B&NES HEALTH PROTECTION BOARD

ANNUAL REPORT 2014/2015

Specialist Health Protection Areas:

Sexual Health

KPIs: chlamydia diagnoses, HIV & under 18 conceptions

Healthcare Associated Infection (HCAI)

KPIs: MRSA / C.difficile

Screening & Immunisation

KPIs: national screening programmes & uptake of universal immunisation programmes

Communicable Disease Control & Environmental Hazards

KPIs: private water supplies / air quality management areas

Substance Misuse

KPIs: hep B vaccination, opiates & non-opiates

Health Emergency Planning

KPIs: Civil Contingencies Act requirements

CONTENTS Page

Executive summary

What's gone well?

- Across the full scope of the specialist work streams commitment to the Board has been demonstrated and assurance has been sought. There are no significant concerns about performance in any area.
- Performance monitoring, identifying risks, ensuring mitigation is in place and escalation processes have worked well.
- A full work plan has been agreed and a number of successful workshops have been held to test the health protection arrangements in a number of scenarios.
- The Board has established a B&NES immunisation sub-group.
- Outbreaks and incidents have been handled well, full debriefs have taken place and lessons identified are being fully implemented.

What are the challenges & recommendations?

The Board is committed to improving all work streams and has recommended 6 priorities to be addressed in order for the Director of Public Health, on behalf of the local authority, to be further assured that suitable arrangements are in place in B&NES to protect the health of the population.

1. Fully operationalise health protection plans in B&NES

2. Help to ensure resilience of health emergency planning in B&NES

3. Support the development of Air Quality Action Plans (AQAPs) for Saltford & Keynsham

4. Improve uptake in all childhood immunisation programmes

5. Improve the uptake of flu vaccinations in target groups

6. Assurance: Continue to monitor performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary

1. Introduction & background

In April 2013 the Health and Social Care Regulations changed the statutory responsibility for health protection arrangements. B&NES Council acquired new responsibilities with regard to protecting the health of their population. Specifically Directors of Public Health (DPHs) need to be assured on behalf of their local authority that relevant organisations have appropriate plans in place to protect the population against a range of threats and hazards and to ensure that necessary action is being taken.

The Health Protection Board was established in November 2013 to help fulfil this role. It provides a forum for professional discussion of health protection plans, performance, risks and opportunities for joint action and ensures strong relationships between all agencies are maintained and developed to provide a robust health protection function in B&NES.

The Board's responsibility covers residents and non-residents who visit or work in B&NES and includes the following health protection areas:

a) Vaccination & immunisations
b) Infection prevention and control (IPC) related to healthcare associated infections
c) Drugs and substance misuse
d) National screening programmes
e) Sexual health
f) Communicable disease control including tuberculosis, blood-borne viruses, gastro-intestinal (GI) infections, seasonal and pandemic influenza
g) Emergency preparedness, resilience and response
h) Environmental hazards and control, biological, chemical, radiological and nuclear, including air and water quality, food safety, contaminated land

The following officers and organisations are members of the Board:

• Director of Public Health (Chair)	B&NES Council
• Consultant in Public Health	B&NES Council
• Cabinet Member for Adult Social Care & Health	B&NES Council
• Health Protection Manager	B&NES Council
• Public Protection & Health Improvement Manager	B&NES Council
• Substance Misuse Commissioning Manager	B&NES Council
• Emergency Planning Manager	B&NES Council
• Director of Nursing & Quality	NHS BaNES CCG
• Consultant in Communicable Disease Control	Public Health England
• Senior Health Protection Practitioner	Public Health England

- Screening & Immunisation Lead — BGSW Area Team
- Head of Public Health — BGSW Area Team

2. Terms of reference

The Terms of Reference for the Board were signed off during the March 2014 Board meeting. Please see Appendix 1.

3. Purpose of the report

This annual report documents the progress made by the Health Protection Board since it was established and highlights key performance indicators, risks, challenges and priorities for the next 12 months in each specialist area.

4. Performance, risks, challenging & priorities in each specialist area

4.1 Infection prevention & control - health care associated infection (HCAI)

4.1.1 Context

The Director for Quality & Nursing attends the Board for NHS Bath and North East Somerset Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by commissioning (buying) health and care services including: planned hospital care, urgent and emergency care, maternity and mental health services.

The CCG has a statutory responsibility to support NHS England improve the quality of primary medical care. Quality includes patient safety, patient experience and clinical effectiveness of provided services.

The CCG assures itself that Infection Prevention & Control is in place in provider organisations through:

1. Quality schedules - zero tolerance of MRSA & minimise rate of *Clostridium difficile (C.Diff).*
2. Commissioning for Quality and Innovation (CQUIN):
3. Site visits of major providers

4.1.2 Key performance

The CCG monitors the number of cases of healthcare acquired *MRSA* & *C. diff* infection as part of their contract with providers.

4.1.3 MRSA blood stream infections

Staphylococcus aureus (S. aureus) is a bacterium that is present on the skin and is the most common cause of localised wound and skin infections. MRSA is a strain of *S. aureus* that is resistant to commonly used antibiotics, for instance, Flucloxacillin.

In 2013/14, the government set the challenge of demonstrating zero tolerance of healthcare acquired MRSA through a combination of good hygiene practice, appropriate use of antibiotics, improved techniques in care and use of medical devices, as well as adherence to all best practice guidance.

In 2014/15 B&NES failed to deliver zero cases of MRSA in all CCG patients, as 2 cases were reported. However this is an improvement of 4 cases in 2013/14 and robust action has been taken by the commissioners and providers to minimise the risk of future cases arising.

4.1.4 Clostridium difficile infection

A *C.diff* infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics.

In 2014/15 the national target for *C. diff* infection was 49 cases for all B&NES CCG patients. The total number of cases of *C. diff* was 61 compared to 56 cases in 2013/14.

The number of cases of *C. diff* infection was highlighted on the Health Protection Board's Risk Log throughout the year and the BaNES HCAI collaborative are taking actions to reduce *C. diff* infections, including focussing on appropriate anti-microbial prescribing and stewardship.

BaNES CCG is also actively monitoring *C. diff* cases with providers and in primary care and is participating in a Bath Gloucestershire Swindon & Wiltshire (BGSW) Area Team pilot. The purpose of the pilot is to ascertain if there are common themes arising within the community acquired *C. diff* cases in BaNES. To date, no common themes have been identified with the small number of cases found and further work is planned.

4.2 Communicable disease & environmental hazards

4.2.1 Context

The Public Health England (PHE) South West, Health Protection South West North team work in partnership with external stakeholders including the Public Health and Public Protection & Health Improvement teams based at B&NES Council, NHS England, acute care, general practitioners and community nursing to deliver an

appropriate co-ordinated response to infectious disease cases, outbreaks and incidents. PHE produce quarterly surveillance reports for the Board to monitor the incidence of different infections and diseases.

PHE reported that in B&NES there were 365 confirmed cases of infectious disease during 2014 that required significant investigation, we have highlighted below some examples of outbreaks or incidents where a multi-agency response and co-ordination was required.

