CABINET

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HEALTH PROTECTION ANNUAL REPORT 2014/15

Portfolio Holder: Councillor David Brake, Adult Services

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Summary

Unitary Local Authorities have statutory duties for health protection which are fulfilled by the Director of Public Health. This report provides an overview of health protection arrangements within Medway in 2014/15 and highlights areas where arrangements should be strengthened.

1. Budget and Policy Framework

1.1 Under the Health and Social Care Act 2012 from April 2013 local authorities assumed new statutory duties for public health including health protection..

1.2 The Director of Public Health is responsible for the local authority's contribution to health protection matters, including the local authority's roles in planning for, and responding to incidents that present a threat to the public's health.

2. Background

2.1 Health Protection involves planning and responding to incidents which may impact on the public's health. These include outbreaks of communicable disease and environmental hazards such as chemicals and radiation. It also includes the delivery of national screening and immunisation programmes.

2.2 Local Authorities are required to "provide information and advice to every responsible person and relevant body within, or which exercises functions in relation to the authority's area, with a view to promoting the preparation of appropriate local health protection arrangements, or the participation in such arrangements, by that person or body"

2.3 The Public Health Directorate works closely with NHS England, Public Health England, Medway CCG and the NHS providers in Medway in fulfilling this role. Governance arrangements are through the Kent and Medway Health Protection Committee and Kent and Medway Local Health Resilience

Partnership both of which are co-chaired by the Director of Public Health. There is also collaboration within the Council particularly with Environmental Health and Emergency Planning to ensure that the Council is able to respond effectively to public health incidents.

3. Advice and analysis

3.1 The annual report provides a review of health protection arrangements during 2014/15 and makes recommendations for further improving health protection arrangements. Of particular importance are the need to:

- Complete the plans for mobilisation of NHS resources in response to health protection incidents
- Improve the accuracy of immunisation data, particularly childhood immunisations, and improve uptake in groups with low uptake rates.
- Improve the coverage of cancer screening programmes, particularly for colorectal cancer.

4. Risk management

Risk	Description	Action to avoid or mitigate risk	Risk rating
Harm may occur to the health of local people through health protection incidents.	Inadequate health protection arrangements by commissioners and providers of NHS or local authority services could result in preventable harm occurring.	Work with partners and through appropriate governance processes to ensure that effective health protection plans are in place.	

5. Financial implications

5.1 There are no direct financial implications for the Council arising from this report.

6. Legal implications

6.1 The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (Regulation 8(1)) made under section 6C of the National Health Service Act 2006 (NHS Act 2006) (as inserted by s18 of the Health and Social Care Act 2012) requires unitary Local Authorities to take certain steps to protect the health of their local population. In particular they are required to provide information and advice with a view to promote the preparation of health protection arrangements by key health and care partners within the Local Authority area.

6.2 The Director of Public Health should be assured that the arrangements to protect the health of the communities are robust and are implemented appropriately to local health needs.

7. Recommendation

7.1 Cabinet is asked to consider and note the Health Protection Annual Report 2014/15 and the assurance given on the adequacy of the local health protection arrangements.

8. Suggested reasons for decision

8.1 Health Protection is a statutory function. Production of an annual report enables Public Health to provide an overview of health protection arrangements within Medway.

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Appendices
Appendix 1 - Health Protection Annual Report 2014/15

Background papers
None

Appendix 1

Health Protection Annual Report 2014/15

1. Introduction

1.1 Health protection is a broad term used to describe a range of activities which prevent or reduce harm to health. It includes

- Communicable disease control
- Environmental hazards such as chemicals and radiation
- National immunisation programmes
- Emergency preparedness, resilience and response
- National screening programmes

1.2 Under the Health and Social Care Act 2012, all Directors of Public Health (DsPH) on behalf of their local authority have a leadership role in providing information, advice, challenge and advocacy to promote the preparation of health protection arrangements by relevant organisations in their local area.

"*the DPH will provide advice, challenge and advocacy on behalf of their local authority, to promote preparation of health protection arrangements by relevant organisations, operating in their local authority area. The DPH, on behalf of their local authority, should be absolutely assured that the arrangements to protect the health of the communities that they serve are robust and are implemented appropriately to local health needs. They also need the opportunity to escalate concerns as necessary, when they believe local needs are not fully met. They should expect a highly responsive service from PHE and other partners in this respect*."

2. Purpose of this report

2.1 This report provides an overview of the current health protection activities within Medway, highlighting any issues or challenges. The report enables the Director of Public Health to provide assurance to Cabinet that the health of Medway residents is being protected effectively.

3. Kent & Medway Health Protection Committee

3.1 This committee was established in April 2013 to support the Directors of Public Health in fulfilling their health protection duties. The committee is co-chaired by the DsPH and membership includes Public Health England, NHS England and CCGs. As these organisations cover both Kent and Medway and because health protection issues often cross local authority boundaries it has been an effective arrangement for ensuring a co-ordinated approach to this agenda across Kent and Medway.

