Report to Rutland Health and Wellbeing Board

Subject:	**Leicester, Leicestershire and Rutland Health Protection Board Assurance Report** (Covering October 2015 to December 2016)
Meeting Date:	**30th June 2017**
Report Author:	**Mike Sandys/ Vivienne Robbins**
Presented by:	**Mike McHugh**
Paper for:	**Note / ~~Approval / Action/~~Discussion**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

As a result of the Health and Social Care Act 2012 the local authority has a statutory function, via its Director of Public Health (DPH), to assure itself that relevant organisations have appropriate plans in place to protect the health of the population and that all necessary action is being taken. In order to discharge the health protection assurance responsibilities, a Leicester, Leicestershire and Rutland (LLR) Health Protection Board, (now LLR Health Protection System Assurance Group) was established as a sub-group of the three LLR Health and Wellbeing Boards.

The purpose of this report is to update the Health and Wellbeing Board of the role that the LLR Health Protection Board and more recently LLR Health Protection System Assurance Group is carrying out to provide assurance for whole system health protection across LLR. It also updates the boards on health protection performance, key incidents and risks that have emerged from October 2015 to end December 2016.

Financial implications:

None

Recommendations:

The Health and Wellbeing Board is recommended to;

- Receive the Health Protection Board Report October 2015- December 2016
- Note the specific health protection issues that have arisen locally and steps taken to deal with these.

Comments from the board:

Strategic Lead:	Mike Sandys/ Vivienne Robbins

Risk assessment: Appendix 1 shows the health protection risk log. This is updated on a quarterly basis for the LLR Health Protection System Assurance Group.

Time	L/~~M/H~~	LLR Health Protection Assurance Report covering October 2015 to end December 2016.
Viability	~~L/~~M/~~H~~	The LLR Health Protection Board was established in June 2013, governance arrangements have

		been reviewed to increase the effectiveness of the health protection assurance across LLR. A key viability risk is to ensure that key partners continue to support the health protection agenda. Key risks are included on the risk log.
Finance	L/~~M/H~~	No specific financial implications.
Profile	~~L~~/M/~~H~~	The LLR Health Protection System Assurance Group is a subgroup of the three Health and Wellbeing Boards. The key role of this group is to gain assurance from key partners (including Public Health England, NHS England, local Clinical Commissioning Groups, Regulatory Services, Local Resilience Forum etc) on health protection across the system.
Equality & Diversity	L/~~M/H~~	The LLR Health Protection System Assurance Group considers health protection assurance across different population and community groups characterised in the 2010 Equality Act (for example gender, ethnicity, disability etc).

Timeline:

Task	Target Date	Responsibility

Leicester, Leicestershire and Rutland Health Protection Board Assurance Report

Covering October 2015 to December 2016

1. Background

As a result of the Health and Social Care Act 2012 the local authority is required, via its Director of Public Health, to assure itself that relevant organisations have appropriate plans in place to protect the health of the population and that all necessary action is being taken.

The purpose of this report is to update the three Health and Wellbeing Boards for Leicester, Leicestershire and Rutland (LLR) of the role that the LLR Health Protection Board and more recently LLR Health Protection System Assurance Group is carrying out to provide assurance for whole system health protection across LLR. It also updates the boards on health protection performance, key incidents and risks that have emerged from October 2015 to end December 2016.

