

HAMPSHIRE COUNTY COUNCIL

Report

Committee/Panel:	Health and Wellbeing Board
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Title:	Health Protection Assurance Report
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Report From:	Director of Public Health

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1. Summary

- 1.1. The purpose of this report is to provide assurance to the Director of Public Health and the Health and Wellbeing Board that mechanisms are in place to protect the health of the population of Hampshire.
- 1.2. The scope of health protection considered by this report includes immunisations, screening, public health aspects of emergency planning resilience, the the control of infectious diseases and healthcare associated infections.

2. The duties of local government

- 2.1. From the 1st of April 2013 local authorities have had a duty to improve the health of their populations. As part of this duty, regulations have been passed describing the health protection duties of local authorities.¹
- 2.2. The regulations state that upper tier and unitary local authorities will have a duty to provide information and advice to 'responsible persons' and 'relevant bodies' on health protection arrangements, in particular to deal with infectious disease, environmental hazards and contamination and extreme weather events. The regulations state that the nature of the information and advice will be locally determined.
- 2.3. The Director of Public Health is required to be assured that there is a robust system in place for health protection in Hampshire. Progress, key issues and risks are reported quarterly to the Public Health Sub-group of the Health and Wellbeing Board.

¹ The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (6C regulations) <http://www.legislation.gov.uk/uksi/2013/351/contents/made>

3. Contextual information

- 3.1. Health protection can be defined as action taken by governments, individuals and organisations intended to protect individuals, groups, and populations from infectious diseases, environmental hazards and radiation. Health protection involves the identification of hazard and threats to health and the response to these risks.
- 3.2. Responsibilities for protecting the health of the public are distributed across many agencies, including Public Health England, NHS Regional Teams, Clinical Commissioning Groups, healthcare providers, and upper and lower tier local authorities.

4. Immunisation

Organisational and assurance arrangements

- 4.1. Immunisation programmes are commissioned by NHS England – South (Wessex) team.² Technical input is provided by public health specialists employed by Public Health England who are embedded into the Wessex team. Immunisations are commissioned from a range of providers, including primary care (GP) services, school nursing services and pharmacies.
- 4.2. Vaccination for Hepatitis B is offered to people at higher risk of acquiring infection in Sexual Health Services and Drug and Alcohol Treatment Services. Babies born to mothers with acute or chronic Hepatitis B infection are also given a course of vaccination to prevent the transmission of the virus from mother to child.
- 4.3. Local assurance is provided through quarterly meetings with the Director of Public Health and the provision of quarterly data and performance reports. The Director of Public Health is also notified of serious incidents and involved in investigations as appropriate.
- 4.4. Hampshire County Council's public health specialists ensure programmes of delivery benefit the population of Hampshire through participation in the multi-agency Wessex Flu Steering Group and the Southampton, Hampshire, Isle of Wight and Portsmouth Immunisation Board.

Key issues and performance 2014/15

- 4.5. Since April 2013 there have been a number of changes to the childhood immunisation schedule. These have included the addition of Rotavirus and Influenza for pre-school children and changes to the schedule for Human Papilloma Virus (HPV) and Meningococcal C (Men C) vaccinations. The Shingles vaccine was also introduced in 2013 for adults aged 70 years and over.

² For the full immunisation schedule see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/422787/8584_PHE_2015_Complete_Immunisation_Schedule_A4_13_accessible.pdf

- 4.6. Good delivery of the childhood immunisation schedule was maintained. As part of the vaccination schedule the Measles, Mumps and Rubella vaccine is given. Unpublished COVER data indicates that uptake of at least one MMR vaccine at age 5 was just above the level of coverage recommended by the World Health Organisation (95%).³
- 4.7. The uptake of the influenza vaccine across the risk groups was equal or above that of the England average, but remains less than the level recommended by the Department of Health (75%) especially in clinical risk groups aged under 65 years (52-56% by CCG%) and pregnant women (40-45% by CCG).⁴ The only exception was the uptake in those aged 65 years and over in South Eastern Hampshire CCG (75%). There was an increase in uptake in healthcare workers in four of five local NHS trusts (range: 30% - 68%). Nationally 54.9% of health care workers received the influenza vaccination.⁵
- 4.8. Routine data collected from GP practices indicates that the uptake for the Shingles vaccination in Quarter 1 2014/15 (September to December) was in line with the uptake for England, with some variation by CCG.⁶

Key opportunities and risks 2015/16

- 4.9. We will need to ensure the future commissioning of school-aged immunisation programme meets the needs of this group including the most vulnerable and hard to reach.
- 4.10. The efficacy of the influenza vaccine in the 2014/15 flu season was found to be low. Maintaining confidence in the influenza vaccination will be a key issue in 15/16, with the risk that uptake will fall. Flu vaccination has been shown to reduce the risk of hospitalisation and death in vulnerable individuals. It can also reduce the wider impact of influenza on health and social care services, through reduced service demand and impact on staff absence.