4.2.2 Tuberculosis (TB)

TB is a disease that mainly affects the lungs and is curable with a full course of treatment. Around 8,000 people develop TB in England and Wales each year and predominantly in urban areas.

B&NES is a low incidence area for TB and it is relatively difficult to catch, however the summer of 2014/15 saw 2 significant TB incidents in a B&NES primary school and a Somerset factory which employed a significant number of B&NES residents.

A total of 74 children from three different classes in the primary school were screened for TB following a confirmed case of TB in a member of the school community. Seven children had positive screening tests, undertook further clinical assessment and were treated accordingly.

Following 2 confirmed cases of TB in the factory, screening was offered to everyone who worked there. Approximately 350 people were screened and extra clinics were put on at the Royal United Hospital (RUH) to clinically assess the 90 or so people who screened positive, provide advice and support and provide appropriate treatment.

The two outbreaks are not known to be connected and this was the first time that a multi-agency incident control team had been tested on such a large scale under the new health system in B&NES. Both outbreaks were managed very well, support and advice was given to all those affected and a lot of learning has been collated through debriefs should a similar incident occur in the future. Both incidents were managed by different Consultants in Communicable Disease Control (CCDCs) / PHE teams working together and the Sirona School Nursing Service were applauded for their efforts in screening the children during the Sirona Awards for Excellence, they were awarded Team of the Year 2014. Funding was agreed between the Council's Public Health Department and the CCG for screening and treatment.

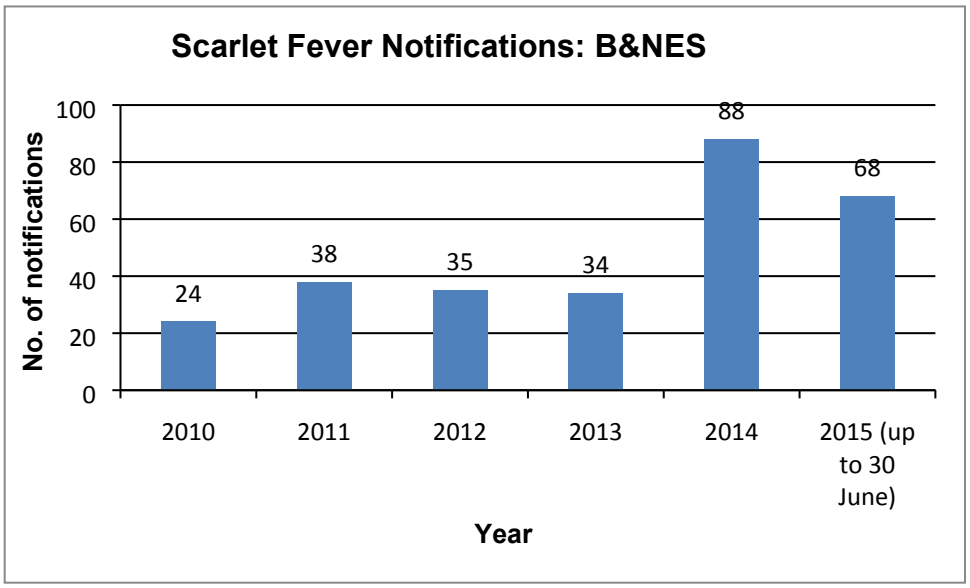
4.2.3 Scarlet Fever

In 2014/15, in keeping with the rest of AGW, B&NES experienced high levels of scarlet fever including a school outbreak.

Scarlet fever tends to be more common in the winter and spring and peaks around end of March/early April. It is mainly a childhood disease and is most common between the ages of two and eight years. It is usually treated with antibiotics and children need to be excluded from their childminder, nursery or school to help minimise spreading the infection.

As a response to the increase in scarlet fever the following public health interventions were put in place:

- Raising awareness with local clinicians, schools and child care establishments to ensure prompt reporting.
- Increased sampling of suspected cases



Source: PHE, 2015

4.2.4 Campylobacter

On 22 December 2014, a member of public telephoned the Council's Public Protection services to report that she was suffering from chronic stomach cramps and diarrhoea, as were five of her colleagues from work following a meal out in Bath.

It transpired that 10 workmates attended a Christmas meal at a relatively new restaurant in Bath city centre on the evening of 15 December. Six of the diners subsequently developed food poisoning symptoms. All of the six people had eaten

chicken liver parfait as a starter, providing strong circumstantial evidence that the restaurant had poisoned these customers. The six people all submitted a clinical specimen, but laboratory results were yet available. Due to the circumstantial evidence, the number of people potentially at risk and it being the Christmas season, an unannounced inspection of the restaurant took place that lunchtime.

The business, part of a small chain, had recently started trading and had previously been inspected in November 2014. The facilities were very good, practices appeared to be good, but they needed to formulate a food safety management system (FSMS) and a letter was written to this effect. The new business was awarded a Food Hygiene rating of 4 – Good.

The inspection on 22 December found evidence of poor hygienic practice in the method used for the production of batches of chicken liver parfait and there was confusion between management and staff of the correct methods. These exemplified the shortcomings identified in November as there was no effective food safety management system. Food samples were taken including chicken liver parfait, high risk foods were removed from the menu and legal Hygiene Improvement Notices were served requiring effective implementation of a FSMS. The Food Hygiene rating was immediately reduced to 1- Major Improvement Necessary which resulted in a lot of social media activity and speculation (something of a twitter storm)

The six people presenting symptoms all subsequently tested positive for Campylobacter. However it transpired that five ate at another venue the next lunchtime (16 December), all were in constant contact during working hours during the incubation period, the restaurant despite failings in processes had good traceability of product and of the 240 covers served on 15 December and the 40 servings of chicken liver parfait there were no other reported cases of illness. All of the food samples tested were negative.

With no direct evidence to link the cases to the restaurant and an absence of any other cases outside the group of work colleagues this investigation did not pass the evidential tests require by the Council Enforcement Policy to proceed to prosecution. However the Food Safety team did invoke the “Business Support Remediation Model”, the managers of the company were called into the Council Offices and after some frank exposure to the evidence gathered, possible consequences and options for the future relationship with the enforcement team, an action plan agreed to attain the highest levels of good practice. Three months later the business was awarded a rating of 5 - Very Good.

4.2.5 Air Quality Management Areas

B&NES Council is legally required to review air quality and designate air quality management areas if improvements are necessary under Part IV of the Environment Act 1995 and the Air Quality Management regulations. Where an air quality management area is designated, an air quality action plan describing the pollution reduction measures must then be put in place in pursuit of the achievement of the Air Quality Strategy and objectives in the designated area.

B&NES Council have declared 3 Air Quality Management Areas (AQMAs) in Bath, Keynsham and Saltford.

An air quality action plan for Bath has been in place for some time. A multi-departmental group in the Council led by the Public Protection & Health Improvement team have recently been identifying potential actions in Keynsham and Saltford.

