Health and Wellbeing SUFFOLK

**Agenda Item 5**

# Suffolk Health and Wellbeing Board

*A committee of Suffolk County Council*

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| **Report Title:** | Health Protection Assurance |
| **Meeting Date:** | 10 September 2015 |
| **Chairman:** | Councillor Alan Murray |
| **Board Member Lead(s):** | Tessa Lindfield, Director of Public Health |
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## Brief summary of report

1. To provide an overview of the health protection arrangements in Suffolk and identify areas that help deliver the Suffolk Health and Wellbeing Strategy

## Action recommended

2. The Board is asked to:

2.1 Support the current approach to assurance of the health protection arrangements for the population of Suffolk.

2.2 Support the work identified as areas where it could assist in improving performance

2.3 Consider how it would wish to be kept informed about trends and key issues regarding Suffolk's health protection status.

## Reason for recommendation

3. To inform the board of how health protection contributes to the Joint Health and Wellbeing Strategy, identify areas for which partner organisations on the Board assist in improving performance and confirm to the Board that the Director of Public Health (DPH) has taken steps to be assured that the full health protection function for Suffolk is in place.

## Alternative options

4. None

## Who will be affected by this decision?

5.1 The population of Suffolk

5.2 Partner organisations across the system including Public Health England (PHE), NHS England (NHSE), local Clinical Commissioning Groups (CCGs), Districts & Boroughs, local Acute and Community NHS Trusts, East of

England Ambulance Service, Suffolk Constabulary, and Suffolk Fire & Rescue Service and Suffolk County Council.

## Main body of report

### Background

6. Health protection is the domain of public health that seeks to prevent or reduce the harm caused by communicable diseases and to minimise the impact of environmental hazards such as chemicals, radiation and extreme weather events.

7. The Director of Public Health's responsibility for health protection is discharged by leadership and influencing rather than a managerial role because the resources deployed to protect the public's health are spread across many organisations. Public Health is well placed to 'identify any issues and advise appropriately'.

8. Guidance[1] indicates that the Director of Public Health should:

   - provide strategic challenge to health protection plans /arrangements produced by partner organisations
   - scrutinise and, as necessary, challenge performance
   - if necessary, escalate any concerns to the local health resilience partnership (LHRP)
   - receive information on all local health protection incidents and outbreaks and take any necessary action
   - provide the public health input into the local authority emergency plans
   - recommends that a health protection forum be established, possibly linked to the health and wellbeing board. This will help ensure that all key organisations meet regularly, share information and plan effectively.

### Current arrangements

9. There are two main groups that are used to ensure that the health of the Suffolk population is protected:

   - Suffolk Health Protection Forum meets quarterly. Chaired by Public Health, the aim is assure the DPH, review performance, share expertise and agree actions. Membership and responsibilities are:
     - PHE – communicable disease control and environmental hazards;
     - NHSE – commissioning and monitoring of immunisation and screening
     - CCGs – health care acquired infections.
     - The governance is to the DPH through DMT (exception reporting). The group has produced a Suffolk Health Protection Profile which gives an overview of performance and is available on request
   - Local Health Resilience Partnership (LHRP), co-chaired by the Director of Public Health and NHSE Area Team, ensures that the health system has

[1] Public Health in Local Government: the public health role of local authorities. Department of Health October 2012

robust arrangements for Suffolk's needs. The LHRP links to the multi-agency executive level Suffolk Resilience Forum.

- Associated mechanisms used to ensure that population health is protected are listed in Appendix 1.

**How Health Protection assists in the delivery of the Joint Health and Wellbeing Strategy**

**Every Child has the best start in life:**

10. The routine childhood immunisation programme protects children from previously common childhood illnesses and their complications. For example, measles, mumps and rubella are highly infectious conditions that can have serious, and potentially fatal, complications, including meningitis, encephalitis (swelling of the brain) and deafness. Since the two-dose MMR vaccine was introduced in 1988, cases have become less common.

11. If enough people in a community are vaccinated, it is more difficult for a disease to spread between people who have not been vaccinated i.e. the chain of infection is broken. This is called "herd immunity" and it is crucially important in protecting people who cannot be vaccinated for various reasons e.g. because they're too ill or their immune system is weak.

12. Vigilance is required to maintain high vaccine uptake as outbreaks may occur and cases of measles in particular have been rising in recent years. Vaccine uptake targets reflect this. For MMR vaccination, 95% uptake will achieve herd immunity and optimum population health protection.

