger networks but that there were insufficient GPs to support this model.

2.2.2 The STP officers’ response to some of the above points, as well as questions from JHOSC members, included an acceptance that there been challenges in the STP process, but assurance that the overall aim of the STP, was a positive one, which was to create a new way of working based on a partnership model to deliver a health service which was fit for the future. The decision to close the A&E at KGH had been made by the Secretary of State rather than the Barking, Havering and Redbridge Hospitals NHS Trust. Bed modelling data was likely to be available by the end of April but officers would confirm the timescale for this. It was accepted that Queen’s Hospital A&E was extremely busy and a lot of capital would be required to expand the department; however, some 50-60% of current A&E cases at KGH could still be treated at a planned enhanced urgent care centre. Work to expand the A&E at Queen’s would take over a year and depended on capital availability. The effect of the Private Finance Initiative process for Queen’s Hospital would be fed into an estates strategy. The impact on Whipps’ Cross on any closure of A&E at King George would also be considered. Furthermore, revised figures for population growth in the local area would be factored into the STP plans and there were further plans for public engagement. It was felt that the STP could be implemented and a more accessible document would be produced explain the differences the STP would make to health services.

2.3 Results of Open Dialogue Trial

2.3.1 The Associate Medical Director at North East London Foundation Trust (NELFT) explained that Open Dialogue was a new approach to that utilised the close networks of people with mental health issues in their treatment. It was based on the considerable rises in discharge rates from mental health services that had used the approach in Finland and the USA. NELFT had submitted a grant application for the evaluation of pilots of the technique that it planned to run in Havering and Waltham Forest. It was hoped that the funding would enable the largest single trial of Open Dialogue to be carried out, followed by evaluation over the next 3-4 years to show that Open Dialogue could produce marked reductions in the relapse rate and re-admission to mental health services. Confirmation of grant funding was hoped to be received by March with pilot teams starting work from mid-2017. Havering and Waltham Forest had been chosen as pilot sites as consultants from these areas had expressed most interest in Open Dialogue. Teams would be based in the Community Recovery Team offices but would also carry out home visits with a 24-hour target response time. If the funding was not
received, other sources of funds would be considered. It was also hoped that local CCGs would fund one to two consultant posts specialising in Open Dialogue.

2.4 Great Ormond Street Hospital

2.4.1 Unfortunately, for the second meeting in succession, Great Ormond Street Hospital had to send apologies and could not send a representative to the meeting.

2.5 London Ambulance Service

2.5.1 Officers from London Ambulance Service NHS Trust (LAS) stated that it had been a challenging time for the Trust with rising numbers of category A calls being received across all Outer North East London boroughs. Growth in demand was due to several factors including more referrals from both GPs and the NHS 111 service. Work was in progress to seek to manage this demand including work with other partner organisations, efforts to reduce demand via social media and, intelligent conveyancing was being introduced, whereby patients could be taken to less busy A&Es. The LAS computer aided dispatch system had failed for some hours on 1 January 2017 and officers apologised for the long patient waits during this time. One patient was known to have died during this period and this matter was currently being investigated.

2.5.2 A quality improvement plan had been published on the LAS website and the purchase of 160 replacement ambulances had been funded. A new monitoring system had been introduced for medicines management and around 700 front line staff had been recruited in the last year. There were, however, some local shortfalls in recruitment and these were being addressed. It was acknowledged that there were sometimes delays at Queen’s Hospital in handing an ambulance patient over to a clinical member of staff; however, it was not usually possible to divert ambulances elsewhere as there were similar pressures at the closest hospitals in other areas. The LAS fleet tended to move considerable distances around London over the course of a shift and there was not a shortage of ambulances themselves.

2.6 Whipps Cross University Hospital

2.6.1 Officers from Barts Health NHS Trust reported that, following an inspection by the Care Quality Commission (CQC) in March 2015, Whipps Cross had been rated as ‘inadequate’ and the Trust had been put into special measures. Since then, the CQC had re-inspected Whipps Cross in July 2016 and issued its report on 15 December 2016. This had shown significant improvements at Whipps Cross although the Hospital’s overall rating had remained at ‘inadequate’. Services at the hospital for children and older people were now as ‘good’ and the A&E department was now rated as ‘requires improvement’ rather than ‘inadequate’.

3. Implications

3.1 There are no legal or financial implications arising directly from this information report.

Background Papers Used in the Preparation of the Report:

Minutes of the JHOSC meeting held on 17 January 2017: http://democracy.havering.gov.uk/ieListDocuments.aspx?MId=3487&x=1

List of appendices: None.
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<tr>
<th>Meeting date</th>
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</table>
| Weds 3 May   | Cancer Scrutiny Review - final report  
(The HASSC will receive the final report arising from the Scrutiny Review on Cancer for agreement).  
Health checks – performance  
(The HASSC will receive a report providing data on the number of eligible people that have been offered and received NHS Health Checks).  
Primary Care Update-  new item, agreed by Chair  
Healthwatch reports  
(Healthwatch, the local consumer champion for health and social care services will present a report providing an overview of the visits it has undertaken and the projects it has worked on since its last report to the HASSC).  
CQC inspections  
(The HASSC will receive a report providing an overview of CQC inspection reports of social care providers, covering the period since the last report to the HASSC).  
Joint Health Overview & Scrutiny Committee update  
(The HASSC will receive an update on the matters discussed at the last JHOSC meeting) | Chair  
Director of Public Health  
Sarah See, BDCCG  
Manisha Modhvadia, Healthwatch  
Principal Commissioning Manager, Adults’ Care & Support  
Chair | Mon 3 April | Mon 10 April | Tue 18 April | Councillor Worby |