Agenda item 8(c)

Health and Wellbeing Board

7 December 2015

Health Protection Forum

1. Purpose

The purpose of this paper is to brief Walsall's Health and Wellbeing Board on the key health protection issues in Walsall.

Summary
Walsall Council has had mandated duties to protect its population from threats to public health from 1 April 2013. Health protection, which involves the control of infectious diseases (including healthcare associated infections) and the health effects of non-infectious environmental hazards, presents considerable challenges for Walsall.

This paper briefs the Walsall Health and Wellbeing Board on key health protection issues for Walsall. The recommendations listed below are put forward to ask for the Heath and Wellbeing Board's support in tackling Walsall's key health protection challenges.

2. Recommendations

The Health and Wellbeing Board is asked to:

2.1. Note the considerable progress that has been made in Walsall in tackling some of the key health protection challenges faced by Walsall and consider some of the major challenges that remain.
2.2 Agree that the Health Protection Forum reports formally to the Health and Wellbeing Board on a twice yearly basis.

3. Report detail

3.1 Introduction and background

'Health protection' is one of three domains of public health. Infectious diseases (including healthcare associated infections) and non-infectious environmental hazards lie at the core of this relatively specialist area of public health.

The Local Authorities (Public Health Functions and Entry to Premises by Local Health watch Representatives) Regulations 2013 delegate to local authorities the critical role of providing information and advice to relevant organisations (including PHE) so as to ensure all parties discharge their roles effectively for the protection of the local population.

The local health protection system involves the delivery of specialist health protection functions by PHE and local authorities providing local leadership for health. In practice, local authorities and PHE work closely together as a single public system. This joint working with clarity of responsibilities between them is crucial for safe delivery of health protection. The aim of the current arrangements is an integrated, streamlined health protection system that delivers effective protection for the population from health threats, based on:

- a clear line of sight from the top of government to the frontline;
- clear accountabilities;
- collaboration and coordination at every level of the system; and
- robust locally sensitive arrangements for planning and response.

The establishment of the Health Protection Forum

The Department of Health has suggested that local authorities establish a local forum for health protection issues, chaired by the Director of Public Health, to review plans and issues that need escalation.

The Walsall Health Protection Forum was established in May 2013. This has been chaired by the Director of Public Health. It meets on a quarterly basis to review health protection issues in Walsall. The Health Protection Forum is accountable to the Health and Wellbeing Board.

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 to support the establishment of new groups where appropriate.

The Health Protection forum receives assurance from Public Health England, Walsall Clinical Commissioning Group, local health resilience partnerships, Health Care Associated Infection Steering Group, sexual health services, Community TB services, NHS England - Screening and Immunisation Team, Environmental Health, and Pollution Control services.

Public Health England have undertaken a review of their local health protection services (including laboratory services and the commissioning of immunisation and screening) They are consulting on changes to their local health protection services. It is anticipated that a finalised model will be published in the New Year. The Walsall Health Protection Forum will assess the impact of the proposed changes to the health protection arrangements in Walsall.

3.2 Health Protection streams

3.2.1 Immunisation and screening

Immunisation is commissioned by NHS England and delivered largely through primary care.

A routine immunisation programme is in place across the UK to protect the population from a vast number of infections. A baby girl born in Walsall today will

be offered 22 vaccine injections in her lifetime to protect her from 16 different infections. This does not include annual flu vaccine.

- The target for childhood immunisations is greater than 95%. Walsall has routinely had good uptake rates of greater than 95%. This quarter there has been a slight drop in uptake of the 5 year diphtheria, tetanus, polio vaccine and *Meningococcal* Group C (Men C) and *Haemophilus influenza* (Hib) vaccine. The Health Protection Forum is monitoring this closely.

- HPV vaccine uptake has fallen this quarter and we are working with PHE to identify the reasons for this decrease.

- Walsall health economy is working hard to improve the Flu vaccine uptake rates amongst at risk groups. There has been a year on year increase in the uptake and innovative initiatives this year include the Flu Fairies working with pregnant women and the CCG programme raising the public's awareness of how to look after themselves this winter with the help of the Health Elf and the Flu Fairy.

3.2.2 Screening

Screening programmes are commissioned by NHS England and delivered largely through secondary care and are delivered on wider geographical footprints than just Walsall depending on the programme.

