Portsmouth CITY COUNCIL

Title of meeting: Health and Wellbeing Board

Subject: Health Protection

Date of meeting: 3rd September 2014

Report by: Director of Public Health

Wards affected: All

---

1. Requested by: Janet Maxwell DPH for the Health and Wellbeing Board.

2. Purpose: To give Health and Wellbeing Board an overview of the role of the local authority in health protection with a particular focus on influenza.

To make recommendations for improvements to governance arrangements for the Health Protection Assurance Group

3. What is Health Protection?

3.1. In order to improve the health of the population, health protection has been deemed one of the five mandated areas of Public Health for the local authority to carry out (along with health checks, core offer to the NHS, sexual health and national child measurement programme).

3.2. Health protection is a term used to describe the branch of public health which deals with protecting the population from infectious diseases and other threats to their health, which may include chemicals and poisons, radiation and environmental health hazards.

3.3. Local leadership from the Director of Public Health is crucial to delivery of the Health Protection function and partnership working both internally and externally to the local authority with Public Health England and local commissioners and providers of health services including Clinical Commissioning Groups.

3.4. National leadership is provided by Public Health England. The Wessex centre for Public Health England is based in Whitely near Southampton.

3.5. The Secretary of State has the overarching duty to protect the health of the population, a duty which will be generally discharged by Public Health England. If

the Secretary of State considers that local arrangements are inadequate, or that they are failing in practice, he must take the action that he believes is appropriate to protect the health of the people in that area.

3.6. Health protection includes measures of prevention such as immunisations and vaccinations (including childhood, flu, travel) and responding to outbreaks to prevent the spread of disease within communities (including meningitis, tuberculosis, influenza, hepatitis and other blood born viruses, measles).

4. What is the role of local authorities?

4.1. Under the terms of the Health and Social Care Act 2012, upper tier local authorities have acquired new statutory responsibilities to protect the health of the population.

4.2. The local authority must;

- Ensure that plans are in place to protect the health of the geographical population from threats ranging from relatively minor outbreaks and health protection incidents to full scale emergencies
- Respond to local outbreaks and incidents- this may require cooperation from commissioners of NHS services to provide NHS resources, depending on the nature of the outbreak or incident.
- Maintain Public Health surveillance of all aspects of the occurrence and spread of disease pertinent to effective control in order to inform and direct public health action

4.3. Preventive roles (examples)

- Working with the Clinical Commissioning Group to ensure there are integrated services in place to prevent and control tuberculosis in line with local need
- Commissioning measures to minimise drug related harm, such as transmission of blood-borne viruses amongst injecting drug users
- Working with NHS England to ensure that rates of immunisations and vaccinations meet the threshold required to maintain herd immunity within populations (herd immunity refers to the population coverage which indirectly protects those who are unvaccinated as the disease is prevented from circulating).
- Developing local initiatives to raise awareness of the risks of infectious diseases based on population needs identified through the Joint Strategic Needs Assessment

- Developing local plans and capacity to monitor and manage acute incidents to help prevent transmission of sexually transmitted diseases, to control outbreaks and to foster improvements in sexual health

- Work with environmental health colleagues who regulate business providing interventions such as tattooing or piercing to reduce risks of harm

- Work with environmental health colleagues to understand and control food safety and hygiene related matters in the city.

- Preparing for extreme weather events such as heat waves and cold weather with the view to preventing and/or reducing morbidity and excess seasonal deaths

- Working with environmental health colleagues to improve air quality/reduce pollution

4.4. Under health protection legislation (Department of Health 2010), local authorities have powers to require, request or take action for the purposes of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination which presents, or could present, significant harm to human health. This might in rare situations include enforcing the requirement for a child to remain off school if their attendance could present significant harm to others and powers of entry to inspect premises.

4.5. Under health protection legislation in other circumstances, a local authority can apply to a Justice of the Peace for an order that imposes restrictions or requirements on a person (s) or in relation to a thing (s), a body or human remains, or premises.

5. Health Protection in Portsmouth City Council

5.1. A health protection assurance group has been formed, which aims to provide assurance to the Director of Public Health of the adequacy of prevention, surveillance, planning and response with regard to health protection issues and to alert the Director of Public Health to any emerging threats to the health of the population of Portsmouth (see appendix a for terms of reference).

5.2. The group meets quarterly and membership includes internal local authority and external National Health Service and Public Health England partners

5.3. A dashboard has been developed which pulls together data from a variety of sources to provide a visual overview of health protection performance and outcomes in the city. This includes all the Health Protection Public Health

indicators as well as other locally identified areas for surveillance including health care associated infections.

5.4. There is a relationship between each of the five priorities of the Health and Wellbeing Board Strategy (2014) and work streams which are addressed through health protection work streams (see table below).

