BATH AND NORTH EAST SOMERSET

HEALTH PROTECTION BOARD ANNUAL REPORT 2015/2016

Specialist Health Protection Areas:

Healthcare Associated Infection (HCAI)
KPIs: MRSA / C.difficile

Communicable Disease Control & Environmental Hazards
KPIs: private water supplies / air quality management areas

Health Emergency Planning
KPIs: Civil Contingencies Act requirements

Sexual Health
KPIs: chlamydia diagnoses, HIV & under 18 conceptions

Substance Misuse
KPIs: hep B vaccination, hep C testing, opiates & non-opiates

Screening & Immunisation
KPIs: national screening programmes & uptake of universal immunisation programmes

Contents

1 Executive summary

1.1 Purpose of the report

This annual report documents the progress made by the Health Protection Board during 2015-16 and highlights key performance indicators, risks, challenges and priorities for the next 12 months in each specialist area.

1.2 Terms of reference & review of working arrangements

The Terms of Reference and working arrangements of the Board were reviewed during the June 2015 Board meeting.

The scope of the Board remained unchanged. A great strength of the Board was highlighted as enabling colleagues to understand more about each other's roles and responsibilities thus improving working relationships which is important when people work together to manage an incident or outbreak.

An area to develop further is the inclusion of providers where the topic under discussion is relevant to them. The terms of reference were amended to reflect this change - please see Appendix 1.

1.3 Progress on 2014-15 priorities that were implemented in 2015-16

In the last Health Protection Board report 2014-15, the Board committed to improving all work streams and identified seven priorities to be addressed in order for the Director of Public Health (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 progress made on each priority has been RAG rated below and more detail of the progress made with each priority is detailed within the report.

No.	Priority	Progress
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 vaccination in target groups	
6	Assurance: continue to monitor performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary.	
7	Ensure that the public are appropriately informed about emerging threats to health	

1.4 Priorities for 2016-17

The following seven priorities have been identified for 2016-17:

1. Assurance: continue to monitor the performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary
2. Support the B&NES Antimicrobial Resistance Strategic Collaborative
3. Support the review of the Bath Air Quality Action Plan and support the implementation of the actions in the Saltford & Keynsham Air Quality Action Plans
4. Continue to ensure that the public are informed about emerging threats to health
5. Improve the uptake of MMR vaccination in B&NES
6. Improve the uptake of flu vaccinations in at risk groups, pregnant women, children and health care workers & support the STP work-stream to run collective campaigns for the influenza and pneumoccal vaccine
7. Continue to reduce health inequalities in screening programmes

2 Introduction

The Health Protection Board was established in November 2013 to enable the Director of Public Health to be assured on behalf of the 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.

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.

Priority 6 from 2014-15 report: Assurance: continue to monitor performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary

RAG: Green

During 2015-16 the Board continued to monitor key performance indicators for each specialist area and was generally very well assured that relevant organisations do have appropriate plans in place to protect the population. A small number of risks were identified throughout the year and logged, describing the mitigation that was in place for each one. These are described and discussed throughout the report.

Assurance: continuing to monitor performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary has been identified as priority 1 for 2016-17.

Sections 3 to 9 in this report go on to describe the performance, risks, challenges and priorities in each specialist health protection area:

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

NHS BaNES Clinical Commissioning Group (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

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

3.1 MRSA blood stream infections

The government continue to 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 2015/16 BaNES failed to deliver zero cases of MRSA in all CCG patients, as 12 cases were reported, an increase from 2 cases in 2014/15.

A root cause analysis of every case of MRSA is carried out and any lessons learned are implemented to minimise the risk of future cases arising.

3.2 Clostridium difficile infection

In 2015/16 the national target for *C. diff* infection was 47 cases for all B&NES CCG patients. The total number of cases of *C. diff* was 237 compared to 61 cases in 2014/15.

The number of cases of *C. diff* infection was highlighted on the Health Protection Board's Risk Log throughout the year.

By looking at the complete patient journey, BaNES CCG, the B&NES HCAI collaborative and HCAI *C.Diff* meetings chaired by the Quality and Safety Manager at NHS England South Central identify actions they can take to reduce *C. diff* infections. Actions include focussing on appropriate anti-microbial prescribing and stewardship, discussing local issues in primary care as well as acute and community care, looking at the *C. diff* trajectories and managing reviews in lapses of care.

3.3 Reducing antimicrobial resistance (AMR)

Antibiotics are drugs used to treat bacterial infections in both humans and animals. However, bacteria can change and find ways to survive the effects of antibiotics. This has resulted in antibiotics losing their effectiveness. The more we use antibiotics and the way that we use them can increase the chance that bacteria will become resistant to them. This is known as antimicrobial resistance.

Modern medical and veterinary practice relies on being able to use antimicrobials to prevent and treat infections in humans and animals. Antibiotics have many important uses such as treating and preventing infections and reducing the risk of potentially life threatening complications in surgery, chemotherapy and transplantation.

The reality is that infections are increasingly developing that are resistant to the drugs we have available. This means that antibiotics are losing their effectiveness at

an increasing rate. Without them many common and vital medical procedures such as gut surgery, caesarean section, setting bones, joint replacements and chemotherapy could become too dangerous to perform.

So what can be done to prevent antibiotic resistance? There are many things that need to be done to cut down on unnecessary use of antimicrobials and increase the supply of new drugs. In B&NES we are working across health and education organisations to improve the way we use antibiotics, making sure that they are not wasted on viral illnesses like colds, coughs and flu. This work will fit within the work plan of the B&NES Antimicrobial Resistance Strategic Collaborative that is being established to implement the UK 5 Year Antimicrobial Resistance Strategy.