The following screening programmes are undertaken in Walsall

<u>Antenatal and newborn screening</u>

The antenatal and newborn screening programme is successful meeting the majority of the nationally set targets. The challenge is to ensure that the number of women eligible for sickle cell and thalassemia testing present early enough for this testing to be completed before 10 weeks gestation. At present Walsall is not meeting this target 49.6 against a target of 50%

<u>Adult cancer screening</u>

- Cervical screening
  This programme is not currently meeting national targets. There has not been any reduction or increase in the uptake in recent years. The coverage is 72.8% compared to a target of 80%. Work is ongoing to increase the uptake

- Breast screening
  There has been a slight fall in the quarterly uptake figures over recent months to 67.9% against a target of 70%. However the overall 36 month coverage remains green 71.5% against a target of 70%

- Bowel cancer screening
  The dashboard shows that uptake of bowel screening is of particular concern at 53.1% against a target of 60%. Awareness raising is being undertaken in community centres, mosques, temples, church groups etc

<u>Adult non-cancer screening</u>

- Abdominal aortic aneurysm (AAA)

This screening programme is working well and invitations and uptake are both on an upward trend. The latest figures show that 99.96% of eligible men have been invited for screening (against a target of 90%) and 79.5% have been screened (against a target of 54%)

- Diabetic eye
  At present this is a very successful programme. The proportion of eligible patients invited to diabetic retinopathy screening by digital photography and take up the offer is 80.9% against a target of 70%. The trend remains stable.

In summary
Collectively the partnership is exploring initiatives to increase uptake further in all screening programmes however in the current financial climate there have been difficulties in funding these projects.

3.2.3 Health care associated infections

Walsall Public Health commission a community infection control service which is provided to care homes, dentists and general practitioners in Walsall. This service is provided by the infection control team based within Walsall Healthcare Trust. This enables a seamless journey for patients with consistent advice and management as well as facilitating follow up of patients with specific infections.

Walsall Health economy has a zero tolerance to avoidable healthcare associated infections. A combined work plan has been agreed at the HCAI Steering Group involves all agencies in preventing infections.

Preventing new infections from MRSA and Clostridium difficile are key objectives of the community infection control services. The current performance in Walsall is as follows

- There have been 40 new cases of C. Difficile attributed to Walsall CCG against a nationally mandated maximum number of 56 new cases for 2015/16
- There have been 5 new cases of C. Difficile attributed to Walsall Healthcare Trust against a nationally mandated maximum number of 18 new cases for 2015/16
- There have been no new cases of MRSA bacteraemia in Walsall for the past 2 years.

Challenges. There is an increase of antibiotic resistant organisms being reported in the region and a small increase has been noted locally. Control will rely on infection prevention precautions and careful use of antibiotics.
There are plans to raise awareness amongst patients on the correct use of antibiotics through a pharmacy and primary care campaign

3.2.4 Tuberculosis

Nationally there has been an increase in the number of TB infections that have been notified. In Walsall, however, rates of tuberculosis infections have remained fairly steady in recent years.

The National TB Strategy was launched in January 2015. There are 10 core actions listed in the strategy. This provides a framework within which to strengthen TB prevention and control.

TB control boards have been set up across the country which will oversee TB interventions at a regional level and be able to respond to local need. The boards will be informed by TB networks. Walsall is part of the Black Country Network which includes Walsall, Wolverhampton and Dudley.

A new initiative has been launched for the identification and management of latent TB. This will be rolled out nationally for all new entrants from high risk countries (those countries with infection rates greater than 150/100,000 population) and will involve identification and treatment of new entrants to the UK who are infected with latent tuberculosis. Walsall has submitted a joint bid with Wolverhampton to secure national funding for the delivery of a latent TB control programme. The programme will be delivered through the Refugee and Migrant Centre in Wolverhampton and local General Practices in Walsall.

3.2.5 Sexually Transmitted infections

In 2014 in Walsall

- Overall there were 2392 new sexually transmitted infections (STIs) diagnosed in residents of Walsall, a rate of 878.9 per 100,000 residents (compared to 797.2 per 100,000 in England).
- Walsall is ranked 53 (out of 326 local authorities in England; first in the rank has highest rates) for rates of new STIs excluding chlamydia diagnoses in 15-24 year olds; with a rate of 896.3 per 100,000 residents (compared to 828.7 per 100,000 in England).
- 50% of diagnoses of new STIs in Walsall were in young people aged 15-24 years (compared to 46% in England). This includes those tested in genitourinary medicine clinics (GUM) only.
- For cases in men where sexual orientation was known, 10.3% of new STIs in Walsall were among men who have sex with men (GUM clinics only).
- The chlamydia detection rate per 100,000 young people aged 15-24 years in Walsall was 2397.6 (compared to 2012.0 per 100,000 in England).
- Walsall is ranked 77 (out of 326 local authorities in England; first in the rank has highest rates) for the rate of gonorrhoea, which is a marker of high levels of risky sexual activity. The rate of gonorrhoea diagnoses per 100,000 in this local authority was 47.4 (compared to 63.3 per 100,000 in England).
- An estimated 8.8% of women and 7.3% of men presenting with a new STI at a GUM clinic during the five year period from 2010 to 2014 were reinfected with a new STI within twelve months.