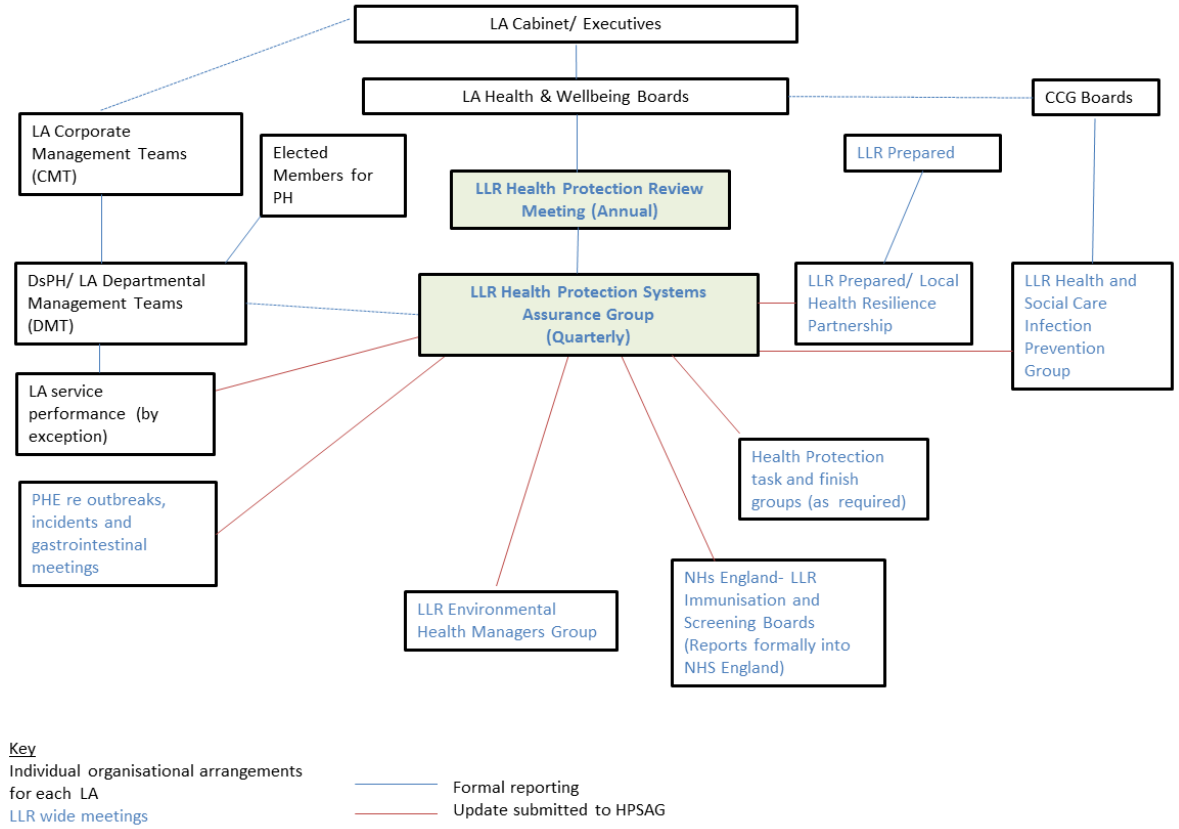
2. Changes to health protection governance arrangements across LLR

In order to discharge the health protection assurance responsibilities a LLR Health Protection Board was established in June 2013 as a sub-group of the three LLR Health and Wellbeing Boards. However some incidents during 2015/16 indicated that whilst all indicators and reports appeared to show that the system functions well, some gaps are present. It was therefore agreed that the current assurance system would be reviewed to ensure Directors of Public Health (DsPH) are appropriately sighted over these gaps.

Discussion with the DsPH and key stakeholders confirmed that although the Health Protection Board is an assurance committee, gaps in the system were not always identified and there was no obvious forum to take forwards strategic health protection work (for example national priorities such as anti-microbial resistance).

It was therefore agreed that a more systematic, confirm and challenge approach was needed. Fig 1 summarises the new approach to health protection assurance across LLR. It can be seen that the majority of assurance can be achieved through systematic quarterly data reports and more detailed verbal updates from key stakeholders. The LLR Health Protection Board has therefore been replaced by a smaller, more focused LLR Health Protection System Assurance Group. The assurance group membership consists of the DsPH, Public Health England (PHE) Consultants in Health Protection, and Local Authority Public Health Consultants who lead on health protection. The assurance group will feedback into each local authority departmental management teams (DMTs), an annual Health Protection Review meeting, and as appropriate Health and Wellbeing boards, Quality Surveillance Group, Corporate Management Teams and Cabinet.

Fig 1 Revised LLR health protection assurance mechanisms.



New ways of working

A key element to develop an effective health protection assurance approach is identification of key health protection risks (proactive and reactive) across the system. This is achieved by a health protection risk log (Appendix 1) and development of health protection dashboards. The dashboards use key data sets across all components of health protection including trend data split by local authority areas and comparisons to similar neighbours and national averages (Appendix 2). Quarterly dashboards, reports and/or updates are received and reviewed at the quarterly assurance group covering the following health protection components; incidents and outbreaks, immunisation and screening, health care associated infections, local authority service performance, environmental hazards and food safety, and emergency planning. This data will be reviewed by the group and if needed, stakeholders will be requested to produce more detailed assurance for the group on an exception basis.

To complement the assurance group an Annual Health Protection Review meeting was held in October 2016 to review the year's progress with all stakeholders and agree the LLR health protection strategic prioritises for the following year.

Initial strategic prioritises highlighted at the 2016 LLR Annual Health Protection Review meeting for development over the next 12-18months include;

- Anti-microbial resistance
- E.coli in urinary tract infections

- Ensuring the breast cancer screening programmes is accessible to women with learning disabilities

These pieces of work will be developed via existing programme boards or specific task and finish groups. Progress will report back to the Health Protection System Assurance Group.