Although this work was delayed due to the elections and has been on the Board's risk log, the action plan will go out to public consultation this year and be complete by December 2015.

Based upon a good body of international evidence which demonstrates a link between air pollution and certain health outcomes, the group working on this area will make a recommendation that the Council accepts the position that air pollution does contribute to poor health. If this is accepted then further exploratory work could include:

- Identify the most effective methods of reducing air pollution (e.g. through a literature review)
- Identify whether there are any physical locations within the 100m buffer zones of the Air Quality Management Areas where people are more vulnerable to the negative effects of poor air quality may congregate (e.g. care homes, sheltered housing, nurseries/pre-school, general practices) and work with them to look at how they can reduce their exposure to poor air quality.

4.3 Health Emergency Planning

A wide range of events can cause health emergencies, including natural hazards, accidents, outbreaks of disease and terrorist attacks. Emergencies can be minor events that threaten the health and lives of local communities or major events that affect the whole population.

As much as possible, we try to prevent these emergencies. But it's important that we are able to respond quickly if they do happen, to reduce their impact on people's lives and to stop lives being lost.

In order to ensure the best emergency planning, preparedness and response it is essential that all organisations in the health community work together in a coordinated way.

4.3.1 Local Health Resilience Partnership

Local Health Resilience Partnerships (LHRPs) have now been established for over two years in order to deliver national Emergency Preparedness Resilience and Response (EPRR) strategy in the context of local risks. This forum brings together the health sector organisations involved in EPRR at the Local Resilience Forum (LRF) level and is a partnership for coordination, joint working and planning for emergency preparedness and response by all relevant health bodies. It offers a coordinated point of contact with the LRF and reflects a national, consistent approach to support effective planning of health emergency response.

4.3.2 Review of local health protection arrangements for responding to incidents & outbreaks

During the spring of 2014 the LHRP carried out a review of local health protection arrangements for responding to incidents and outbreaks as part of a national audit. In B&NES a number of capabilities and gaps in funding and resources were found. As a result the LHRP produced a strategic document entitled 'Communicable Disease Incident Outbreak Control Plan' and an operational plan with a directory of response activities identifying which organisation has lead responsibility and resources and skills to deliver each activity.

To help inform the operation plan a series of scenario based workshops have been held, where all partners came together to discuss very practical issues. A number of debriefs from real incidents or outbreaks have also been used.

4.3.3 The Council's Emergency Planning Department

The Council's Emergency Planning Department is represented on the Board and supports local health emergency planning preparedness and response by providing the Council's first line of contact out of hours, maintaining the Council's community risk register and Major Incident Plan, organising training and exercises and video advice and expertise. During 2014/15 the Council's Customer Services Dept. restructured bringing together the Emergency Management team, CCTV and the Contact Centre to form the Communications Hub.

Due to the re-organisation and recruitment the inability to plan/exercise and the inability to respond to emergencies long term was on the Board's risk log. The matter

was escalated and one of the results was that a Design Group was established to have a Council wide overview of emergency planning, keep up-to-date with the latest guidance and developments, agree roles and responsibilities, discuss risk, review incidents and identify and implement lessons learned.

An internal audit of the Communications Hub recently took place. It was assessed as level 3 (Satisfactory) and all actions accept one have now been completed. The outstanding action to have a silver control senior manager rota is currently being considered.

There is no formal out of hours provision for the Council's Public Protection & Health Improvement department. This has been included on the Board's risk log. To mitigate against this the Public Protection Manager's and senior manager's contact details are on the Council's emergency contacts list and a cascade 'best endeavour' approach has been adopted. This system was recently tested out of hours when Protection officers were needed to investigate a potential case of Legionnaires disease.

4.3.4 Ebola

Since March 2014, there has been an outbreak of the Ebola Virus Disease (EVD) affecting several countries in West Africa.

EVD is a rare and infectious disease caused by the Ebola virus and is spread through human populations through direct contact with the blood and bodily fluids of an infected person.

The risk of Ebola to the UK remains very low. While the UK might see cases of imported Ebola, there is minimal risk of it spreading to the general population due to the health care system within England with robust infection control systems and processes and disease control systems in place.

The DPH and LHRP have been working hard to ensure that local response plans are as robust as possible. Local workshops and planning exercises have been held, to work through plans in detail, with all organisations involved. This is to ensure that if an Ebola situation were to arise in B&NES, all agencies are ready and prepared to respond effectively and rapidly.

4.3.5 Near evacuation of Bridgemead Residential and Nursing Home

On 24 December 2013 and following an assessment of the likelihood and impact of flooding, Bridgemead Care Home in Bathwick took steps in preparation for a full

evacuation of its premises. The incident was deemed to be a local incident and a number of health system and multi-agency partners were involved in preparatory actions, some at the scene, others working remotely to support the premises and ensure the safety of service users and staff. The decision was eventually taken to keep residents on the premises.

Following 'stand down' of this incident, a debrief was conducted in order to identify any lessons arising.

The following actions were identified:

- Share documentation pertaining to evacuation
- Confirm local (B&NES) transport options and contact numbers
- Bridgemead to develop existing plans to include:
  - Clarity around roles and responsibilities for on-site incidents (including accountability for decisions to evacuate)
  - Route for escalation if encountering difficulties (to commissioners)
  - Potential roles for emergency services responding to flooding at the premises
  - Plans to be shared with commissioning organisations (Local Authority/Clinical Commissioning Group) and other organisations with response role.

Use learning from Bridgemead incident as basis for on call staff training:

- Threshold -activating telecom for involved parties
- Threshold-setting up coordination hub and when to request multi-agency Incident Coordination Centre via Local Authority

- Review risks (short to long-term).
- Ensure plans are in place for these risks

4.4 Sexual Health

4.4.1 The Sexual Health Board

The Sexual Health Board was re-launched in Spring 2014, aiming to promote good sexual health amongst the population of B&NES. The Board has three main purposes:

1. To oversee the development and delivery of a strategic plan for sexual health in B&NES.
2. To influence the commissioning and delivery of high quality sexual health promotion, clinical provision and sexual health-related social care, ensuring equitable provision according to need.
3. To ensure effective partnership responses are developed and delivered in respect of all sexual health services for B&NES residents.

