Health and Wellbeing Board

17 October 2016

Health Protection Forum Annual Report 2015/16

1. Purpose

The first Health Protection Forum Annual Report (Appendix 1) draws together a brief summary of the work undertaken by all agencies working together to improve and protect the health of Walsall residents.

The Health Protection Forum is part of the Health and Wellbeing Board infrastructure and is therefore required to report to the Health and Wellbeing Board as part of its governance structure.

2. Recommendations

That the Health and Wellbeing Board notes the main points of the Health Protection Forum Annual Report that describes the key actions of 2015/16 and recommendations for future work.

3. Report detail

The Walsall Health Protection Forum is a subgroup of the Health and Wellbeing Board and has been in existence since Public Health moved to Walsall Council in 2013.

The Health Protection Forum is a partnership forum which covers the following areas

- Health emergency planning
- Immunisation and screening
- Control of communicable diseases, including tuberculosis, sexually transmitted disease and healthcare associated infections
- Pollution control
- Environmental health and trading standards.

The purpose of the Walsall Health Protection Forum is to:

- Facilitate a co-ordinated strategic approach to health protection issues in Walsall
- Provide an accountability framework for a number of existing partnership groups with a health protection remit and support the establishment of new groups where appropriate
- Receive assurance from the partner organisations leading relevant work streams regarding:
  - Appropriate strategies/plans and testing arrangements
  - Progress against outcomes
  - Review all significant incidents/outbreaks to identify lessons learned and to make recommendations to commissioners/providers/partners regarding necessary changes

    - Receive and review risk registers from all subgroups, make recommendations to subgroups regarding mitigating actions and to commissioners where appropriate
- Encourage continuous quality improvement in health protection services in Walsall
- Provide health protection input into the Joint Strategic Needs Assessment

The Health Protection Annual Report provides a summary of each organisations work in the past year and recommendations for service improvement (Please see Appendix 1).

4. Implications for Joint Working arrangements:

The Health Protection Forum is made up of a number of agencies who are required to work together to coordinate health protection within Walsall, maximising the impact we have and minimising identified risks. The Forum is aware that we constantly need to reassess the way we work as resources become more constrained and further risks emerge.

5. Health and Wellbeing Priorities:

The Health Protection Forum and its work contributes to a number of the Health and Wellbeing strategy's themes

- Give every child the best start in life and enable them to make the most of who they are – e.g. Childhood immunisations
- Create healthy sustainable places and communities
- Reduce the burden of preventable disease, disability and death

In addition it also meets the Marmott objectives, which the themes of the strategy mirrors in particular

- Give every child the best start in life
- Create and develop healthy sustainable places and communities
- Strengthen the role and impact of ill health prevention – e.g. cancer and non-cancer screening, immunisation, infection control and communicable disease control

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Walsall

Health Protection

Annual Report

2015/16

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Executive summary

This is the first health protection annual report. It draws together a brief summary of the work undertaken by all agencies working together to improve and protect the health of Walsall residents. This report summarises activities that have been undertaken by the members of the Health Protection Forum in the last year and includes recommendations for future work and a list of risks that may jeopardise future plans.

Health Protection in Walsall – a summary of the situation in 2015/16

- Health emergency planning – 2 desktop exercises have been undertaken in 2015/16 covering the local response to health protection incidents and pandemic flu planning.
- There have been 12 local (level 1) incidents and outbreaks in Walsall over 2015/16; all of these have been limited in scope and managed appropriately. 11 of these incidents related to infectious diseases.
- The incidence of tuberculosis in Walsall was an average of 40 cases per year (2013- 2015). There have been no outbreaks of tuberculosis in 2015/16; screening of contacts has been undertaken for all cases as appropriate.
- Immunisation uptake in Walsall for children aged 0-5 has remained very high (over 95%)
- Uptake of flu vaccination in 2015/16 was better than regional and national averages but below national targets across all areas. Uptake has been increasing in pregnant women year on year, but remains a concern in high risk groups and children.
- The uptake of antenatal and newborn screening in Walsall is high and meets national targets
- The uptake of all cancer screening programmes(breast, bowel and cervical) is below national targets and requires improvement
- The uptake of non cancer screening programmes (diabetic retinopathy and abdominal aortic aneurysm screening) is fairly high and meets national targets.
- Amongst sexually transmitted diseases
    - the incidence of gonorrhoea has been increasing and antibiotic resistant strains of gonorrhoea are a concern
    - the proportion of late diagnoses of HIV (49% of all HIV diagnoses), while improving, remains a concern in Walsall
- Healthcare associated infection
- Pollution control
- Environmental health

Recommendations

Discipline	Recommendations for ongoing work
Health Emergency Planning	• Ongoing work to clarify roles and responsibilities for management of outbreaks.
TB	• Implementation of latent tuberculosis screening and treatment programme in Walsall,
Immunisation programme	• Promote flu vaccination in Walsall in 2016/17 with specific

	emphasis on high risk groups and children.
Cancer and non cancer screening	• Continue to work as a health economy to promote bowel screening uptake. • Continue to work as a health economy to improve understanding of poor uptake of cancer screening programmes within targeted populations in the Walsall Borough.
Sexual Health	• Continue to implement the Gonorrhoea Resistance Action Plan for England and Wales • Continue to incentivise HIV testing of all general practice admissions and all new registrants in primary care • Evaluate the success of expanded HIV testing.
Healthcare Associated Infections (HCAI)	• Continue to work as a health economy to tackle HCAI through surveillance, audit, education, policy and implementation of national guidance. • Support initiatives to ensure good antimicrobial stewardship and embed screening and management of multi drug resistant organisms in line with national guidance • Continue monitoring other organisms of concern such as E.coli, MSSA bacteraemias.
Pollution Control	• Consideration is given to the implementation of Low Emission Zone corridors to reduce traffic pollution on key roads, or the adoption of a designated Clean Air Zone (CAZ) in accordance with Defra guidance. • Following completion of West Midland LETCP Low Emissions Vehicle Strategy and the adoption of the Black Country Air Quality Supplementary Planning Document, Automatic Number Plate Recognition (ANPR) is installed on key road networks to inform data (vehicle fleet composition) related to air quality modelling and/or any LES or CAZ initiative. • Air Quality modelling across Walsall and neighbouring authorities is continued and updated annually. • The Walsall $PM_{2.5}$ health impact study is expanded to include the combined effects of $PM_{2.5}$ and NO_2. • Following completion of (annual) $PM_{2.5}$ monitoring, an annual borough-wide $PM_{2.5}$ model is produced that is systematically updated to inform health impact statistics. • Consideration is given to structuring a formal Black Country Air Quality Unit to facilitate on-going resources to undertake air quality modelling and health impact assessments.
Environmental Health and Trading Standards	• That Food Safety and Standards - implement inspection programmes that will provide the basic level of health protection for residents whilst also focussing diminishing resources on issues of local, regional and national priority. • To continue to work with Public Health to ensure the service

	uses its access to business and the local community to actively promote key Public Health messages, obesity, smoking cessation, alcohol etc. • To continue to ensure that the H&S programme of work meets national priorities but also identifies local areas of risk such as skin piercing and effective targeted interventions are undertaken to reduce risks for staff and consumers.

Introduction

The Health Protection Forum provides assurance to the Director of Public Health, Walsall Council and the Health and Wellbeing Board, that there are safe and effective arrangements and plans in place to protect the health of Walsall Residents.

The Health Protection Forum improves integration and partnership working on health protection issues between the Local Authority, NHS England, Public Health England and local Trusts and the CCG. The scope of health protection considered by the Forum includes: prevention and control of infectious diseases including TB, vaccination, screening, health-care associated infections, sexual health, health emergency planning and environmental hazards such as pollution. The terms of reference are attached in appendix 1.

The Forum meets quarterly and extraordinary meetings may be called as and when needed. The Forum is chaired by the Director of Public Health. The Walsall Health Protection Forum reports to the Health and Wellbeing Board on a six monthly basis. Concerns and risks are escalated through the Health and Wellbeing Board, Local Health Resilience Partnership, Senior Management team of Walsall Council, CCG or NHS England as appropriate.

The Walsall Health Protection Forum has been established for 3 years. The Forum is made up of the following organisations:

- NHS England/ Public Health England screening and immunisation team
- Public Health England Health Protection Unit
- CCG representative
- Health emergency planning
- Tuberculosis Lead
- Pollution Control
- Environmental Health
- Trading Standards
- Walsall Public Health:
    - Sexual Health Commissioner
    - Infection prevention and control commissioner
    - Public Health Consultants

The purpose of the Walsall Health Protection Forum is to:

- Facilitate a co-ordinated strategic approach to health protection issues in Walsall
- Provide an accountability framework for a number of existing partnership groups with a health protection remit and support the establishment of new groups where appropriate
- Receive assurance from the subgroups regarding:
    - Appropriate strategies/plans and testing arrangements
    - Progress against outcomes
    - Review all significant incidents/outbreaks to identify lessons learned and to make recommendations to commissioners/providers/partners regarding necessary changes

- Receive and review risk registers from all subgroups, make recommendations to subgroups regarding mitigating actions and to commissioners where appropriate
- Encourage continuous quality improvement in health protection services in Walsall
- Provide health protection input into the Joint Strategic Needs Assessment

The purpose of this document

This is the first annual report developed by the members of the forum and will provide a summary of developments that have taken place during 2015/16 and capture the recommendations from each organisation for 2016/17. This report will be in the public domain and will be presented to the Health and Wellbeing Board for their assurance and information.

Introduction

The recent NHS changes have led to many organisations being held responsible for specific parts of health protection. The following table demonstrates the complexities and interdependencies and how responsibilities are allocated and shared. The shading denotes responsibility. Dark shading indicates greater responsibility.

Figure 1: Health protection responsibility matrix

	Responsible Agency						
Health Protection issue	**PHE HPT**	**Walsall Public Health**	**CCG**	**NHS England**	**EH and trading standards**	**Pollution Control**	**Local NHS Trusts**
Communicable diseases							
Environmental hazards							
Immunisations							
Screening							
Tuberculosis							
Sexual health							
Environmental health and trading standards							
Pollution control							
Health emergency planning							
Infection control							

Health Emergency Planning and major incident response

Background

The Director of Public Health (DPH) has a statutory responsibility set within the Health and Social Care Act 2012 concerning Emergency Planning and Health Protection. These responsibilities are to lead and ensure on behalf of the Local Authority that any incident or emergency that affects the health of the community are planned against.

DPH through the Secretary of State has the responsibility to exercise by the authority of any of its functions that relate to planning for, or responding to, emergencies involving a risk to public health[1]

Current situation

- **Health Protection Forum (HPF) work plan 2016-2017** has been agreed outlining the work programme on key areas with outlined timeframes for Emergency Planning Resilience and Response (EPRR) work streams, underpinned by the Health and Social Care Act 2012, NHS England Core Standards and statutory responsibility under the Civil Contingencies Act (2004). Furthermore the work plan summarises the assurance and scrutiny process for the DPH within the HPF by identifying lead organisations on each work programme or areas.

- **HPF Risk Register** is updated and presented at each meeting to allow a deep dive into what current risks are in place that may impact on local capabilities or local population. The risk register ties into the work plan as action are identified to mitigate against each risk.

- **Exercise Pledge** (17th November 2015) was a regional workshop run by NHS England on behalf of the Local Health Resilience Partnership (LHRP) to exercise pandemic capabilities. Walsall took part in the exercise that included Directors of Public Health, Public Health, Social Care, Emergency Planning, Walsall CCG and Walsall Healthcare NHS Trust. A report was published in February 2016 that outlined a number of actions for the LHRP to consider and resulted in a local assurance request to each DPH.

- **Exercise Chadwick (20th April 2016)** was an exercise to test Walsall capabilities against a number of health protection incidents and outbreaks. Attendance at the exercise including all members of the HPF, including further attendance from social care and Walsall Council Emergency Planning Unit. The Walsall Outbreak plan was tested against this exercise and all findings with further action for HPF was captured within the post exercise report.

- **Exercise Kanagawa (9th September 2016)** was an exercise aimed to test local capabilities against pandemic influenza regional and national expectations. The exercise validated the Walsall Council pandemic plan and the actions previously outlined from Exercise Pledge. A post exercise report will be published following the exercise for HPF to sign-off. Identified gaps will be addressed.

- **Severe weather planning** has been updated annually to reflect the Cold Weather and Heatwave national plans in advising and protecting the most vulnerable people in society against severe weather, aligned to national guidance.

Recommendations

- Implement a training programme that has been outlined as part of the statutory responsibility of the council to ensure all essential staff have been trained against planning expectations. Training includes the following:
    - Loggist Training
    - On-call Training with key Public Health Staff

Risks

Clarification about which organisation pays for medication and staff time during large outbreaks remains an unresolved issue. A national decision has been requested.

Resignation of current Health Emergency Planner within Public Health/CCG

Public Health England Health Protection Team

Public Health England's role is to protect and improve the nation's health and wellbeing, and reduce health inequalities. PHE employs 5,000 staff mostly scientists, researchers and public health professionals. There are 8 local centres plus an integrated region and centre in London and 4 regions (north of England, south of England, Midlands and East of England and London). The West Midlands Centre has 3 Health Protection Teams based in Birmingham, Kidderminster and Stafford. At present Walsall's local health protection team is based in Kidderminster.

PHE are responsible for:

- Providing challenge and support to national bodies and organisations to make the public healthier
- Supporting the public so they can improve their own health
- Protecting the nation's health through the national health protection service
- Sharing information and expertise
- Researching and improve understanding of health and public health improvements
- Reporting on improvements in health - and informing on next steps
- Helping to develop the public health work force

The local Health Protection Team representative attends the health protection forum and reports back on incidents and outbreaks affecting Walsall residents. Joint exercises are held to help plan and prepare for emergency situations. The incidents and outbreaks that occurred in Walsall in 2015/16 can be found in Appendix 2

Recommendations

Continue close working as a health economy

Risks

Changes in organisational structure and ways of working as part of the PHE national strategy 'Securing Our future'; this proposes a single central Acute Desk based in Birmingham that will deal with all calls and notifications concerning infectious disease and environmental hazards and investigate and issue advice as appropriate on a daily basis.