3. Key health protection risks, emerging issues and mitigation

The Annual Health Protection Review provided an opportunity to review key LLR health protection incidents/situations over the previous year and the lessons learnt. Table 1 summarises the main incidents/ situations and confirms the areas for future development that will be followed up via the assurance group. Reoccurring themes from the outbreaks and situations include the importance of PHE leadership in managing local situations and outbreaks and the need to consider a more strategic approach to vulnerable people at risk of multiple drug resistant TB (such as the homeless.)

Other key health protection developments include;

- **Establishing a data sharing agreement between LLR local authorities and Leicestershire Partnership Trust for sharing of the school census data**. This will ensure appropriate delivery of public health services (including immunisations, national childhood measurement programme and 0-19 children's service) to all eligible students. This will reduce administrative workload for schools and LPT, whilst identifying the full cohort of students that need to be offered services.
- **LLR Prepared Assurance Framework** confirmed that partners are generally well prepared to respond to major incidents. Key areas for development include ensuring there is health capacity at coordinating groups (national issue) and that all local partners can maintain their response after the initial 48hr period.
- **LLR Prepared exercise on pandemic flu (Cygnus).** This live exercise tested the strategic coordinating groups, feeding into national COBR mechanisms in real time. Key learning included the need to set up a further pandemic flu exercise for 2-3 weeks following the initial event (due summer 2017), clarifying some roles and responsibilities and reviewing the current plan following the review of the national pandemic flu guidance. A further mass fatalities exercise (Jerboa) was also completed to test the initial blue light response (Jerboa 1) and communication between the strategic and tactical coordinating groups (Jerboa 2). This exercise was well received by all partners and a similar approach is likely to be taken in 2017.
- **Improved influenza vaccination uptake in Leicestershire County Council frontline staff** following an evaluation and more corporate approach to flu vaccination including access to flu clinics, vouchers and claiming expenses. Initial figures have identified an increase from 117 in 2015 to 466 frontline staff in 2016 accepting the offer of a free flu vaccination. N.B. Not all flu vouchers were used reducing actual uptake figures.

4. Health Protection performance

As discussed in section 2, health protection dashboards have been developed to support the DsPH to review health protection performance trends and identify areas for further investigation. Appendix 2 provides a local copy of the key health protection dashboards. Overall LLR performs similarly or better for health protection performance as compared to national and similar neighbours apart for the following exceptions;

Sexual Health

- In 2014, Leicester City and Leicestershire are below the England average for HIV testing coverage within the sexual health service at 56.5% and 66.2% as compared to 68.2%. Further investigation has suggested this is due to a coding error caused by the local integrated sexual health service including contraception in the data returns.
- In 2014, Leicester City had a higher HIV diagnosed prevalence of patients per 1,000 population aged 15-59 and late HIV diagnosis rate per 100,000 over 15years, than the England average and similar neighbours.
- In 2015, Leicestershire and Rutland have lower Chlamydia detection rates per 100,000 population aged 15-24years than the national average; however these are not statistically different to most similar neighbours.

Tuberculosis (TB)

- Leicester City had a higher TB (three year average) incidence than similar neighbours at 48.0 per 100,000 in 2012-14 as compared to 13.5 for England overall.
- When compared to similar neighbours, in 2014, a lower proportion of Leicester City TB patients starting treatment within four months of symptom onset.
- When compared to similar neighbours, a lower proportion of Leicester City and Leicestershire TB patients are offered a HIV test in 2014, however the recent trends do show improvement.

Immunisation and Screening

- In 2015/16, Leicester City performed lower than similar neighbours for population coverage for human papilloma virus (HPV) vaccine at 88.6%, even though this was above the England average at 86.7%.
- In 2015/16, Rutland performed lower than similar neighbours for the preschool diphtheria, tetanus, whooping cough and polio given by 5years old with 89.7% uptake. However performance is still above the England average at 86.9%. A similar trend is found with the 5year old MMR dose 2.
- LLR population flu vaccination uptake in over 65years and at risk groups decreased in winter 2015/16 following the national trend. However initial results for 2016/17 are showing improvement on last year's performance.
- In 2014/15, Leicester City performed lower than the England average for all screening programme indicators except the uptake of breast cancer screening within 6months of invitation in women aged 50-70years. Leicestershire and Rutland performed above the national average for all screening indicators.