Health and Wellbeing Board Priority		Workstream link to health protection outcomes (examples)
One	Giving children and young people the best start in life	1a. Review and redesign of pre-birth to 5 pathway; Opportunity to maximise opportunities to promote childhood vaccinations and protect children and their families from avoidable disease. PHOF indicator 3.3.
Two	Promoting prevention	2a. Create sustainable and healthy environments; Public Health contribution to air quality strategy/reduction in air pollution with active travel initiatives PHOF indicator 3.1.
Three	Supporting Independence	3c. Implement the new City of Service model of high impact volunteering; recognition of comparatively high level of excess winter deaths in city. Local implementation of national cold weather plan led by Health Protection team in public health. PHOF indicator 4.15.
Four	Intervening earlier	4b. Deliver the Portsmouth Clinical Commissioning Group's strategic priorities; appropriate surveillance of health protection outcomes e.g. flu vaccination rates in the over 65 age group can reduce demand on primary and secondary care services PHOF indicator 3.3.
Five	Reducing inequality	Health Protection PHOF domain 3 objective is all encompassing. "The population's health is protected from major incidents and other threats, whilst reducing health inequalities"

5.5. Portsmouth has a number of challenges in relation to health protection outcomes. Two examples of areas where improvement is needed are:

- Childhood vaccinations rates at 5 years old remain poor with vaccination rates for DTaP/IPV/HiB (diphtheria, tetanus, pertussis, polio and Haemophilus influenzae) and MMR (measles, mumps and rubella) at 90% and 89.2% respectively although both have continued to increase

- Pneumococcal vaccination rates have decreased in recent years from 72% in 2010/11 to 67.8% in 2012/13 against a 75% target rate.

5.6. Commissioning of vaccination programmes is led by NHS England who work in partnership with Public Health Portsmouth to improve local outcomes. For example partnership working during 2013 to maximise the local impact of the national MMR campaign.

5.7. An example where outcomes are positive but still with room for improvement is:

- Tuberculosis levels at 9.2/100.000 population are lower than the England average of 15.4/100,000 and treatment completion levels at 96% exceed both the national target of 95% and national average of 84.3%.

6. Influenza

6.1 The annual influenza vaccination campaign will be used as an example of a health protection issue in the city. This is described below.

6.2 Influenza is a viral infection that is highly transmissible and can cause a spectrum of illness from mild to severe, even among people who are previously well. Influenza vaccine is therefore offered annually to protect patients in a number of high risk groups who at increased risk of the more serious effects of influenza infection including death. This is achieved either directly by giving the patient themselves the vaccine or indirectly by offering vaccine to staff and carers responsible for the care of the patient.

6.3 Influenza can also have significant effects on organisations and the economy, including the exacerbation of winter pressures on health and social care services. Staff with influenza may be absent from work for up to 6 days and may need up to two weeks to fully recover.

6.4 Influenza vaccine is a very safe vaccine with a high efficacy, which can completely prevent influenza infection and should ideally be given between September and early November each year before influenza the virus starts to circulate in the community. Circulating influenza viruses change slightly every year which is why new vaccines need to be developed and given every year.

7. At Risk Groups

7.1 The target groups for influenza vaccination for 2014/15 include:-

- Those aged 65 years and over
- Those aged six months to under 65 in clinical risk groups
- Pregnant women
- All two, three and four year olds
- Those in long-stay residential care homes
- Carers

7.2 Clinical risk groups include those with:

- Chronic respiratory disease e.g. asthma requiring continuous treatment
- Chronic heart disease e.g. congenital heart disease
- Chronic liver disease e.g. liver cirrhosis
- Chronic kidney disease e.g. chronic kidney failure
- Chronic neurological disease e.g. stroke
- Diabetes
- Immunosuppression e.g. HIV infection
- No spleen or poorly functioning spleen

7.3. Children aged two and three years not in a clinical at-risk group were added to the target groups for the 2013/14 season. This is based on a recommendation by the Joint Committee for Vaccination and Immunisation (JCVI), the Governments vaccination advisors, that the flu programme should be extended to all children aged two to 17 years. This provides direct protection to children but will also reduce transmission of influenza to unvaccinated children and adults including those in clinical at-risk groups. The introduction of childhood flu vaccination will be phased over a number of years starting in 2012/13 with two and three year olds and in 2014/15 this will be extended to four year olds.

7.4. In addition to these at risk groups, employers are responsible for ensuring that arrangements are in place for the vaccination of their health and social care workers with direct patient contact. Vaccination of healthcare workers and social care staff with direct patient contact is likely to reduce the transmission of influenza to vulnerable patients, some of whom may have impaired immunity that may not respond well to their own vaccination.