There is reduced general practitioner support with regards to prophylaxis prescribing and infectious disease screening e.g. Hepatatis B contacts, meningococcal contacts, Scabies contacts especially in care homes following 2015 BMA letter around essential services in the GP Contract

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Recommendations

Continue close working as a health economy

Risks

Changes in organisational structure and ways of working

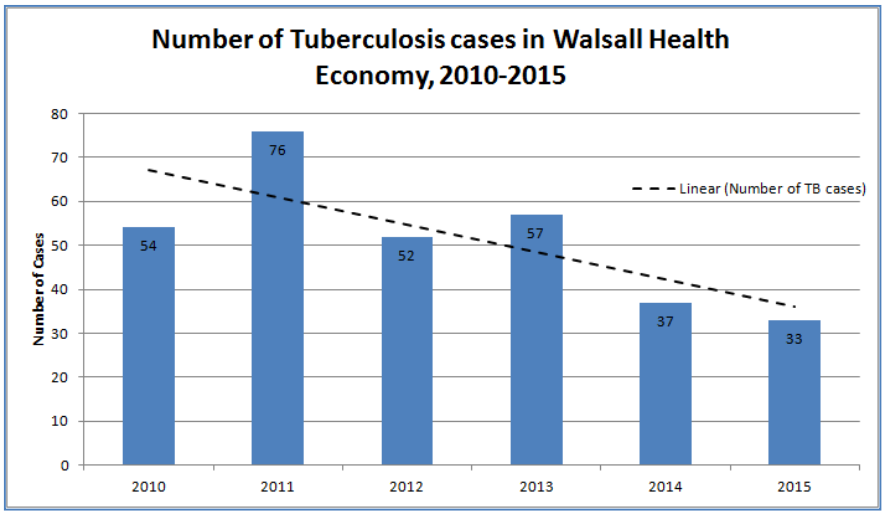
Reduced general practitioner support with regards to prophylaxis prescribing and infectious disease screening in care homes following BMA letter

Tuberculosis

Current situation

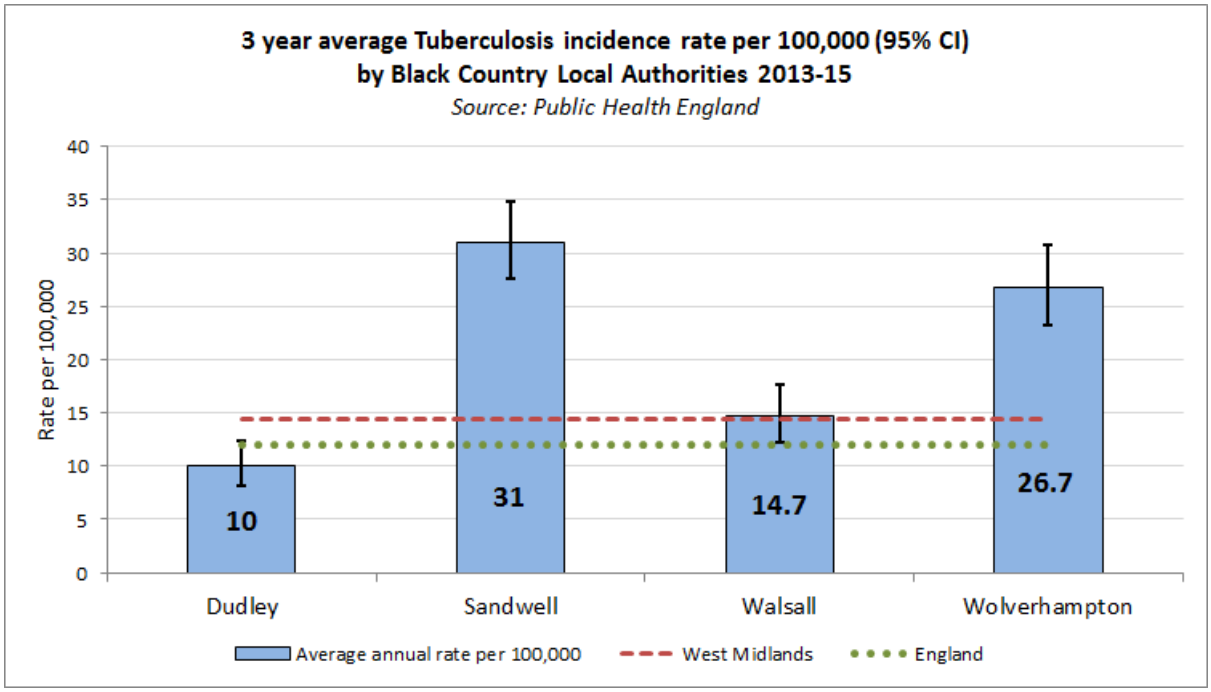
In 2015, Walsall health economy had 33 cases of TB which continued the downward trend that has been observed since 2011 (see Figure 2). However numbers have recently increased and it is possible that the number of cases could double in 2016.

Figure 2: Number of Tuberculosis cases in Walsall, 2010 - 2015



Source: Walsall Healthcare NHS Trust, TB team.

Figure 2a: Three year average rate of TB per 100,000



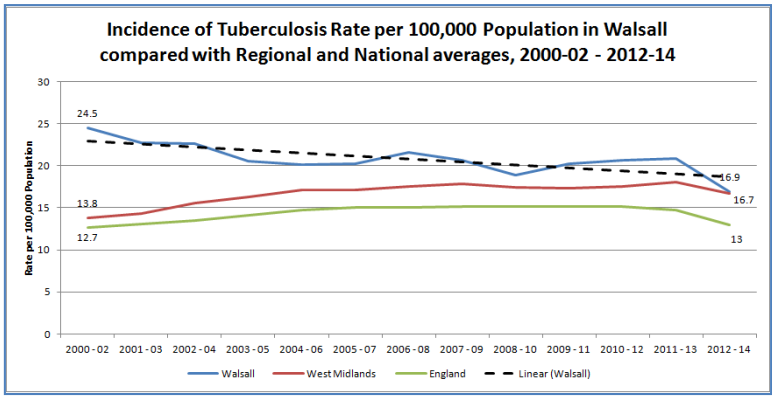
Source: Public Health England:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/555298/TB_Official_Statistics_2016_GTW2309.pdf

Number of new cases of Tuberculosis in Walsall

Based on three year averages between 2013 and 2015, the number of new cases per year in Walsall was 40. This gives a rate of 14.7 cases per 100,000 population which is similar to the incidence rate for the West Midlands (14.4 per 100,000). Comparing Walsall with its Black Country neighbours, Walsall is higher than Dudley, but not significantly so. However, Walsall's rate is statistically significantly lower than both Sandwell and Wolverhampton.

Figure 3 shows that since 2000-02 Walsall incidence rate has been above the regional and national averages, however in recent years Walsall incidence rate has reduced by 7.6 cases per 100,000 which has closed the gap on the regional average as well showing a downward trend. In contrast the regional average has shown slight increase and England average has stayed relatively stable with a increase of only 0.3 cases per 100,000. This suggests the incidence in Walsall is decreasing faster than the regional and national incidence rates.

Figure 3: Incidence Rate per 100,000



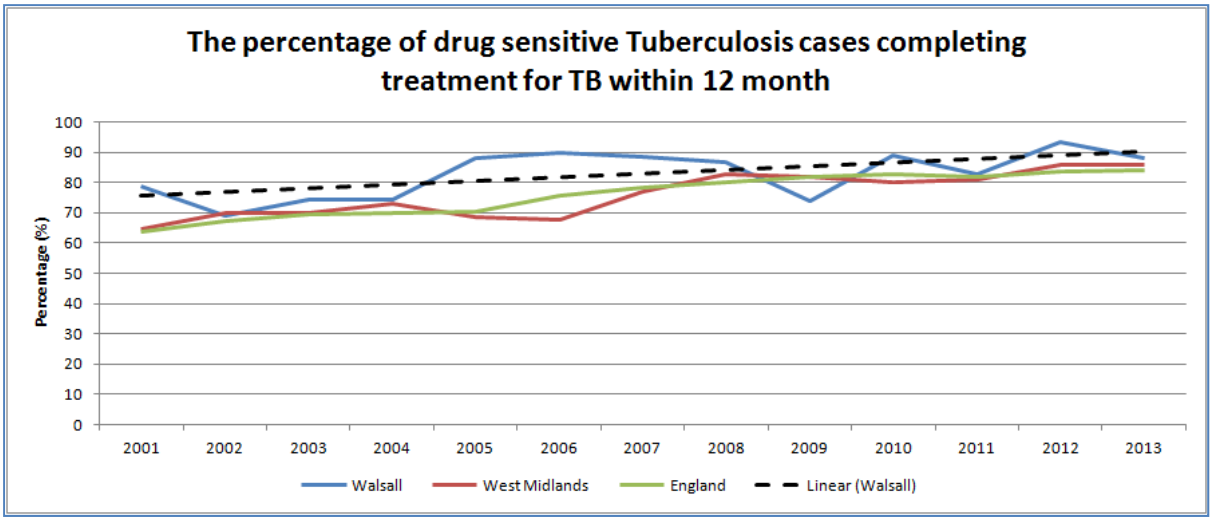
Source: Public Health England

However in Walsall the incidence is still higher than national average. 56% of all TB cases occurred in those born abroad in countries with a high TB burden (based on TB cases in 2014). There is also a strong association between TB and social deprivation. Walsall has a higher than average proportion of deprived residents particular in central and west of the borough.

Treatment completion

The percentage of treatment completion in Walsall has fluctuated over the years with a peak of 93.5% in 2012 which has seen local performance above the regional and national averages (Figure 3a)

Figure 3a: Percentage of treatment completion of active TB in Walsall, 2001-2013



Source: Public Health England

Neonatal BCG vaccination programme

BCG vaccine supply has been disrupted for the second year running. A waiting list of neonates born to high risk families was created and the Trust has run extra clinics to vaccinate the children when the vaccine became available. An RCA was undertaken as the Trust had stopped using vaccine which had run out of date despite a letter from the CMO saying that the vaccine should be used. This resulted in a large number of babies waiting for vaccine. This has now been rectified and lessons learned.

Prevention

In 2015 the Collaborative Tuberculosis Strategy for England was launched. This is a 5 year strategy and aims to achieve 10 key areas:

Table 1: Tuberculosis 5 year strategy 10 key areas

	Key area	WHT progress August 2016
1	Improve access to services and ensure early diagnosis	2 week waiting time being met
2	Provide universal access to high quality diagnostics	Access to full diagnostics is available
3	Improve treatment and care services	WHT achieves a very high treatment completion of nearly 100%
4	Ensure comprehensive contact tracing	The new enhanced caseload paper work is being used which facilitates very detailed contact tracing
5	Improve BCG vaccination uptake	BCG vaccine supplies continue to be disrupted. WHT create waiting lists and put on specific vaccination clinics when vaccine is available
6	Reduce drug resistance	There have been no reported cases of drug resistance in Walsall in the last 10 years. Care is taken to support patients in completing their treatment course through directly observed therapy.

7	Tackle TB in under-served populations	Further work is required in this area. A new TB nurse has been appointed and it planned that engagement will take place in faith centres and homeless venues to raise awareness
8	Systematically implement new entrant latent TB screening	This programme is under discussion at present
9	Strengthen surveillance and monitoring	There is an improved network across the West Midlands.
10	Ensure an appropriate workforce to deliver TB control	From October 2016 there will be 2 TB nurses in post at WHT. They have been without a second nurse for a while due to long term sickness and resignation

The TB Service at WHT will be reviewed during 2016/17.

The West Midlands TB Control Board has been established in the 2015/16. The Black Country TB Network now meets and provides opportunities for sharing good practice and developing initiatives on a larger footprint. Latent TB screening for new entrants has been delayed due to concerns about funding and future commitments.

Recommendations

Walsall Health Economy works with partners to embed the strategies and aims of the 5 year strategy

Develop a TB plan for Walsall in line with the National Strategy

Undertake a review of the WHT TB service

Risks

Concerns about Latent TB screening funding delaying introduction of the programme

Capacity in the TB service at Walsall Healthcare Trust

Disruption in BCG vaccine supplies for neonatal BCG vaccination and associated waiting lists and catch up programmes

Rising numbers of cases of TB in 2016

Immunisation and screening

Screening and Immunisation is part of the section 7A programmes which are commissioned by NHS England.

Seasonal Flu and Flu Vaccination

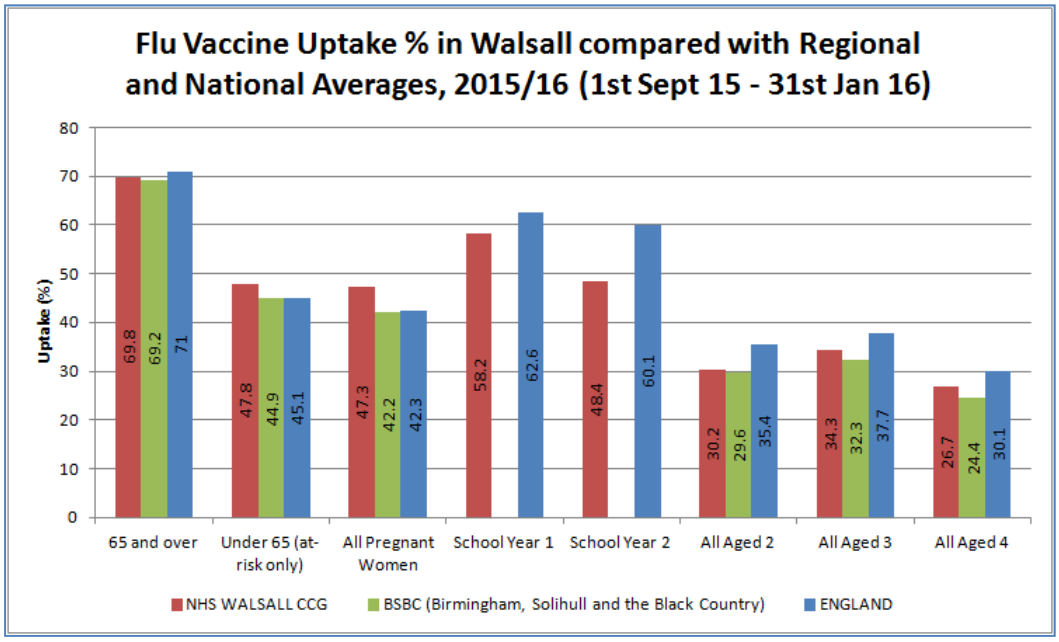
Current situation

The national data shows that the flu activity for 2015/16 peaked later than in previous years. Records show that it was more predominant in the 5-44 years old. H1NI (swine flu) was the main influenza A strain circulating this year and it was a component of the seasonal flu vaccine.

The 2015/16 influenza vaccine uptake rates can be seen at Figure 4. Within Walsall the group which has the highest uptake of flu vaccine is the over 65s (65.7%) which is above the regional average (64.9%) but lower than national average (66.9%) and below the national target of 75%. Walsall Clinical Commissioning Group (CCG) has higher uptake in Under 65's (at risk groups) and pregnant women groups than the regional and national averages in 2015/16.

Figure 4 shows Walsall CCG flu vaccination of two, three and four year olds remains above the regional averages but still below the national average and the target which is set at 40%.

Figure 4: Flu Vaccination Uptake, Jan-2016



Source: PHE

Planning for 2016/17 season is well underway. A joint communications plan has been developed through the Walsall Health Economy seasonal flu group.

Recommendations

The focus for 2016/17 is very much the at risk groups, pregnant women and pre-school children

Support Trust Midwives as they develop their programme to vaccinate pregnant women

Working with the Trust agree best ways to use the Flu Fairies this year

NHSE/PHE continue to support struggling practices

Risks

Practice nurse facilitator no longer in post to support and train general practice nurses

Health and social care staff do not take up the offer of vaccination

Vaccine Preventable Diseases

Current Situation

In Walsall, the child immunisation and vaccination programme has been successfully delivered above national target (95%) and has continued to perform better than regional and national averages.

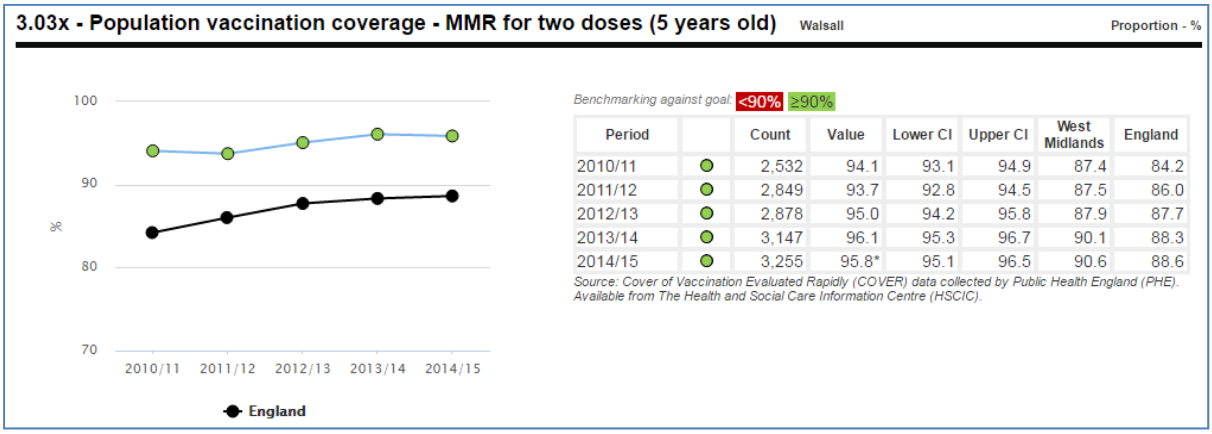
The latest data in quarter 4 2015/16 shows that all childhood vaccinations are above target except 5 Year MMR Dose 2 (94.4%) (See Figure 5).