3.2 The remit of the committee includes communicable disease control, emergency planning, health care acquired infections and national screening and immunisation programmes. In addition, the committee also monitors the incidence of communicable disease, key performance indicators (KPIs) and reviews all significant incidents/outbreaks.

4. Community Outbreaks

4.1 Outbreaks of communicable disease are reported to Public Health England and the Director of Public Health. Outbreaks particularly of *Norovirus* continue to be a significant challenge for health and social care settings. The classical pattern of the 'winter vomiting disease' (Norovirus) has shifted paradoxically over the years and Norovirus infection occurs sporadically throughout the year rather than seasonally.

4.2 Specialist infection control advice is provided to Public Health through an arrangement with Medway CCG for a part time infection control nurse. This allows the provision of specialist support and advice to Medway care homes as well as the commissioners of care and public health services in the Council. This role has been instrumental in the engagement of care homes with the infection control agenda and support in managing and preventing outbreaks.

4.3 Support has been provided to care homes to undertake root cause analysis of outbreaks. The lessons learnt from such cases are invaluable in improving practice and ensuring safer practice when faced with the same or similar situations.

4.4 An Infection Prevention & Control Conference was held on 12th October 2015 to engage and update frontline healthcare staff and managers from care homes across Medway and Swale. This was well attended and received very positive feedback.

5 Health Care Associated Infections (HCAIs)

5.1 The prevention and control of Healthcare-associated infections (HCAI) is key to improving the safety and quality of care provided to patients in both health and social care settings.

5.2 There are many determinants for the acquisition of HCAI, and not all can be controlled by the care providers. As such it is necessary that Infection Prevention and control (IPC) precautions are consistently employed across the Health and Social care settings. The most common HCAIs are caused by methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile).

Methicillin-resistant *Staphylococcus* aureus (MRSA)

5.3 All CCGs and Acute Trusts have an annual limit of zero cases of MRSA bacteraemia.

5.4 All MRSA bacteraemia cases are reported to the Department of Health (DH) as part of mandatory surveillance of HCAI and also investigated to identify

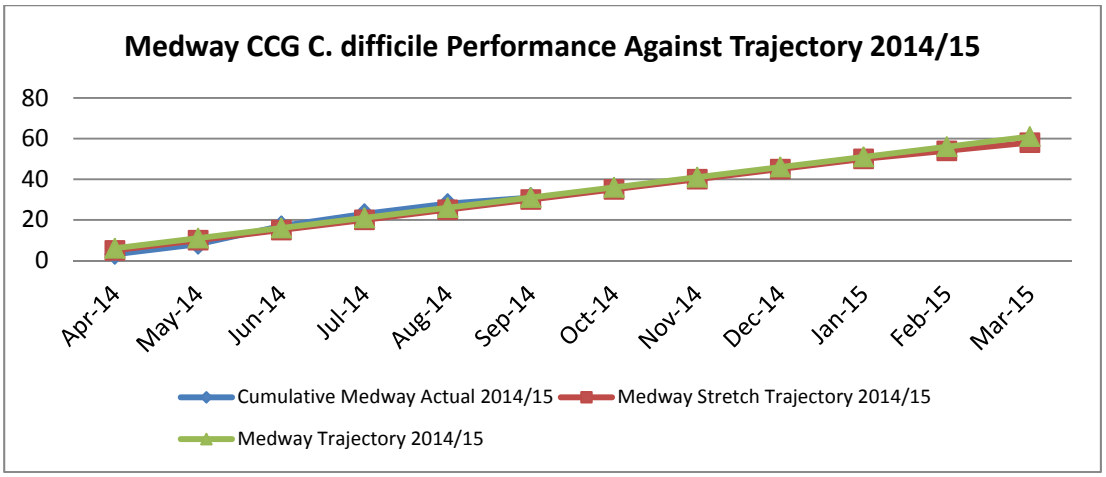
potential causes. Information and lessons learnt from the arising cases are used to plan for improvements to future care, to prevent and reduce the incidence of further avoidable cases. In 2014-15, Medway Foundation NHS Trust (MFT) had one confirmed case of MRSA bacteraemia.

Clostridium difficile (C. difficile)

5.5 *C. difficile* infection (CDI) is a type of bacterial infection that can affect the gastrointestinal system. It often occurs amongst people who have taken antibiotics, with older people, particularly those who are frail or who have medical conditions being most vulnerable to infection. The symptoms of infection include diarrhoea, fever and abdominal pain, and can range from mild to severe. Life threatening complications can occur, including severe inflammation of the bowel.

5.6 NHS organisations are required to demonstrate stretching year on year reductions in C. difficile cases. Significant achievements have been made in recent years with respect to reductions in the numbers of cases occurring locally. An improvement plan is in place for the CCG and Medway Foundation Trust. Medway CCG remained on trajectory throughout 2014/15 (figure 1).