Supporting the B&NES Antimicrobial Resistance Strategic Collaborative has been identified as priority 2 for 2016-17.

3.4 Antimicrobial resistance programme in schools

To support European Antibiotic Awareness Day (18 Nov 2016) and World Antibiotic Awareness Week (14-21 Nov 2016) in B&NES, a poster competition is being run for Year 3 pupils in all B&NES primary schools. There are 4 categories: hand washing, flu vaccinations, antibiotics don't work for coughs, cold and flu and 'Catch it, Bin it, Kill it' – preventing the spread of infection. Judging of the posters will take place early Jan 2017 and the winning posters will be displayed between Jan and March within the local community to raise AMR awareness.

All secondary schools in B&NES will be offered a lesson to Year 9 pupils taught by trainee GPs and pharmacists which includes key AMR educational messages, self-care messages and information on access to healthcare services.

4 Communicable disease & environmental hazards

4.1 Confirmed or probable cases of infectious disease during 2015-16

The Health Protection Team in Public Health England (PHE) South West works in partnership with external stakeholders including the Public Health and Public Protection teams based at B&NES Council to deliver an appropriate co-ordinated response to infectious disease cases, outbreaks and incidents.

PHE reported that in B&NES there were 476 confirmed or probable cases of infectious disease during 2015-16, all of which needed some degree of follow-up or investigation. This number of cases is as expected for our population size.

There were 6 confirmed cases of Legionellosis in B&NES in 2015-16. We have highlighted below an example of a typical operational investigation into a near classic case of Legionellosis.

4.2 What is Legionellosis?

Legionellosis is a respiratory disease caused by a type of Legionella bacteria. The severity of legionellosis varies from mild febrile illness (Pontiac fever) to a potentially fatal form of pneumonia (Legionnaires' disease) that can affect anyone, but principally affects those who are susceptible due to age, illness, immunosuppression or other risk factors, such as smoking. Water is the major natural reservoir for Legionella, and the bacteria are found worldwide in many different natural and artificial aquatic environments, such as cooling towers; water systems in hotels, homes, ships and factories; respiratory therapy equipment; fountains; misting devices; and spa pools.

4.3 Legionellosis case study

An elderly member of the public (the 'case') was admitted to hospital with Pneumonia. The case was found to be suffering from chronic obstructive pulmonary disease, coronary heart disease and, Legionellosis. The laboratory results sparked off an out-of-hours response from both Public Health England and B&NES Council Public Protection/Environmental Health staff, on a Friday evening. [The lack of formal out of hours provision for the Council's Public Protection & Health Improvement Service is a long standing risk on the Board's risk log; however the Council's emergency contacts list and a cascade 'best endeavour' approach that has been adopted worked on this occasion].

Whilst very ill the case was interviewed in hospital. Information gathered on the initial surveillance form suggested that during the incubation period, the case had had very limited exposure to environments outside the home where there might have been exposure to water aerosols containing legionella bacteria, the transmission route of Legionellosis. The person had used a home shower, visited a local hand car wash, attended a local club to pursue a hobby, and attended hospital as an out-patient.

On Saturday morning the case's home, the hand car wash, and the immediate environment were surveyed for obvious aerosol risks with a view to putting precautionary restriction in place to protect public health. However, no obvious risks were found. On Saturdays no laboratory support is available to receive and process water samples so none were taken.

After the weekend full in-depth inspections of these locations were carried out together with water sampling. The case's home was inspected, and Legionella management plans and water systems of the car wash were scrutinised and found to be satisfactory.

Interviewing the case to verify the information gathered by the surveillance form revealed that the case regularly attended a specific venue to take part in a hobby. Officers were dispatched to the venue where the water systems, including the

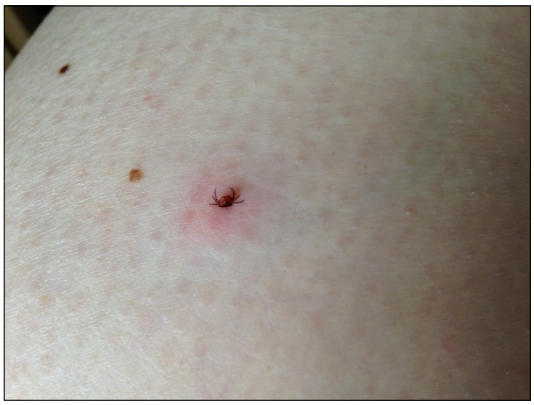
sprinkler system for the green and shrubs, all proved to be well maintained and managed.

Clearance of the all the water systems in the investigated locations suggest the cause was incidental exposure of this isolated susceptible individual to an infectious water aerosol of unknown origin.

4.4 Ticks & Lyme Disease

Ticks are small spider-like creatures that can be found where there are deer, small mammals or wild birds. They tend to prefer damp, shady dense vegetation, leaf litter and long grass but can also be found in woodland, open country, public parks or gardens. They don't jump or fly, but live on vegetation and climb onto animals or people as they brush past. They can be found throughout the year, but are most active between spring and autumn.

Castor Bean Tick (Ixodes Ricinus) All Stages



Tick Biting

Ticks can pass on a bacterium which can lead to an illness called Lyme disease in an estimated 2000-3000 people each year in England and Wales. Symptoms of Lyme disease include flu like illness and a rash, however, the infection can be treated effectively with antibiotics if caught in the early stages.

4.4.1 Tick Awareness

Priority 7 from 2014-15 report: Ensure that the public are appropriately informed about emerging threats to health

RAG: Green

This ‘tick awareness’ work is an example of one way that the public are appropriately informed about emerging threats to health.