Figure 5: Immunisation & Vaccination Programmes in Walsall, Q4 2015/16

Indicator Description	Period	Walsall	Target /Trajectory	Trend (high/low values highlighted)	Trend Period
12 Month Diphtheria/IPV/HIB	2015/16 Q4	97.5%	95%		2013/14 Q1 - 2015/16 Q4
12 Month Meningitis C	2015/16 Q4	98.7%	95%		2013/14 Q1 - 2015/16 Q4
12 Month PCV 13	2015/16 Q4	97.0%	95%		2013/14 Q1 - 2015/16 Q4
24 Month Diphtheria/IPV/HIB	2015/16 Q4	98.7%	95%		2013/14 Q1 - 2015/16 Q4
24 Month Meningitis C/HIB (Booster)	2015/16 Q4	98.2%	95%		2013/14 Q1 - 2015/16 Q4
24 Month MMR	2015/16 Q4	98.1%	95%		2013/14 Q1 - 2015/16 Q4
24 Month PCV 13 Booster	2015/16 Q4	98.2%	95%		2013/14 Q1 - 2015/16 Q4
5 Year Diphtheria/Tetanus/Polio	2015/16 Q4	99.2%	95%		2013/14 Q1 - 2015/16 Q4
5 Year Diphtheria/IPV Booster	2015/16 Q4	95.4%	95%		2013/14 Q1 - 2015/16 Q4
5 Year Meningitis C/HIB (Booster)	2015/16 Q4	95.6%	95%		2013/14 Q1 - 2015/16 Q4
5 Year MMR Dose 1	2015/16 Q4	99.1%	95%		2013/14 Q1 - 2015/16 Q4
5 Year MMR Dose 2	2015/16 Q4	94.4%	95%		2013/14 Q1 - 2015/16 Q4

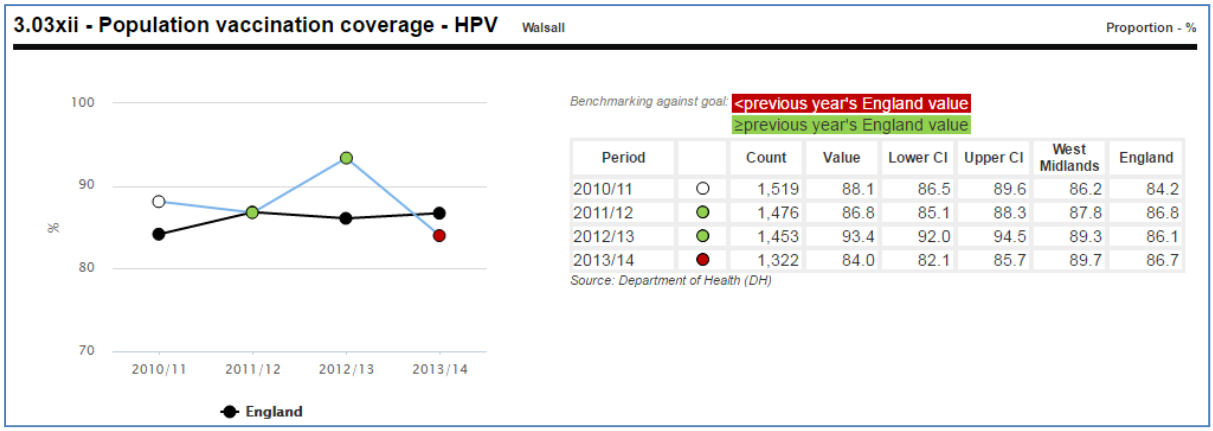
Source: Public Health Protection Forum Dashboard

Figure 6: MMR for two doses (5 years old), 2010/11 - 2014/15



Source: PHOF

Figure 7: HPV vaccination coverage (3 doses, females 12-13 years old) in Walsall, 2010/11 - 2014/15



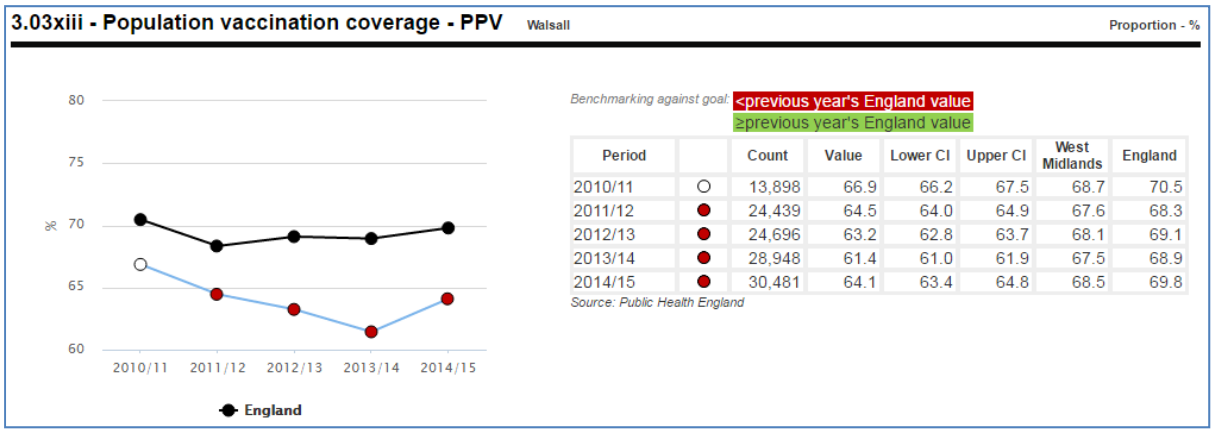
Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2010/11	○	1,519	88.1	86.5	89.6	86.2	84.2
2011/12	●	1,476	86.8	85.1	88.3	87.8	86.8
2012/13	●	1,453	93.4	92.0	94.5	89.3	86.1
2013/14	●	1,322	84.0	82.1	85.7	89.7	86.7

Source: Department of Health (DH)

Source: PHOF

New providers commissioned for the 2015/16 programme and are providing catch up sessions for the 2014/15 cohort.

Figure 8: Pneumococcal Polysaccharide Vaccine Uptake, 2010/11 - 2014/15



Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2010/11	○	13,898	66.9	66.2	67.5	68.7	70.5
2011/12	●	24,439	64.5	64.0	64.9	67.6	68.3
2012/13	●	24,696	63.2	62.8	63.7	68.1	69.1
2013/14	●	28,948	61.4	61.0	61.9	67.5	68.9
2014/15	●	30,481	64.1	63.4	64.8	68.5	69.8

Source: Public Health England

Source: PHOF

The PPV vaccination coverage in Walsall in 2014/15 was 64.1%, significantly lower than the West Midlands and England. Walsall saw an increase in coverage in 2014/15 from 2013/14, which mirrors the increase seen regional and national in 2014/15 (Figure 8).

Recommendations

Undertake joint working to increase PPV and HPV uptake

Review specialist immunisation and vaccine training and support to General Practice staff

Risks

Waiting lists for primary immunisations

General practice workforce not receiving immunisation updates and annual training

Screening Programmes

Current Situation

Figure 9: Screening Programmes in Walsall

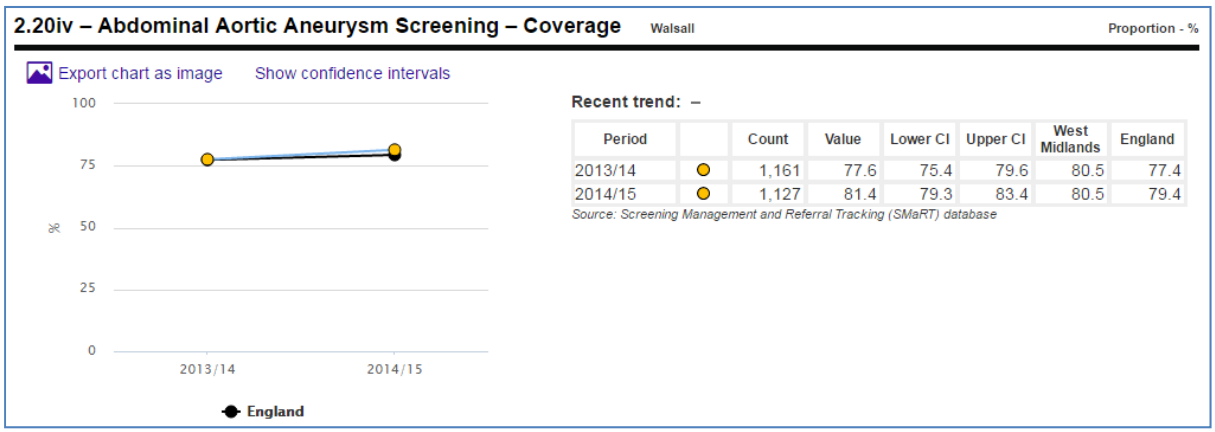
Indicator	Indicator Description	Period	Walsall	Target /Trajectory	Trend (high/low values highlighted)	Trend Period	Source
36	**AAA screening:** Number of men eligible for AAA screening who have been screened (65 years)	2015/16 Q4	76.8%	75%		2014/15 Q2 - 2015/16 Q4	WCCG
37	**Bowel Screening** Uptake % (60 to 74 yrs)	Feb-16	50.2%	60%		01/03/2015 - 01/02/2016	OE
38	**Bowel Screening** 2.5 Year Coverage % (60 to 74 yrs)	Feb-16	53.6%	60%		01/03/2015 - 01/02/2016	OE
39	**Bowel screening:** Proportion of those who have returned a FOBt kit, out of those invited (no adjustment made for undelivered kits and letters)	2015/16 Q4	49.0%	52%		2013/14 Q2 - 2015/16 Q4	WCCG
40	**Bowel screening:** FOBt positivity	2015/16 Q2	1.86%	<2%		2013/14 Q1 - 2015/16 Q2	WCCG
41	**Breast Screening** for 50 to 70 Year Olds Uptake %	Feb-16	72.6%	70%		01/03/2015 - 01/02/2016	OE
42	**Breast Screening** for 50 to 70 Year Olds 36 Month Coverage %	Feb-16	71.3%	70%		01/03/2015 - 01/02/2016	OE
43	**Breast Screening:** The percentage of eligible women aged 50-70 years who attended screening following invitation	2015/16 Q3	66.4%	70%		2015/16 Q1 - 2015/16 Q3	CSWBSP
44	**Cervical Screening** 3.5/5.5-year coverage % (25 to 64 Yrs)	Feb-16	71.7%	80%		01/03/2015 - 01/02/2016	OE
45	**Cervical screening:** Proportion of eligible women screened within 5 years of their previous screen (coverage)	2015/16 Q3	76.10%	80%		2013/14 Q4 - 2015/16 Q3	PC
46	**Diabetic Eye screening:** The proportion of those invited to diabetic retinopathy screening by digital photography who have a digital screening outcome (Diabetics aged 12 or over).	2015/16 Q3	80.6%	70%		2014/15 Q1 - 2015/16 Q3	WPCT

Source: Walsall Public Health Protection Dashboard

Abdominal Aortic Aneurysm (AAA)

Figure 10 shows the percentage of men eligible for AAA whom an initial offer of screening was made. The AAA screening rates in Walsall are above regional averages and significantly above national averages, however there has been a very small reduction in 2014/15 from 2013/14.

Figure 10: Abdominal Aortic Aneurysm (AAA) Screening offer in Walsall, 2013/14 - 2014/15



Source: PHOF

Following last year's local review on AAA uptake which found in general there is lower uptake in deprived areas where there is a higher incidence of aneurysm detection, a CQUIN has been offered to the AAA provider to improve access and uptake through patient engagement. The programme will run for two years (2016/17 and 2017/18).

Recommendation

The local authority Public Health team work with the provider and other stakeholders on the CQUIN to improve understanding of poor uptake within targeted populations in the Walsall Borough.

Bowel Screening

Figure 11 shows the percentage of residents in the population eligible for bowel screening who screened adequately within the last 2 ½ years. The bowel screening uptake between April 2014 and March 2015 was lower in Walsall (54.4%) than the regional (57.3%) and national averages (57.1%) and below the 70% target.

Figure 11: Bowel Cancer Screening Programme in Walsall, 2014/15

2.20iii - Cancer screening coverage - bowel cancer 2015 Proportion - %

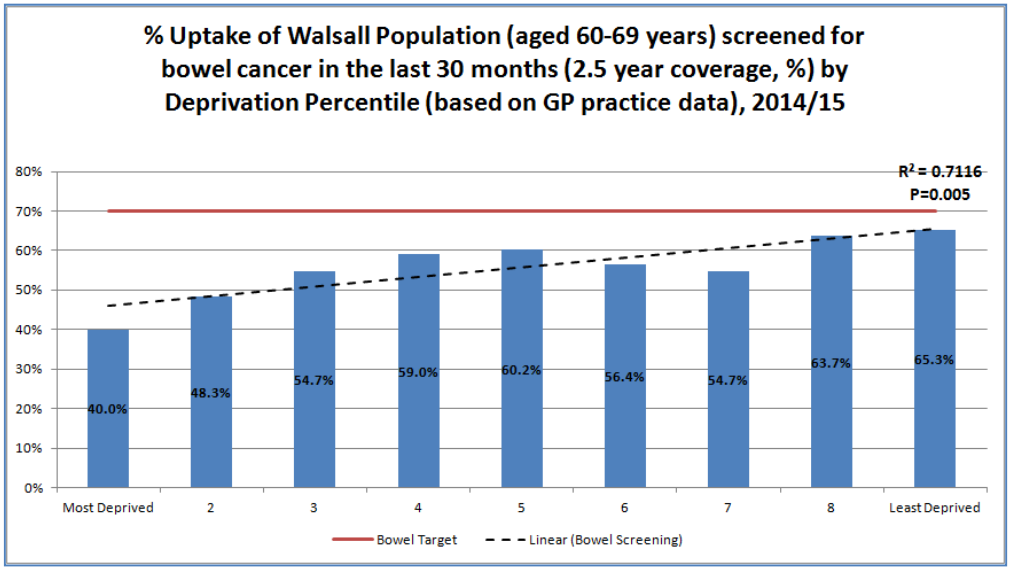
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	4,406,923	57.1	57.1	57.1
West Midlands region	–	479,641	57.3	57.2	57.4
Birmingham	–	58,713	48.7	48.4	49.0
Coventry	–	23,019	57.9	57.4	58.4
Dudley	–	29,512	59.1	58.7	59.6
Herefordshire	–	21,446	62.8	62.3	63.3
Sandwell	–	19,656	49.6	49.1	50.1
Shropshire	–	33,189	58.4	57.9	58.8
Solihull	–	20,662	61.2	60.7	61.8
Staffordshire	–	86,028	60.0	59.7	60.2
Stoke-on-Trent	–	18,182	51.0	50.5	51.6
Telford and Wrekin	–	13,526	53.9	53.3	54.5
Walsall	–	20,515	54.4	53.9	54.9
Warwickshire	–	55,708	63.1	62.7	63.4
Wolverhampton	–	17,498	52.9	52.4	53.5
Worcestershire	–	61,987	62.4	62.1	62.7

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Source: PHOF

Figure 12 shows that the bowel screening uptake in Walsall is significantly lower in most deprived percentile (40%) compared with least deprived (65.3%) which represents a difference of -25.3%.

Figure 12: Bowel Cancer Screening by Deprivation Percentile, 2014/15



Source: GP Practice Profiles

Note about figure 13 : Using bowel screening eligible cohort and those undertaken screening for each Walsall GP practice and the associated deprivation percentile for practice was used to calculate the percentage uptake per deprivation percentile for Walsall.

- A new test (Faecal Immunochemical Test) will replace guaiac Faecal Occult Blood test in the near future. Timescales for rollout are yet to be agreed.
- A Commissioning for Quality and Innovation (CQUIN) has been agreed to improve access and increase uptake in the Black Country. A bowel screening group has been convened to focus and target interventions to improve uptake.
- Uptake improvement strategy meetings are being attended by the Walsall Macmillan Cancer Lead, the Screening and Immunisation Team (SIT), Cancer Research UK and the provider team. The Bowel Screening HUB which is also commissioned by the Screening and Immunisation Team is working with GP practices to encourage endorsement of the programme.
- A campaign to increase uptake in Walsall, led by the Walsall MacMillan Cancer Lead, is also underway with participating surgeries contacting their patients to encourage them to take the test.
- Bowel Scope Screening has been rolled out across Walsall. This involves an examination called flexible Sigmoidoscopy which looks inside the lower bowel to find polyps which may develop into bowel cancer. This is a single screen offered at age 55yrs. Early indications show that the uptake of this programme is poor with most areas not exceeding 40% uptake.