Figure 1



Source: Medway CCG

5.7 Significant and sustained reductions have been seen in recent years in the numbers of cases of MRSA bacteraemia and C. difficile infection occurring in Medway. Increasingly challenging targets around HCAI are set year on year for both CCGs and Acute Trusts. Locally the NHS and the council continue to work collaboratively to make sustainable improvements to HCAI rates through surveillance, infection control programmes and initiatives and antibiotic prescribing policies.

5.8 For 2015/16 to date, there has been an increase in the numbers of recorded MRSA bloodstream infections compared to 2014/15. The reasons for this increase are under investigation by the CCG. Preliminary investigations have not revealed any consistent themes of contributory factors.

5.9 Recommendations

Support for good infection control practice within health and care organisations and prudent use of antibiotics is critical to the control of outbreaks and HCAI.

6 Immunisations

Commissioning and accountability arrangements

6.1 NHS England is responsible for commissioning immunisation programmes in line with the national immunisation schedule. Specialist public health staff employed by Public Health England are based within NHS England Teams to provide specialist advice and leadership for the commissioning of the programmes.

6.2 Local authorities through the Director of Public Health have, as part of their health protection remit, a duty to ensure robust immunisation services are in place to protect the population and to scrutinise and challenge commissioners and providers to ensure uptake of all childhood and adult vaccinations remains high and improves.

The routine immunisation schedule in England- see appendix 1

Primary childhood immunisations

6.3 Historically, the uptake of primary immunisations in children under the age of five years in Medway has been generally high. A decline in the uptake of childhood vaccinations in Medway has, however, been apparent since 2013. This decline has, in general, persisted and can be seen to a varying degree across a number of the routine childhood vaccinations (Table 1). These trends should be interpreted with caution and have been the subject of investigations by Public Health England, supported by Medway's Public Health Directorate. The reason for the decline in uptake is very likely to be a data quality issue. Concerns have been raised with NHS England and assurance given that action will be taken to resolve this matter. Public Health will continue to monitor uptake.

Table 1: Childhood primary immunisation uptake in Medway, 2014-15

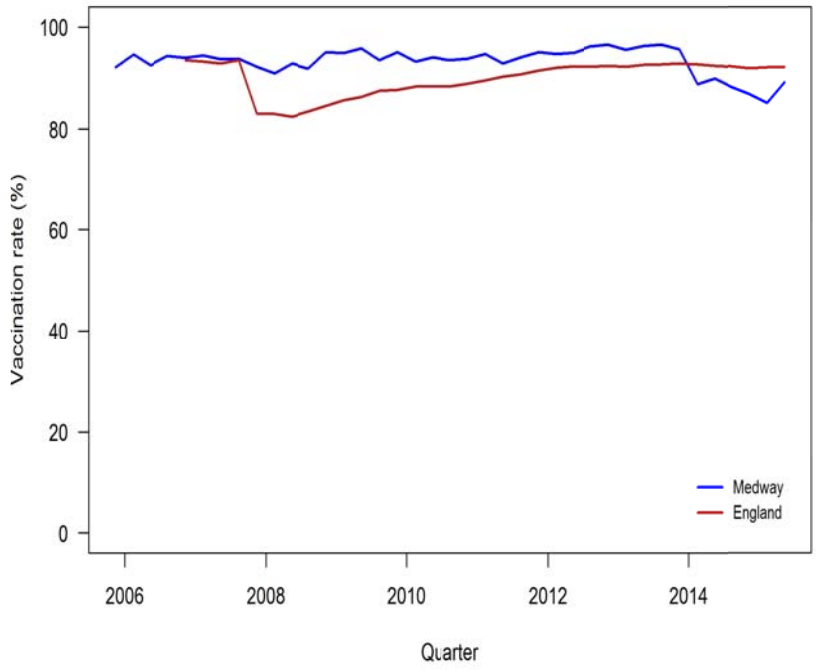
Immunisation	Target	2013/14		2014/15	
		Medway (%)	England (%)	Medway (%)	England (%)
Aged one year:					
DTaP/IPV/Hib3*	≥95%	94	94.3	89.5	94.2
PCV2	≥95%	93.5	94.1	89.1	93.9
Aged two years:					
Hib/MenC***	≥95%	92.0	92.5	89.3	92.1
MMR1******	≥95%	91.4	92.7	88.6	92.3
PCV booster	≥95%	91.0	92.4	88.3	92.2
Aged five years:					
DTaP/IPV booster	≥95%	89.0	88.8	84.8	88.5
MMR2	≥95%	86.6	88.3	84.4	88.6

Source: COVER data – www.gov.uk. Produced by Kent & Medway Screening & Immunisation Team.

*DTaP/IPV/Hib: Single vaccine that protects against diphtheria, tetanus, pertussis, polio and Haemophilus influenza type B.
**PCV: This vaccine protects against pneumococcal infection
***Hib/MenC: Single vaccine that protects against Haemophilus influenza type B and meningococcal type C infection
****MMR: A single vaccine that protects against measles, mumps and rubella vaccination

Figure 2 shows how the uptake rate for the first MMR vaccination has changed in Medway over the last ten years from a stable rate which remained consistently above the national average until 2013 when the decline in uptake began.