The understanding and knowledge about ticks is increasingly nationally and locally, so B&NES Council Public Health team are currently encouraging residents and visitors to become ‘tick aware’ to continue enjoying outdoor activities with the knowledge and confidence of how to manage ticks should they come into contact with them. A poster and leaflet has been produced in collaboration with Public Health England and contains all the key messages. The key messages are:

1. Know what ticks look like, where they can be found, and practise prevention behaviours to help avoid tick bites
2. Check your clothes and body regularly for ticks when outdoors and when you return home
3. Remove ticks as soon as possible with tweezers or a tick removal tool. Once removed apply antiseptic to the bite area and keep an eye on it for any changes

Parish Councils are being sent copies of the publicity materials asking them to display the posters on their noticeboards and also to use other ways that they have to pass on the information to their residents. For areas of Bath not covered by a Parish Council other ways to make the information available are being utilised. GP practices and Pharmacies have also been asked to display the materials.

Further information about ticks can be found on the Council’s Public Health webpages: http://www.bathnes.gov.uk/services/public-health/latest-health-messages/tick-awareness

Continuing to ensure that the public are informed about emerging threats to health has been identified as priority 3 for 2016-17.

4.5 Air Quality Management Areas

Priority 3 from 2014-15 report: Support the development of the Air Quality Action Plans (AQAPs) for Saltford & Keynsham

RAG: Green

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.

The Council has reviewed air quality throughout B&NES as part of its Annual Status Report and at the time of writing this is being submitted to DEFRA for peer review, before being published.

Last year the Board supported the development of Air Quality Action Plans (AQAPs) for Saltford & Keynsham. In 2016 a public consultation reviewed the air quality action plans for Keynsham and Saltford before they were formally adopted in May 2015. The actions fall under the following themes:

- Alternatives to private vehicle use
- Policy guidance and development control
- Promoting low emission transport
- Promoting travel alternatives
- Public information
- Transport planning and infrastructure
- Traffic management
- Vehicle fleet efficiency

One action being delivered in the next 12 months includes a trial for a one way system in Keynsham High Street with associated monitoring to understand the impact of this change.

An AQAP for Bath has been in place for some time and will be reviewed in 2016. The team has already started to update our information in relation to the sources of pollution and have engaged with stakeholders over this review to ensure that all views and ideas are properly considered.

Supporting the review of the Bath Air Quality Action Plan and support the implementation of the action in the Saltford & Keynsham Air Quality Action Plans has been identified as priority 4 for 2016-17

5 Health Emergency Planning

Priority 1 from 2014-15 report: Fully operationalise health protection plans in B&NES

RAG: Amber

During the spring of 2014 the Local Health Resilience Partnership (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 recommended that each Local Authority produce 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 were held, where all partners came together to discuss very practical issues. A number of debriefs from real incidents or outbreaks have also been used. All the information has been pulled together in a useful document entitled 'B&NES Health Protection Incident Response Plan'. This plan is underpinned with a Memorandum of Understanding agreed by all stakeholders.

Priority 1, to fully operationalise health protection plans in B&NES, remains rated as amber to allow these plans to be fully tested and reviewed during future outbreaks/incidents.

Priority 2 from 2014-15 report: Help to ensure resilience of health emergency planning in B&NES

RAG: Amber

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

Due to the re-organisation and recruitment in the Council's Communications Hub and Emergency Planning Team the inability to plan/exercise and the inability to respond to emergencies long term has been on the Health Protection Board's risk log for some time. A substantial amount of work and training has been done in this area and as a result the inability to plan and exercise was removed from the risk register in March 2016.

Whilst the likelihood of the inability to respond to an emergency long term has been reduced, it remains on the Board's risk log, as there is still a need to train further Council staff to ensure that a suitable response to an outbreak or incident could be maintained for a long period of time if necessary.

The World War II Bomb incident, Ebola debrief and Pandemic Flu exercise described below, are all examples of situations where resilience of the health emergency planning system in B&NES was tested and of how planning and exercising takes place and is put into practice.

5.1 World War II Bomb Incident

On Thursday 12 May 2016, contractors unearthed a shell from beneath the surface of a former school playground in Lansdown Rd, Bath. A multi-agency response was put into action, including many services of B&NES Council e.g. emergency planning and highways. A 300 metre exclusion zone was set-up and residents in the zone were advised to evacuate. B&NES Council, Sirona Care & Health and the Red Cross worked to set-up a rest centre for residents who chose to evacuate.

All agencies worked together to remove the device and get everything back to normal.

5.1.1 What went well?

Preparedness

- Emergency Planning team preparedness and training before incident
- Bronze & Silver training of senior Council staff before the incident
- Key plans updated before the incident and previous work taken place to engage with the voluntary sector and confirm the Rest Centre Plan with Sirona Care & Health

During the incident

- Control room opened, roles and responsibilities assigned, key officers identified and contacted, link between Portishead (Gold), Lansdown (Bronze) and Lewis House (Silver Control) established, media and communications channels set up and worked well
- Rest Centre set up (using Rest Centre Plan) and link with Sirona/Red Cross established. Transport and food for Rest Centre arranged
- 250 tons of sand arranged to remove bomb
- Police assisted with road closures
- Trained staff in place to log incident
- Handover between shifts worked well and enough resilience in system for duration of incident (2/3 days)

5.1.2 What didn't go well and could be improved?

- There was a delay in the time that the Police first notified the Council about the incident, which meant the Council could not respond as quickly as they would have like
- The Police decided to evacuate to Lansdown Racecourse, however the Council was not asked for their assistance in the first instance
- Shut down of the incident was not fully completed.
- Personal mobiles were being used during the incident due to lack of signal etc
- There was not one Control Room number, so calls were coming into the Council's control room via different channels, making tracking and logging calls difficult

All lessons identified will be tracked as actions by the Board.