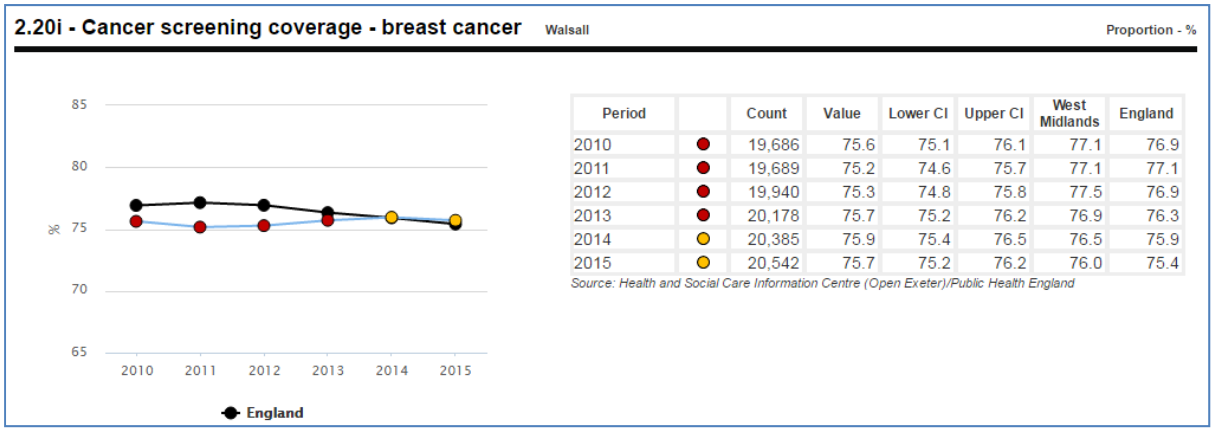
Recommendation

The local authority Public Health department continue to work with all stakeholders to promote both traditional bowel Screening and Bowel Scope Screening.

Breast Cancer

Figure 13 shows the percentage of residents in the population eligible for breast screening who screened adequately within the last 5 years. In Walsall as in the West Midlands this reduced slightly in 2015 (75.2%) when compared to 2014 (76.5%), however still is above the national level (75.4%).

Figure 13: Breast Cancer Screening Programme in Walsall, 2010-2015



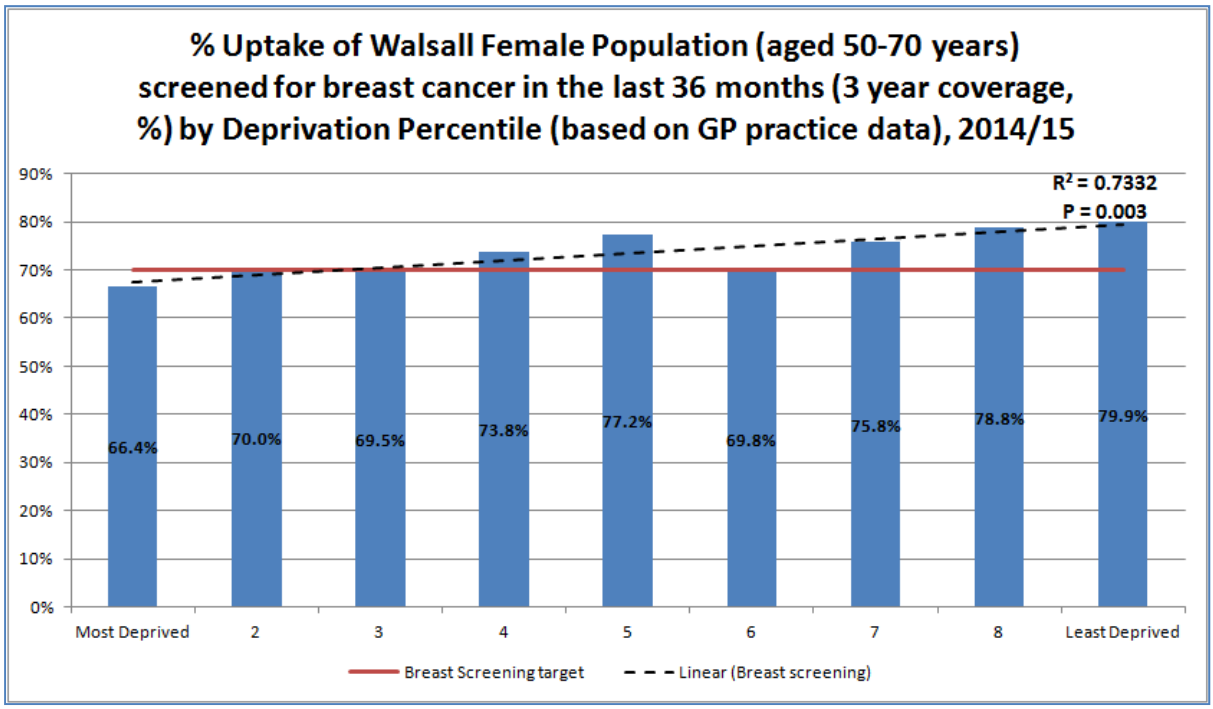
Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2010		19,686	75.6	75.1	76.1	77.1	76.9
2011		19,689	75.2	74.6	75.7	77.1	77.1
2012		19,940	75.3	74.8	75.8	77.5	76.9
2013		20,178	75.7	75.2	76.2	76.9	76.3
2014		20,385	75.9	75.4	76.5	76.5	75.9
2015		20,542	75.7	75.2	76.2	76.0	75.4

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Source: PHOF

Figure 14 shows that the breast screening uptake in Walsall is significantly lower in most deprived percentile (66.4%) compared with least deprived (79.9%) which represents a difference of -13.5.

Figure 14: Breast Cancer Screening by Deprivation Percentile, 2014/15



Source: GP Practice Profiles

Note about Figure 15: Using breast screening eligible cohort and those undertaken screening for each Walsall GP practice and the associated deprivation percentile for practice was used to calculate the percentage uptake per deprivation percentile for Walsall.

- The Screening & Immunisation Team monitor the performance of the Walsall Breast Screening Programme. Uptake of Breast Screening varies as it goes through the 3 year round dependant on which area is being screened. Walsall is reported as being higher than the service uptake as a whole with Birmingham and Sandwell uptake being lower. There is nonetheless variation in uptake in Walsall. There is a CQUIN (Commissioning for Quality and Innovation) agreement with the service that has had successes in working with GP's in areas of poor uptake to address particular issues.
- A new provider of High Risk Breast Screening has been commissioned. The programme will be delivered in accordance with NICE and NHS Breast Screening Programme guidance, offering women at high risk of breast cancer annual MRI and/or Mammography depending on their genetic condition and age.
- During 2016/17 the Screening and Immunisation Team will undertake a strategic review of the provision of Breast Screening across NHS England West Midlands. The review will include all aspects of the current service and benchmarking to ensure that the service is right for the future.

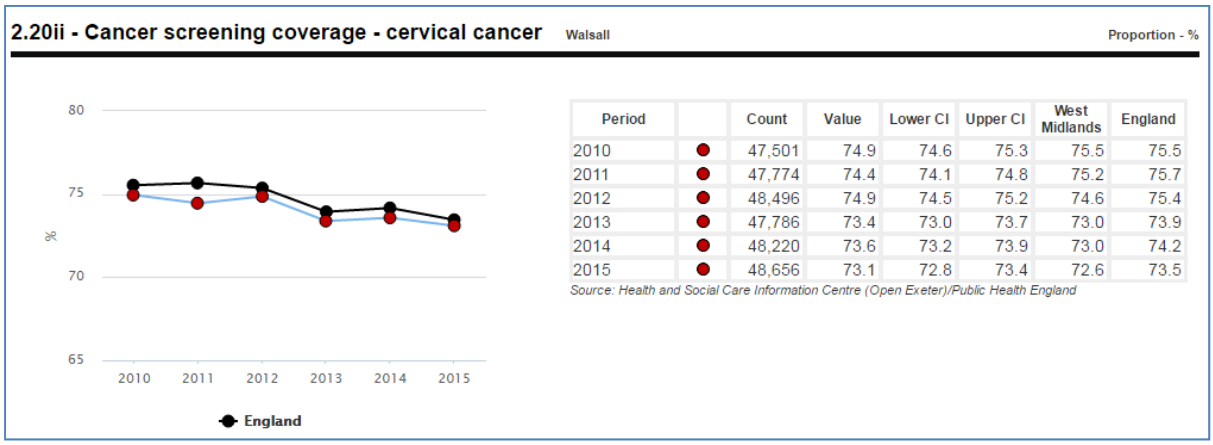
Recommendation

The Local Authority Public Health team work with the provider and other stakeholders to further target areas of poor uptake within the Walsall Borough.

Cervical Screening

Figure 15 shows the percentage of women in the resident population for cervical screening who were screened adequately in the last 3.5 year (women aged 25-49) and 5.5 years (50-64) on 31st March. The screening rates have been reducing slightly year on year by -1.6% over the last 5 years which mirrors the trend seen at regional (-2.9%) and national averages (-2%) but to smaller degree locally.

Figure 15: Proportion of Women for Cervical Screening with 3.5 years or 5.5 years



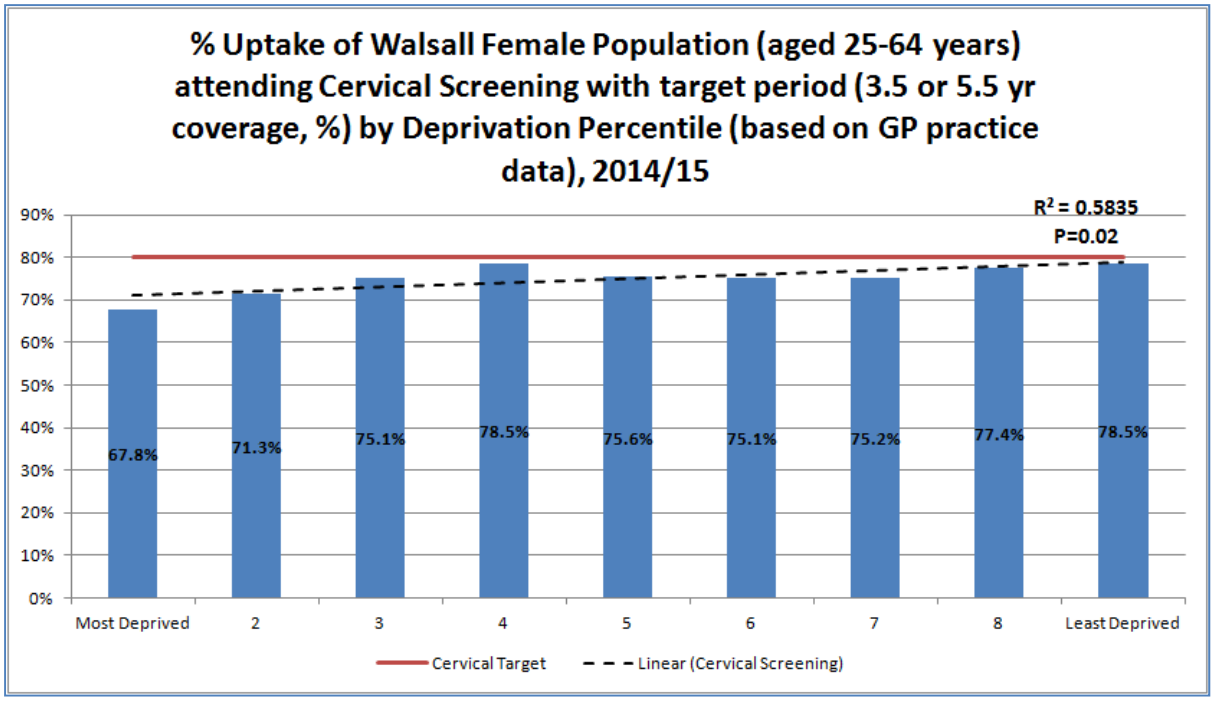
Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2010		47,501	74.9	74.6	75.3	75.5	75.5
2011		47,774	74.4	74.1	74.8	75.2	75.7
2012		48,496	74.9	74.5	75.2	74.6	75.4
2013		47,786	73.4	73.0	73.7	73.0	73.9
2014		48,220	73.6	73.2	73.9	73.0	74.2
2015		48,656	73.1	72.8	73.4	72.6	73.5

Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Source: PHOF

Figure 16 shows that the cervical screening uptake in Walsall is lower in most deprived percentile (67.8%) compared with least deprived (78.5%) which represents a difference of -10.7%.

Figure 16: Cervical Cancer Screening by Deprivation Percentile, 2014/15



Source: GP Practice Profile

- Cervical Screening Coverage is declining in line with the national trend. Improving uptake through primary care is a strategic priority for NHS England West Midlands in 2016/17.
- The Walsall outreach nurse funded by NHS England continues working with low uptake practices, vulnerable groups and housebound patients in the area. Uptake of Cervical Screening in Walsall has remained consistent compared to the regional & national downturn.
- Targeted interventions by the laboratory at Royal Wolverhampton Trust and the Screening and Immunisation Team have led to women now receiving the result of their tests in a timely manner.
- The UK Cervical Cancer Screening Programme has announced that testing for Human Papillomavirus (HPV) as the primary screening test should be adopted. Timescales are yet to be set and the pilots are continuing.

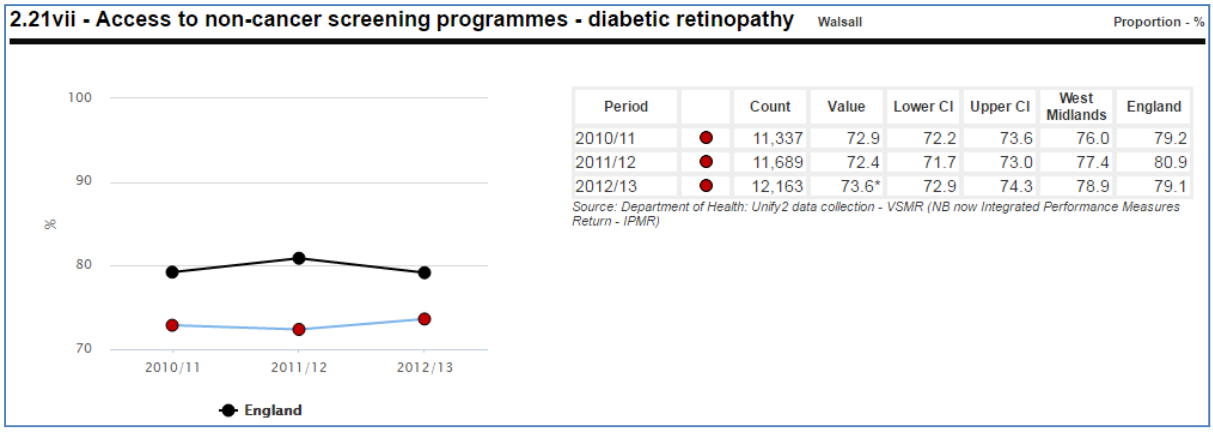
Recommendation

The local Authority Public Health Department offers support to the Screening Outreach Service to enable it to address health inequalities across the borough.

Diabetic Retinopathy Screening

Figure 17 shows the percentage of patients offered screening who attended a digital screening encounter during the reporting period.

Figure 17: Proportion of patients offered screening who attended a digital screening, 2010/11 -2012/13



Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2010/11		11,337	72.9	72.2	73.6	76.0	79.2
2011/12		11,689	72.4	71.7	73.0	77.4	80.9
2012/13		12,163	73.6*	72.9	74.3	78.9	79.1

Source: Department of Health: Unify2 data collection - VSMR (NB now Integrated Performance Measures Return - IPMR)

Source: PHOF

- The screening programme provided by Heart of England Foundation Trust (HEFT) underwent a Quality Assurance visit from the National Team on the 8th March 2016. The visit was a success with only minor recommendations made for improvements and these will be monitored through the Screening Programme Board. The Screening and Immunisation Team have been working closely with the providers and The Walsall CCG Diabetes Group to better understand variation in uptake and to improve access.
- The new Diabetic Eye Screening Programme (DESP) indicator Quality 1 has been introduced to reflect the continued work on offering diabetic retinopathy screening to all pregnant women with pre-existing diabetes. Following the work with Manor Hospital Maternity Unit the uptake has steadily increased.