Figure 2: Uptake of MMR1 vaccination, Medway, 2005-2015



Source: Quarterly COVER data, published on www.gov.uk

6.4 There is substantial variation between local GP practices in the proportion of children receiving vaccination. Provisional data for 2014/15 indicates that the uptake at practice level ranges from just over 50% to almost 100%. Medway Council's Public Health Directorate will continue to work with Public Health England and Medway Clinical Commissioning Group to identify practices with low uptake and support them to address these variations.

6.5 The childhood Rotavirus vaccination programme was introduced in July 2013. The proportion of babies in Medway who received the recommended two doses of rotavirus vaccine in 2014/15 was 89.3%, compared with 88.1% for Kent and Medway overall.

School-based immunisations

Human Papilloma Virus (HPV)

6.6 The human papillomavirus (HPV) national childhood vaccination programme was introduced in 2008 for secondary school year 8 girls (12 to 13 years of age) as a three-dose schedule given within a six-month period. In 2014/15 the schedule changed to two doses; one in the Autumn term and the second in the Summer.

6.7 For 2014/15, HPV vaccination uptake for Medway of two doses was 80.8% compared to 80.4% for Kent (ImmForm). This is lower than the coverage for England overall which for 2014/15 was 86.7%.

6.8 It should be noted that the data collection for HPV immunisation is incomplete and does not include HPV given in general practice. This is expected to be included for the first time from 2015/16.

Teenage booster (Td/IPV) and adolescent Meningitis C vaccine

6.9 These immunisations are given by the School Nursing Service and data from Medway NHS Foundation Trust for 2014/15 indicate:

- 69.4% uptake of the Td/IPV teenage booster vaccination
- 72.9% uptake of the adolescent meningitis C booster

6.10 In September 2015, a dose of Meningitis C vaccine was introduced to all young people aged between 17 and 25 years entering university for the first time: those who have never received Men C vaccination or were previously last vaccinated at pre-school age are eligible. From September 2016, the Meningitis C vaccine will be replaced with the vaccine Meningitis ACWY.

Seasonal flu vaccination

6.11 The national seasonal influenza immunisation programme aims to protect those who are most at risk of serious illness or death should they develop influenza and to reduce transmission of the infection, thereby contributing to the protection of vulnerable individuals who may have a suboptimal response to their own immunisation. Vaccination is required annually for these groups. Flu vaccine eligibility for the 2014/15 was as follows:

- those aged 65 years and over on or before 31 March 2015
- those aged six months to under 65 years in clinical risk groups
- pregnant women at any stage of pregnancy
- all children aged two, three and four years on or before 1 Sept 2014 (DOB on or after 2/9/09 and on or before 1/9/12)
- school-aged children in pilot areas
- those in long-stay residential care homes
- carers

6.12 In 2014-15, the overall coordination of the influenza vaccination programme was organised and monitored by the Screening and Immunisations Team in NHS England. Medway Council's public health team developed a local Flu plan to enable communications to be disseminated to all appropriate council run services as well as the general public. The target uptake for all eligible groups and healthcare workers was 75% and the delivery of the childhood flu vaccination programme was extended to include all 2, 3 and 4 year olds.

6.13 Surveillance of influenza vaccine uptake took place throughout the 2014/15 season. The final report for the 2014/15 influenza season was published by Public Health England in March 2015. Medway's uptake was, for all groups, slightly higher than that for Kent and Medway overall but nevertheless lower

than the target uptake of 75%, significantly so for all vaccination groups other than the over-65s group (Table 2).

Table 2: Seasonal Influenza vaccination uptake by target group 2014/15: performance data

Indicator	Medway	Kent & Medway average	England
% uptake (over 65s)	71.4%	70.9%	72.8%
% uptake (under 65 and in a clinical risk group)	50.7%	48.2%	50.39%
% uptake (pregnant women)	44.6%	42%	44.1%
% uptake (children aged 2,3 and 4 years)	38%	36.9%	37.6%

Source: Kent and Medway Screening and Immunisation Team

6.14 As part of Medway CCG's Winter Resilience programme, a programme of pharmacy-led flu vaccination targeting frontline nursing/ care staff across Medway's care homes was rolled out across Medway from December 2014 to March 2015. Initial good progress was unfortunately slowed by the adverse publicity nationally around the effectiveness of the vaccine. Final vaccination uptake, as measured by the proportion of frontline care staff within participating care homes who were immunised, was 54.6%: slightly short of the uptake target of 60%.

Shingles vaccine

6.15 The shingles annual programme began on 1st September 2014, with patients aged 70 years being offered immunization. Patients aged 78-79 years were included in the catch-up programme. Eligibility was determined by the patient's age on 1st September 2014.