- In 2014 among genitourinary medicine (GUM) clinic patients from Walsall who were eligible to be tested for HIV, 63.4% were tested (compared to 68.9% in England).
- There were 19 new HIV diagnoses in Walsall and the diagnosed HIV prevalence was 1.8 per 1,000 population aged 15-59 years (compared to 2.1 per 1,000 in England).
- Between 2012 and 2014, 49.1% (95% CI 35.1-63.2) of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm^3 within 3 months of diagnosis) compared to 42% (95% CI 41-43) in England

Sexual Health Delivery in Walsall

The Local Authorities Regulations 2013 require local authorities to arrange for the provision of: Open access genitourinary medicine (GUM) and contraception services for all age groups for everyone present in their area; covering firstly free sexually transmitted infections (STI) testing and treatment, and notification of sexual partners of infected persons; and secondly free contraception reasonable access to all methods of contraception

Genito Urinary Medicine (GUM) services

The service is located on the Walsall Healthcare Trust main site and is led by a Consultant with a specialism in sexually transmitted infections testing, diagnosis and treatment. During 2014 there were 2392 sexually transmitted infections diagnosed from attendances at GUM clinics attributed to Walsall residents of which 82% of attendees' accessed services at the Walsall Healthcare Trust.

Reproductive Sexual Health Services

Within Walsall, specialist contraceptive and sexual health services (CaSH) is provided by Walsall Health Trust via a mixture of open access and booked appointments, clinics are provided 6 days a week. The service has approximately 15,000 attendances a year of which a little over 87% are Walsall residents. The service will see anyone regardless of age and place of residency and offers a fully confidential service.

The consistent and correct use of effective contraception is the best way for sexually active women (and men) to avoid an unplanned pregnancy. There is a correlation between good contraception services and lowering rates of teenage conceptions, which is one of the indicators in the Public Health Outcomes Framework

Chlamydia Screening Programme

Chlamydia is the most common bacterial sexually transmitted infection, with sexually active young people at highest risk. The number of diagnoses of Chlamydia in the 15–24 age group is one of the sexual health indicators in the Public Health Outcomes framework, this recommends local areas achieve an annual Chlamydia diagnosis rate of at least 2,300 per 100,000 15-24 year old

resident population reflecting the important role that testing for and treating Chlamydia plays in improving sexual health among young people.

Maintaining and increasing Chlamydia testing is expected to reduce the prevalence of Chlamydia amongst young people and offering good access to Chlamydia testing is important to achieve the indicator. The council participates in the National Chlamydia Screening Programme (NCSP).
Locally Walsall Chlamydia Screening Programme coordinates screening contributions from GPs, community pharmacies, specialist sexual health services and youth services. The Walsall Chlamydia Screening Programme was one of only two Local Authorities in this region to achieve the above diagnosis rate of 2,300 per 100,000 15-24 year old resident population.

HIV

The vast majority of HIV infections are contracted sexually, although there are other routes of transmission. In 2014, an estimated 103,700 people living with HIV and an estimated 18,100 do not know that they have the infection, and around half of people newly diagnosed with HIV are diagnosed after the point at which they should have started treatment. This can have implications not just for the care of the individual person with HIV, but also for the onward transmission of the infection. Locally, JSNAs can be used to prioritise and inform the provision of appropriate HIV testing services, to deliver against this indicator

Whilst the council is not responsible for providing specialist HIV treatment and care services the provision of HIV testing is part of the local authority requirement. Reducing the late diagnosis of HIV is one of the Public Health Outcome Framework indicators, and increasing access to HIV testing is important to meet this indicator. In 2014 63.4 % of Walsall residents eligible for testing attending a GUM clinic accepted the offer of a HIV test. There is clearly more work to be done to reduce late HIV diagnosis by increasing testing and raising awareness particularly amongst high risk groups

Education and prevention

Walsall council commissions a number of third sector organisations to provide education and prevention targeted to those people most at risk of poor sexual health. Following procurement of the sexual health services, joined up commissioning and seamless care pathways across the full range of sexual health services will be put in place. This is crucial to improve outcomes and the health of the local population. In particular, robust prevention targeted at vulnerable groups can support people to develop the knowledge and skills to prevent poor sexual health and therefore reduce demand for services such as STI testing and treatment

Redesign of Sexual Health Services

In Walsall we are committed to supporting all residents, to live a healthy sexual and reproductive life, free of discrimination, regret, coercion and violence

In March 2013, the Department of Health published ‘A Framework for Sexual Health Improvement’ which sets out the national ambition for good sexual health

and provides a comprehensive package of evidence, interventions and actions to improve Sexual Health outcomes.

Crucially there is now a national driver towards the provision of integrated sexual health services and a national service specification[1] to support this model of sexual health service delivery

Public Health Walsall has gone to the market to procure a joined-up, integrated, 'sexual health system' which provides good quality and value for money. That ensures a greater role for third sector organisations. This proposed new system will support people in making informed, confident choices and will especially focus on those people at greatest risk

Conclusion:

Reducing the burden of HIV and STIs requires a sustained public health response based around early detection, successful treatment and partner notification, alongside promotion of safer sexual and health-care seeking behaviour.