13. Uptake in Suffolk is very close to the target (94.3% at one year, 93% at five years) but outperforms the UK average (92.5% and 90% respectively). This indicates significant progress has been made in five years (2010/11: 88% and 84% respectively) but there remains room for improvement. (Appendix 2)

14. Similarly, the recent introduction of rotavirus vaccine will have reduced demand on primary care and on hospitals. Rotavirus is a highly infectious stomach bug that typically strikes babies and young children and is often associated with outbreaks in nurseries and schools. Most children recover within days, but nearly one in five will need to see their GP, and one in 10 of these end up in hospital as a result of complications such as extreme dehydration. A very small number of children die from rotavirus infection each year.

15. Since 2013, an oral Rotavirus vaccine has been given to two and three month old babies and has coincided with 70% fewer confirmed cases. The difference is likely due to the new vaccine with a reduction from 13,674 cases in 2004/05 to 5107 cases in 2013/14 (Appendix 2). This will have reduced demand on services in primary care and at hospitals. However, as with MMR, uptake is not yet universal and every effort must be made to improve this.

16. To improve vaccine (and screening) uptake requires better quality information from the commissioner (NHS England) so as to understand the profile of children who have not received all that is due. In particular, better quality data is needed on children (and families) who may be subject to other inequalities

that compound to limit their life chances. Without this, there cannot be assurance that inequalities within Suffolk are being addressed.

**Suffolk residents have access to a healthy environment and take responsibility for their own health and wellbeing**

17. Frontline health and social care workers have a duty of care to protect their patients and service users from infection. Vaccination of healthcare workers with direct patient contact against flu has been shown to significantly lower rates of flu-like illness and mortality in healthcare settings. This applies to social care providers and independent health care providers such as dental practices, optometry and GP practices. These benefit the health & social care system, not just the direct employer.

18. The national targets for health care workers are 100% offer rate and 75% uptake rate. The offer of vaccination by employers is an occupational health responsibility and not part of the nationally funded flu programme.

19. Recognition of employees' critical roles and the need for organisations to secure business continuity and/or surge capacity in the event of an epidemic or pandemic is also a valid reason for flu vaccination. Workplace vaccination programmes should be defined, e.g. for business continuity or as a workplace offer – this will influence who is targeted, the scale of intervention and who pays. Failure to define, target or scale correctly will limit the system benefit of these interventions.

20 For optimum benefit to the system, it is crucial that all frontline workers across the health and social care system are appropriately identified and targeted on a suitable scale. It is recommended to the Board that all system organisations represented consider adopting the national target for health care workers.

**Older People in Suffolk have a good quality of life**

21. Influenza and pneumonia account for 13.4% of emergency admissions in the UK (2009/10), at a cost of £286 million per year. This affects the elderly and people with certain chronic medical conditions as the ageing immune system makes people more susceptible to infectious diseases but less responsive to vaccinations. This is reflected in levels of invasive pneumococcal disease which rises between ages 50-64y to become a major cause of morbidity and mortality in people aged 65 years and above. It accounts for just 6% of pneumonia but 24% of case fatalities.

22. A one-off pneumococcal vaccine is offered to people aged 65 years and over, typically delivered in GP practices as part of the national immunisation schedule. Uptake in Suffolk is 70%. Uptake of the annual seasonal flu vaccine in the same age group is 73%. (Appendix 3)

23. This means that up to 30% of the population aged 65 years and over has not benefitted from these cost-effective preventive measures which can improve their quality of life and contribute to reduced demand on the health and social care system.

24. Better quality information and analysis is required to profile the older people who do not take up vaccination offers. In particular, older people should be stratified by clinical risk and likelihood of hospital admission, to ensure that vaccination has been recommended. NHS England should lead this, working with their providers and supported by PHE. Without this, the Board cannot be assured that the full benefit of vaccination as a preventive measure is being utilised.

25 For all age groups, information about Waveney residents is routinely obscured by analysis by CCG (Great Yarmouth & Waveney). This limits the ability to fully understand issues in Waveney and ensure that they are, at least, no worse than the average in Suffolk.

26 The recommendations for action by NHS England apply to the full schedule of immunisation and screening, and are not limited to the examples used.

**Financial implications**

27. This paper does not propose any change to the current financial arrangements but highlights the potential costs to the system if the health protection function is not robust.

**Risk management issues**

28. Health protection measures are a complex web of interdependent processes, across several organisational boundaries with ongoing daily activities as well as the escalated responses to incidents and outbreaks.

29. Risks can be considered in the context of likelihood and impact. For example, in 2014/15, nearly 20,000 children aged 0 to 5 years received routine immunisation, an average of almost 400 contacts every week. Systems are in place to minimise risk, to investigate incidents and near misses and learn lessons.