8. Commissioning Arrangements in Portsmouth

8.1 In Portsmouth city, vaccination of at-risk groups is commissioned by the Wessex Local Area Team (LAT) of NHS England and provided by GP practices in the city. Wessex LAT have regular regional flu meetings to

oversee the flu programme which includes all key stakeholders across the region including Public Health Portsmouth. Portsmouth Clinical Commissioning Group (PCCG) have also commissioned GP practices to provide influenza vaccination to patients in residential and nursing homes.

8.2 Vaccination of health and social care staff in the city is the responsibility of their employing bodies and includes Portsmouth Hospitals Trust, Portsmouth CCG, Portsmouth City Council, NHS Solent, Southern Health and GP practices. Residential and nursing homes need to be encouraged to provide flu vaccination where this is not available.

9. Local Performance

9.1 The target for influenza vaccination is 75%. **Figure 1** highlights the influena vaccination uptake rates in Portsmouth and is summarised in the text below.

Figure 1: Flu Vaccination Uptake Rates by At-Risk Group Portsmouth City 2012/13 and 2013/14

Target Group	2013/14 Uptake	2012/13 Uptake	Trend	Wessex	England
Over 65s	75.7%	75.2%		74.0%	73.2%
Unders 65s	53.7%	52.9%		53.1%	52.3%
Pregnancy	38.5%	43.1%		39.4%	39.8%
Children Aged 2 years	43.0%	N/A	N/A	50.5%	42.6%
Children Aged 3 years	40.0%	N/A	N/A	46.2%	39.6%

Key

Target Achieved/Increasing/Portsmouth Rate is Higher

Target Not Achieved/Decreasing/Portsmouth Rate is Lower

9.1.1. Over 65s

Portsmouth City achieved and uptake rate of 75.7% in the 2013/14 season, a small increase of 0.5% from the 2012/13 season. This is higher than both the Wessex (74%) and England (73.2%) rates.

9.1.2. Under 65s

The under 65 uptake rate for 2013/14 was 53.7%, a small increase of 0.8% from 2012/13. Again this is higher than both the Wessex (53.1%) and the England (52.3%) rates, but significantly lower than the target of 75%.

In the under 65s, the lowest uptake rates are found in the chronic liver disease (44%) and chronic neurological disease (51%) clinical risk group.

9.1.3 Pregnant Women

The uptake rate for pregnant women for 2013/14 was 38.5%, a significant decrease of 4.6% from 2012/13. This is lower than both the Wessex (39.4%) and England (39.8%) uptake rates and is significantly below the target of 75%.

9.1.4 Children

The uptake rates for 2 and 3 year olds were 43% and 40% respectively, both lower than Wessex (50.5% and 46.2%) but higher than England (42.6% and 39.6%). Both rates are significantly lower than the 75% target, but this is expected as it is the first year that this has been offered.

9.1.5 Staff

Figure 2 below details the uptake rates for staff in the main health and social care providers in Portsmouth City for 2013/14.

Figure 2: Flu Vaccination Uptake Rates by Health and Social Care Provider Portsmouth City 2013/14

Provider	2012/13 % Uptake	2013/14 % Uptake	Trend
GP Practices	58.2%	71.1%	
PHT	46.4%	59.9%	
NHS Solent	54.6%	53.7%	
Southern Health	30.0%	28.2%	
Adult Social Care	N/A	14.5%	
Children's Social Care	N/A	7.5%	

Key

Target Achieved/Rate Increasing

Target Not Achieved/Rate Decreasing

As can be seen, none of the main providers have achieved the target for flu vaccination amongst their staff and only 2, GP practices and Portsmouth Hospitals Trust (PHT) have improved on their 2012/13 rates. However it must be noted that staff members who had flu vaccination at their GP may not be reflected in these figures so these figures in reality may be higher.

Portsmouth City Council took the decision for the 2013/14 season and recently also for the 2014/15 flu season to offer flu vaccination to its entire staff including schools staff. The final uptake rate was 11.9% (981 staff).

10. Conclusion and Recommendations

10.1 As can be seen performance is good in some areas but poor in many more. Much more work needs to be done across health, social care, workplace and community organisations to improve vaccination rates in clients, patients, staff and residents and this will involve responsible organisation's willingness and leadership to improve uptake. Ultimately, improved vaccination rates will reduce illness and deaths due to influenza infection and will reduce winter pressures on health and social care organisations.

10.2 In order to drive this and other health protection issues it is important that the Health and Well-being Board have oversight of the Health Protection Agenda. It is therefore recommended that the DPH escalates any concerns relating to the protection of the health of the population to the health and wellbeing board. The DPH may request an annual report from the Health Protection Assurance Group or escalate on the basis of the ongoing surveillence and reporting which underpins the work of the health protection assurance group.