3.2.6 Environmental Health

Environmental Health have a statutory responsibility for food safety, health and safety, infectious disease control, aspects of drinking water quality, pest control and (farmed) Animal Health and Welfare. The way in which the Authority deals with these issues is reported to and monitored by central government on an annual basis through data submission, service plan reviews and occasional audits.

The Service is at the forefront of local health protection, working with businesses and residents every day to ensure risks to health are swiftly delta with to prevent spread of disease or the proliferation of environmental hazards. The service has traditionally worked proactively to tackle health risks in a bid to stop them actually occurring however this is has become increasingly difficult with current resource levels.

Against a backdrop of staffing reductions the service is increasingly reliant on prioritisation of work based on risk and/or actual harm caused. Intelligence is also being used more frequently to target areas of significance such as legionella in water supplies, health impacts from skin piercing, pest infestations in food production and major accidents in workplaces.

3.2.7 Pollution control

The West Midlands is the second most polluted region in the UK, (London being the first) with regards to nitrogen dioxide levels (NO_2). 6 out of 7 West Midlands metropolitan authorities have declared whole borough air quality management areas in this regard.

[1] Department of Health (2013) Integrated Sexual Health Services: National Service Specification
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210726/Service_Specification_with_covering_note.pdf

Key sources of pollutants are the road traffic networks in Walsall; M6, A454 and A461 for example. Walsall exceeds the national air quality objective and EU limit value for NO_2. The UK as a member state is subject to pending infraction proceedings on behalf of the EU parliament.

Initiatives that Walsall is participating in:

- West Midlands low emissions town and city programme
- Draft integrated transport authority strategic transport plan
- DEFRA consulting on clean air zones
- Combined Authority devolution

3.2.8 Emergency Planning Arrangements

Since April 2013 following public health transition into the council, Walsall PCT Health Emergency Planner transferred with Public Health to support the Director of Public Health statutory responsibility (further outlined in Appendix C) under the Health and Social Care Act 2012 stating:

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[2]

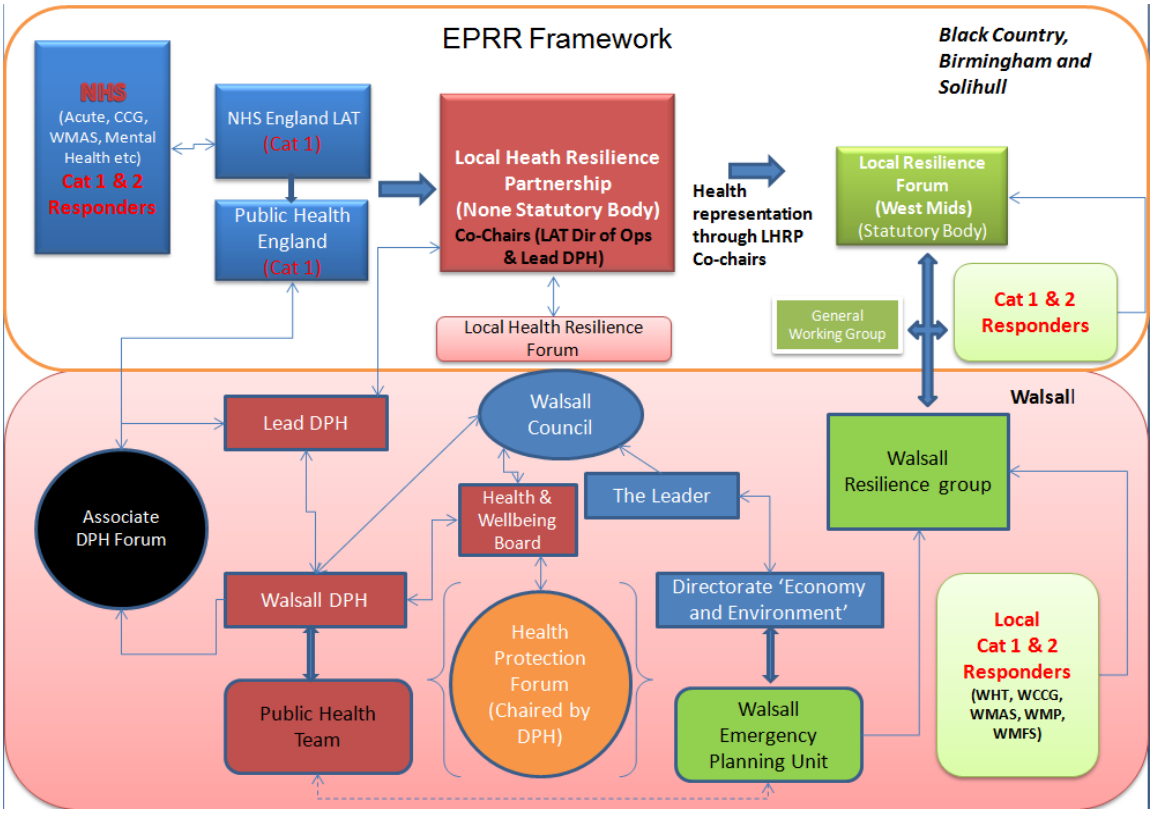
DPH role and responsibility is to provide local leadership through information, advice, challenge and advocacy on behalf of the local authority, to ensure Walsall council and NHS organisational preparedness to health protection and emergency arrangements.