30. Most incidents will be dealt with locally, efficiently and promptly. For reasonably foreseeable incidents which may have a greater impact or profile, measures are in place to anticipate these.

31. In addition to robust plans, Suffolk has the benefit of good working relationships between agencies and communities at a local level as well as between agencies at local, regional and national levels. A memorandum of understanding and mutual aid plans are also in place to facilitate prompt action when needed.

**Recommendations**

- That the Board supports the current approach to assurance of the health protection arrangements for the population of Suffolk.
- That the Board supports the work identified as areas where it could assist in improving performance, including:

- NHS England to provide better quality information and analysis
- All organisations to consider vaccination of appropriate frontline staff

- That the Board is asked to consider how it would wish to be kept informed about trends and key issues regarding Suffolk's health protection status.

**Sources of further information**

a) Public Health in Local Government: the public health role of local authorities. Department of Health October 2012

b) Public Health Outcomes Framework

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

d) NHS vaccination schedule

**APPENDIX 1**

**Other associated mechanisms used to ensure that population health is protected**

Public Health has input/access to:

1. Suffolk Screening & Immunisation Forum (monthly)
2. Regional health protection teleconferences (monthly) to review out of hours incidents & trends plus lesson sharing.
3. Norfolk & Suffolk Tuberculosis Network and Cohort Review (quarterly)
4. Routine information and intelligence e.g. PHE's Eastern Field Epidemiology Unit (monthly surveillance bulletin)
5. Work with the Suffolk's Joint Emergency Planning Unit and others to influence public health protection through the local emergency planning agenda.
6. District & borough council Environmental Health/Protection teams (via PHE)
7. Incident/Outbreak Control meetings
8. Health impact considerations at the planning stage of development applications (residential and industrial)
9. Business continuity advice e.g. to local businesses including the academic community e.g. during the West African Ebola outbreak
10. Workplace health at SCC e.g. offered workplace flu jabs last winter.
11. Responds to councillor/member/public enquiries
12. Media requests on topical issues for Suffolk
13. Work with colleagues from Norfolk County Council where it is expedient so to do.
14. All Public Health Consultants participate in the PHE out of hours rota for Health Protection. This ensures there is always a specialist with local knowledge of Suffolk in the event of an emergency

**APPENDIX 2**

## Selected childhood vaccination data

Table 1: Measles, Mumps & Rubella vaccine uptake in 2014/15 (%)

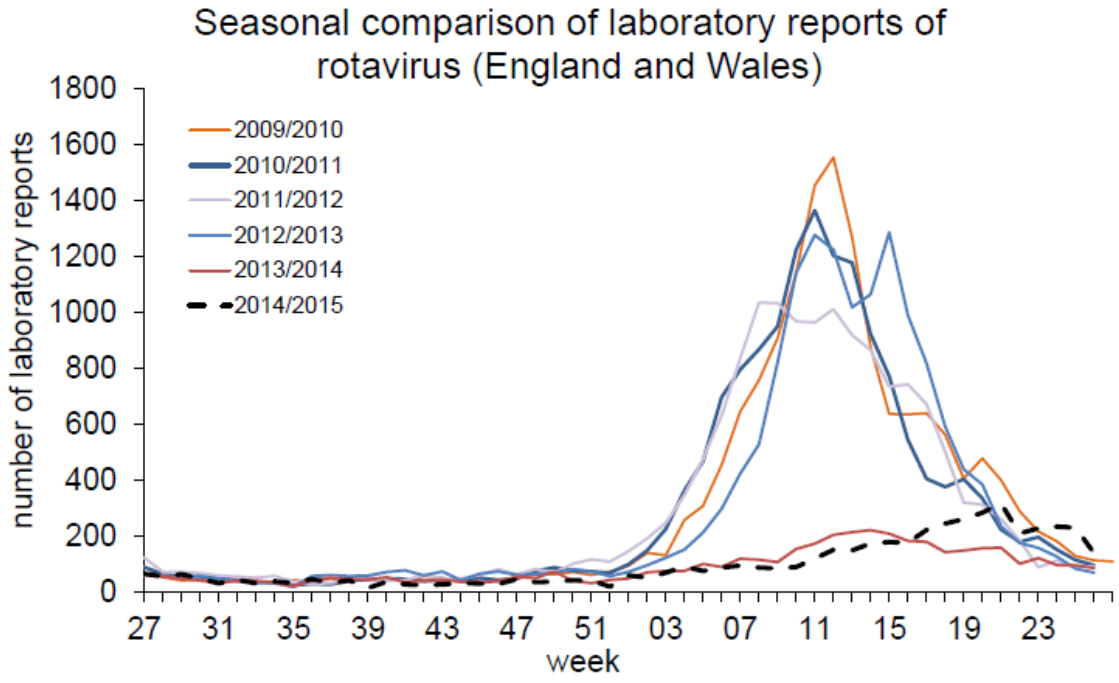
| 2014/15 | Suffolk | | | | UK |
|---|---|---|---|---|---|
| % | Q1 | Q2 | Q3 | Q4 | full year |
| MMR at 1y | 95.0 | 94.0 | 94.3 | 94.1 | 92.5 |
| MMR at 4-5y | 92.9 | 93.9 | 93.3 | 91.8 | 90 |