5.2 Ebola Debrief

With the outbreaks of Ebola officially over in West Africa and the threat to the UK subsided, structured debriefing sessions were held across Public Health England South West geographical area to assess how robust agency response plans were.

The response to the risk of Ebola was a good example of how the LHRP can be responsive to support emergent response requirements. NHS England South (South West) and PHE ran a table top exercise for LHRP partners to identify gaps in their response arrangements and provide the opportunity to identify and escalate common issues.

Some recommendations could be closed down locally e.g. internal practices in acute trusts, identifying training leads and sharing lessons identified, but other issues required national escalation;

- Timely cascade of the algorithm
- National communications for staff (eg on personal protective equipment)
- National call centre arrangements
- PHE Porton (laboratory) capacity challenges

One action that Directors of Public Health were asked to put in place through their Health Protection Boards was to ensure all areas are covered by communicable disease outbreak plans on a Local Authority footprint which cover roles and responsibilities for all responding organisations including primary care. As described in 3.3 above, this has been completed.

5.3 Pandemic Flu Exercise

A LHRP Pandemic Flu table top exercise was undertaken in November 2015. There was good engagement from partners and the exercise report was shared with the

LHRP. Outcomes of the exercise were as expected; they highlighted that the response to a flu pandemic will be much more challenging than in 2009 (Swine Flu Pandemic) with reduced estate footprint, resources and bed base in acute trusts.

Following the exercise the strategic LHRP Pandemic Flu Response Framework was completed in December 2015 to support the delivery of an effective response in the event of an Influenza Pandemic.

6 Sexual Health

6.1 Sexual Health Strategy and Action Plan

The Sexual Health Strategy was ratified in autumn 2015 and runs to 2018. It built upon the recommendations of the 2015 Sexual Health Needs Assessment. The strategy sets out three population-level outcomes:

- Outcome 1: Sexually active adults and young people are free from STIs
- Outcome 2: Sexually active adults and young people are free from unplanned pregnancies
- Outcome 3: Young people are supported to have choice and control over intimate and sexual relationships

A number of indicators have been developed which help us identify progress against these three outcomes. These indicators are reported quarterly to the Sexual Health Board, see 6.5-6.8 below. The Sexual Health Action Plan flows from the strategy and sets out a range of measures to improve sexual health across B&NES.

6.2 Achievements

There are a number of achievements that have occurred as a result of the development of the strategy. The level of data coming from providers has improved which has enabled a more accurate picture of certain sexual health issues in B&NES to be gained, such as rates of chlamydia infection and the range of qualifications and skills in primary care for those who deliver Long Acting Reversible Contraception (LARC) to B&NES service users.

Service provision has been strengthened by developing a more peripatetic model for the Clinic in a Box service, which delivers outreach sexual health services in schools and youth clubs.

Sexual health services in the Chew Valley area have increased and have been developed and co-location of Contraception and Sexual Health (CaSH) Service, and Genitourinary Medicine (GUM) service into a central Bath location is underway.

6.3 Challenges

Although data improvement has been seen in some services, work continues with other providers to ensure accurate, detailed data is available to support our planning to improve sexual health, especially for more vulnerable groups.

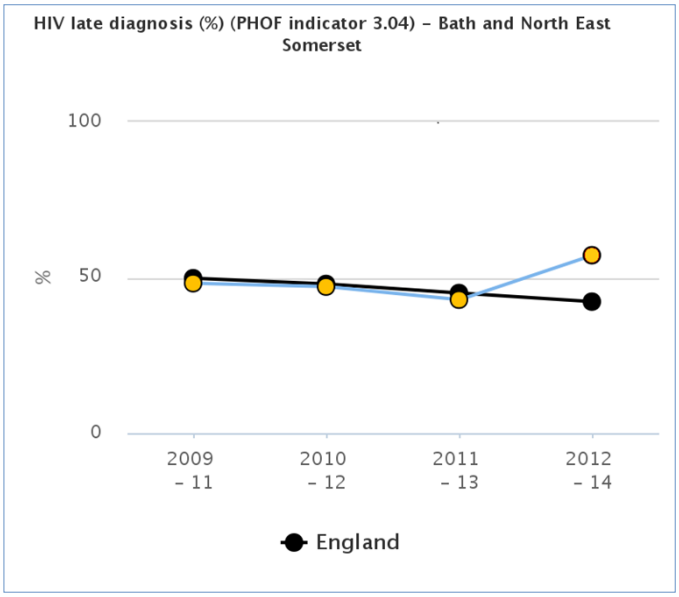
The number of people with HIV who are diagnosed late in B&NES has increased slightly.

As part of the wider financial climate affecting B&NES Council some services have been decommissioned and/or reduced as a result of reduced public health budgets. This includes new age restrictions on those who can access free emergency hormonal contraception (EHC) from pharmacies and a deprioritisation of chlamydia testing outside mainstream sexual health services for those under 25 years old.

6.4 Sexual Health Indicators

As detailed above the Sexual Health Board has devised an indicator set to assess progress against our three defined outcomes which support our vision.