5. Screening

Organisational and assurance arrangements

- 5.1. National screening programmes are commissioned by the NHS England – South (Wessex) team using a national delivery framework.⁷ Technical input is provided by public health specialists employed by Public Health England who are embedded into the Wessex team. Screening services are commissioned from a hospitals, primary care (GP) services and private providers.

³ COVER (Cover of vaccination data evaluated rapidly) data for 2014/15 will be available in the next two months at <https://www.gov.uk/government/collections/health-protection-report-latest-infection-reports#immunisation>

⁴ Data is available at

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407946/2903322_SeasonalFlu_GP_Jan2015_acc2.pdf

⁵ Data is available at

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414493/SeasonalFlu_HCWs_February2015.pdf

⁶ Data is available at

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/397892/hpr0315_shngls.pdf

⁷ Please see <http://www.screening.nhs.uk/nhs-timeline> for details of the national screening programme

- 5.2. Assurance is provided through quarterly meetings with the Director of Public Health and the provision of quarterly data and performance reports. Screening programmes are also subject to external quality assurance visits to which the Director of Public Health is invited.
- 5.3. The public health team are members of the Wessex wide immunisation and screening committee which has become operational in 2015. This will enable Hampshire County Council public health specialists to work with commissioners to improve the quality and uptake of screening programmes.

Key issues and performance 2014/15

- 5.4. Performance against the key performance indicators for antenatal and newborn screening programmes up to quarter 2 is in line with historic performance. The expanded new bloodspot screening programme was successfully introduced across providers in January 2015.
- 5.5. Coverage for the breast and cervical screening programmes was above the England average in 2013/14 with 78% of eligible women being screened in the breast screening programme and 77% in the cervical screening programme.⁸ Figures for quarter one show a fairly stable picture with some variation in trend by CCG population. Unvalidated data for the Bowel Screening programme indicates that uptake was 59% in 2013/14. Figures for the first three quarters of 2014/15 indicate an upward trend in uptake.
- 5.6. The Abdominal Aortic Aneurysm (AAA) screening programme was fully rolled out nationally in 2013/14. The coverage in Hampshire in 2013/14 was 81%, higher than the England uptake of 77%. Data for quarter two 2014/15 indicates the programme is exceeding national standards.⁹
- 5.7. The uptake of diabetic eye screening in 2013/14 was reported as 77%. This was below the England average of 79% although higher than the national minimum standard of 70%. Data reporting of this indicator for some programmes has been affected by a software issue nationally, locally sourced data indicates that there has been an improvement to quarter 3 in the two of three local programmes who use this software. The third local programme is already achieving uptake above the England average.

Key opportunities and risks 2015/16

- 5.8. The Hampshire County Council public health team will work with commissioners to increase the offer and uptake of eye screening in people with diabetes.
- 5.9. Survival rates for some cancers are lower in the UK than in other European countries. Population screening has an important role to play in detecting

⁸ Data available at <http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/1/par/E12000008/are/E10000014>

⁹ Data available at <http://aaa.screening.nhs.uk/2013-14datareports>

cancer at an earlier stage.¹⁰ Whilst coverage is generally good in Hampshire, a significant minority of the population are not taking up the offer of screening. We need to better understand how we can increase uptake in our population. We will use analysis from the Joint Strategic Needs Assessment to identify the populations where increasing uptake will be a priority.

6. Emergency Planning Resilience and Response

Organisational and assurance arrangements

- 6.1. Arrangements for preparing for and responding to major incidents are defined in the Civil Contingencies Act 2004. The Hampshire and Isle of Wight Local Resilience Forum has a Local Health Resilience Partnership (LHRP), jointly chaired by the Director of Public Health for Hampshire County Council and the Director of Operations, NHS England South (Wessex). The main purpose of the LHRP is to facilitate health sector and multi-agency planning for emergencies.
- 6.2. In terms of public health response Public Health England is a category 1 responders and is also responsible for mobilising the Scientific Advisory Cell (STAC) in an emergency should one be required. This role is supported by local authority public health teams who are trained to chair the STAC and provide public health leadership in the Tactical Coordinating Group in the event of a major incident. This role supports the Local Resilience Forum and the Hampshire County Council response to emergencies
- 6.3. Hampshire County Council Public Health Specialists also work closely with the Council's Emergency Planning team to support the Council on specific issues.