Table 2: Measles, Mumps & Rubella vaccine uptake in 2010/11 (%)

| 2014/15 | Suffolk | | | |
|---|---|---|---|---|
| % | Q1 | Q2 | Q3 | Q4 |
| MMR at 1y | 87.7 | 87.3 | 90.1 | 90.3 |
| MMR at 4-5y | 83.5 | 83.8 | 83.2 | 83.0 |

Figure 1: Rotavirus reports: before and after introduction of the vaccine

**Figure 8: Seasonal comparison of laboratory reports of rotavirus (England and Wales)**




Source: Public Health England

**APPENDIX 3**

**Selected adult vaccination data**

Table 3: Pneumococcal vaccine uptake in persons aged 65y and over

| Organisation Name | Pneumococcal vaccine uptake: 65y+ | | | | | |
|---|---|---|---|---|---|---|
| | % of GP practices reporting | No. of Patients registered | Received pneumococcal vaccine April 2014 to March 2015 | | Received pneumococcal vaccine anytime to March 2015 | |
| | | | Number | % | Number | % |
| IPSWICH AND EAST SUFFOLK CCG | 97.6 | 80,857 | 4,032 | 5.0 | 58,564 | 72.4 |
| WEST SUFFOLK CCG | 100 | 53,202 | 2,116 | 4.0 | 35,904 | 67.5 |
| GREAT YARMOUTH AND WAVENEY CCG* | 96.2 | 52,852 | 2,871 | 5.4 | 37,788 | 71.5 |
| SUFFOLK | 97.5 | 160,485 | 7,583 | 4.7 | 113,362 | 70.6 |
| ENGLAND | 96.7 | 9,464,112 | 441,671 | 4.7 | 6,604,515 | 69.8 |

Source: Immform

*Includes Great Yarmouth

Table 4: Influenza vaccine uptake in persons aged 65y and over

| Organisation Name | Flu Vaccine Uptake % (Target: 75%) | | |
|---|---|---|---|
| | 65y and over | Under 65y (at-risk only) | All Pregnant Women |
| NHS IPSWICH AND EAST SUFFOLK CCG | 73.9 | 46.9 | 50.6 |
| NHS WEST SUFFOLK CCG | 72.4 | 44.3 | 52.4 |
| NHS GT YARMOUTH AND WAVENEY CCG* | 71.5 | 48.9 | 36.8 |
| SUFFOLK TOTAL | 73.0 | 46.4 | 48.9 |

Source: Immform

*Includes Great Yarmouth

**APPENDIX 4**

**A life course overview of the full schedule of routine screening and immunisation.**

| | Screening | Immunisation | Comment |
|---|---|---|---|
| **Pregnancy & pre-birth** | HIV<br>Hepatitis B<br>Rubella (german measles)<br>Sickle cell disease<br>Thalassaemia<br>Down's syndrome | Pertussis (whooping cough)<br>Influenza | Promoted by midwives during antenatal care |
| **Newborn** | Bloodspot (for cystic fibrosis, Inherited metabolic diseases, congenital hypothyroidism, Sickle cell disease)<br><br>Hearing test | | 100% uptake is crucial for early diagnosis. This enables the child, family & carers to link into appropriate health & social care support. |
| **Under 5's** | | Diphtheria<br>Tetanus<br>Pertussis, Polio<br>Haemophilus IB<br>Pneumococcus<br>Meningitis C<br>Measles, Mumps<br>Rubella<br>Rotavirus<br>Influenza | Key role for Health Visitors to ensure children get the best start in life.<br><br>Opportunity to reiterate at playgroups and Children's Centres |
| **School aged children & young people** | | HPV (for cervical cancer)<br>Meningitis C | |
| **Adults 19y – 59y** | Breast cancer<br>Cervical cancer<br>Diabetic Retinopathy | Meningitis ACWY | |
| **Older adults 60y+** | AAA (abdominal aortic aneurysm)<br>Bowel cancer | Pneumococcus<br>Shingles<br>Influenza | |