Assurance and scrutiny is through the Walsall Health Protection Forum, chaired by DPH that review local capabilities in line with Civil Contingencies Act (2004)[3] statutory requirements. The Health Protection Forum ties into local and regional emergency planning groups as outlined within the Emergency Preparedness, Resilience and Response (EPRR) Framework Figure 1.

DPH can escalate concerns to the lead DPH, who on behalf of all DsPH within NHS England local footprint co-chairs the Local Health Resilience Partnership (LHRP) as the strategic forum to ensure joint Emergency Preparedness, Resilience and Response planning across the NHS England Local footprint covering Black Country, Birmingham, Solihull and Coventry are met in supporting the health sector's contribution to multi-agency planning through the Local Resilience Forum.

[2] Health and Social Care Act (2012)
[3] Civil Contingencies Act (2004)

Figure 1: Emergency Preparedness, Resilience and Response (EPRR) Framework



Current Work Programme for Emergency Planning

A health protection work programme has been developed to outline timeframes and actions to ensure local arrangements, risks, plans, training and exercises are developed or implemented alongside key partners internally and external to the Local Authority. This involves representation at local and regional forums, workshops and exercises to ensure local collaboration with multi-agency partners through the following groups:

- Walsall Resilience Group (Chaired by Police)
- Local Health Resilience Forum (Co-chaired by NHS England and Lead DPH)

A number of local plans covering health protection have been developed and are awaiting dates to be agreed in running an exercise to test the plan. The following plans are to be exercised within 2016:

- Walsall Council Outbreak Plan
- Walsall Council Pandemic Plan

The health emergency planner supports the development of the work programme alongside emergency planning colleagues within Walsall provider Trusts,

Emergency Planning Unit (Walsall Council), Public Health England and NHS England, as well as supporting Walsall CCG on a part time basis.

4. Implications for Joint Working arrangements:

The Health and Wellbeing Board members fully recognise that in order to make progress in achieving the priorities within the Health and Wellbeing Strategy and identify future needs, we must involve and engage with our providers as well as our wider public. The Health Protection Forum is intended to involve key providers and partners in addressing the health protection priorities of the Health and Wellbeing Board, thereby increasing the resource 'out there' to tackle the identified priorities.

5. Health and Wellbeing Priorities:

The Health Protection Forum brings together an identified group of key providers and partners to provide assurance and support work across the borough to protect the health of the population. This obviously impacts on all of the priorities of the Health and Wellbeing Board.

6. Background papers

The minutes of the Health Protection Forum can be made available electronically by contacting Uma Viswanathan, contact details below.

Authors

Dr Uma Viswanathan – Consultant Public Health
☎ 653751
✉ uma.viswanathan@walsall.gov.uk