Air Quality and Food Safety

- In 2013, Leicester City was ranked as having a higher fraction of mortality attributable to particulate air pollution than similar neighbours (ranked 15/16). Blaby, Charnwood and North West Leicestershire district councils were ranked as being within the bottom 26% of districts for the fraction of mortality attributable to particulate air pollution.

- There is a large variance in the number of food premises across each upper and lower tier local authority. Harborough was the only district to have a smaller proportion of food premises not achieving food standards A-E than the England average at 83% as compared to 86.2% nationally.

Health Care Associated Infections

- Leicestershire and Rutland CCGs are currently over their 2016/17 year to date C. difficile trajectory at 54 cases. Work is being completed with the CCGs to understand this trend and reduce future cases.

For more detail on overall health protection performance please see Appendix 2. Further health protection data can also be found using the Public Health England fingertips tool available at https://fingertips.phe.org.uk/profile/health-protection.

5. Conclusion

Overall the LLR DsPH are assured that the correct processes and systems are in place to protect the health of the population. Areas to continue to progress include ensuring health has the capacity to respond to major incidents (national issue), and maintaining and improving progress on key health protection indicators. The new health protection governance structure is now in place to provide improved oversight and risk management, and allow a more strategic approach to health protection across the LLR system. These structures will continue to monitor progress over areas identified within this report and will continue to report back to Health & Wellbeing Boards on an annual basis and exceptional basis as appropriate.

Table 1 Summary of key health protection outbreaks, incidents and situations across LLR from October 2015 to end December 2016.

	Outbreak/ Situation	Key Lessons Learnt	Areas for future development
Leicester City Council			
1.	**TB in homeless in Leicester City- Same strain as Loughborough** In May 2016 a case of TB was identified as a service user at the Dawn Centre. In July 2016 the Find and Treat Team screened 171/344 of people from the homeless population in Leicester. A number of acute and latent TB cases were identified and majority of these have now completed treatment. Sequencing and epidemiological data confirmed this outbreak was linked to the Loughborough outbreak (see below).	• Collaboration with CCG went well • Uncertainty as to whether the most effective use of Find and Treat was made • Resources to manage such incidents are limited both nursing and clinical	• More strategic approach needed for managing large TB outbreaks and particularly in the homeless population • Consider how this strain of TB will be managed longer term across LLR.
2.	**Extensively drug resistant TB cases** December 2015 TB case admitted to hospital with extensively drug resistant TB acquired outside of the UK. Family member diagnosed with extensively drug resistant TB in March 2016 and further cases were identified in family members following screening. Service issues due to identification of appropriate isolation facilities, locally and nationally. August- September 2016 further two children and student identified with extensively drug resistant TB cases.	• No negative pressure facilities for children in the Midlands • No appropriate isolation facilities for long term isolation • Public Health Law is inadequate to support solutions for the problems • Complexities of isolating extensively TB resistant cases for a prolong period of time.	• National specialised commissioning discussion needed regarding negative pressure facilities for children.

	Outbreak/ Situation	Key Lessons Learnt	Areas for future development
Leicestershire County Council			
3.	**Salmonella outbreak in pub restaurant in Blaby District** In March 2015, PHE were made aware of 21 cases with Salmonella typhimurium. Seven cases required hospitalisation and all cases were shown to be linked by whole genome sequencing of isolates. Further analysis over several months identified a total of 113 cases of which 103 were confirmed and 10 possible. PHE continued to lead outbreak control meetings for several months due to the ongoing source and number of cases identified. In November 2015 the drains of the pub were identified as the source of the infection by whole genome sequencing and final control measures were put in place to stop the outbreak.	• Methods of working – complex outbreaks need leading at the local level and not remotely • Questionnaires need to be developed in conjunction with EHOs • Lots of difficulties coordinating responses as many local authorities involved – need to use data sharing agreements drawn up with LLR Prepared.	• Consider more local PHE leadership approach in complex outbreaks. • Confirm data sharing agreements are already in place via the LLR Prepared for sharing of information in outbreak situations
4.	**TB in injecting drug user community in Loughborough**. In January 2015, PHE requested the DPH to chair a multiagency outbreak control meeting due to the identification of a cluster of highly infectious TB cases within the injecting drug user community in the Loughborough area. This was the follow on from a cluster originally identified in the 1990's. A multiagency approach was needed to include the local substance misuse, criminal justice and social care services to map patient networks and identify key individuals to target to attend a 'Find and Treat' van in May 2016. In total 136 cases were screened for TB and blood borne viruses. Small numbers of active and latent TB and Hepatitis B and C were identified and followed up.	• Strong multiagency approach to the outbreak. • Strong leadership from PHE due to dedicated senior registrar leading the outbreak management • Quick decision making and financial agreement from West Leicestershire CCG. • Learning translated to Leicester City TB outbreak (see above.) • Good proactive relationship with the media, providing information in advance meant they did not intervene on the day.	• Significant amount of PHE leadership capacity needed to organise the Find and Treat van event. • Need to engage district partners earlier on. • Consider how TB information and updates can be linked into substance misuse, social care and housing staff training.