Recommendation

DESP providers have an uptake improvement strategy in place; it would be useful for the Local Authority to continue to work with the CCG Diabetes Group to assist in this programme.

Risks

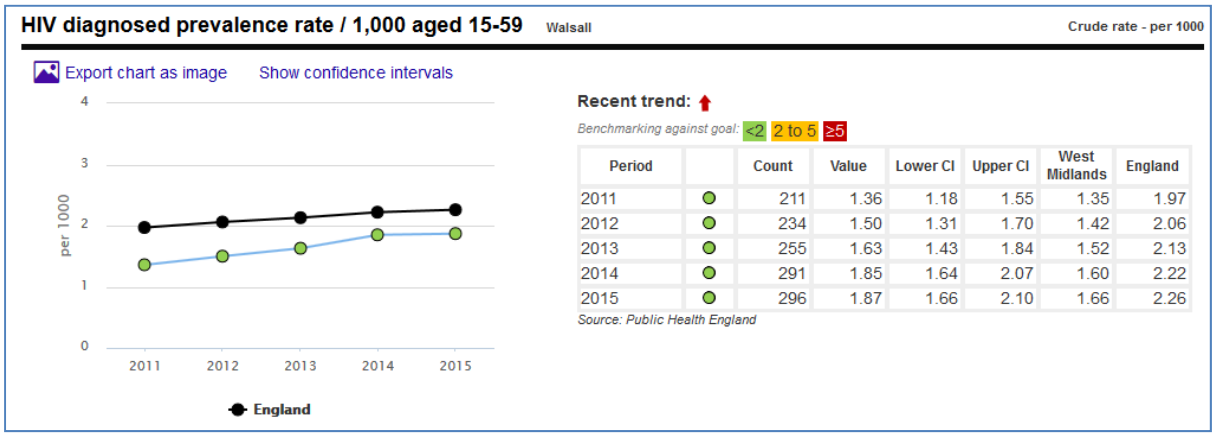
The CCG Diabetes Task and Finish Group has been disbanded since April 2016 due to changes in the CCG structure

Sexually Transmitted Disease

HIV

In Walsall the prevalence of diagnosed HIV cases (aged 15-59) has been increasing every year since 2011, this mirrors the West Midlands and National trend.

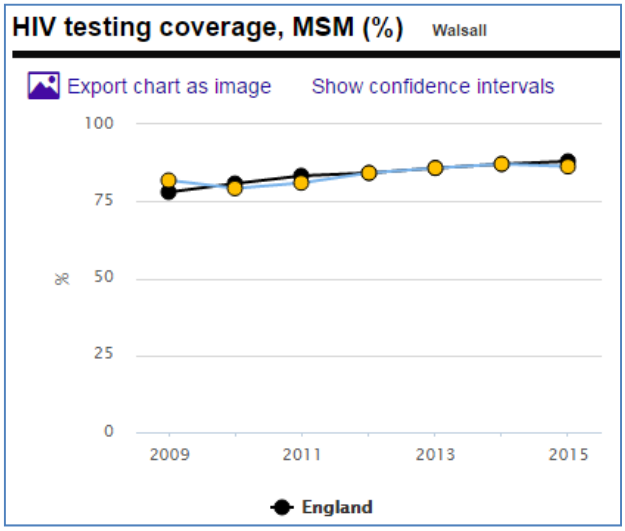
Figure 18: HIV diagnosed prevalence rate per 1,000 (aged 15-59) in Walsall. 2011 - 2015



Source: PHOF

Public Health England recommends that local authorities with a high prevalence of HIV (over 2 diagnosed per 1,000 residents) strengthen their provision of HIV testing services via the implementation of routine HIV testing for all general practice medical admissions and for all new registrants in primary care. This initiative is incentivised by Walsall Public Health.

Figure 19: HIV testing coverage, MSM in Walsall, 2009-2015



Source: PHOF

In 2014, for cases in men where sexual orientation was known, 12.0% of new STIs in Walsall were among men who have sex with men (MSM).

Figure 20: HIV testing uptake, men (2009-2015)

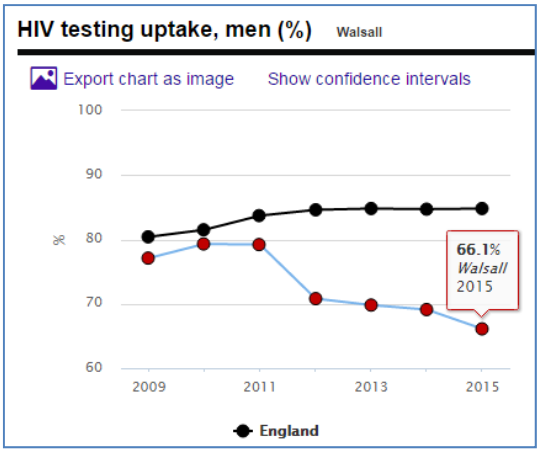
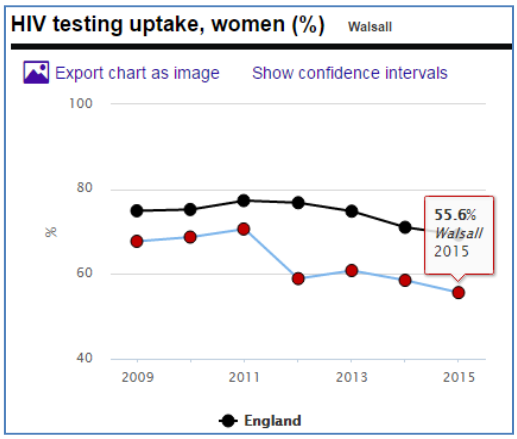


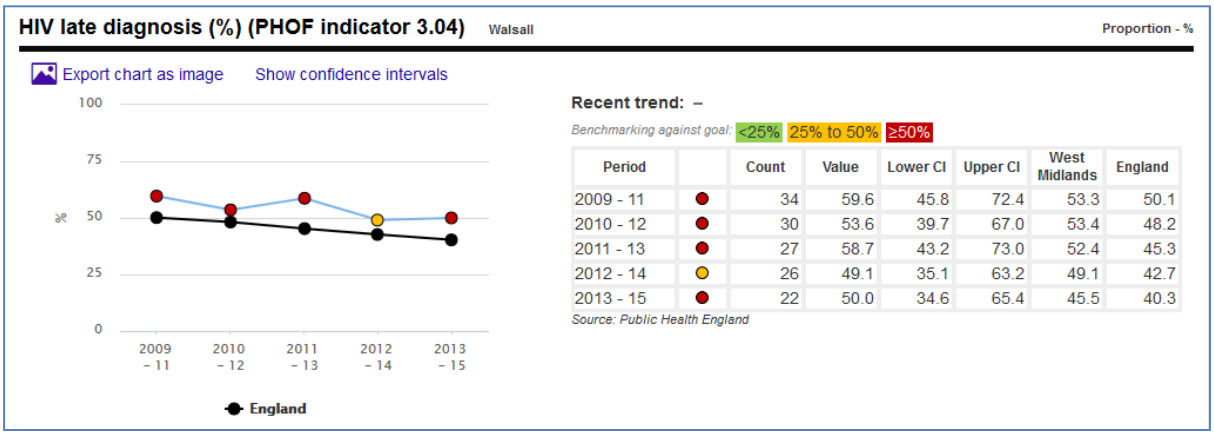
Figure 21: HIV testing uptake, women (2009-2015)



Source: PHOF

In 2015, 69% of women and 84% of men in England attending GUM clinics for a new episode of care accepted a HIV test. In 2015 55% of women and 66 % of men in Walsall attending their local GUM clinic accepted a HIV test. This represents one of the lowest achievements actually tested across the West Midlands.

Figure 22: HIV late diagnosis in Walsall, 2009/11 - 2013/15



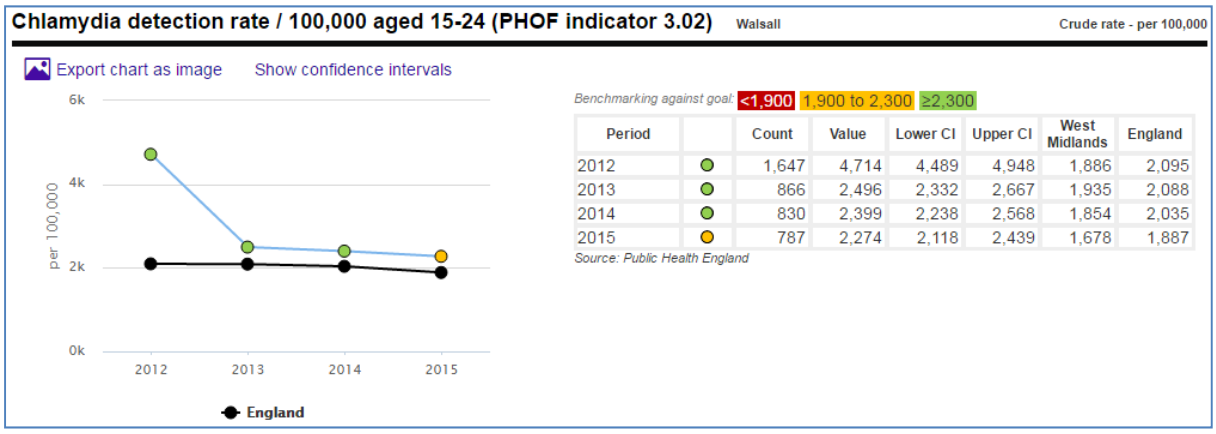
Source: PHOF

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. It is a critical component of the Public Health Outcomes Framework and monitoring is essential to evaluate the success of expanded HIV testing.

In Walsall, between 2012 and 2014, 49% (95% CI 35 -63) of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm³ within 3 months of diagnosis) compared to 42% (95% CI 44-46) in England. 36% (95% CI 13-65) of men who have sex with men (MSM) and 68% (95% CI 49-83) of heterosexuals were diagnosed late.

Chlamydia Screening

Figure 23: Chlamydia detection rate per 100,000 (aged 15-24) in Walsall, 2012 - 2015



Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2012		1,647	4,714	4,489	4,948	1,886	2,095
2013		866	2,496	2,332	2,667	1,935	2,088
2014		830	2,399	2,238	2,568	1,854	2,035
2015		787	2,274	2,118	2,439	1,678	1,887

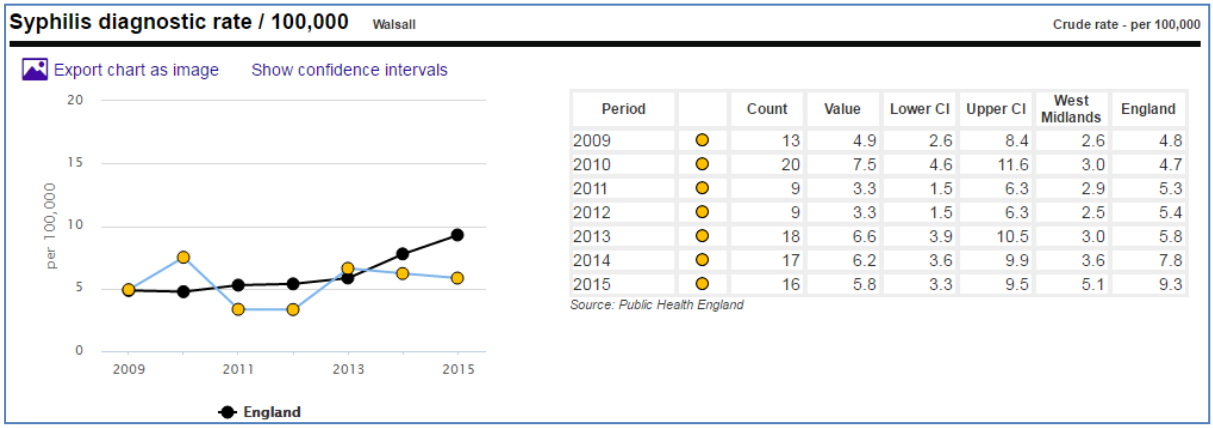
Source: Public Health England

Source: PHOF

Public Health England recommends that local areas should be working towards achieving a Chlamydia diagnostic rate of at least 2,300 per 100,000 population aged 15-24 year. In 2015 no upper tier local authority in the West Midlands achieved the recommended rate, although Walsall achieved the highest diagnostic rate for the region fell just short. The sudden drop from 2012 to 2013 reflects changes in screening strategy using a more targeted approach (see Figure 23).

Syphilis

Figure 24: Syphilis diagnostic rate per 100,000 in Walsall, 2009 - 2015



Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2009		13	4.9	2.6	8.4	2.6	4.8
2010		20	7.5	4.6	11.6	3.0	4.7
2011		9	3.3	1.5	6.3	2.9	5.3
2012		9	3.3	1.5	6.3	2.5	5.4
2013		18	6.6	3.9	10.5	3.0	5.8
2014		17	6.2	3.6	9.9	3.6	7.8
2015		16	5.8	3.3	9.5	5.1	9.3

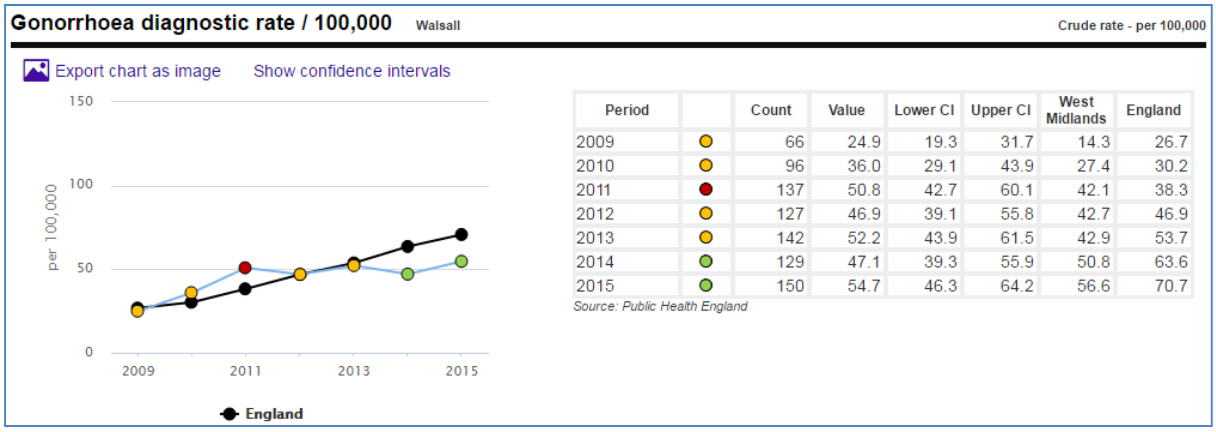
Source: Public Health England

Source: PHOF

In England diagnosis rates increased rapidly from very low levels in 2000 to a peak in 2005-2006, before falling sharply until 2012 (see Figure 24). Disappointingly, rates have increased in each of the last three years. However in 2015 Walsall has seen rates stabilise. The peak in 2010 was caused by a local outbreak involving street workers, taxi drivers and men who have sex with men.