Dr Barbara Watt
Director Public Health
☎ 653752
✉ Barbara.watt@walsall.gov.uk

Date

7th December 2015

Appendix A: Health Protection Forum Summary Dashboard November 2015

	Indicator	Indicator Description	Period	Walsall	Target /Trajectory	Trend	Trend Period	Source
Vaccination & Immunisation	1	**12 Month Diphtheria/IPV/HIB**	Q1 2015/16	96.7%	95%		Q1 10/11 - Q1 15/16	PC
	2	**12 Month Meningitis C**	Q1 2015/16	98.5%	95%		Q1 10/11 - Q1 15/16	PC
	3	**12 Month PCV 13**	Q1 2015/16	96.5%	95%		Q1 10/11 - Q1 15/16	PC
	4	**24 Month Diphtheria/IPV/HIB**	Q1 2015/16	98.6%	95%		Q1 10/11 - Q1 15/16	PC
	5	**24 Month Meningitis C/HIB (Booster)**	Q1 2015/16	98.1%	95%		Q1 10/11 - Q1 15/16	PC
	6	**24 Month MMR**	Q1 2015/16	97.7%	95%		Q1 10/11 - Q1 15/16	PC
	7	**24 Month PCV 13 Booster**	Q1 2015/16	97.8%	95%		Q1 10/11 - Q1 15/16	PC
	8	**5 Year Diphtheria/Tetanus/Polio**	Q1 2015/16	94.6%	95%		Q1 10/11 - Q1 15/16	PC
	9	**5 Year Diphtheria/IPV Booster**	Q1 2015/16	94.1%	95%		Q1 10/11 - Q1 15/16	PC
	10	**5 Year Meningitis C/HIB (Booster)**	Q1 2015/16	94.1%	95%		Q1 10/11 - Q1 15/16	PC
	11	**5 Year MMR Dose 1**	Q1 2015/16	98.5%	95%		Q1 10/11 - Q1 15/16	PC
	12	**5 Year MMR Dose 2**	Q1 2015/16	94.2%	95%		Q1 10/11 - Q1 15/16	PC
	13	**HPV (12-13 years girls)**	Sep/13 - Aug/14	84.0%	86.8%		2012/13 - 2013/14	SNS
	14	**Influenza Vaccination** in Over 65's	2014/15	71.2%	75%		2010/11 - 2014/15	PHOF
	15	**Influenza Vaccination** in Under 65's & 'At Risk Groups	2014/15	52.5%	51%		2010/11 - 2014/15	PHOF
	16	**Influenza Vaccination** in Pregnancy	upto 31st Jan 15	46.5%	75%		2012/13 - 2014/15	PC
	17	**Influenza Vaccination** in Frontline Healthcare workers	upto 31st Jan 15	46.0%	45.6%		2012/13 - 2014/15	PHE
	17i	**Influenza Vaccination** in 2 Years	upto 31st Jan 15	34.1%	36.5%		2013/14 - 2014/15	PC
	17ii	**Influenza Vaccination** in 3 Years	upto 31st Jan 15	39.2%	33.9%		2013/14 - 2014/15	PC
	17iii	**Influenza Vaccination** in 4 Years	upto 31st Jan 15	28.80%			2013/14 - 2014/15	PC
	18	**Pneumococcal (65 yrs & over)**	2013/14	64.1%	68.3%		2012/13 - 2013/14	PC
Screening	19	**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.	Q4 2014/15	99.9%	90%		Q1 13/14 -Q4 14/15	WHNT
	20	**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	Q3 2014/15	85.7%	70%		Q4 12/13 -Q3 14/15	WHNT
	21	**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	Q1 2014/15	98.5%	97%		Q4 12/13 -Q1 14/15	BWL
	22	**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.	Q3 2014/15	99.9%	95%		Q1 13/14 -Q3 14/15	WHNT
	23	**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.	Q4 2014/15	49.6%	50%		Q1 13/14 -Q4 14/15	BWL
	24	**Antenatal and Newborn Screening:** ST3 - The porportion of antenatal sickle cell and thalassemia samples submitted to the laboratorues which are supported by a completed Family Origin Questionnaire (FOQ).	Q1 2014/15	100.0%	90%		Q4 12/13 -Q1 14/15	BWL
	25	**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.	Q1 2014/15	96.9%	95%		Q4 12/13 -Q1 14/15	BCH
	26	**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.	Q4 2014/15	1.6%	2%		Q4 12/13 -Q4 14/15	WCHIS
	27	**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	Q1 2014/15	99.6%	95%		Q1 13/14 - Q1 14/15	WCHIS
	28	**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).	Q3 2014/15	100.0%	95%		Q1 13/14 - Q3 14/15	WHNT
	29	**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.	Q3 2014/15	100.0%	90%		Q1 13/14 - Q3 14/15	WHNT
	30	**Antenatal and Newborn Screening:** NP1 - The proportion of babies eligible for the newborn physical examination who were tested within 72 hours of birth.	Q4 2014/15	99.2%	95%		Q1 14/15 - Q4 14/15	WHNT
	31	**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.	Q3 2014/15		95%		Q1 14/15 - Q3 14/15	WHNT
	32	**AAA screening:** Proportion of men eligible for AAA screening to whom an initial offer of screening is made – completion of offer	Q4 2013/14	99.96%	90%		Q1 13/14 - Q4 13/14	BCAAA
	32i	**AAA screening:** Number of men eligible for AAA screening who have been screened (65 years)	Q4 2014/15	79.5%	54%		Q1 14/15 - Q4 14/15	WCCG
	33	**Bowel Screening** Uptake % (60 to 74 yrs)	Apr-15	53.1%	60%		Apr/14 - Apr/15	OE
	34	**Bowel Screening** 2.5 Year Coverage % (60 to 74 yrs)	Apr-15	53.7%	60%		Apr/14 - Apr/15	OE
	35	**Bowel screening:** Proportion of those who have returned a FOBt kit, out of those invited (no adjustment made for undelivered kits and letters)	Q3 2014/15	54.7%	52%		Q4 13/14 - Q3 14/15	WCCG
	36	**Bowel screening:** FOBt positivity	Q3 2014/15	1.9%	<2%		Q1 13/14 - Q3 14/15	WCCG
	37	**Breast Screening** for 50 to 70 Year Olds Uptake %	Apr-15	67.9%	70%		Apr/14 - Apr/15	OE
	38	**Breast Screening** for 50 to 70 Year Olds 36 Month Coverage %	Apr-15	71.5%	70%		Apr/14 - Apr/15	OE
	39	**Breast screening:** The percentage of women who are sent their results within two weeks	Jul-13	99.2%	90%			CSWBSP
	40	**Cervical Screening** 3.5/5.5-year coverage % (25 to 64 Yrs)	Apr-15	72.8%	80%		Apr/14 - Apr/15	OE
	41	(coverage)	Q4 2014/15	76.8%	80%		Q1 13/14 - Q4 14/15	PC