Sexual health is a broad topic and the following areas are included within the Board's scope:

1. Sexually transmitted infections
2. Unintended pregnancy and safe termination of pregnancy
3. Young people's sexual health; and relationships and sexual health education
4. Psychosexual issues
5. Promotion of safe sexual experiences
6. Teenage pregnancy
7. HIV

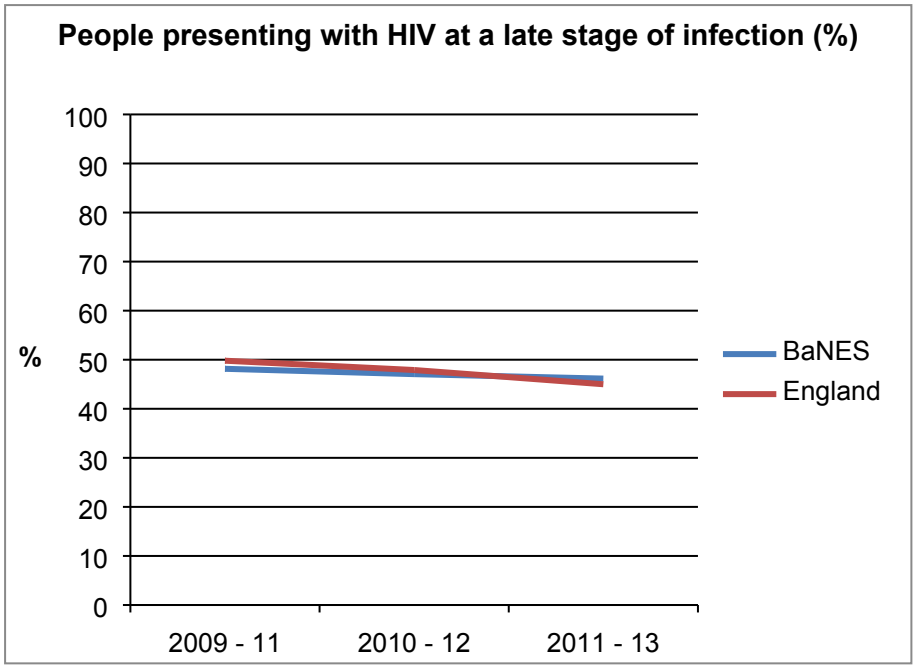
Other areas such as rape, sexual violence and sexual exploitation, fertility, sexual dysfunction and gynaecological issues, whilst linked to the area are out of direct scope, although linkages with these areas will be developed where required

4.4.2 Sexual Health Needs Assessment (SHNA)

The new SHNA completed in March 2015 provided useful information in a number of areas relating to health protection:

- B&NES is a low prevalence area for HIV (0.66 infections per 1,000 population aged 15-59 years), compared to 2.1 per 1,000 in England. 25% of people living with HIV locally receiving treatment and care are Black African. If HIV is diagnosed early it can be successfully treated and people with HIV can live to near-normal life expectancies in good health. Early diagnosis also means that the risk of HIV being passed on as a result of people being unaware of their HIV status is reduced. As can

be seen in the chart, in B&NES and in the UK just under half the people diagnosed with HIV between 2011 – 2013 were diagnosed late. B&NES Council has signed up to the national Halve It campaign to promote early diagnosis.



Source: Public Health Outcomes Framework

- B&NES is a low prevalence area for gonorrhoea (27 per 100,000 in B&NES compared to 55 per 100,000 in England), genital herpes (38 per 100,000 in 2013, compared to 60 per 100,000 in England) and genital warts (123 per 100,000 compared to 137 per 100,000 in England)
- In 2013, B&NES had a very low incidence of syphilis, consistent with the national picture (5 per 100,000 compared to 6 per 100,000 in England)
- There were relatively small numbers of people with chronic hepatitis B virus diagnosed year on year from 2010 – 2013 (10 or less per year). There were also relatively small numbers of new diagnoses of hepatitis C diagnosed from 2010 – 2012 (average of 63 per year)
- Achieving a higher chlamydia detection rate reflects improved control of chlamydia infection; identifying and treating more infections means individuals will have reduced risk of serious consequences from the infection and will no longer be infectious to others. Although data is limited due to some data coding issues in the testing laboratories, it appears chlamydia detection rates in B&NES are below the recommended rate of 2,300 chlamydia diagnoses per 100,000 15 to 24 year olds, averaging 1,607 per 100,000 in 2013 compared to 1,907 per 100,000 in the Avon, Gloucestershire and Wiltshire PHE centre area and 2,016 per 100,000 in England
- B&NES has a low number of under 18 conceptions each year (generally between 50 and 55 pregnancies). The under 18 conception rate in 2013 was 17 per 1000 women aged 15-17, and this is significantly lower than national

rates. Maintaining this low rate will continue to be a priority for partners on the Sexual Health Board

Following the sexual health needs assessment recommendations will be addressed from 2015/16 through a strategy and action plan under five themes:

1. Strengthening intelligence and research
2. Strengthening sexual health service provision
3. Strengthening prevention and promotion
4. Working with recent technologies
5. Strengthening training and development

4.5 Substance Misuse

4.5.1 Context

The aim of this programme is to coordinate the local response to the treatment and prevention strand within HM Government's National Drug Strategy (2010) 'Building Recovery: Supporting People to Live a Drug Free Life' by commissioning effective substance misuse services for B&NES residents who are affected by drug and/or alcohol problems. The key objective is to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services. This is achieved through the delivery of recovery and outcome focussed integrated services. Nationally, for every £1 spent on drug treatment and recovery £2.50 is gained in benefits. It is evidenced in the Local VFM tool that benefits accrued to B&NES are considerably higher, with £3.43 gained in benefits for every £1 spent on the local treatment system (2012-13).

4.5.2 Drug and alcohol performance

The main substance-misuse related indicator in the public health outcomes framework (PHOF) relates to improving client outcomes through increased successful completions from treatment and prevention of re-presentations (through relapse). The table below shows performance for opiate clients and non–opiate clients. Opiate clients' outcomes in B&NES are higher than the national comparators (10.8% compared with 7.7%), with non –opiate clients' outcomes similar to national comparators (39.6% compared with 38.3%).

Indicator*	Year to end Oct 2014 - BaNES	Year to end Oct - England
Treatment completion and non-representation (% opiate clients)	10.8%	7.7%
Treatment completion and non-representation (% non-opiate clients)	39.6%	38.3%

*Source: NDTMS

Improving outcomes has been the greatest achievement of 2014/15. For opiate users, outcomes are considerably above 2013/14 performance and the baseline of 6.7% set in 2010. For non-opiate users, outcomes are also considerably above 2013/14 performance and the baseline set of 21% in 2010.

The treatment services have been innovative in meeting increased demands for alcohol misusers and with high client successful completions as shown in the following chart:

Finally, the national indicator in the government's Health Premium Incentive Scheme has been confirmed as 'successful completion of drugs treatment' (with combined data for opiate and non-opiate users), which will give an additional local focus to this area of work.

4.5.3 Blood Borne Viruses

Hepatitis B (HBV) and Hepatitis C (HCV) are blood-borne viruses (BBVs), transmitted via infected blood and are known to be the leading cause of liver disease worldwide.

Injecting drug use continues to be the most important risk factor for people in the UK who have chronic HCV infection.

B&NES treatment services are effective and proactive at supporting appropriate clients to be tested for HCV. During 2014/15, 93% of injecting drug users in B&NES (engaging in drug treatment) had been tested for HCV. This is substantially above the national performance (71%).

4.5.4 Hepatitis B project

A briefing by Public Health England in 2013 stated that HBV prevalence dropped from 44% in 1990 to current 20% due to increased immunisation. Department of Health Clinical Guidelines recommends offering HBV immunisation to all drug users, and recommends immunisation of priority groups (such as injecting drug users).