6.5 HIV late diagnosis



Source: Public Health England, 2016

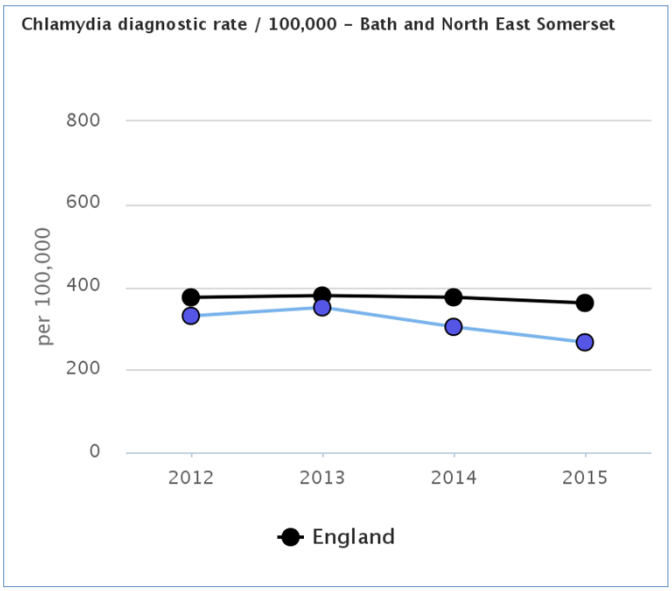
If HIV is diagnosed early it can be successfully treated and people with HIV can live to near-normal life expectancies in good health. Early diagnosis also means that the risk of HIV being passed on as a result of people being unaware of their HIV status is reduced. Although B&NES is generally a low prevalence area for HIV, as can be seen in the chart below, the percentage of people diagnosed late with HIV increased during 2012-2014, although this increase is not statistically significant.

Work is being undertaken with colleagues at the Department of HIV and Sexual Health at the RUH to review these cases and examine what actions might need to be taken to reduce late diagnoses in the future.

6.6 Chlamydia diagnosis

Another helpful indicator is the rate of chlamydia diagnoses amongst young people aged 15-24. We know from national and local data that people in this age range are

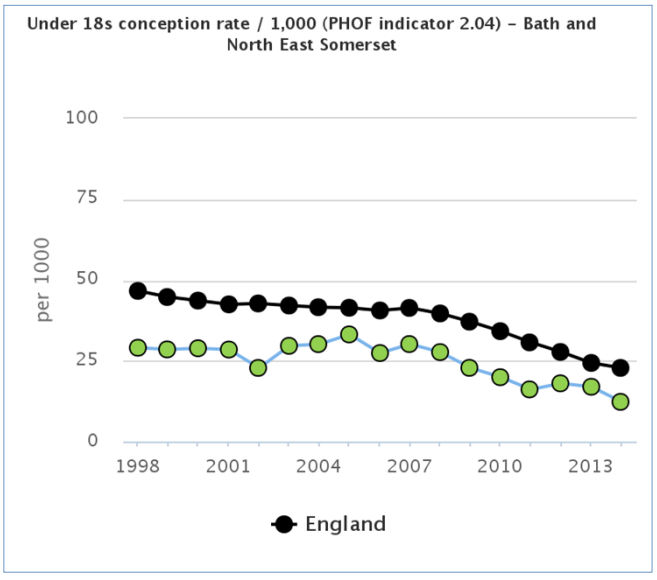
more likely than other ranges to experience chlamydia infection, and as such it can be helpful proxy measure of the sexual health of this cohort. The chart below details that the diagnostic rate per 100,000 people aged 15-24 in B&NES has dropped since 2012:



Source: Public Health England, 2016

Although that may be an indicator of low rates of chlamydia infection, it will be important to ensure in future that the offer of chlamydia screening to this cohort is maintained within core services, as any reduction in testing numbers may have an effect on the numbers of those subsequently diagnosed.

6.7 Under 18s Conceptions



A final helpful indicator is that of the number of conceptions under the age of 18. Low levels of teenage conceptions can be an indicator of good access to contraceptive and sexual health services, and good education provision that enables young people to be aware of the risks and potential adverse implications of unprotected sex. B&NES has historically had a consistently low rate of teenage conceptions which continues on a downwards trend as shown.

Source: Public Health England, 2016

The continuing reduction in under 18 conceptions gives B&NES one of the lowest rates in England.

7 Substance Misuse

7.1 Drug Performance Year End 2015-16

The substance misuse indicators in the public health outcomes framework (PHOF) aim to improve client outcomes through increased successful completions from treatment and prevention of re-presentations (through relapse).

Nationally, PHOF performance has declined since 2014/15. The chart below shows performance in B&NES for opiate clients (indicator 2.15i) and non–opiate clients (indicator 2.15ii) for the year ending 2015/16. Opiate clients' outcomes are slightly lower than the national comparators (6.8 % national), with non –opiate clients' outcomes slightly above the national average (37.3%).

Source: Public Health England, 2016

The key national Health Premium Incentive Scheme (HPIS) indicator has been confirmed as 'successful completion of drugs treatment' (with combined data for opiate and non-opiate users).

Public Health Outcome Framework		2015-16	
Indicator 215i		*Indicator 2.15ii*	
Opiate clients		*Non -opiate clients*	
6%	Similar	39%	Similar

Note: Similar = Similar to England

Public Health England has recently announced the expansion of the substance misuse indicators. As well as the opiate (2.15i) and non-opiate (2.15ii) indicators, there will be two new additional indictors as detailed below:

2.15iii – Successful completions of alcohol treatment. B&NES is monitoring outcomes for clients in alcohol treatment and this will now form part of the PHOF.