Gonorrhoea

Figure 25: Gonorrhoea diagnostic rate per 100,000 in Walsall, 2009 - 2015



Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2009		66	24.9	19.3	31.7	14.3	26.7
2010		96	36.0	29.1	43.9	27.4	30.2
2011		137	50.8	42.7	60.1	42.1	38.3
2012		127	46.9	39.1	55.8	42.7	46.9
2013		142	52.2	43.9	61.5	42.9	53.7
2014		129	47.1	39.3	55.9	50.8	63.6
2015		150	54.7	46.3	64.2	56.6	70.7

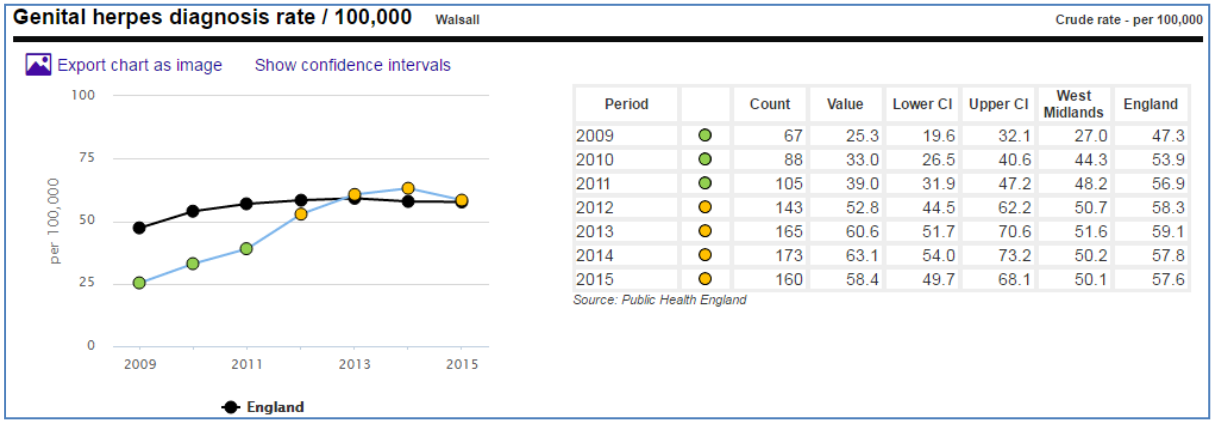
Source: Public Health England

Source: PHOF

The gonorrhoea diagnosis rate increased for the second year running in 2015, reaching the highest level ever recorded since surveillance began in 1996 (see Figure 26).
Reducing gonorrhoea transmission, and ensuring treatment resistant strains of gonorrhoea do not persist and spread remains a public health priority. The Gonorrhoea Resistance Action Plan for England and Wales (April 2013) makes recommendations on ensuring prompt diagnosis, contact tracing, prescribing guideline adherence, identifying and managing potential treatment failures effectively, and reducing transmission. In Walsall testing has changed to a urine test in response to this action plan.

Genital Herpes

Figure 26: Genital herpes diagnosis rate per 100,000 in Walsall, 2009 - 2015



Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2009		67	25.3	19.6	32.1	27.0	47.3
2010		88	33.0	26.5	40.6	44.3	53.9
2011		105	39.0	31.9	47.2	48.2	56.9
2012		143	52.8	44.5	62.2	50.7	58.3
2013		165	60.6	51.7	70.6	51.6	59.1
2014		173	63.1	54.0	73.2	50.2	57.8
2015		160	58.4	49.7	68.1	50.1	57.6

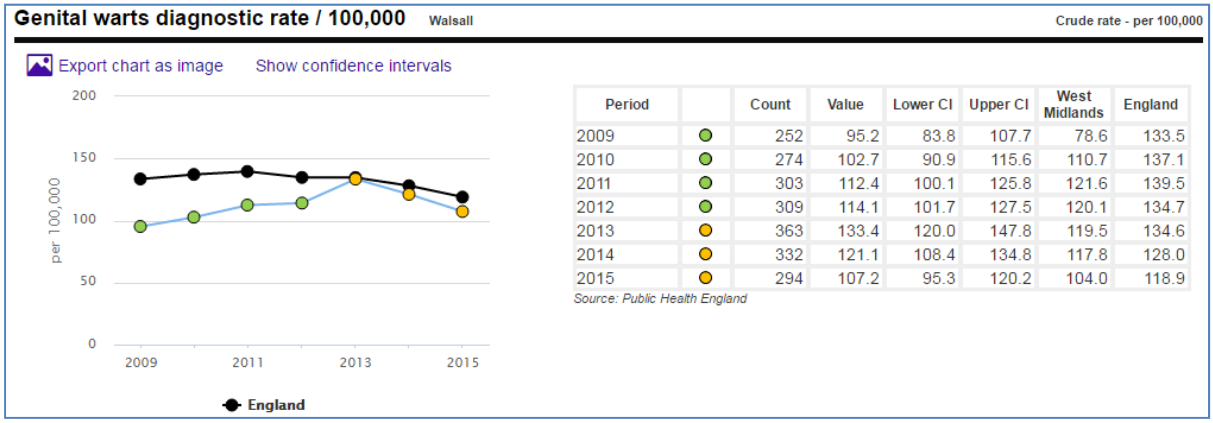
Source: Public Health England

Source: PHOF

In 2015 the rate of new STI diagnoses amongst residents of Walsall was above the national rate for England (see Figure 26)

Genital Warts

Figure 27: Genital warts diagnostic rate per 100,000 in Walsall, 2009 - 2015



Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2009		252	95.2	83.8	107.7	78.6	133.5
2010		274	102.7	90.9	115.6	110.7	137.1
2011		303	112.4	100.1	125.8	121.6	139.5
2012		309	114.1	101.7	127.5	120.1	134.7
2013		363	133.4	120.0	147.8	119.5	134.6
2014		332	121.1	108.4	134.8	117.8	128.0
2015		294	107.2	95.3	120.2	104.0	118.9

Source: Public Health England

Source: PHOF

Diagnosis rates of ano-genital warts have declined each year since 2010 but were still 25% higher in 2015 than in 1996 (see Figure 27).

Recommendations

Continue to implement the Gonorrhoea Resistance Action Plan for England and Wales
Continue to incentivise HIV testing of all general practice admissions and all new registrants in primary care
Evaluate the success of expanded HIV testing

Risks

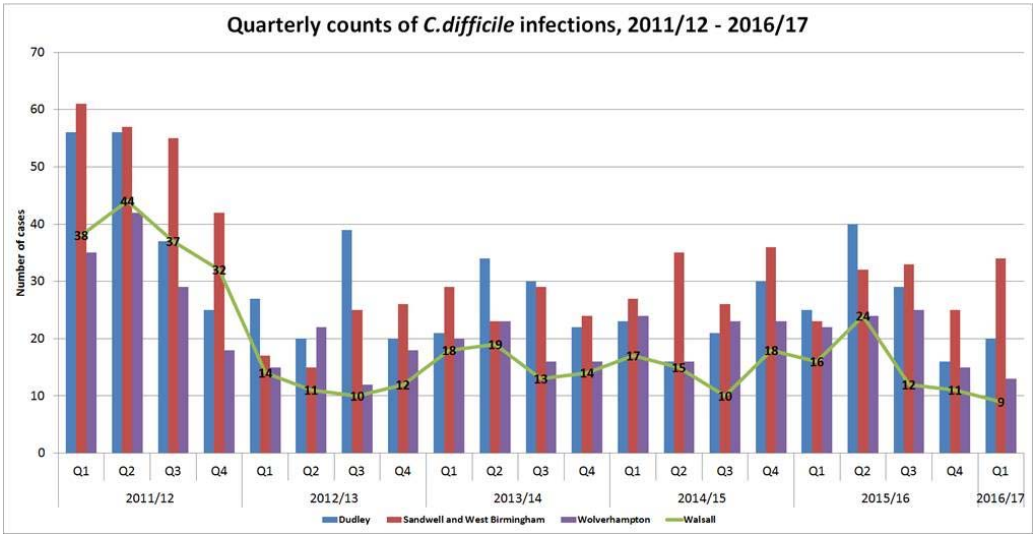
Increasing resistance to antibiotics in some sexually transmitted organisms such as Azithromycin resistant gonorrhoea
Late diagnosis of HIV infection
National reporting mechanisms (GUMCAD/ SRHAD) remain separate impacting on local IT/ data processing
Teenage Pregnancy
Increase in STI rates in the over 40s

Health Care Associated Infections (HCAIs)

Background

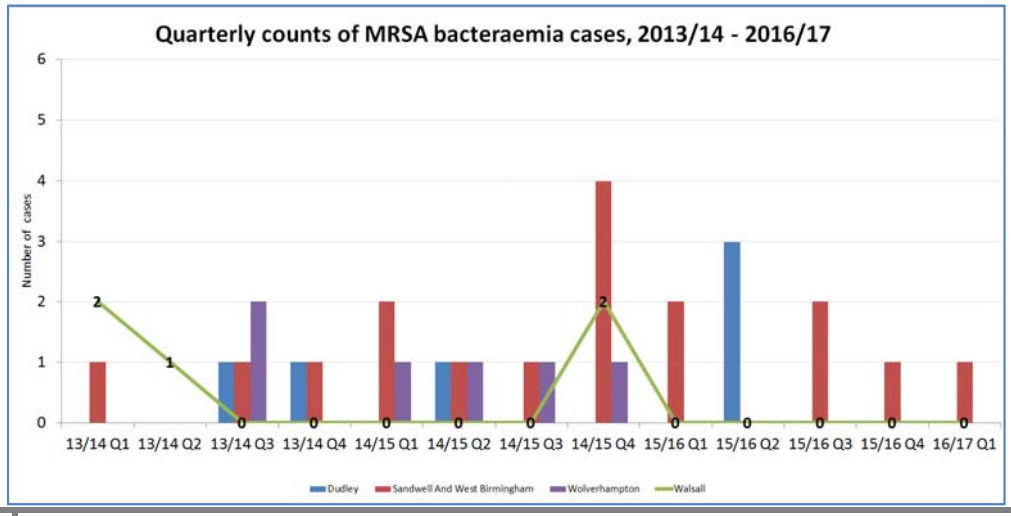
Health care associated infections can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare environment. The Department of Health expects a year on year reduction in the numbers of specific infections reported by the NHS. Walsall Clinical Commissioning Group (CCG) is set objectives each year by the Department of Health. In 2016/17 the objective is to have no more than 56 cases of *Clostridium difficile* in Walsall residents. Walsall Healthcare Trusts must not have more than 18. Due to the many interventions and successes in infection prevention and antimicrobial stewardship across Walsall there has been a decrease in the number of *Clostridium difficile* infections since December 2012, as seen in 30.

Figure 30: Quarterly counts of *Clostridium Difficile* cases, 2011/12 - 2016/17



MRSA bacteraemia

Figure 31: Quarterly counts of MRSA cases, 2013/14 - 2016/17



Source: PHE

The Department of Health sets a zero tolerance for Meticillin resistant *Staphylococcus aureus* blood stream infections (MRSA bacteraemias.) The numbers of people developing this infection has been falling for a number of years and may now be at an irreducible minimum, as seen in Figure 31. There was one case of MRSA blood stream infection reported in November 2015 by Walsall Healthcare Trust.

The health economy based approach to infection prevention and control ensures that all healthcare providers have access to an infection prevention service providing advice and support as well as audit and training. An integrated infection prevention team serves both the acute trust and the independent healthcare providers. Dudley and Walsall Mental Health Partnership Trust has a fully staffed effective infection prevention team.

Work undertaken to encourage antimicrobial stewardship amongst prescribers has contributed to the reduction in the prevalence of both MRSA bacteraemia and *Clostridium difficile* infection.

Recommendations

Continue to work as a health economy to tackle HCAI through surveillance, audit, education, policy and implementation of national guidance.
Support initiatives to ensure good antimicrobial stewardship
Continue monitoring other organisms of concern such as E.coli, MSSA bacteraemias
Embed screening and management of multi drug resistant organisms in line with national guidance

Risks

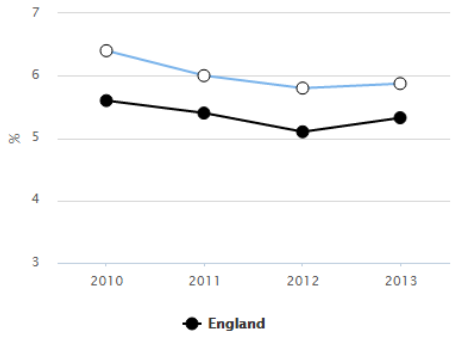
Potential reduction in funding for the independent health care providers
Capacity issues within the Trusts that may prejudice infection prevention controls
Changes in antibiotic prescribing may lead to more cases of *Clostridium difficile*

Pollution control

The public outcome framework indicator relating to air pollution indicates that Walsall is above regional and national averages over the years (see Figure 28).

Figure 28: Fraction of mortality attributable to particulate air pollution in Walsall, 2010 - 2013

3.01 - Fraction of mortality attributable to particulate air pollution Walsall Proportion - %



Period		Count	Value	Lower CI	Upper CI	West Midlands	England
2010	○	-	6.4	-	-	5.7	5.6
2011	○	-	6.0	-	-	5.3	5.4
2012	○	-	5.8	-	-	5.1	5.1
2013	○	-	5.9	-	-	5.4	5.3

Source: Background annual average $PM_{2.5}$ concentrations for the year of interest (here 2011) are modelled on a 1km x 1km grid using an air dispersion model, and calibrated using measured concentrations taken from background sites in Defra's Automatic Urban and Rural Network (http://uk-air.defra.gov.uk/interactive-map.) Data on primary emissions from different sources and a combination of measurement data for secondary inorganic aerosol and models for sources not included in the emission inventory (including re-suspension of dusts) are used to estimate the anthropogenic (human-made) component of these concentrations. By approximating LA boundaries to the 1km by 1km grid, and using census population data, population weighted background PM2.5 concentrations for each lower tier LA are calculated. This work is completed under contract to Defra, as a small extension of its obligations under the Ambient Air Quality Directive (2008/50/EC). Concentrations of anthropogenic, rather than total, PM2.5 are used as the basis for this indicator, as burden estimates based on total PM2.5 might give a misleading impression of the scale of the potential influence of policy interventions (COMEAP, 2012).

Source: Public Health Outcome Framework

Pollution Control undertakes a specialist range of monitoring, investigation, advisory and regulatory (enforcement) functions, principally involved with:

- air pollution and air quality
- contaminated land / ground contamination
- acoustics, noise and vibration

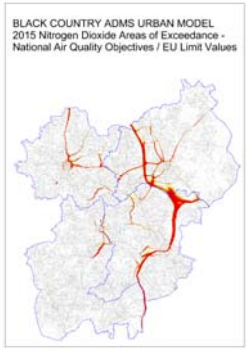
HEADLINE ISSUES

Air Quality – Nitrogen Dioxide

Nitrogen dioxide (NO_2) is monitored at 6 sites across Walsall. The data is reported annually to DEFRA and also verifies the council's borough wide NO_2 air quality model.

NO_2 air quality modelling has over the course of 2015 been extended to include all Black Country metropolitan authorities as part of a strategic work stream to inform transport planning and air quality action planning. This work has been shared with the Integrated Transport Authority.

Figure 29: Black Country ADMS urban model 2015 nitrogen dioxide areas



Air Quality – Particulate Matter (PM)

Air pollution is an invisible killer, costing the lives of 29,000 people a year in the UK. A new partnership initiative jointly sponsored by Walsall Public Health has commenced to examine $PM_{2.5}$ particulate matter[2]. New monitoring equipment has been acquired through use of Public Health Transformation Fund monies to complement a suite of existing moth-balled units that have been deployed to four sites within the borough, with a fifth remote mobile unit awaiting deployment to South Staffordshire.

The $PM_{2.5}$ project will not only serve to demonstrate a PM2.5 concentration experienced around main roadways, but is intended in due course to:

i) inform the need for health-based interventions based on correlations with respiratory and cardio-vascular illnesses;
ii) validate a (base) $PM_{2.5}$ model that has been produced for the borough of Walsall;
iii) aid construction of a Black Country $PM_{2.5}$ concentration model and potentially other combined authority areas;
iv) provide information in respect of Public Health Outcomes Framework Indicator 3.01 '*Fraction of mortality attributable to particulate air pollution*'; and
v) to assist in demonstrating whether $PM_{2.5}$ emissions are reducing and what efforts are being made to secure reductions on the basis of local needs and policies in line with new DEFRA air quality policy guidance

Air Quality – Black Country Supplementary Planning Document

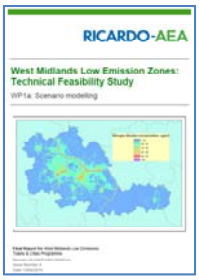
A joint Supplementary Planning Document (SPD) to address planning and air quality issues has been produced by the four Black Country metropolitan authorities. It is subject to a formal public consultation.

West Midlands Low Emissions Towns and Cities Programme (LETCP)

[2] PM 2.5 Fine particles $PM_{2.5}$ which include most combustion particles such as those emitted from diesel engine exhaust, waste burning. $PM_{2.5}$ has been associated, along with other air pollutants, with cancer, respiratory and cardiac symptoms, pre term birth, cognitive performance in children and a possible association with disorders of the endocrine and nervous system.