During 2014/15 the B&NES Substance Misuse Commissioning Manager undertook a study to look at how to increase drug misusers' uptake of HBV immunisation and to implement processes to ensure continued high performance.

The main findings and what worked in B&NES:

- Appropriate targeting of priority groups
- Task focussed BBV nurse on-site
- Offering BBV at start of treatment when motivation is highest, and with rapid follow up of boosters
- Promote BBV at needle exchange & steroid clinics
- Risk flow-chart (& process) identifying who is responsible for follow up
- Obtaining & recording accurate data is challenging e.g. from prisons/GP practices/out-of-area providers

B&NES continues to perform substantially above national performance for HBV immunisation.

4.6 Immunisations

4.6.1 Context

Responsibility for commissioning all universal immunisation programmes was passed to NHS England Area Teams as a seconded function from the Department of Health and Public Health England provide the public health and system leadership capacity in the way of seconded / embedded workforce (Screening and Immunisation Teams, SIT). All B&NES universal immunisation programmes are commissioned by NHS England South (South Central), formally the Bath, Gloucestershire, Swindon and Wiltshire (BGSW) NHS England Area Team supported by the PHE Centre Health Protection South West North. The programmes commissioned are part of the Section 7a agreement between the Secretary of State for Health and NHS England, all programmes are commissioned against a national Service Specifications (Part c of the S7a), subject to local agreements on appropriate additional initiatives.

These changes have meant that there have been a number of challenges, and the screening and immunisation public health leadership and its commissioning has been nationally acknowledged as one of the key risks. Some of these risks relate to: access of appropriate, timely and reliable data specifically enabling small area analysis; clarity of roles and responsibilities on incident management; working arrangements across NHS England and PHE; staff feed-back. Specifically the Screening and Immunisation Team have faced some additional challenges including: relatively late formation, lack of capacity, and lack of admin support; however by the end of 2014/15 these challenges have been largely addressed.

The Screening & Immunisation team provide the Board with quarterly performance reports and briefings.

4.6.2 B&NES Immunisation Sub-group

The Health Protection Board has recognised the above challenges and has set-up a B&NES Immunisation Sub-group which will meet for the first time on 22 July 2015.

It is necessary to have one operational group with the responsibility for taking a system-wide overview of organisations and other stakeholders contributing to B&NES immunisation programmes with the aim to protect the health of the local population, reduce health inequalities and minimise and deal promptly with any threats that may occur.

The group will provide a structured approach to monitoring, identifying & mitigating risks and updating action plans relating to immunisation programmes. It will work collaboratively to exchange information, share knowledge; good practice and provide

practical solutions and ideas to for the purpose of improving and strengthening local immunisation programmes.

The group will also aim to seek assurance that immunisation services in B&NES are compliant with the Department of Health guidelines and ensure that all national and local immunisations programmes are delivered safely, effectively and in a timely manner to all B&NES residents.

4.6.3 Immunisation programmes

4.6.4 Childhood immunisation programmes

The COVER (Cover of Vaccination Evaluated Rapidly) programme evaluates childhood immunisation by collating immunisation coverage data from child health systems for children aged one, two and five years of age. Data is evaluated against the World Health Organization (WHO) targets of 95% coverage annually for each antigen (except MenC) by two years of age.

Pre-school booster vaccinations (DTaP/IPV and MMR 2nd dose at 5 years) are consistently not reaching the national target of 95%, however B&NES is still slightly higher than the England average.

Hib/MenC booster, PCV booster and MMR 1st dose coverage at 2 years are also higher than the England average but are generally lower that the nation target of 95%, although considerable improvement was seen for PCV booster and MMR 1st dose coverage at 2 years in the last quarter of 2014/15.

One of the first priorities of the B&NES Immunisation Group will be to discuss the performance of the childhood immunisations programmes to see what can be done to make improvements.

4.6.5 Adolescence and school based immunisation programmes

School aged immunisation programmes (HPV, school leaver booster and MenC booster) are provided by the school nursing service and as necessary by general practice.

85.3% of all 12-13 yr old girls attending a B&NES school were given 3 doses of HPV in 2013/14 academic year, this compares against a national target of 90% and was lower than the England average of 86.7%. The Area Team is working with the provider to try and improve uptake for HPV during the next academic year

There are a number of changes to the adolescence and school based immunisation programmes which have recently taken place are or currently taking place.

- From September 2015, the number of doses of HPV vaccine that is given to teenage girls will be reduced from three to two
- From 2014/15 academic year Td/IPV and MenC will be given to pupils in both Yr 9 and Yr 10 and in 2015/16 to Yr 9 only
- Meningococcal C adolescent booster: From June 2013 the second dose (given to infants at 4 months of age) of MenC was removed from the routine schedule and an adolescent booster dose to be given to school year 10 children was introduced for the academic year 2013 -14. The school nursing service was commissioned to deliver the MenC booster alongside the existing school leaver booster for the 13/14 academic year.
- The Men C programme is expected to change for the 2015/16 academic year to incorporate Men ACWY into the adolescent schedule.
- MenC fresher's vaccination programme: this was an opportunistic programme offered to first time university students (17 – 25 year olds) who have received notification from Universities and Colleges Admissions Service (UCAS). Students were signposted to their own GP. The programme was effective from 1 April – 31 March 2015. All practices in B&NES agreed to provide this programme to their registered population. The programme has been extended for 2015-16. Information will be cascaded about future plans for the Men C schedule when this information is received from DH however it is anticipated that the MenC vaccine will be replaced with the Men ACWY vaccine in response to the increasing number of MenW cases.

4.6.6 Adult immunisation programmes

Adult immunisation programmes (Shingles, Pneumococcal and Pertussis) are provided by general practice.

a) Shingles vaccination programme:

The shingles vaccination programme was launched on 1 September 2013, with a view of to reduce Shingles transmission and preventing associated long term conditions. The routine programme delivers a single vaccination of Zostavax® to those aged 70 with a catch up programme for those aged 79, both delivered by general practice.

Both programmes continued in 2014/15, with the second year commencing on 1 September 2014. The routine programme is for patients aged 70 as of 1 September 2014, with the catch up programme for patients aged 78 or 79 years on 1 September 2014.
The B&NES Shingles programme performs above the England average.

b) Pneumococcal vaccination programme:

This is a single dose vaccine that is only required once in a lifetime. Coverage is calculated using the percentage of people aged 65 and over who have received the pneumococcal vaccine anytime up to 31/3/2014. In 2014 coverage in B&NES was 72.5%, 2.8% higher than the Bath, Gloucestershire, Swindon and Wiltshire area team average of 69.7%.

c) Pertussis (whooping cough) vaccination programme:

Pertussis is a vaccination programme for pregnant women. The temporary programme introduced in October 2012 was extended for 2014/15. In July 2014 it was announced that the programme will continue for a further five years. All pregnant women will be invited to their GP practice for a single dose of the vaccine.

This chart shows that performance is above the England average.