2.15iv – Deaths from drug misuse. Public Health England produced a report 'Understanding and preventing drug-related deaths'

The report highlights a number of principles for action by local authorities, drug treatment providers and others, including:

- coordinate whole-system approaches that can address health inequalities and meet complex needs, with better access to physical and mental healthcare, and to other support which could include housing and employment.
- improve access to good quality drug treatment, especially for those not currently in treatment who are harder to reach, for example, through outreach and needle and syringe programmes
- maintain a personalised approach to drug treatment and recovery support, tailored to the user's needs, according to national guidelines
- ensure that the risk of death is properly assessed and understood, addressing any identified poor practice

B&NES is currently developing an approach to reduce drug related deaths which includes, developing a strategy to widen the availability of Naloxone (prenoxad). (Naloxone is the emergency antidote for overdoses caused by heroin and other opiates/opioids such as methadone and morphine) and responding to complex treatment resistant drinkers (often known as 'Blue Light' clients because they require frequent ambulance or police attendance).

7.2 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. Preventing BBVs is a Local Authority responsibility to 'promote the economic, social and environmental wellbeing of communities'.

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

B&NES is effective and proactive at supporting appropriate clients to be tested for HCV. At the end of 2015/16 only 8% of injecting drug users in B&NES (engaging in drug treatment) had not been tested for HCV. This is substantially above the national performance of 19% without a test.

8 Immunisations

A full report with in depth information about all childhood, adolescence and school based and adult immunisations can be found here: http://www.bathnes.gov.uk/services/public-health/public-health-strategies-and-policies

8.1 Childhood immunisation programmes – Focussing on Measles, Mumps & Rubella Vaccination (MMR)

Priority 4 from 2014-15 report: Improve the uptake in all childhood immunisation programmes

RAG: Amber

8.1.1 Uptake of childhood immunisations 2015-16

The World Health Organisation (WHO) has set vaccination coverage targets at global and WHO regional levels, which have been adopted by the Department of Health at national and local levels. The 95% target for childhood vaccination coverage is recommended nationally to ensure control of vaccine preventable diseases within the UK routine childhood vaccination programmes, with at least 90% coverage in sub-national areas such as local authority or CCG areas. This relates specifically to diphtheria, tetanus, pertussis, polio, Haemophilus influenza type b (Hib), measles, mumps and rubella (MMR).

The B&NES uptake across all four quarters in 2015/16 for all childhood immunisations were higher than the England average; however uptake of pre-school booster vaccinations fell below the national 95% and MMR dose 2 at 5 years has been struggling to stay above 90% (see 3.6.3 below).

8.1.2 MMR Vaccination

Although MMR vaccine uptake rates in England are currently among the highest in Europe, an increase is still needed to reach the WHO's 95% target for MMR vaccination.

The measles immunisation gap in England equates to approximately 24,000 children in England every year (2,000 a month) who are not currently receiving MMR vaccination at the scheduled time (from 12 months of age) and who remain susceptible to the diseases the vaccine protects against.

The current English routine immunisation schedule is for dose one to be given at 12 months of age and dose 2 to be administered at 3 years 4 months.

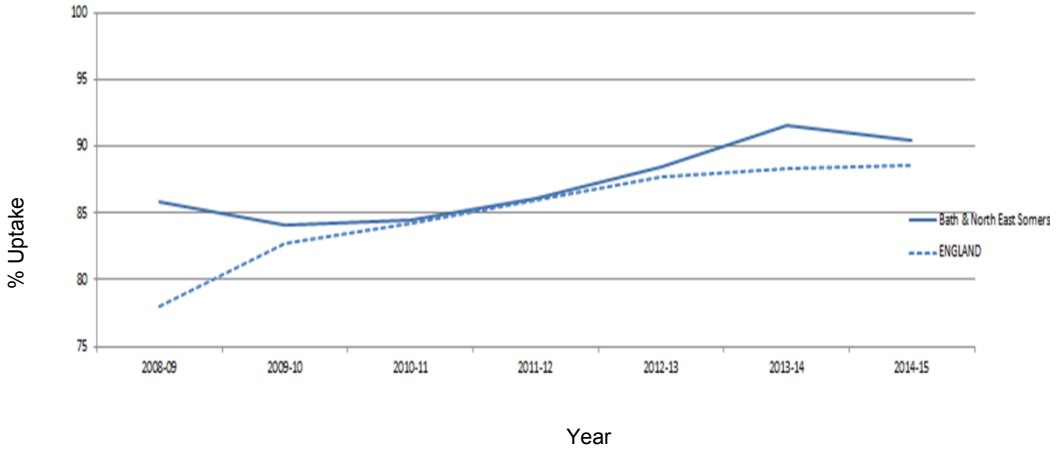
Why is PHE focusing on MMR Vaccination?

- The cessation of rubella screening in pregnancy and the number of babies being born with congenital rubella syndrome (3 cases in the last 18 months).
- Public Health England (PHE) is reminding teenagers and young people to make sure they are vaccinated against measles after new cases were reported across England. These are primarily aged 14 years to 40 years and have an unknown or incomplete MMR status.

- A significant number of these cases, linked to music festivals and other large public events, have been reported since June 2016. This follows an increase in measles over the year with 234 cases confirmed between January and June 2016, compared with 54 for the same period last year. There have been 38 suspected measles cases reported in people who attended events in June and July 2016.

8.1.3 The B&NES situation & what is happening locally?

Uptake of MMR Dose 2 by 5 years old in B&NES 2008-2014



The graph above shows that uptake of MMR vaccinations (dose to by 5 years of age) steadily increased in B&NES between 2010 and 2014, however since 2014 has been gradually dropping to around 90%.