6.16 The survey collects data for two cohorts:

- *Routine Cohort* - registered patients aged 70 on 1st September 2013 and born between 02.09.1942 and 01.09.1943
- *Catch up Cohort* - registered patients aged 79 on the 1st September 2013 and born between 02.09.1933 and 01.09.1935

6.17 For September 2014 – February 2015, 100% of Medway GP practices reported their shingles uptake data, compared with 97% nationally. Percentage uptake was as follows:-

Table 3 Shingles vaccine uptake, September 2014 - February 2015, Medway and England

Cohort	Medway uptake	England uptake
Routine	44.6%	48.7%
Catch up (78 years)	46.4%	50.3%
Catch up (79 years)	47%	48.1%

Source: Pubic Health England. Shingles vaccine coverage report, England, September 2014 To February 2015.

Pneumococcal vaccine

6.18 A single (one-off) Pneumococcal vaccination is routinely offered to all adults over the age of 65 years. Only a single vaccination is required for this group which offers lifelong protection.

6.19 Children and adults with certain chronic health conditions and children under the age of two years should also have the vaccine.

6.20 Uptake amongst over 65s in Medway has remained steady at around 70% since 2013/14. National comparator data are not currently published.

Pertussis vaccination in pregnancy

6.21 Overall uptake of prenatal Pertussis vaccination has been low since its introduction. Uptake for 2014/15 for Medway was 60.2%, compared to 56.3% for Kent and Medway overall.

6.22 Campaigns have raised awareness amongst midwives and in general practice to actively invite pregnant women. There is now widespread engagement with and support for this vaccination in general practice and Midwifery. Immunisation directly through midwifery is under discussion.

6.23 Recommendations

- It is important that efforts to ensure optimum uptake of immunisations continue:
    - Maintaining accurate data is of critical importance in improving immunisation rates.
    - GP practices with relatively low immunisation uptake should be identified and supported to optimise reporting of data and delivery of immunisations.
    - Population groups who are at risk of not accessing immunisations should be identified and encouraged by service providers to come forward for immunisation.

- Continue to support local communications strategies where appropriate, for example, for seasonal flu vaccination.

7. Sexually Transmitted Infections including HIV

7.1 Table 3 compares key indicators relating to major STIs in Medway with England overall. Data are benchmarked against the England average. Those indicators which are highlighted green are significantly better than the England value. Indicators highlighted amber are similar to the England value.

Table 3: Key indicators relating to major STIs in Medway and England

Year	Indicator	Medway	England
2014	All new STI diagnoses (excludes Chlamydia in under-25s)	652	829
2014	Syphilis diagnosis rate/100,000	3.3	7.8
2014	Gonorrhoea diagnosis rate/100,000	28	63.3
2014	Chlamydia detection rate/100,000 people aged 15-24	2048	2012
2013	HIV diagnosed prevalence rate/1,000 people aged 15-59	1.4	2.14

Source: Public Health England Sexual and Reproductive Health Profiles. http://fingertips.phe.org.uk/profile/sexualhealth/data#page/0 [accessed 11/09/2015]

Chlamydia

7.2 Chlamydia is the most commonly diagnosed sexually transmitted infection in the UK. The chlamydia detection rate amongst under 25s is a measure of chlamydia control activities and represents infections identified.

7.3 Annual Chlamydia screening, or on a partner change, is recommended for all sexually active people under 25. The Department of Health recommends that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population aged 15-24. The Chlamydia detection rate for Medway for 2014 was 2048 per 100,000 population aged 15-24. This is similar to the rate for England (table 3).

HIV

7.4 In 2013, the HIV prevalence for Medway (1.4 per 1,000 population aged 15-59) was similar to the rate for England.

7.5 HIV testing coverage in Genitourinary Medicine (GUM) settings has increased in recent years in Medway from 57.4% in 2009 to 75.5% in 2014. This is significantly higher than the England coverage for 2014 of 68.9%. Working with local charities, during 2014/14 community based testing targeting the black African population and an extension of the HIV testing week targeting men who have sex with men have been commissioned.

7.6 Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection and is essential to monitor the success of expanded HIV testing. Over time, measuring this indicator will show whether there is a trend towards earlier diagnosis. HIV late diagnosis (percentage of adults (aged 15 or above) newly diagnosed with HIV with a CD4 count less than 350 cells per mm3) has remained similar for Medway compared with England since 2009-11, and was 48.7% for Medway for 2011-13 compared to 45% for England for the same period.

Sexual health services

7.7 Sexual Health services are currently provided by Medway NHS Foundation Trust (MFT) (Genito Urinary Medicine) and Kent Community NHS Health Foundation Trust (KCHT) (Contraceptive and Sexual Health services). Point of care testing for HIV is currently provided in the community by Health Action Charity Organisation (HACO), a charity supporting black Africans to improve their health.

7.8 A sexual health network was established in 2014 by Public Health with the aim of improving communication between those working to improve sexual health and to develop a common strategy. The network includes representation from Public health, Social Care Services, MFT GUM Clinics, KCHT CASH Clinics, KCHT Student Health Services, Metro (Sexual health Charity), HACO, Healthwatch, Public Health England, Marie Stopes (Sexual health charity), Youth Offending Team and Turning Point (Drug and alcohol treatment services)

7.9 The tendering of an Integrated Sexual Health service is progressing and will include all aspects of sexual heath currently delivered by Pubic Health including Chlamydia Screening Programme, condom distribution scheme (CCard), Emergency Hormonal Contraception (EHC) in pharmacies, Long Acting Reversible Contraception (LARC) in primary care and community based HIV screening.