The West Midlands LETCP published its Technical Feasibility Study Work Package WP1a: *Scenario modelling* in April 2015 which is part of a study investigating the feasibility of creating a transferable Low Emission Zone model for the West Midlands. It pulls in various data and develops a series of recommendations following a range of scenario case studies and scenarios. A series of recommendations are presented for the various case study scenarios, which for the Walsall borough are concerned with the Walsall-Wolverhampton A454 inter-urban road corridor and M6 motorway.

A draft Low Emission Strategy for vehicles has been produced by the LETCP which will be reported to cabinet later in the year prior to reporting to the Combined Authority.



Contaminated Land Part 2A – Willenhall Town Gas Works

Following determination of land associated with the (former) Willenhall Town Gas Works as statutorily contaminated and the subsequent issue of remediation notices to rectify ground conditions, appeals against the notices were heard in December 2015 and January 2016. Whilst the appeal hearings were in the form of a public inquiry before an Inspector of the Planning Inspectorate, the ramifications of the decision are such that they may affect statutory guidance and legislation. As consequence, the appeal determination has been called in by the Secretary of State and the decision is expected later in the year.

Reduction

- Consideration is given to the implementation of Low Emission Zone corridors to reduce traffic pollution on key roads, or the adoption of a designated Clean Air Zone (CAZ) in accordance with Defra guidance.
- Following completion of West Midland LETCP Low Emissions Vehicle Strategy and the adoption of the Black Country Air Quality Supplementary Planning Document,
- Automatic Number Plate Recognition (ANPR) is installed on key road networks to inform data (vehicle fleet composition) related to air quality modelling and/or any LES or CAZ initiative.
- Air Quality modelling across Walsall and neighbouring authorities is continued and updated annually.
- The Walsall $PM_{2.5}$ health impact study is expanded to include the combined effects of $PM_{2.5}$ and NO_2.
- Following completion of (annual) $PM_{2.5}$ monitoring, an annual borough-wide $PM_{2.5}$ model is produced that is systematically updated to inform health impact statistics.
- Consideration is given to structuring a formal Black Country Air Quality Unit to facilitate on-going resources to undertake air quality modelling and health impact assessments.

Risks

The current (and on-going) air quality work streams are driven by both UK and EU policies, Regulations, national initiatives and local drivers. Given the 2016 'Brexit' Referendum there is naturally some uncertainty going forward in so far as achieving compliance with EU Air Quality Limit Values, however these have been transposed in to UK legislation and The Air Quality Strategy for England, Scotland, Wales and Northern Ireland which is a requirement of The Environment Act 1995. Risks are nonetheless present, and are summarised as follows:

- Reduction in Revenue Budget for Pollution Control; this sustains the necessary service and maintenance contracts for continued operation of the air quality monitoring network.
- Reduction in personnel. Loss of key officers has a definite potential to halt the air quality programme, and future re-organisation of Pollution Control's functional roles and priorities/commitments may additionally have a bearing on this.
- Shared Services. This could feasibly exist between two authorities, the Black Country as whole or across the Combined Authority, and the apportionment of resources would be a key factor.
- Changes in central government policies. These include not only those directly related to air quality, but other over-arching national policies which incorporate air quality considerations.
- Legislative change.

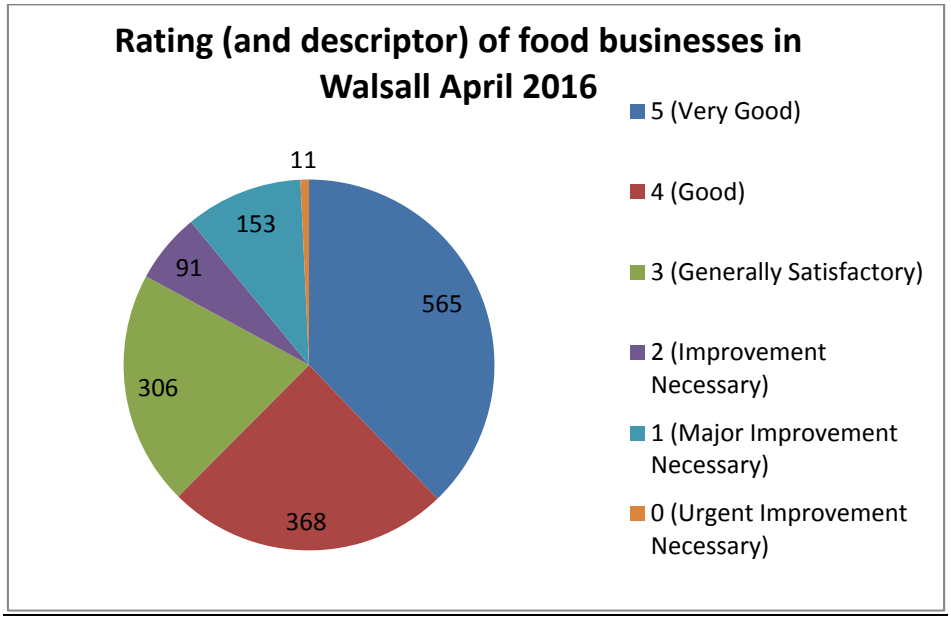
Environmental health

Within Local Government regulatory services such as Environmental Health, Trading Standards and Licensing make a significant contribution to the protection of public health.

The service uses the licensing regime, statutory inspection programmes, risk and intelligence based interventions and reactive response to identify and remove hazards from the food chain, environment, workplace or dwelling. The service also takes the opportunity during these interventions to promote public health initiatives particularly around tobacco control and smoking cessation, Making Every Contact Count (MECC), obesity through interventions at takeaways called 'Health Switch' and healthy workplaces.

Within Environmental Health notable interventions included two food poisoning outbreaks affecting people who had eaten food from local businesses. Swift identification of poor practices within businesses and potential sources of contamination meant further spread of disease was prevented. The Service has carried out over 1000 food inspections this year and seen levels of compliance generally increasing. Where conditions are not acceptable however robust action has been taken with 15 businesses being prosecuted for issues posing a risk to public health such as filthy conditions or infestations by rodents.

Figure 30: Walsall food businesses rating, April-16



Health and Safety

Health and Safety staff have carried out proactive and educational interventions in relation to Legionella from spa pools, carbon monoxide poisoning cause by solid fuel appliances, infection control practices at tattooists and sun bed safety in terms of businesses duty of care to customers. Enforcement often results from accident reports or reports of injuries to staff or customers and over 70 enforcement actions have been taken relating to prohibition or improvement of work equipment, structures or activities in order to protect health.

Recommendation

The service will continue during the next year to focus on areas of work that pose the most significant threat to Public Health. Proactive monitoring, intelligence lead interventions and reactive response to emerging threats will be the basis upon which the service operates. The unique position as Regulators enables staff to undertake health interventions relating to obesity, tobacco, alcohol and workplace safety in support of Public Health.

Trading Standards

Trading standards carry out investigations and enforcement activities under a wide range of legislation covering most goods and services. The service works in partnership with Police, HMRC, Border Agency and many other organisations. The service also provides advice to businesses based in Walsall and Consumer advice to vulnerable customers. Our Licensing service process applications for many activities including taxis, alcohol, gambling, street trading and entertainment events. Fees are charged for this part of the service which generates an income.

Food Sampling

During 2015/16 Walsall Trading Standards Service secured funding of £11,350 from the Food Standards Agency to sample a range of foods identified as being of national priority. Of the 65 samples taken, 23 (35%) were analysed by the Public Analyst and reported as unsatisfactory. Issues uncovered ranged from illegal and unsafe ingredients in body building supplements to aflatoxin contamination of cereals and spices.

Walsall also organised a Central England pizza description project. This survey discovered that 77% of pizza's across the region were being misdescribed - mainly due to cheese substitute being used in place of real cheese and turkey ham in place of real ham. Furthermore 47% of meat toppings were adulterated with undeclared chicken and 25% of supposed Halal meats contained traces of pork. A significant proportion of the adulterated meat originated from a Belgium supplier and Walsall is co-ordinating a response with the National Food Crime Unit and Food Standards Agency as the UK Single Liaison Body to investigate this further.

A local food standards sampling programme was also undertaken during 2015/2016. Trading Standards officers submitted 101 samples for analysis and 47% were found to be unsatisfactory. Problems were found with the presence of illegal, carcinogenic food colours in Asian sweets, beef and lamb being sold as goat meat, adulteration of meat species and illegal colours in takeaway meals, peanuts in peanut free takeaway meals and adulterated Basmati rice. This has resulted in a number of referrals to the National Food Crime Unit, FSA incidents team and further interventions and advice at a local level.

Food Standards Advice

Trading Standards officers have played a vital role in advising and assisting food businesses on compliance with new Food Labelling legislation and will continue to do so as more changes take effect from December 2016.

Feed Hygiene

In order to ensure the safety of food from "farm to fork" Trading Standards Officers have undertaken grant funded Feed hygiene work at farms and businesses supplying waste food for animal feed. This has resulted in a number of advisory notes being issued to improve the level of feed hygiene.

Underage and illegal sales

Trading Standards have worked well with Walsall Police colleagues to visit shops selling 'Legal Highs'. Over 228 packets were confiscated in joint operations at three shops. With changes to legislation regarding these products further joint working will take place to tackle this growing menace.

Trading Standards continue to carry out investigations into underage sales of alcohol and tobacco as well as raids on shops selling counterfeit or non duty paid tobacco. The interventions are carried out with partners such as the Police, Her Majesties Revenue and Customs (HMRC) and Border Control. They are also designed to disrupt the supply network for these products, raise public awareness and lead to prosecution of those people profiting from supply of products harmful to the health of those that buy them including children.

Trading Standards carry out regular test purchases for age restricted products including cigarettes and alcohol. Persistent sellers of illegal products are prosecuted. Illicit/ counterfeit tobacco exercises including unannounced visits with police and HMRC have resulted in large quantities of illegal products being sold and challenges to alcohol licences.

Trading standards also carry out regionally and nationally co-ordinated projects including product safety sampling and New Psychoactive Substances (legal highs). We also attend Doorstep crime instances involving rogue traders.

Recommendation

Next year we are planning further investigations and sampling projects including enforcement activity at local markets.

Risks

Reduced staffing levels, changing structures and loss of experience, and how to prioritise standard incidents across a very broad area of work for but also how to respond to emergency incidents effectively.

Unplanned or substantial changes to local or national legislation or policies without the necessary resources or experience to effectively implement the change.

Changes to other Council Departments, Public Sector or Government Agencies that subsequently have an impact on the workload or operational efficiency of the service i.e. closure of Good Hope Hospital food, water and environmental laboratory

APPENDIX 1 Health Protection Forum Terms of Reference

WALSALL HEALTH PROTECTION FORUM

TERMS OF REFERENCE

PURPOSE

The purpose of the Walsall Health Protection Forum is to:

- provide an accountability framework for a number of existing partnership groups with a health protection remit and support the establishment of new groups where appropriate. The Health Protection forum will receive assurance from the following:
  - Public Health England
  - Walsall Clinical Commissioning Group
  - Local Health Resilience Forum
  - Health Care Associated Infection Steering Group (infection control)
  - sexual health
  - NHS England - Screening and Immunisation Team
  - Environmental Health
  - Pollution Control
- facilitate a co-ordinated strategic approach to health protection issues in Walsall
- receive assurance from the subgroups regarding
  - Appropriate strategies/plans and testing arrangements
  - Progress against outcomes
- review all significant incidents/outbreaks to identify lessons learned and to make recommendations to commissioners/providers/partners regarding necessary changes
- receive and review risk registers from all subgroups, make recommendations to subgroups regarding mitigating actions and to commissioners where appropriate
- encourage continuous quality improvement in health protection services in Walsall
- provide health protection input into the JSNA

MEMBERSHIP

- Director of Public Health
- Consultants in Public Health
- Public Health England, Consultant in Communicable Disease Control
- NHS England Screening and Immunisation Coordinator
- Screening and Immunisation Lead
- Sexual Health Commissioner
- Emergency Planning Officer
- Environmental Health Lead
- Pollution Control Lead

- General Practitioner
- TB Lead
- Heads of Infection Prevention and Control
- CCG Lead Nurse (or representative)

QUORUM
Members representing subgroups/workstreams will be required to attend or to ensure that a suitable deputy is available to attend

ACCOUNTABILITY AND REPORTING FRAMEWORK
The group will report to the Health and Wellbeing Board at Walsall Council. The group will also report to the Quality, Safety and Performance subgroup of the Walsall CCG on a regular basis

FREQUENCY OF MEETINGS
The group will meet quarterly unless otherwise required when an extraordinary meeting may be called.

CHAIR
The Health Protection Forum will be chaired by the Director of Public Health.

Minutes will be produced by the administrative team of the Director of Public Health.

Meeting papers will be circulated 7 days ahead of meetings, with minutes circulated in a timely fashion to members following each meeting

REPORTS
Each subgroup will be expected to submit a short update report 10 days prior to the Health Protection Forum to allow time for collation and circulation to the group. I

It is expected that the focus of feedback at the meeting will be on exception reporting

STANDING ITEMS
Standing agenda items for each work stream/subgroup will include summary of current situation, progress against outcomes, incidents managed and changes made, risks, and suggestions for improvement.

ROTATING ITEMS
On an annual basis, representatives from each of the workstreams/subgroups are expected to present an annual review which will include (in addition to the items detailed above) details of new policies and developments, as well as progress against action plans in existence.

REVIEW
The terms of reference will be reviewed on an annual basis.

Public Health England

APPENDIX 2 Walsall Annual Health Protection Summary

The following data shows the Health Protection outbreaks and incidents and diseases reported to the Health Protection Team during the year 2015/16.