	Indicator	Indicator Description	Period	Walsall	Target /Trajectory	Trend	Trend Period	Source
Screening	32	**AAA screening:** Proportion of men eligible for AAA screening to whom an initial offer of screening is made – completion of offer	Q4 2013/14	99.96%	90%		Q1 13/14 - Q4 13/14	BCAAA
	32i	**AAA screening:** Number of men eligible for AAA screening who have been screened (65 years)	Q4 2014/15	79.5%	54%		Q1 14/15 - Q4 14/15	WCCG
	33	**Bowel Screening** Uptake % (60 to 74 yrs)	Apr-15	53.1%	60%		Apr/14 - Apr/15	OE
	34	**Bowel Screening** 2.5 Year Coverage % (60 to 74 yrs)	Apr-15	53.7%	60%		Apr/14 - Apr/15	OE
	35	**Bowel screening:** Proportion of those who have returned a FOBt kit, out of those invited (no adjustment made for undelivered kits and letters)	Q3 2014/15	54.7%	52%		Q4 13/14 - Q3 14/15	WCCG
	36	**Bowel screening:** FOBt positivity	Q3 2014/15	1.9%	<2%		Q1 13/14 - Q3 14/15	WCCG
	37	**Breast Screening** for 50 to 70 Year Olds Uptake %	Apr-15	67.9%	70%		Apr/14 - Apr/15	OE
	38	**Breast Screening** for 50 to 70 Year Olds 36 Month Coverage %	Apr-15	71.5%	70%		Apr/14 - Apr/15	OE
	39	**Breast screening:** The percentage of women who are sent their results within two weeks	Jul-13	99.2%	90%			CSWBSP
	40	**Cervical Screening** 3.5/5.5-year coverage % (25 to 64 Yrs)	Apr-15	72.8%	80%		Apr/14 - Apr/15	OE
	41	(coverage)	Q4 2014/15	76.8%	80%		Q1 13/14 - Q4 14/15	PC
	43	**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).	Q4 2014/15	80.9%	70%		Q1 14/15 - Q4 14/15	WPCT
Infection Control	44*	*Clostridium difficile* - Actual counts (Walsall CCG attributed)	Q1-Q2 2015/16	40	28		Q1 11/12 - Q2 15/16	PHE
	45	*Escherichia coli* (BSI) - Actual counts	Q1-Q2 2015/16	88			Q2 11/12 - Q2 15/16	PHE
	46	**Methicillin Resistant** *Staph. aureus* (BSI) - Actual counts (Walsall CCG attributed)	Q1-Q2 2015/16	0	0		Q1 11/12 - Q2 15/16	PHE
	47	**Methicillin Sensitive** *Staph. aureus* (BSI) - Actual counts	Q1-Q2 2015/16	16			Q1 11/12 - Q2 15/16	PHE
	48	Tuberculosis - Actual counts	Jan-Oct 2015	25			Q1 2011 - Q3 2015	WHNT
	49	**Surgical site infections** - SSI caesarean section (emergency)	2014/15	14			Apr/14 - Mar/15	WHNT
	50	**Surgical site infections** - SSI caesarean section (elective)	2014/15	9			Apr/14 - Mar/15	WHNT
	51	**Surgical site infections** – large bowel	2014/15	16			Apr/14 - Mar/15	WHNT
	52	**Surgical site infections** – abdominal hysterectomy	2014/15	3			Apr/14 - Mar/15	WHNT
	53	**Surgical site infections** - Trauma Hip	2014/15	6			Apr/14 - Mar/15	WHNT
	54	**Surgical site infections** - Knee replacement	2014/15	0			Apr/14 - Mar/15	WHNT
	55	**Surgical site infections** - Hip replacement	2014/15	9			Apr/14 - Mar/15	WHNT
	56	**30 day mortality C.Diff**	Apr/15-Sep/15	1			Apr/14 - Sep/15	WHNT
	57	**Contaminated blood cultures - % of total blood cultures (Actual counts)**	Apr/15-Sep/15	1.68% (38)			Apr/14 - Sep/15	WHNT
Sexual Health	58	**Chlamydia diagnosis** (Rate per 100,000 population)	2014	187.0			2001-2014	PHE
	59	**Gonorrhoea diagnosis** (Rate per 100,000 population)	2014	47.4			2001-2014	PHE
	60	**Infectious syphilis diagnosis** (Rate per 100,000 population)	2014	6.2			2001-2014	PHE
	61	**Anogenital herpes simplex (first episode) diagnosis** (Rate per 100,000 population)	2014	63.6			2001-2014	PHE
	62	**Anogenital warts (first episode) diagnosis** (Rate per 100,000 population)	2014	122.0			2001-2014	PHE
	63	**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	2012-2014	49.1			2009/10 -2012/2014	PHOF
Other	64	Fraction of all-cause adult mortality attributable to long term exposure to current levels of anthropogenic particulate air pollution	2013	5.9			2010-2013	PHOF

* YTD Trajectory target for C.Diff.