Key issues and performance 2014/15

- 6.4. 2014/15 was the second year of the new arrangements for the NHS and public health, and saw the development and consolidation of the system following the re-organisation of the NHS in 2013.
- 6.5. Winter 2014 saw widespread flooding in Hampshire. Whilst this was not declared a major incident it did require sustained multi-agency response. Hampshire County Council Public Health specialists provided professional support in the response and recovery phases.
- 6.6. The Ebola Virus Disease outbreak in West Africa required the development and testing of the systems wide response in the event of a case being detected locally. Public Health England and health service partners were heavily involved in planning and responding the threat of Ebola Virus Disease.

Key opportunities and risks 2015/16

¹⁰ De Angelis R, Sant M, Coleman MP, et al. Cancer survival in Europe 1999-2007 by country and age: results of EURO-CARE-5 – a population-based study. **The Lancet**. Published online December 5 2013
[http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(13\)70546-1/abstract](http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(13)70546-1/abstract)

6.7. Pandemic Flu remains a high priority risk for civil emergencies nationally. There is a need to test plans for pandemic flu locally to ensure all local partners are prepared for this potential emergency.

7. Infectious Disease Control

Organisational and assurance arrangements

- 7.1. The Public Health (Control of Diseases Act) 1984 and accompanying regulations give public organisations the power to prevent and control risks to human health. Registered Medical Practitioners and laboratories are required by statute to notify certain infectious diseases to the proper officer of their local authority. The proper officer role is undertaken by the local Public Health England health protection team. Local authorities also have powers and duties enshrined in law which defines their health protection role. In Hampshire these powers and duties are discharged by the District Authorities.
- 7.2. Public Health England has a well established local and national surveillance system for monitoring the incidence of infectious disease and outbreaks. Surveillance data is regularly reported locally and nationally. The Director of Public Health is notified of individual cases of infectious disease and outbreaks according to agreed local criteria. Hampshire County Council's public health specialists provide professional support to Public Health England and Clinical Commissioning Groups in their response to individual cases and outbreaks.
- 7.3. Nationally, Public Health England identifies emerging threats to health, undertakes risk assessments and puts in place mitigating actions. The Director of Public Health is notified of emerging threats to health.
- 7.4. Single cases of rare or serious infectious disease and outbreaks/clusters of infectious disease often require a multi-agency response. This response is led and managed through multi-agency incident and outbreak control teams and guided by the Wessex Outbreak Plan and relevant national guidance.

Key issues and performance 2014/15

- 7.5. There have been a number of unusual incidents and outbreaks in Hampshire in 2014/15 that have required a multi-agency response. These have included a large salmonella outbreak, avian influenza in a local chicken farm, an incident involving infectious TB and a Hepatitis A incident. The multi-agency response, led by Public Health England has been successful in responding to these incidents. Minor issues have arisen regarding agency roles and responsibilities.
- 7.6. Moderate levels of influenza activity were seen last winter. There was a marked increase in outbreaks of respiratory infections especially in care homes and a higher number of influenza confirmed hospital admissions than compared to the previous two years. Laboratory data showed the highest age-specific activity

was in the 65+ year group. Nationally the highest number of excess winter deaths for a number of years was seen.¹¹

- 7.7. Last winter there was decreased effectiveness of the flu vaccine against the dominant circulating flu virus. This was due to antigenic changes in the Influenza A (H3N2) virus. This demonstrates the inherent difficulties of predicting the dominant flu virus six months in advance each year. Mismatches between one of three strains of virus in the influenza vaccine and the circulating virus has occurred five times between 2003/04-2014/15.¹²
- 7.8. Following the national increase in cases of scarlet fever in 2013/14, a similar picture was seen in 2014/15.¹³ The disease mainly affects children aged 2-10 years. Whilst scarlet fever is usually a mild illness that can be treated with antibiotics, it can, rarely, cause serious complications.

Key opportunities and risks 2015/16

- 7.9. We need to reinforce good infection prevention and control across settings including schools, nursing and residential homes.
- 7.10. Whilst the absolute number of people identified with Tuberculosis (TB) in Hampshire is low, the treatment completion rates are above the national average. We currently do not have a programme in place to screen higher risk individuals for latent TB. With the establishment of TB Control Boards, as part of the National TB Strategy we will be able to explore the feasibility of introducing latent TB screening in areas of higher incidence.