Indicator:	Target (%)	July 2014 (%)	August 2014 (%)	September 2014 (%)	October 2014 (%)	November 2014 (%)	December 2014 (%)
Pertussis in pregnancy (BGSW)	None	62.3	63.0	62.5	64.8	67.1	70.9
England	None	53.5	55.6	55.6	58.0	60.6	62.3

Source: PHE

4.6.7 Seasonal Flu vaccination programme

During the 2014/15 flu season free vaccinations were offered to the following 'at risk' groups of people through general practice:

- 2, 3 & 4 years olds
- Pregnant women
- Those aged 65 or over
- Carers
- Under 65 year olds with certain medical conditions
- Those living in long stay care.

In addition to these target groups, all employers had a responsibility to maximise vaccination rates in their front line health and social care staff. Increasing uptake amongst these groups can effectively help to reduce the pressures on health and social care services during the winter months.

a) Childhood flu programme:

The flu vaccination programme for all children aged 2 and 3 years was introduced for the 13/14 flu season. Delivered in general practice all children were offered a single dose Fluenz®.

The 2014/15 programme was extended to 4 year olds. In 2015/16 this will be extended to include all children in school years 1 and 2.

Performance

Indicator: Flu vaccine coverage	Target (%)	B&NES 2013/14 1/9/13-31/1/14 (%)	BGSW 2013/14 1/9/13-31/1/14 (%)	England 2013/14 1/913-31/1/14 (%)	B&NES 2014/15 1/9/14-31/1/15 (%)	BGSW 2014/15 1/9/14-31/1/15 (%)	England 2014/15 1/9/14-31/1/15 (%)
Children: 2 years	None	42.6	46.6	42.6	46.8	43.9	38.5
Children: 3 years	None	40.1	43.2	39.5	48.3	46.2	41.3
Children: 4 years	None	-	-	-	39.8	35.9	32.9

Source: PHE

- 100% of eligible children should be offered the vaccination. A target between 40% - 60% has been set for all age ranges in the childhood programme.
- B&NES achieved the highest uptake in all three age groups in the childhood programmes across BGSW.
- BGSW increased uptake for 3 year olds by 3% compared to the overall uptake for last year. B&NES increased by 8.2% compared with last year.
- There has been an overall decline across BGSW with the 2 year olds programme by 2.7%. However, B&NES increased by 4.2% compared with uptake last year.
- Uptake for 4 year olds across BGSW was 35.9%. Uptake in B&NES was 39.8% which was 6.9% above the England average.
- Further communication and liaison with Health Visiting Services and GP practices is planned for this season, to increase awareness and uptake for the childhood flu programme.

b) Adult flu programme:

This programme is delivered between September and January each year and the data is broken down into a range of population groups all of which are eligible for a flu vaccination. These groups are:

- Aged 65 and over
- At risk individuals from age six months to under 65 years, e.g. patients with diabetes or chronic heart disease
- Pregnant women

Performance

Indicator:	Target (%)	B&NES 2013/14 1/9-31/1 (%)	B&NES 2014/15 1/9-31/1 (%)	BGSW 2013/14 1/9-31/1 (%)	BGSW 2014/15 1/9/-31/1 (%)	England 2013/14 1/9-31/1 (%)	England 2014/15 1/9-31/1 (%)
Flu vaccination coverage (aged 65 and over)	75.0	73.6	72.9	73.6	73.7	73.2	72.8
Flu vaccination coverage (at risk individuals from age six months to under 65 years)	-	48.0	45.4	51.1	48.3	52.3	50.3
Flu vaccine coverage: Pregnant women	-	39.7	45.7	39.7	44.9	39.8	44.1

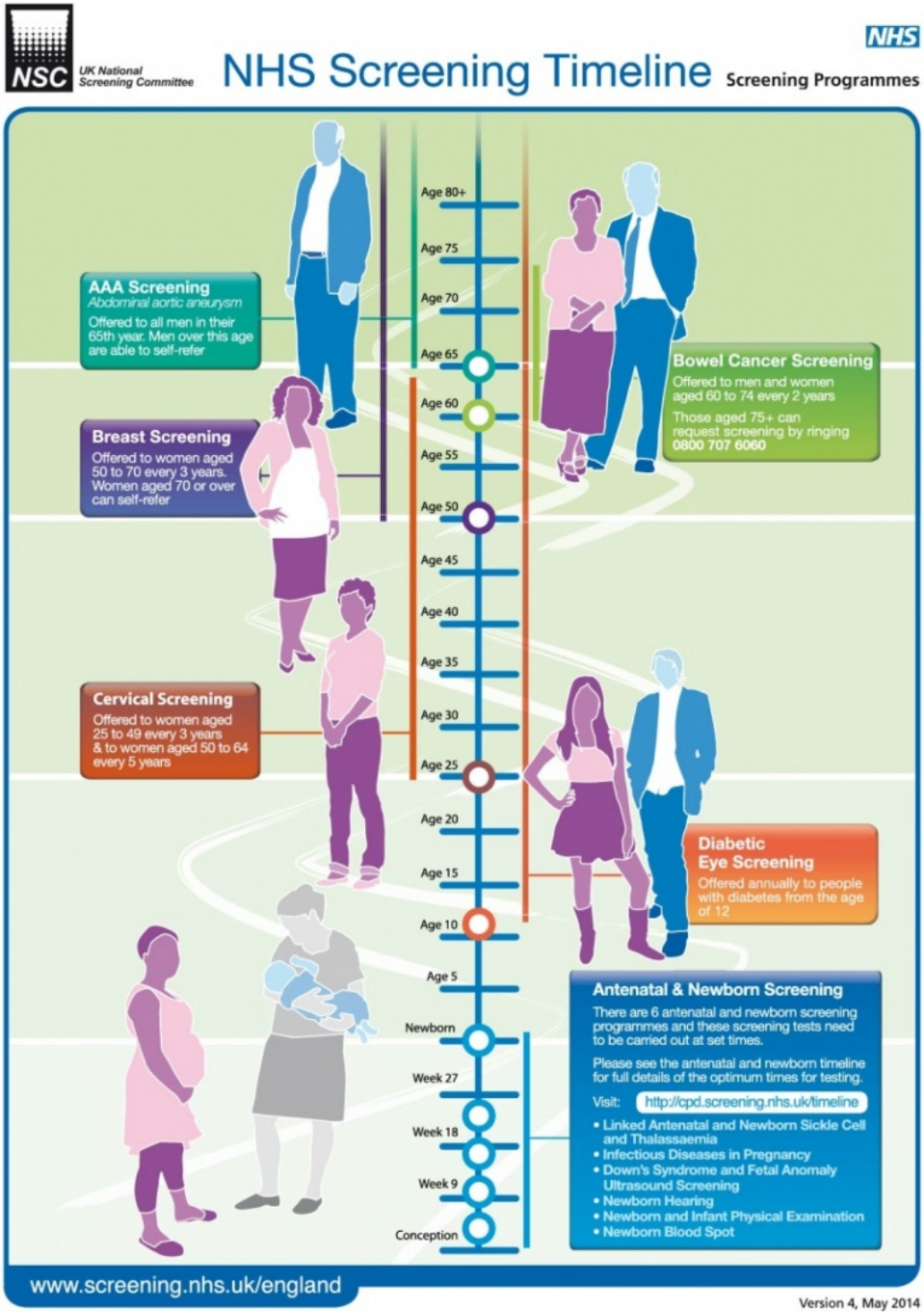
Source: PHE

- Planning and preparation for the 2015/16 flu season will continue throughout the year. A planning workshop which includes local authorities and CCG's took place at the end of April. Meetings will continue on a monthly basis throughout the season.
- There is a proposal to run workshops for practices prior to the start of the season to discuss the priorities of the flu plan and provide an overall update on flu vaccination
- The annual flu letter and flu plan for 2015/16 has been published. The target for the over 65's remains 75%