The B&NES Immunisation Group (see below 8.2), B&NES Council Public Health Team and NHS England South (South Central) Public Health Commissioning Team have been supporting PHE to implement a programme of work to increase the uptake of MMR vaccinations; the work includes:

- Practice Nurse workshops & Practice Nurse training
- B&NES Immunisation Group & Childhood Immunisation Working group
  - Revise invite letter
  - Working with Child Health Information System (CHIS) & health visitors to review systems/processes
  - Promotional material and campaigns
- Briefing at Practice Managers meeting and call to action for GP practices:
  - For children less than 5 years, work with CHIS to keep recalling the child in to receive their MMR vaccination and use a flagging system to prompt discussions with parents
  - Notify the heath visitor that the conversation has taken place, enabling the health visitor to contact the parent/carer to follow up on the conversation.

Inform the health visitors of any children who are overdue their MMR dose 2, thus allowing health visitors the opportunity to contact the family about this

- For children and adults over 5 put a mechanism in place to offer the vaccination on an opportunistic/self-referral basis
- Consider promoting MMR in the waiting room
- Ensure reception staff are aware of the drive to vaccinate so that they may have a factual conversation with the patient when they are booking in

Increasing the uptake of MMR vaccination in B&NES has been identified as priority 5 for 2016-17.

8.2 B&NES Immunisation Group

The B&NES Immunisation Group was established in July 2015 due to concerns about uptake of MMR vaccination and consensus that local coordination of all stakeholders would be beneficial. The group reports to the Health Protection Board. Please see Appendix 2 for terms of reference.

It was deemed 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 provides a structured approach to monitoring, identifying & mitigating risks and updating action plans relating to immunisation programmes. It works collaboratively to exchange information, share knowledge and good practice, and provide practical solutions to improving and strengthening local immunisation programmes.

The group also aims 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.

One of the first priorities of the B&NES Immunisation Group was to discuss the performance of the childhood immunisations programmes to see what could be done to make improvements see 8.1.3 above. The group has had a focus on school based immunisations, immunisations given during pregnancy and immunisation training of practice nurses. The inadequate provision of and access to immunisation training for Practice Nurses has been identified as a risk on the Board's risk log. An immunisation training audit completed by NHS England South (South Central) Public Health Commissioning Team highlighted a number of areas of concern which are being addressed. Two dates for childhood immunisation training have since been

arranged in late September and early November 2016 and a MMR, seasonal flu vaccination and others immunisations question and answer session has been arranged with Practice Nurses in October 2016.

8.3 Seasonal Flu Vaccination Programme

Priority 5 from 2014-15 report: improve the uptake of flu vaccinations in target groups

RAG: Red

In 2015-16 uptake of flu vaccination in B&NES did not improve in any of the target groups compared to the previous 2014-15 year. The table below shows that for each eligible group the decrease was small and in all cases except the under 65s at risk was above the England average.

The uptake in 5 & 6 year olds was also lower than the England average due to it being a GP based programme. In 2016-17 flu vaccination will be delivered in school for Years 1, 2 & 3 and the uptake is expected to increase in line with pilots that have been carried using similar models in different areas.

B&NES uptake of seasonal flu vaccination 2014-15 & 2015-16

Eligible Group	B&NES Uptake 2015-16 (%)	B&NES Uptake 2014-15 (%)	England Average Flu Vaccine Uptake 2015-16 (%)
65 and over	72.0	72.9	71.0
Under 65 (at risk only)	43.0	45.4	45.1
All Pregnant Women	44.0	45.7	42.3
All aged 2	42.6	46.8	35.4
All aged 3	47.8	48.3	37.7
All aged 4	39.6	39.8	30.0
All aged 5	38.5	N/a	53.6
All aged 6	33.7	N/a	52.1

8.4 The 2016-17 seasonal flu programme and action to be taken

Eligible groups & vaccine uptake ambitions for 2016/17

a) **Children (2, 3 & 4 year olds & School Years 1,2 & 3)** – 40-65% across all cohorts and settings

b) **Under 65 year olds in clinical risk groups and pregnant women** – At least 55% in all of the groups, and maintaining higher rates where those have already been achieved.
c) **Aged 65 and over** – 75%
d) **Healthcare workers –** 75% (a Trust-level ambition to reach a minimum of 75% uptake and an improvement in every Trust)
e) **Carers**
f) **Those in long-stay residential care**

A number of recommendations for the delivery of the seasonal flu vaccination programme in B&NES, Gloucestershire, Swindon & Wiltshire have been prioritised and focus on the childhood programme, under 65 year olds in clinical risk groups, pregnant women and health care workers. A full report on the seasonal flu vaccination programme 2015-16 and recommendations for the 2016-17 season can be found here: http://www.bathnes.gov.uk/services/public-health/public-health-strategies-and-policies

8.5 Sustainability & Transformation Plan

B&NES, Swindon and Wiltshire CCGs with local NHS and other partners are working together to create a Sustainability and Transformation Plan (STP). The purpose of the STP is to deliver vision in NHS England's Five Year Forward View:

- improve the health & wellbeing of our local population
- improve quality of local health & care services
- deliver financial stability & balance throughout the local health care system

The priorities are being assessed and developed through three care work-streams and three enabling work-streams.

- Urgent and Emergency Care
- Planned Care
- Preventative and Proactive Care
- Workforce
- Estates
- Digital

Running collective campaigns for influenza and pneumococcal vaccinations is one strand of work within the Prevention and Proactive Care work-stream. Key stakeholders from across B&NES, Swindon and Wiltshire are currently putting together a Project Initiation Document to get this underway.

Improving the uptake of flu vaccinations in at risk groups, pregnant women, children and health care workers & supporting the STP work-stream to run collective campaigns for the influenza and pneumococcal vaccine has been identified as priority 6 for 2016-17.

9 Screening programmes & reducing health inequalities

There are no major concerns about any of the screening programmes in place across B&NES. A full report with in depth information about all screening programmes can be found here: http://www.bathnes.gov.uk/services/public-health/public-health-strategies-and-policies

This report highlights some of the good work which is taking place in Bowel Screening.