8. Infection prevention and control and health care acquired infections

Organisational and assurance arrangements

- 8.1. Health and adult social care organisations have a legal duty to implement the Health and Social Care Act 2008 code of practice and related guidance on the prevention and control of infections. The Care Quality Commission, as the regulator of health and social care services has a duty to provide assurance that providers meet essential levels of quality and safety. Clinical Commissioning Groups have to be assured that their commissioned services meet the requirements laid out in statute. In practice all Hampshire CCGs have infection control/quality capacity.
- 8.2. Nationally there is mandatory surveillance of MRSA (meticillin-resistant staphylococcus aureus), MSSA (Meticillin-sensitive Staphylococcus aureus) and E. coli bacteraemia and C. difficile laboratory confirmed cases. The number of cases in each NHS trust and CCG is reported monthly. The NHS

¹¹ Public Health England. Surveillance of influenza and other respiratory viruses in the United Kingdom: winter 2014 to 2015. **Public Health England**. May 2015.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/429617/Annualreport_March2015_ver4.pdf

¹² van der Werf S, Lévy-Bruhl D. Influenza – the need to stay ahead of the virus. **Euro Surveill**. 2015;20(5):pii=21030. Available online: <http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=21030>

¹³ Data is available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/432898/hpr1915_sf-gas.pdf

imposes penalties on hospitals and Clinical Commissioning Groups for all cases of MRSA that are attributed to NHS trusts and for *C. difficile* cases that are deemed to be due to a lapse in care.

- 8.3. Locally there is a multi-agency Commissioning Infection and Prevention Group. Members are from the 5 CCGs, NHS England, Hampshire County Council and Public Health England. The group facilitates and supports infection prevention initiatives with local provider organisations and the wider population. There is also an infection prevention control group within the County Council.

Key issues and performance 2014/15

- 8.4. In 2013/14 there was a slight increase in laboratory cases of MRSA bacteraemias in Hampshire (16 by CCG registered population) compared to 10 in 2012/13. Nationally there have been dramatic reductions in MRSA bacteraemias in the last eight years.¹⁴
- 8.5. In 2014/15 there was a slight reduction in the laboratory confirmed cases of *C. difficile* infection with 293 cases being reported across the registered population of the five CCGs compared to 299 in 2013/14.¹⁵
- 8.6. Given the clinical complexities inherent in some patients and the movement of people between different community and acute providers the continued reduction of HCAs will be challenging in the future. MRSA and *C. difficile* act as indicators of quality and safety in hospital and care settings.
- 8.7. In 2013 Public Health England published the national antimicrobial strategy. This strategy recognises the importance of action on good stewardship for existing antimicrobials and the need to develop new antibiotics and therapies.

Key opportunities and risks 2015/16

- 8.8. There is a need to continually work as a system to reduce HCAs. A fragmented health and social care system is caring and treating for patients who have complex and multiple needs. There is a need to understand patterns of infection acquisition and control as a system.
- 8.9. HCAs are not only serious for patients but are a burden on the health and social care system. HCAs, including norovirus cause significant disruption to care facilities. This arises from the requirement to close wards and nursing homes to contain infection, the inability to move people from hospital to lower level facilities when clinically appropriate, as well as the costs associated with staff sickness.
- 8.10. Whilst many of the actions in the antimicrobial strategy are nationally driven, there is a need to ensure local action is taken when required.

9. Recommendations

¹⁴ Data is available at <https://www.gov.uk/government/collections/staphylococcus-aureus-guidance-data-and-analysis#epidemiology>

¹⁵ Data is available at <https://www.gov.uk/government/collections/clostridium-difficile-guidance-data-and-analysis>

9.1. This report shows that risks to the health of the population have been assessed and mitigating measures put in place. This report provides assurance to the Health and Wellbeing Board that systems and processes are in place to protect the population.

9.2. It is recommended that:

- a. The Health and Wellbeing Board note this report
- b. That a work plan is developed based on the key issues raised in each section of this report
- c. That Hampshire County Council Public Health specialists ensure the relevant processes are in place to provide assurance to the Director of Public Health for 2015/16.

CORPORATE OR LEGAL INFORMATION:**Links to the Corporate Strategy**

Hampshire safer and more secure for all:	yes
Corporate Improvement plan link number (if appropriate):	
Maximising well-being:	yes
Corporate Improvement plan link number (if appropriate):	
Enhancing our quality of place:	no
Corporate Improvement plan link number (if appropriate):	

Other Significant Links

Links to previous Member decisions:		
<u>Title</u>	<u>Reference</u>	<u>Date</u>
Direct links to specific legislation or Government Directives		
<u>Title</u>		<u>Date</u>
The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (6C regulations) http://www.legislation.gov.uk/uksi/2013/351/contents/made		18 th February 2013

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

<u>Document</u>	<u>Location</u>
None	

IMPACT ASSESSMENTS:

1. Equality Duty

1.1. The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;
- b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;
- c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionately low.

2. Equalities Impact Assessment:

2.1. This report provides information. If actions are due to be taken as a result of the development of an action plan, any impact will then be considered.

3. Impact on Crime and Disorder:

3.1. This report provides information. If actions are due to be taken as a result of the development of an action plan, any impact will then be considered.

4. Climate Change:

This report provides information. If actions are due to be taken as a result of the development of an action plan, any impact will then be considered.