7.10 Medway Council's Health Improvement Team have developed the A Better Medway website where, amongst other information relating to health improvement, comprehensive information on local sexual health and

contraceptive services is available, as well as links to useful information relating to sexual health.

7.11 Tuberculosis

7.12 TB incidence in Medway is low and below the national average. There were 16 cases (rate 6 per 100,000 population) of TB amongst Medway residents in 2014. This is a decline compared to the previous five years when the number of cases ranged from 20 – 28. 75% of cases in 2014 were amongst non-UK born patients.

7.13 The treatment completion rate at 12 months in Medway for 2012-2014 was 82%. All Medway TB patients whose HIV status is not already known are offered an HIV test.

7.14 A Consultant in Public Health Medicine from Medway Council's Public Health Directorate takes part in regular TB network meetings and cohort reviews where case discussions and reviews of best practice take place, with the aim of improving the quality and outcomes of TB services.

7.15 A new national TB strategy *("Collaborative Tuberculosis Strategy for England 2015 to 2020")* was developed by Public Health England and published in January 2015. The strategy outlines how TB services in England will be organised and resourced. A key change will be the establishment of TB Control Boards which will aim to strengthen the co-ordination and oversight of all aspects of TB control. Medway will be covered by the South East TB Control Board, which will have representatives from NHS England, Local Authorities, Clinical Commissioning Groups, TB clinicians and other relevant partner organisations. The current Cohort Review and TB network meetings will feed into this board.

7.16 All local TB services participate actively in the Kent TB cohort and network meetings and that there are currently no known major issues in the provision of TB services.

7.17 Recommendation

Promote a joined up approach across statutory agencies and local authority departments in order to plan for better outcomes and processes with respect to TB control. This could include, for example, joined up working between housing, TB teams and commissioners to agree policies for the provision of accommodation of homeless persons with TB.

8. Screening Programmes

Ante-natal and Newborn Screening Programmes

Sickle cell and thalassaemia

8.1. All pregnant women are offered screening for sickle cell and thalassaemia, using family origin information obtained by the Family Origin Questionnaire (FOQ) to support laboratory results. Medway achieved the three Key Performance Indicators (KPIs) associated with this screening:

- Screening coverage of 98.2% [ST1] of eligible women against a target of 95%.
- Family Origin Questionnaire was completed in 98.6% of cases, against a target of 95%.
- Conclusive screening results were made available within 10 weeks in 52.5% of cases. This exceeds the acceptable level of 50%, but is lower than the achievable level of 75%.

Infectious diseases in pregnancy

8..2 Screening for HIV, Syphilis, Hepatitis B and Rubella is routinely offered to all pregnant women.

- Uptake of HIV screening was 99.4% for 2014/15, with no reported cases in one quarter and fewer than five cases diagnosed in each of the remaining three quarters of 2014.

- Diagnosis of Syphilis is rare, with fewer than five cases recorded in each quarter of 2014.

- Diagnosis of Hepatitis B is also uncommon, with fewer than five cases recorded in each quarter of 2014. Performance in respect of referrals of Hepatitis B positive women to an appropriate specialist within six weeks of identification was inconsistent. On average, this target was achieved in 60% of cases which falls short of the acceptable level, defined as 70%. Babies born with Hepatitis B are offered immunisation at birth.

- Women identified as non-immune to Rubella are offered vaccination following delivery, prior to discharge from maternity services.

Fetal Anomaly Screening

8.3 Requests for Down's Syndrome screening were completed in full and within the prescribed timescales in 98.9% of cases, against a target of 97%.

Newborn Blood Spot Screening

8.4 These blood tests are used to diagnose nine inherited conditions, namely:

- sickle cell disease
- cystic fibrosis
- congenital hypothyroidism
- phenylketonuria (PKU)
- medium-chain acyl-CoA dehydrogenase deficiency
- maple syrup urine disease (MSUD)
- isovaleric acidaemia
- glutaric aciduria type 1
- homocystinuria (pyridoxine unresponsive)

8.5 In 2014/15, 95.3% of babies in Medway CCG received results within 17 days (performance threshold is 95.0%).Although not all the results were known within 17 days, all babies have received results.

8.6 In Medway, avoidable repeat tests (the percentage of babies from whom it is necessary to take a repeat blood sample due to an avoidable failure in the sampling process) were necessary for an average of 1.97% of babies over 2014/15, against a target of ≤2.0%. This compares with the average for Kent and Medway overall of 2.63%.

8.7 Timely (within six weeks of birth) availability of negative test outcomes (the proportion of newborn blood spot screening results which are screen negative for all nine conditions, available for communication to parents within six weeks of birth) was 99.6% for Medway for 2014/15 against a target of 95%.