- No set target for the under 65's at risk and pregnant women although an improvement on 2014/15 season is required particularly for those who are at highest risk of severe disease or mortality. This includes those with chronic liver and neurological disease and people with learning disabilities.
- Uptake for the under 65's at risk declined slightly this year. BGSW uptake was 48.3%, an overall decrease of 2.8% compared with last year. This is also below the England average of 50.3%. B&NES decreased by 2.6% from last year. Improving uptake in this group will be one of the main focuses for 2015/16.
- Communication and liaison with maternity services will continue for the 2015/16. Further updates for midwives will be arranged to ensure that midwives are updated to enable them to discuss flu vaccination with women. Uptake for pregnant women increased both nationally and across BGSW. B&NES increased by 6.0% for 2014/15.
- For the upcoming 2015/16 flu season the offer for Health Care workers has been set at 100% which has changed from last year. A 75% uptake target remains

4.7 Screening programmes

There are six NHS England national screening programmes. The NHS Screening Timeline is a new visual representation of all national screening programmes, particularly focusing on the adult and cancer programmes.



4.7.1 Bowel screening

The Bowel Screening Programme invites all men and women aged 60-74 years, who are registered with a GP to complete a faecal occult blood test in the form of a home testing kit every two years. Those patients found to have abnormal tests are then referred to their local Screening Centre for further assessment and if necessary to have further investigation with a colonoscopy.

The Bath Swindon and Wiltshire bowel screening programme (based at Salisbury Foundation Trust) provides bowel screening for the registered populations of Wiltshire, Swindon and B&NES. B&NES residents are offered colonoscopies and follow up care at the RUH.

This is a fairly new screening programme. Uptake (the percentage adequately screened (last 6 months) out of the subjects who were sent a letter) is around 60% each quarter. Recently the programme has experienced some challenges trying to ensure that there is enough capacity to ensure all patients are offered colonoscopy within 2 weeks.

Bowel scope screening is an addition to the existing NHS Bowel Cancer Screening Programme and is currently being rolled out as a one off for all 55 year olds. Bowel scope screening is an examination called 'flexible sigmoidoscopy'' which looks inside the lower bowel. The aim is to find any small growths called 'polyps', which may develop into bowel cancer if left untreated.

4.7.2 Breast screening

The Breast Screening Programme is a national programme that invites all eligible women aged 50-70 years registered with a GP for mammographic (X-ray) screening every three years. Women aged 47-49 years and 71-73 years may also be invited as part of the national age extension study. Women over 70 years of age can request screening but are not routinely invited. Women identified with abnormal changes in breast tissue on screening (about 4 in 100 women) are referred for further assessment. Of these, one will be found to have cancer and offered treatment by the breast cancer service at their local acute hospital. The Independent Review of the Harms and Benefits of Breast Cancer Screening estimates that early detection and treatment of breast cancer by screening can reduce the risk of dying of breast cancer by 20%.

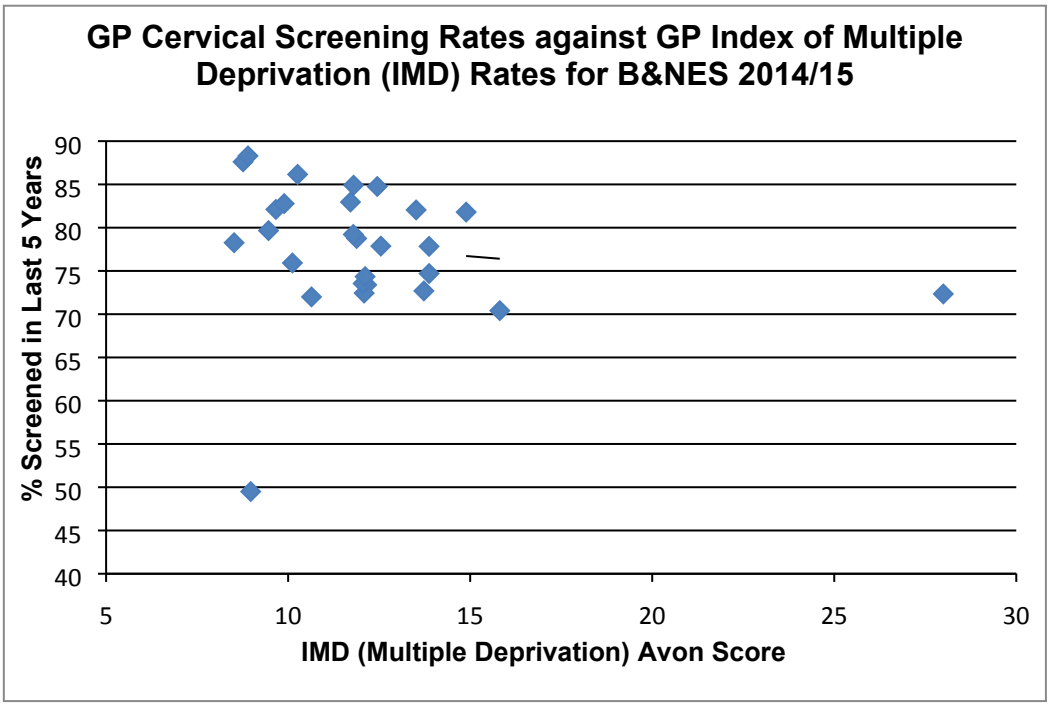
The programme is well established and there are no concerns about the programme’s performance which is good.