10.3 It is anticipated that opportunities will continue to arise from the public health transfer to local authorities and working in partnership with services to influence the wider determinants of health which will allow greater improvement in health protection outcomes.

……

Signed by Director of Public Health

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document
Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199773/Health_Protection_in_Local_Authorities_Final.pdf
Health Protection Legislation (England) Guidance 2010.
Commissioning Fact Sheet for Clinical Commissioning Groups (2012) http://www.england.nhs.uk/wp-content/uploads/2012/07/fs-ccg-respon.pdf
Annual CMO Letter 2014/15 https://www.gov.uk/government/publications/flu-immunisation-programme-2014-to-2015 Annual Flu Plan https://www.gov.uk/government/publications/flu-plan-winter-2014-to-2015

Appendix A:

Portsmouth Health Protection Assurance Group

1. Aim

As a result of the Health and Social Care Act 2012, upper tier and unitary local authorities have acquired new statutory responsibilities to protect the health of their population. Specifically the local authority is required, via its Director of Public Health (DPH) to assure itself that relevant organisations have appropriate plans in place to protect the population and that necessary action is being taken and to support and challenge providers in order that health outcomes are improved for those who live work and play in Portsmouth City.

The aim of the Portsmouth Health Protection Assurance Group (PHPAG) is to provide assurance to the Director of Public Health of the adequacy of prevention, surveillence, planning and response with regard to health protection issues and to alert the DPH to any emerging threats to the health of the population of Portsmouth.

2. Scope

- Issues that are within the scope of the PHPAG, but are not restricted to:

- Infectious diseases in the community

- Healthcare associated infection (HCAI)
- Immunisation programmes
- Sexually transmitted infections including HIV and chlamydia
- Blood borne viruses
- Tuberculosis

- Pandemic influenza

- Environmental hazards
- National screening programmes
- Emergency Planning Resilience and Response to Public Health Incidents

- Issues that are specifically out of scope of the PHPAG include:
- Business continuity

- Predictable “business as usual” events such as NHS/Social Care winter planning

3. Methods of working

The PHPAG will seek to assure the DPH in the following ways:

1. It will develop a health protection dashboard, pulling together data from a variety of sources including Public Health England Centre (PHEC); NHS Portsmouth Clinical Commissioning Group (CCG); Solent NHS Trust; Portsmouth Hospitals NHS Trust; NHS Commissioning Board Local Area team and the Portsmouth environmental health teams in order to assess performance.
2. The Public Health Outcomes Framework indicators will be reflected in the contents of this dashboard
3. The PHPAG will coordinate work with health and social care colleagues to ensure that health protection issues inform future updates of the Joint Strategic Needs Assessment (JSNA)
4. The PHPAG will ensure that learning from incidents has been established in order to inform future working practices
5. The PHPAG will ensure that evidence based practice is being followed in all areas of health protection practice
6. The PHPAG will raise any concerns with the relevant commissioners and/or providers
7. The PHPAG will escalate concerns to commissioners to initiate work with providers to ensure actions plans are in place where targets are not being met
8. That plans are in place to protect the health of the population
9. If necessary it will escalate concerns to the Health and Wellbeing Board and/or to the chief executive level of the Local Authority or National Commissioning Board Local Area Team as appropriate

4. Governance

1. The PHPAG will be directly accountable to the Director of Public Health. Minutes from the meeting will be sent routinely to the Public Health Directorate Management Team for consideration.
2. Any emerging threats will be reported immediately to the DPH alongside an action plan
3. Sub groups will be convened as appropriate and report to the PHPAG

5. Membership

- Consultant in Public Health (Chair)
- Senior Development Manager Health Protection
- Development Manager Health Protection
- Public Health England Centre representative
- Environmental health representative
- Head of Public Health NHS England (Wessex)
- Screening and Immunisation Consultant in Public Health Public Health England (Wessex area team)
- Portsmouth Public Health lead for sexual health
- Public Health Portsmouth intelligence team representative
- CCG quality lead responsible for HCAI commissioning
- Civil Contingencies Unit representative
- Portsmouth CCG representative
- Head of Emergency Planning NHS England

6. Secretariat

- Meetings will take place on a quarterly basis and will last no more than 2 hours
- Papers will be circulated no less than 3 working days in advance of the meeting
- Minutes will be circulated no more than 10 working days after the previous meeting
- The meeting will be deemed to be quorate with the following in attendance:

  Public Health consultant or Director of Public Health or Senior Development Manager Public Health

  Plus 3 other members of the PHPAG

Terms of Reference agreed ……..25/9/13
For review…… September 2014