Newborn Hearing screening

8.8 97.5% of eligible babies in Medway CCG were screened by four weeks of age during January-December 2014, against an acceptable level target of 95.0%. The percentage of babies that received an audiological assessment within four weeks of a decision to refer them for assessment was 61.9%, against a target of 95%. The poor performance has been raised with the CCG.

8.9 Recommendation

- The reasons for and solutions to the poor performance with respect to audiological assessments of babies referred following newborn hearing screening need to be determined.

9. Adult Screening Programmes

9.1 The effectiveness of all screening programmes depends on the coverage and a high quality service. Coverage is the proportion of the population who were eligible for screening who were screened within a specified period.

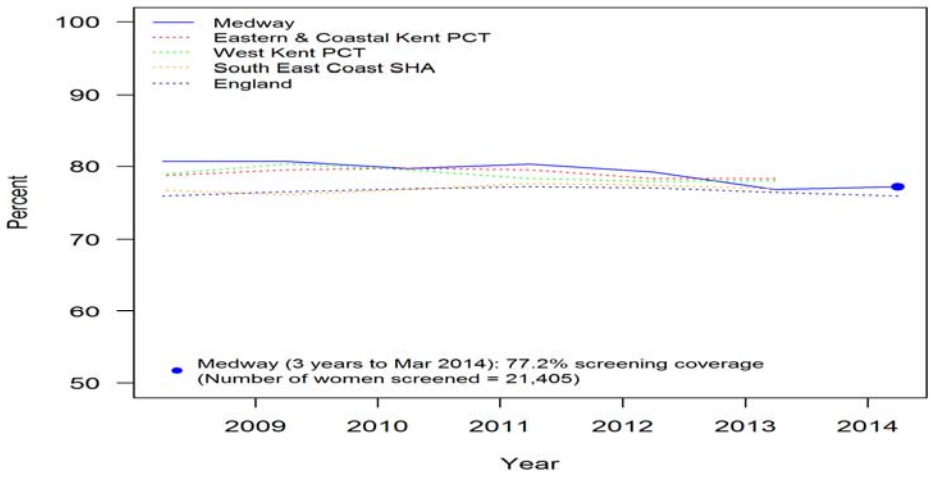
Breast Cancer Screening

9.2. Women aged 50-70 years are sent a written invitation for breast screening every three years. A randomised trial, where women aged 47 to 49 and 71-73 years are invited for breast screening started in 2010 will end in 2016. Abnormal results are assessed within two weeks. The programme aims to detect breast cancer at an early stage, when treatment can be more effective and less invasive. Cancer screening is an important way to detect cancer early with around a third of breast cancers now diagnosed through screening.

9.3 Although, there has been a slight decline in screening coverage over the last few years in Medway, coverage is above the minimum standard (>70%) and above the average for England (Figure 3). However, there are variations across General Practices in Medway and Medway is yet to achieve the national target (80%).

9.4 An action plan was developed and implemented jointly with Medway CCG in 2014 through to 2015, to improve cancer screening uptake as part of a wider cancer mortality reduction plan in Medway.

Figure 3: Breast Screening Coverage: 53-70 years



9.3 Recommendation

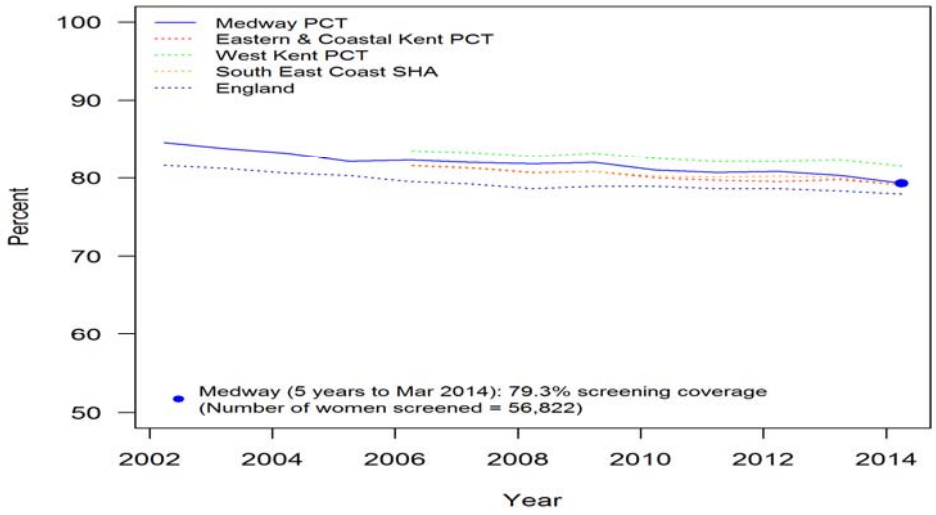
- Good coverage and uptake of breast screening should be maintained through public and health professional screening awareness raising programmes.