4.7.3 Cervical screening

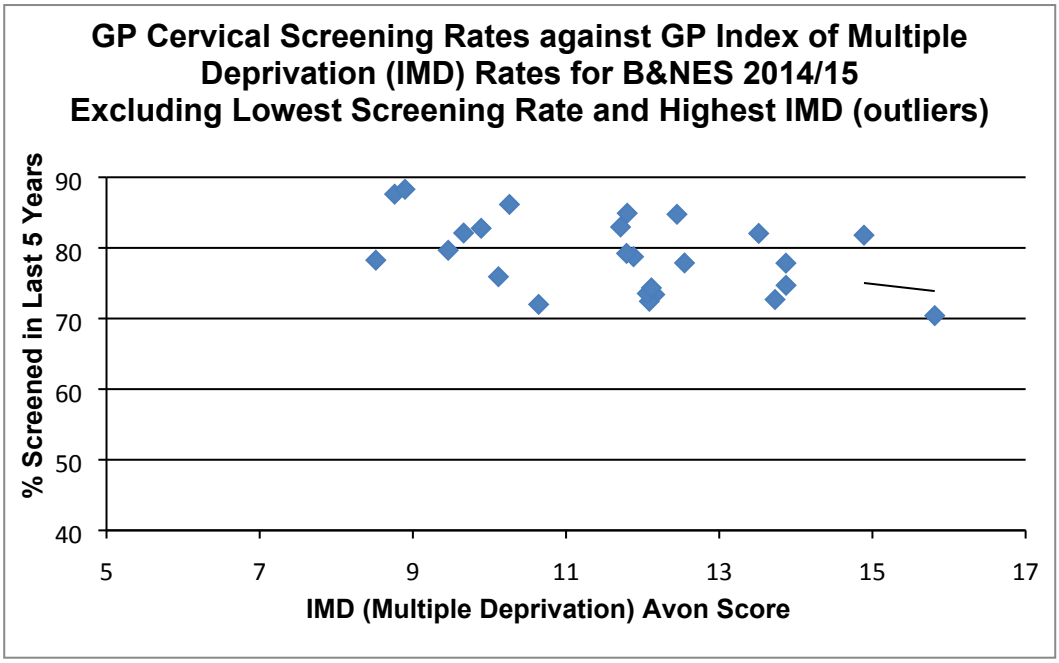
The Cervical Screening Programme invites all eligible women registered with a GP aged between 25 to 64 years for a cervical screen every three or five years (depending on age). Screening primarily takes place in GP practice and women with an abnormal test may be referred directly to colposcopy for further investigation and/or treatment. Some samples will be tested for the presence of high-risk Human Papilloma Virus types before either being returned to call/recall or referred to colposcopy.

The programme is not meeting the 80% target for the percentage of women screened within 5 years and we know that women aged 25-29 are least likely to have a test. This is in line with the national trend.

Uptake of women under 35 is 30% and strongly linked with deprivation. This is particularly concerning because the incidence of cervical cancer is also strongly linked to deprivation and so it is those most likely to be at risk of the disease who are not taking advantage of the programme. There are also known issues with access for Black and Minority (BME) groups. The next two graphs demonstrate this issue. A working group is being set up to look at ways of increasing uptake.



Source: South West Commissioning Support Unit



Source: South West Commissioning Support Unit

4.7.4 Diabetic Eye screening

The UK National Screening Committee recommends a systematic population diabetic screening programme with the aim of significantly reducing the prevalence of sight loss through the prompt identification and effective treatment of the diabetic retinopathy. Each local programme invites diabetics (Type 1 and 2) who are registered with a GP and 12 years or older for annual screening and where required more frequent monitoring or referral to the Hospital Eye Service for further assessment and treatment.

The Bath programme, based at the RUH provides a service for patients registered with a B&NES, North West Wilts and Mendip GP practice. Screening takes place at multiple venues mainly GP practices.

The programme has recently experienced significant challenges with recruitment; training and sourcing sufficient rooms for screening etc. a number of serious incidents have also taken place, but they have been handled well.

The resilience of the programme is on the Health Protection Board's risk log and the Board has been assured that things are under control. The RUH are reviewing the capacity of the programme on an on-going basis to identify extra resources required to ensure resilience and are utilising a national capacity tool to analyse their capacity and highlight any gaps. The programme has recruited a Screener Grader on a fixed term 12 month contract to address immediate capacity issues and has a training programme in place for newly appointed members of staff. This risk and mitigating actions is discussed at quarterly screening board meetings. Currently the grader staffing situation has improved.

4.7.5 Abdominal Aortic Aneurysm screening

The Abdominal Aortic Aneurysm Screening Programme is a national screening programme that invites all men in England aged 65 who are registered with a GP to be screened for an abdominal aortic aneurysm. If the aneurysm is beyond a certain size it is prone to rupture, leading to an acute surgical emergency and risk of death. One in 25 men aged 65-74 have an abdominal aortic aneurysm and there are approximately 6,000 deaths each year across England and Wales as a result of rupture. Women are at a lower risk and therefore not included in the programme.

B&NES residents are offered screening by the Bristol, Bath and Weston AAA Screening Programme provided by University Hospitals Bristol, service users are invited to attend their local GP practice for screening.

Performance of this programme is generally good, although recently there have been some problems with surgical capacity to see everyone on time.

4.7.6 Antenatal and Newborn screening

The Antenatal Screening Programme is a series of three screening programmes offered to women during pregnancy. These programmes are:

- NHS Foetal Anomaly Screening Programme which incorporates the Down's Syndrome (Trisomy 21) screening between10+0 - 20+0 weeks gestation and the Foetal Anomaly Scan at 18+0 – 20+6 weeks gestation
- NHS Infectious Diseases in Pregnancy Screening which offers screening for four viral diseases – HIV, Hepatitis B, Syphilis and Rubella so that appropriate intervention can be provided to protect and / or treat the mother and foetus

NHS Sickle Cell and Thalassaemia Screening Programme which offers screening for Sickle Cell Disease and other Haemoglobinopathies within the first trimester to allow parents of potentially affected foetuses to undergo further testing and genetic counselling regarding their pregnancy outcome. Screening is determined by the prevalence of Sickle Cell Disease and Thalassaemia in the area and the completion of a Family Origin Questionnaire, ideally by 10 weeks gestation, is used to support laboratory interpretation of blood test results and the identification of women and their partners who are then offered additional tests.

A recent quality assurance visit found the programmes to generally be performing well with some areas for improvement needed. An action plan will be signed off by the programmes screening board.

5. Recommendations

These recommended priorities have been jointly agreed by all Board members as key issues that need to be addressed in order for the DPH, on behalf of the local authority, to be further assured that suitable arrangements are in place in B&NES to protect the health of the population.

The process on reaching the priorities has been systematically carried out by monitoring key performance indicators, maintaining a risk log and through intelligence, debriefs of outbreaks and incidents and work plans of the LHRP & LRF which are based on Community Risk Registers.

1. Ensure that Local Health Resilience Partnership/Local Resilience Forum plans are effectively operationalised for B&NES by;

    a) Sign-off the B&NES Health Protection Incident Control Plan to agree roles and responsibilities, identify gaps and practical solutions to ensure preparedness and response.

    b) Identify lessons learned from outbreaks and incidents and implement action plans

2. Help to ensure resilience of Health Emergency Planning in B&NES

3. Support the development of Air Quality Action Plans (AQAPs) for Saltford & Keynsham.

4. Improve the uptake in all childhood immunisation programmes.

5. Improve the uptake of flu vaccinations in target groups.

6. Continue to monitor performance in specialist areas, identify risks and ensure mitigation is in place and escalate as necessary.

Appendix 1: B&NES Health Protection Board Terms of Reference (see attached document)