	Outbreak/ Situation	Key Lessons Learnt	Areas for future development
5.	**Cryptosporidiosis in petting farm in Melton** PHE identified an excess of cases of Cryptosporidiosis in April 2016. Seven of the cases had visited a petting farm in Melton over the Easter holidays and had petted lambs. The facility was visited by environmental health officers and an improvement notice served to improve hand washing, provide hot water for handwashing and to improve advice given to customers about hand hygiene. Control measures reduced the exceedance in Cryptosporidiosis cases.	• Good working relationships between PHE and environmental health meant control measures were quickly put in place. • PHE led on reactive communication that was released due to media enquiry. • Lead members for Melton and Health were informed of incident early on.	• Continue to review petting farm hand washing facilities.
6.	**Asbestos in Wigston** In April 2016, PHE were notified of an asbestos situation affecting 15 properties following the spray washing of nearby private garage roofs. Local residents had contacted PHE following paying for a private asbestos assessment and contacting their local MP. Clean up took from April until end of September 2016 and has now been completed.	• Legislation not helpful in this area, making it difficult to confirm who was responsible for enforcing the clean-up when the landlord would not engage in the process. Oadby and Wigston borough council management team agreed to fund the assessment and clean up and recharge the garage owner. • Communication/ media response difficult due to no specific media post within the district. (This has now been rectified.)	• Use LRF media contact list to identify communication leads for each district or borough. • Ensure environmental health capacity in each district to support situations. • Need for debrief on long standing situations such as this.

	Outbreak/ Situation	Key Lessons Learnt	Areas for future development
Rutland County Council			
7.	No Rutland specific incidents. Individual cases have been managed through standard PHE operating procedures. Outbreaks of sickness and diarrhoea in nursing homes have been supported by the community infection prevention control service.		
8.	**Bird identified with Avian Flu** Dead bird identified with avian flu just before Christmas. Situation dealt with via Chief Vet and linked with PHE. National communication messages were incorrect stating Leicestershire.	• Difficult to informally notify Rutland chief officers and communication lead on the evening. • PHE produced advice for the public very quickly.	• Confirm routes to informally inform Rutland senior officers of incidents out of hours.
Leicester, Leicestershire and Rutland			
9.	**Flu incident at LRI – Haematology and Oncology** February 2016 small numbers of confirmed cases of Influenza H1N1 Swine on cancer haematology unit at Leicester Royal Infirmary. Following investigation 23 out of 45 patients were affected. Flu outbreak created significant additional winter pressure on UHL. However due to outbreak over 400 health care staff were vaccinated against flu taking UHL to the highest rate of vaccination for acute trusts in the East Midlands.	• Emergency coordination and management reviewed – issues now taken over by Urgent Care Board. • Needed a top down approach to ensure joined up approach across health and social care to reduce pressures on UHL. • Difficulties with communicating messaging and delivering a joined up response to the outbreak. • Outbreak improved flu vaccination uptake in staff.	• Health and social care management arrangements to be communicated across LLR. Role of Local Health Resilience Partnership confirmed as proactive system management rather than acute response. • Review and implement learning from exercise Cygnus (national pandemic flu exercise.)

	Outbreak/ Situation	Key Lessons Learnt	Areas for future development
East Midlands			
10.	**Pathway incident at Sexual Assault Referral Centre** In summer 2016, it was identified that 25 patients across the East Midlands had not been appropriately offered PEPSI (Post-exposure prophylaxis for HIV after sex) following a sexual assault. Serious incident called and Gold command in Nottinghamshire initiated. Full thematic review of incident completed and patients were contacted for follow up. DsPH across East Midlands drafted letter to NHS England to gain assurance that the incident was appropriately dealt with.	• Ensuring PHE is linked into the incident meetings early on. • Communication with all sexual health services and commissioners was needed (not just those attending the meeting.) • DsPH coordinating a letter to NHS England via the Regional DsPH meeting.	• Additional work is needed to confirm referral pathways between the SARC and each sexual health services across the East Midlands.