PHE - Public Health England; OE - Open Exeter; HSCIC - Information centre; WHNT - Walsall Healthcare NHS Trust; PHOF - Public Health Outcome Framework; WCHIS - Walsall Child Health Information System

PC - Primary Care; BCAAA - Black Country AAA Screening Cohort; SNS - School Nursing Service; BWL - Bham Women's Laboratory; BCH - Bham Children's Hospital; WPCT- Walsall PCT;

RMBCSP: Rugby Hub, Midlands & N. West Bowel Cancer Screening Programme; CSWBSP: City, Sandwell and Walsall BSP; BDRSP: Birmingham Diabetic Retinopathy Screening Programme; WCCG: Walsall Clinical Comission Group

Appendix B: Work plan for the Health Protection Forum

Walsall Health Protection Forum

Work plan 2013-15

Area of work	Action	Lead	Completion date/comments
Provide assurance to the Health and Wellbeing Board about the adequacy of prevention, surveillance, planning and response in relation to health Protection	Establishment of the health protection forum Develop a briefing paper for the Health and Wellbeing Board on health protection issues.	BW UV/MB	Health and Wellbeing Board did not have any sub structures. Structures will be put in place 2015/16. Annual report to be written for July meeting
To develop a collaborative approach to meet local health protection needs	To undertake a gap analysis of health protection across Walsall that will inform the ongoing work of the health protection forum.	All/UV	"Flu fairies" project completed – demonstrable increase in seasonal flu vaccine uptake in pregnant women. Infection control audit of day care and supported living at home services completed. Infection control manuals sent to all participants. Further support to these providers is required
To undertake surveillance of health protection issues within Walsall	Standing agenda items at the health protection forum to inform members of trends and key issues	PHE/PH IT/NHS England	Dashboard developed and being monitored and updated on key issues
To identify and highlight health protection risks in Walsall to ensure that mitigation plans are in place	Develop a risk register for health protection in Walsall Create a library of health protection plans	AB MB	Risk register in place Emergency plans waiting for sign off
To ensure robust locally sensitive arrangements for planning and response are in place	Table top exercise minor to major incidents Table top exercise with Severn Trent Water	AB NH/DE/ AB	Plans now developed and require testing Not done

BW – Barbara Watt
UV – Dr Uma Viswanathan
PHE – Public Health England representative
PHIT – Public Health Intelligence Team
NHS England – NHS England representative
AB – Adam Biggs
NH – Neil Harris
DE – David Elrington
MB – Mandy Beaumont
SW – Simon Ward

Suggested areas for future work

- Development of school, children's centres and private nurseries education on infection control
- Implementation of TB strategy across Walsall Health economy
- Focus on bowel screening and increase uptake amongst eligible population
- Introduce opportunity for routine screening in some work places in Walsall
- Maintain impetus of Flu Fairies work

Appendix C: DPH Statutory Duties with EPRR and Health Protection

Introduction

The Director of Public Health (DPH) has statutory responsibilities to ensure that they are able to lead and ensure on behalf of the Local Authority within any incident or emergency that affects the health of the community.

Statutory Responsibility

- 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[4]

- Exercising their local authority's functions in planning for, and responding to, emergencies that present a risk to public health. Ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to public health[5]

- The director of public health on behalf of the local authority will therefore provide advice, challenge and advocacy to protect the local population (Department of Health: Health protection and local government, 2012).
- Directors of public health will support clinical commissioning to reflect the need of the population.

- Lead on health protection, ensuring appropriate arrangements are in place, escalating concerns and holding local partners to account.

- Lead adviser on health to the local authority and a statutory chief officer, influencing decisions across the range of the authority's business, as well as carrying out on the authority's behalf its new functions relating to public health.

- Government sees local authorities having a critical role at the local level in ensuring that all the relevant organisations locally are putting plans in place to protect the population against the range of threats and hazards. The director of public health, lead the initial response to public health incidents at the local level, in close collaboration with the NHS lead. NHS with advice from the director of public health decides, at what point the lead role will transfer, if required, to the NHS[6].

- Local authorities (and directors of public health acting on their behalf) will prevent threats arising and ensure appropriate responses when things do go wrong. They will need to have available to them the appropriate specialist health protection skills to carry out these functions. To deliver this function successfully the director of public health will need access to a range of public health expertise in their Team.[7]

[4] Health and Social Care Act (2012)
[5] Department of Health (2012): Directors of Public Health in Local Government: *i) Roles, responsibilities and context*
[6] Department of Health (2012): The new public Health role in Local Authority
[7] Department of Health (2012): Health protection and local government