9.1 Bowel screening programme & people with learning disabilities

People with learning disabilities have a considerably shorter life expectancy and poorer health than the population as a whole, yet are less likely to access health care. They also have a higher than average chance of health problems such as obesity and poor diet which are associated with bowel cancer. It is therefore really important that we do all that we can to help people with learning disabilities take advantage of the preventive health services that we have to offer.

The bowel screening test has been found to be difficult for people with learning disabilities to complete due to difficulties with reading invitations, getting to appointments and fear of the process. A project has been established in B&NES to help this group of people to complete these tests and access the other NHS screening programmes that they are eligible for. This is a joint project between B&NES Council, BANES Clinical Commissioning Group, Sirona Care & Health and NHS England South (South Central) Public Health Commissioning Team.

With the support of these different organisations, Sirona's community learning disability nurses have been working with people with learning disabilities and their support workers to produce easy read resources and visual aids, increase knowledge of the bowel screening programmes, and therefore reduce anxiety and fear linked to the test.

Picture: Sirona Care & Health's Community Learning Disabilities Nurses

9.2 Bowel Health Equity Audit

A review of equity in the Bowel Cancer Screening Programme in Bath and North East Somerset, Swindon and Wiltshire (BSW) has just been completed. It considers the first stage of bowel cancer screening, the faecal occult blood (FOB) test. The review describes patterns of uptake by age, gender, local deprivation and local ethnic diversity. This review is intended to provide greater detail about who is and isn't taking up the offer of screening. It is the first health equity audit of this local programme.

The review makes a number of recommendations for local consideration:

- Consider ways of increasing uptake among men and neighbourhoods with lower IMD scores and greater ethnic diversity.
- Work with the Screening Programme Centre to encourage GP practices to access and act on screening results.
- Discuss activity with the programme centre, providers and the commissioner so that capacity can be managed.

Continuing to reduce health inequalities in screening programmes has been identified as priority 7 for 2016-17.

10 Screening & Immunisation Incidents

Incidents requiring investigation in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from incidents to minimise the risk of the incident happening again. When an incident occurs it must be reported to all relevant bodies.

Between April 2015 and March 2016 there were a total of two screening incidents and four immunisation incidents in Bath & North East Somerset. There were no serious incidents.

10.1 Screening incidents

The two screening incidents occurred within the Foetal Anomaly Screening Programme (FASP) provided by the Royal United Hospital (RUH). Both incidents were appropriately investigated with lessons learned, and have since been closed.

The first incident related to a late booking for the 20-week scan for a pregnant mother moving from Bath to Swindon. The scan was conducted at 21 weeks and the result was normal with no adverse effects. To mitigate the risk of this incident

recurring training was arranged for all midwives on how to book patients in at other hospitals for their scans.

The second incident related to a handwritten transcription error of a pregnant mother's date of birth. This led to a recalculation of Downs' screening risk, which remained a low-risk value. There were no adverse effects. To mitigate the risk of this incident recurring the RUH have now made it mandatory to use demographic stickers in place of handwritten details, which should be confirmed when the patient is present.

10.2 Immunisation incidents

There were four incidents when vaccines were exposed to temperatures outside of the required range; these are referred to as breaks in the cold chain. The incidents occurred within four separate general practices. Each incident was appropriately investigated with lessons learned, and have since been closed.

A vaccine administration error was also reported when two doses of adult pneumococcal vaccine (PPV) were administered after a fridge had failed (breaching cold chain limits). Clinical advice was taken and confirmed that there were no risks to the patients receiving the vaccines, but that the efficacy of the doses may be compromised. Both patients were invited to receive another dose of PPV a month after the original.

Vaccines for the national immunisation programmes are provided free of charge to practices. The cost of vaccine wastage results in a significant and largely avoidable financial burden that needs to be reduced both locally and nationally.

In the 2015-16 financial year the cost of vaccine wastage due to the four cold chain events in Bath & North East Somerset was £15,221.69, representing a loss of 537 doses. Causes for the cold chain incidents reported are outlined below.

Cause of cold chain incident	No. of incidents reported (April 2015-March 2016)
Fridge equipment failure not due to power loss	2
External power supply problem (power cut)	1
Fridge switched off in error	1

An audit of all cold chain incidents reported across BGSW in the 2015/16 financial year revealed that the potential vaccine wastage cost was more than £82,000.

The NHS England South (South Central) Public Health Commissioning Team shared the results of their audit with GP practices and included useful hints and tips for maintaining the cold chain and reducing vaccine wastage, as well as links to national guidance. They also produced fridge magnets that offer a reminder to staff on the steps to take to maintain the cold chain.

It is hoped that these measures will be used to strengthen cold chain processes within BGSW and help to minimise the cost of vaccine wastage in future.

11 Recommendations

These recommended priorities have been agreed by the Board as key issues 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 informed through 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. Assurance: continue to monitor performance of specialist areas, identify risks, ensure mitigation is in place and escalate as necessary
2. Support the B&NES Antimicrobial Resistance Strategic Collaborative
3. Continue to ensure that the public are informed about emerging threats to health
4. Support the review of the Bath Air Quality Action Plan and support the implementation of the actions in the Saltford & Keynsham Air Quality Action Plans
5. Increase the uptake of MMR vaccination in B&NES
6. Improve the uptake of flu vaccinations in at risk groups, pregnant women, children and health care workers & support the STP work-stream to run collective campaigns for the influenza and pneumococcal vaccine
7. Continue to reduce health inequalities in screening programmes

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

Appendix 2: B&NES Immunisation Group Terms of Reference (see attached document)