Table 1: Summary of issues, outbreaks and incidents reported to the HPT for Walsall (2015/16)

Infection / scenario	Level 1	Routine	Grand Total
Norovirus		17	17
Scabies mite		8	8
Mycobacterium tuberculosis complex	5	1	6
Fire		6	6
Varicella-zoster virus		6	6
Streptococcus, Group A		4	4
Enterovirus (Coxsackie / Echo)		3	3
Infection control		3	3
Chemical agent, unknown		2	2
Gastroenteritis		2	2
Legionella spp	1	1	2
Influenza A virus, Seasonal	1	1	2
Chemical agent, other specified		1	1
Hepatitis B virus	1		1
Staphylococcus aureus, other/unspecified		1	1
Acute hepatitis B		1	1
Cancer cluster	1		1
Escherichia coli, other/unspecified		1	1
Giardia lamblia		1	1
Bordetella spp	1		1
Health Care Associated Infection	1		1
Conjunctivitis		1	1
Water		1	1
Parainfluenza virus		1	1
Contaminated land		1	1
Pseudomonas spp	1		1
Respiratory		1	1
Grand Total	**12**	**64**	**76**

Source: HP Zone

Table 2: Annual summary of diseases reported to the HPT (2015/16)

Disease	2011/12	2012/13	2013/14	2014/15	2015/16

Vaccine preventable	**Measles**	26	34	43	12	20
	Mumps	26	34	48	52	38
	Rubella	4	2	5	3	3
	Whooping cough	8	42	13	18	11
Blood borne virus	**Hepatitis B, acute**	0	0	1	0	3
	Chronic hep B	34	20	28	25	30
	Hepatitis C	34	16	28	24	44
Gastrointestinal disease	**Campylobacteriosis**	223	216	204	180	166
	Cryptosporidiosis	4	20	6	13	13
	E coli 0157	3	3	2	2	0
	Giardiasis	3	6	4	13	9
	Hepatitis A	3	1	2	3	1
	Hepatitis E	3	0	4	4	5
	Listeriosis	0	1	0	3	1
	Paratyphoid fever	0	1	0	1	0
	Salmonellosis	29	15	34	19	26
	Shigellosis	8	1	3	11	5
	Typhoid fever	2	1	0	4	3
Other	**Malaria**	2	0	0	1	3
	Scarlet Fever	9	23	22	137	67
	IGAS	12	10	6	7	6
	Legionnaires Disease	6	0	2	1	7
	Staphylococcus aureus (PVL)	1	5	4	4	0
	Tuberculosis	55	49	52	39	36
Meningococcal disease	**Meningococcaemia**	7	3	8	2	8
	Meningoccal meningitis	9	11	4	3	7

Source: HP Zone

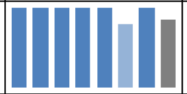
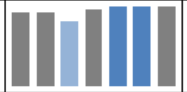
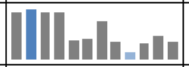
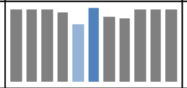
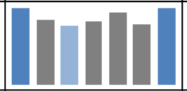
APPENDIX 3 Summary of Risks

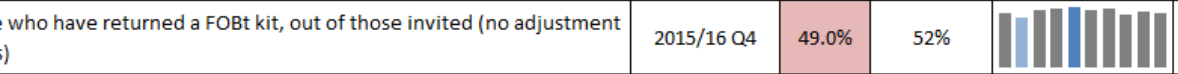
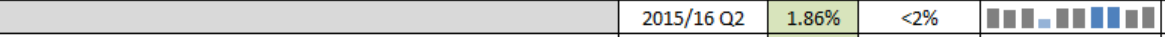
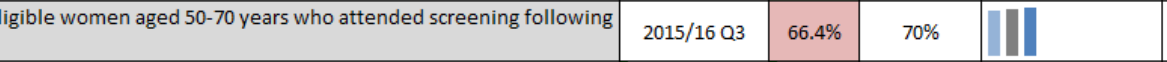
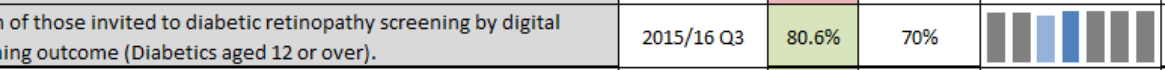
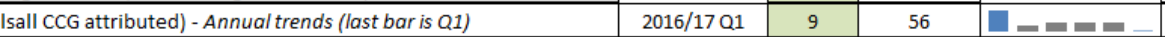
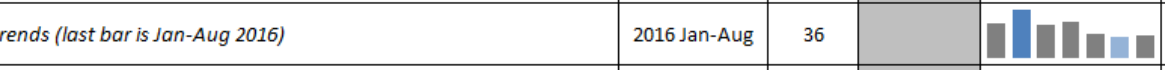
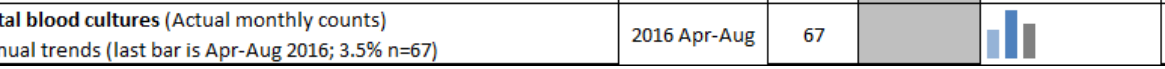
Discipline	Risk
Health Emergency Planning	Clarification about which organisation pays for medication and staff time during large outbreaks remains an unresolved issue. A national decision has been requested. Resignation of current Health Emergency Planner within Public Health/CCG
Public Health England	Changes in organisational structure and ways of working Reduced general practitioner support with regards to prophylaxis prescribing and infectious disease screening following BMA letter
TB	Concerns about Latent TB screening funding delaying introduction of the programme Staffing levels in the TB service at Walsall Healthcare Trust Disruption in BCG vaccine supplies for neonatal BCG vaccination and associated waiting lists and catch up programmes Rising numbers of cases of TB in 2016
Immunisation programme	Health and social care staff do not take up the offer of flu vaccination Waiting lists for primary immunisations General practice workforce not receiving immunisation updates and annual training
Cancer and non cancer screening	The CCG Diabetes Task and Finish Group has been disbanded since April 2016 due to changes in the CCG structure
Sexual Health	Increasing resistance to antibiotics in some sexually transmitted organisms
Healthcare Associated Infections (HCAI)	Potential reduction in funding for the independent health care providers Capacity issues within the Trusts that may prejudice infection prevention controls Changes in antibiotic prescribing and implementation of sepsis bundles may lead to more cases of *Clostridium difficile*

Pollution Control	Reduction in Revenue Budget for Pollution Control; this sustains the necessary service and maintenance contracts for continued operation of the air quality monitoring network. Reduction in personnel. Loss of key officers has a definite potential to halt the air quality programme, and future re-organisation of Pollution Control's functional roles and priorities/commitments may additionally have a bearing on this. Shared Services. This could feasibly exist between two authorities, the Black Country as whole or across the Combined Authority, and the apportionment of resources would be a key factor. Changes in central government policies. These include not only those directly related to air quality, but other over-arching national policies which incorporate air quality considerations. Legislative change.
Environmental Health and Trading Standards	Reduced staffing levels, changing structures and loss of experience, and how to prioritise standard incidents across a very broad area of work for but also how to respond to emergency incidents effectively. Unplanned or substantial changes to local or national legislation or policies without the necessary resources or experience to effectively implement the change. Changes to other Council Departments, Public Sector or Government Agencies that subsequently have an impact on the workload or operational efficiency of the service i.e. closure of Good Hope Hospital food, water and environmental laboratory

APPENDIX 4: Health Protection Forum Dashboard

Indicator	Indicator Description	Period	Walsall	Target /Trajectory	Trend (high/low values highlighted)	Trend Period
1	**12 Month Diphtheria/IPV/HIB**	2015/16 Q4	97.5%	95%		2013/14 Q1 - 2015/16 Q4
2	**12 Month Meningitis C**	2015/16 Q4	98.7%	95%		2013/14 Q1 - 2015/16 Q4
3	**12 Month PCV 13**	2015/16 Q4	97.0%	95%		2013/14 Q1 - 2015/16 Q4
4	**24 Month Diphtheria/IPV/HIB**	2015/16 Q4	98.7%	95%		2013/14 Q1 - 2015/16 Q4
5	**24 Month Meningitis C/HIB (Booster)**	2015/16 Q4	98.2%	95%		2013/14 Q1 - 2015/16 Q4
6	**24 Month MMR**	2015/16 Q4	98.1%	95%		2013/14 Q1 - 2015/16 Q4
7	**24 Month PCV 13 Booster**	2015/16 Q4	98.2%	95%		2013/14 Q1 - 2015/16 Q4
8	**5 Year Diphtheria/Tetanus/Polio**	2015/16 Q4	99.2%	95%		2013/14 Q1 - 2015/16 Q4
9	**5 Year Diphtheria/IPV Booster**	2015/16 Q4	95.4%	95%		2013/14 Q1 - 2015/16 Q4
10	**5 Year Meningitis C/HIB (Booster)**	2015/16 Q4	95.6%	95%		2013/14 Q1 - 2015/16 Q4
11	**5 Year MMR Dose 1**	2015/16 Q4	99.1%	95%		2013/14 Q1 - 2015/16 Q4
12	**5 Year MMR Dose 2**	2015/16 Q4	94.4%	95%		2013/14 Q1 - 2015/16 Q4
13	**HPV (12-13 years girls)**	2014/15	82.8%	86.8%		2012/13 - 2014/15
14	**Prenatal Pertussis** (monthly)	Mar-16	55.6%			01/07/2015 - 01/03/2016
15	**Influenza Vaccination** in Over 65's	2015/16	69.8%	73.2%		2008/09 - 2015/16
16	**Influenza Vaccination** in Under 65's & 'At Risk Groups	2015/16	47.8%	52.3%		2010/11 - 2015/16
17	**Influenza Vaccination** in Pregnancy	2015/16	47.3%	39.8%		2012/13 - 2015/16
18	**Influenza Vaccination** in Frontline Healthcare workers	2014/15	46.0%	45.6%		2012/13 - 2014/15
19	**Influenza Vaccination** in 2 Years	2015/16	30.2%	42.6%		2013/14 - 2015/16
20	**Influenza Vaccination** in 3 Years	2015/16	34.3%	39.5%		2013/14 - 2015/16
21	**Influenza Vaccination** in 4 Years	2015/16	26.7%			2013/14 - 2015/16
22	**Pneumococcal (65 yrs & over)**	2014/15	64.1%	68.3%		2012/13 - 2014/15

Indicator	Indicator Description	Period	Walsall	Target /Trajectory	Trend (high/low values highlighted)	Trend Period
23	**Antenatal and Newborn Screening:** ID1 - The proportion of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result.	2015/16 Q4	99.9%	90%		2013/14 Q2 - 2015/16 Q4
24	**Antenatal and Newborn Screening:** ID2 - The proportion of pregnant women who are hepatitis B positive who are referred and seen by an appropriate specialist within an effective timeframe (6 weeks from identification).	2014/15 Q3	85.7%	70%		2012/13 Q4 - 2014/15 Q3
25	**Antenatal and Newborn Screening:** FA1 - The proportion of laboratory request forms including complete data prior to screening analysis, submitted to the laboratory within the recommended timeframe of 10+0 to 20+0 weeks gestation.	2014/15 Q1	98.5%	97%		2012/13 Q4 - 2014/15 Q1
26	**Antenatal and Newborn Screening:** ST1 - The proportion of pregnant women eligible for antenatal sickle cell and thalassemia screening for whom a conclusive screening result is available at the day of report.	2014/15 Q3	99.9%	95%		2013/14 Q1 - 2014/15 Q3
27	**Antenatal and Newborn Screening:** ST2 - The proportion of women having antenatal sickle cell and thalassemia screening for whom a conclusive screening result is available by 10 weeks gestation.	2015/16 Q4	66.4%	50%		2013/14 Q2 - 2015/16 Q4
28	**Antenatal and Newborn Screening:** ST3 - The porportion of antenatal sickle cell and thalassemia samples submitted to the laboratories which are supported by a completed Family Origin Questionnaire (FOQ).	2014/15 Q1	100.0%	90%		2012/13 Q4 - 2014/15 Q1
29	**Antenatal and Newborn Screening:** NB1 - The proportion of babies registered within the PCT both at birth and at the time of report who are eligible for newborn blood spot screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe. For this KPI, PKU is used as a proxy for all test and the test must be completed by 17 days of age.	2014/15 Q1	96.9%	95%		2012/13 Q4 - 2014/15 Q1
30	**Antenatal and Newborn Screening:** NB2 - The percentage of babies from whom it is necessary to take a repeat blood sample due to an avoidable failure in the sampling process.	2015/16 Q4	1.5%	2%		2013/14 Q1 - 2015/16 Q4
31	**Antenatal and Newborn Screening:** NB3 - The proportion of newborn blood spot screening results which are screen negative for all five conditions, available for communication to parents within six weeks of birth.	2014/15 Q1	99.6%	95%		2013/14 Q1 - 2014/15 Q1
32	**Antenatal and Newborn Screening:** NH1 - The proportion of babies eligible for newborn hearing screening for whom the screening process is complete by 4 weeks corrected age (hospital programmes-well babies, NICU babies) or by 5 weeks corrected age (community programmes-well babies).	2015/16 Q4	98.5%	97%		2013/14 Q2 - 2015/16 Q4
33	**Antenatal and Newborn Screening:** NH2 - The percentage of referred babies receiving audiological assessment within 4 weeks of the decision that referral of assessment is required or by 44 weeks gestational age.	2014/15 Q3	100.0%	95%		2013/14 Q1 - 2014/15 Q3
34	**Antenatal and Newborn Screening:** NP1 - The proportion of babies eligible for the newborn physical examination who were tested within 72 hours of birth.	2015/16 Q4	96.1%	95%		2014/15 Q2 - 2015/16 Q4
35	**Antenatal and Newborn Screening:** NP2 - The proportion of babies who, as result of possible abnormality of the hips being detected at the newborn physical examination, undergo assessment by ultrasound within two weeks of birth.	2014/15 Q3	0.0%	95%		2014/15 Q1 - 2014/15 Q3

Indicator	Indicator Description	Period	Walsall	Target /Trajectory	Trend (high/low values highlighted)	Trend Period
36	**AAA screening:** Number of men eligible for AAA screening who have been screened (65 years)	2015/16 Q4	76.8%	75%		2014/15 Q2 - 2015/16 Q4
37	**Bowel Screening** Uptake % (60 to 74 yrs)	Feb-16	50.2%	60%		01/03/2015 - 01/02/2016
38	**Bowel Screening** 2.5 Year Coverage % (60 to 74 yrs)	Feb-16	53.6%	60%		01/03/2015 - 01/02/2016
39	**Bowel screening:** Proportion of those who have returned a FOBt kit, out of those invited (no adjustment made for undelivered kits and letters)	2015/16 Q4	49.0%	52%		2013/14 Q2 - 2015/16 Q4
40	**Bowel screening:** FOBt positivity	2015/16 Q2	1.86%	<2%		2013/14 Q1 - 2015/16 Q2
41	**Breast Screening** for 50 to 70 Year Olds Uptake %	Feb-16	72.6%	70%		01/03/2015 - 01/02/2016
42	**Breast Screening** for 50 to 70 Year Olds 36 Month Coverage %	Feb-16	71.3%	70%		01/03/2015 - 01/02/2016
43	**Breast Screening:** The percentage of eligible women aged 50-70 years who attended screening following invitation	2015/16 Q3	66.4%	70%		2015/16 Q1 - 2015/16 Q3
44	**Cervical Screening** 3.5/5.5-year coverage % (25 to 64 Yrs)	Feb-16	71.7%	80%		01/03/2015 - 01/02/2016
45	**Cervical screening:** Proportion of eligible women screened within 5 years of their previous screen (coverage)	2015/16 Q3	76.10%	80%		2013/14 Q4 - 2015/16 Q3
46	**Diabetic Eye screening:** The proportion of those invited to diabetic retinopathy screening by digital photography who have a digital screening outcome (Diabetics aged 12 or over).	2015/16 Q3	80.6%	70%		2014/15 Q1 - 2015/16 Q3
47	*Clostridium difficile* - Actual counts (Walsall CCG attributed) - *Annual trends (last bar is Q1)*	2016/17 Q1	9	56		2011/12 - 2016/17 Q1
48	*Escherichia coli* (BSI) - Actual counts - *Annual trends (last bar is Q1)*	2016/17 Q1	38			2012/13 - 2016/17 Q1
49	**Methicillin Resistant** *Staph. aureus* (BSI) - Actual counts (Walsall CCG attributed) - *Annual trend*	2016/17 Q1	0	0		2011/12 - 2016/17 Q1
50	**Methicillin Sensitive** *Staph. aureus* (BSI) - Actual counts - *Annual trends (last bar is Q1)*	2016/17 Q1	8			2011/12 - 2016/17 Q1
51	**Tuberculosis** - Actual counts - *Annual trends (last bar is Jan-Aug 2016)*	2016 Jan-Aug	36			2010 - 2016 Jan-Aug
52	**Vancomycin Resistant Enterococci** - Number of postive patients (Acute and Community) - *Annual trends (last bar is Apr-Aug 2016)*	2016 Apr-Aug	7			2013/14 - 2016 Apr-Aug
60	**30 day all cause mortality C.Diff** *(monthly trends)*	Aug-16	0			01/09/2015 - 01/08/2016
61	**Contaminated blood cultures - % of total blood cultures** (Actual monthly counts) Annual trends (last bar is Apr-Aug 2016; 3.5% n=67)	2016 Apr-Aug	67			2014/15 - 2016 Apr-Aug

Indicator	Indicator Description	Period	Walsall	Target /Trajectory	Trend (high/low values highlighted)	Trend Period
62	**Chlamydia diagnosis** (Rate per 100,000 population aged 15-24)	2015	2274			2012 - 2015
63	**Gonorrhoea diagnosis** (Rate per 100,000 population - all ages)	2015	54.7			2004 - 2015
64	**Infectious syphilis diagnosis** (Rate per 100,000 population - all ages)	2015	5.8			2004 - 2015
65	**Anogenital herpes simplex (first episode) diagnosis** (Rate per 100,000 population - all ages)	2015	58.4			2004 - 2015
66	**Anogenital warts (first episode) diagnosis** (Rate per 100,000 population - all ages)	2015	107.2			2004 - 2015
67	**People presenting with HIV at a late stage of infection** % of adults (aged 15+) newly diagnosed with HIV with a CD4 count <350 cells per mm3	2012/14	49.1			2009/10 - 2012/14
68	Fraction of all-cause adult mortality attributable to long term exposure to current levels of anthropogenic particulate air pollution	2013	5.9			2010 - 2013