Cervical Cancer Screening

9.5 Women are sent a written invitation to make an appointment for cervical screening, either in their general practice or at a contraceptive and sexual health clinic, every three years from age 25 to 50 and 5 yearly from age 50 to 65. The programme aims at reducing the number of women who develop invasive cervical cancer and the number of women who die from it, by detecting and treating early abnormalities in the neck of the womb, which if left untreated could lead to cancer.

9.6 At the end of March 2014, the coverage for eligible women in Medway was 79.3%, above the average for England (Figure 4). However there are variations across general practices in Medway. Coverage remains low (73.5%) for eligible women aged 25-49 years in Medway, as in the rest of the country.

Figure 4– Cervical screening 25-64 years



9.7 Recommendation

- Maintain good coverage and uptake of cervical cancer screening through targeted public cancer screening awareness raising programmes in particular amongst women aged 25-49 years.

Bowel Cancer Screening

9.8 The programme started in West Kent and Medway in 2009. It aims to detect bowel cancer at an early stage, when treatment is more likely to be effective or to help prevent cancer from developing. Men and women aged between

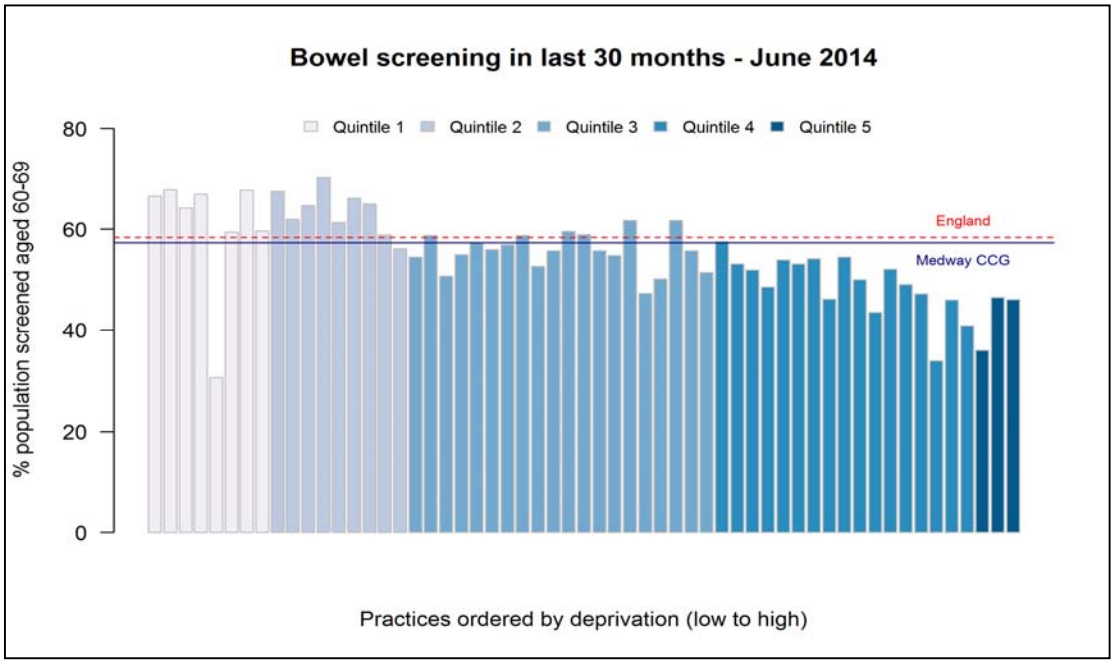
60-69 years who are registered with a GP are sent a self-testing kit every two years as part of the programme. This was extended to include those aged 70 to 74 years in West Kent and Medway in January 2012.
The Southern Hub in Guildford sends and organises invitations, sample processing and result letters.

9.9 Figure 5 shows variation of bowel cancer screening uptake across general practices in Medway (30.7% to 70%) 2013/14. As expected, uptake was lower in practices located in the slightly more deprived areas.

9.10 In 2014/15, bowel cancer screening uptake in Medway (56%) was above the minimum standard of 52% target.

9.11 Medway GPs are working with the Southern Hub Bowel Cancer Screening Programme to improve bowel cancer screening uptake in Medway (Pearl Project -Patient Endorsed Additional Reminder Letter). This project led by the Southern Hub send out a GP endorsed reminder letter on behalf of the practice to patients who have not returned their bowel cancer screening kit. Forty three of fifty five Medway GPs (78%) have signed up to participate in this project.

Figure 5 – Bowel screening in last 30 months – June 2014



Bowel Scope Screening

9.12 In 2013, West Kent and Medway was one of six national pilot sites chosen to launch the Bowel Scope Programme (BSP) – a one off test for 55 year olds,

which uses a camera on a flexible scope to look for and remove surgically, pre-cancerous growths in the lower part of the bowel. The roll out of the BSP has been phased across three years, with the final lists rolled out in early 2016.

9.13 Medway accounts for one fifth of the centre's Bowel Scope work and since the start of the programme, 1274 participants have taken part, with an uptake rate of 47%.

9.14 Work is underway with provider and GP practices to ensure that patients eligible to opt in are aware of the programme.

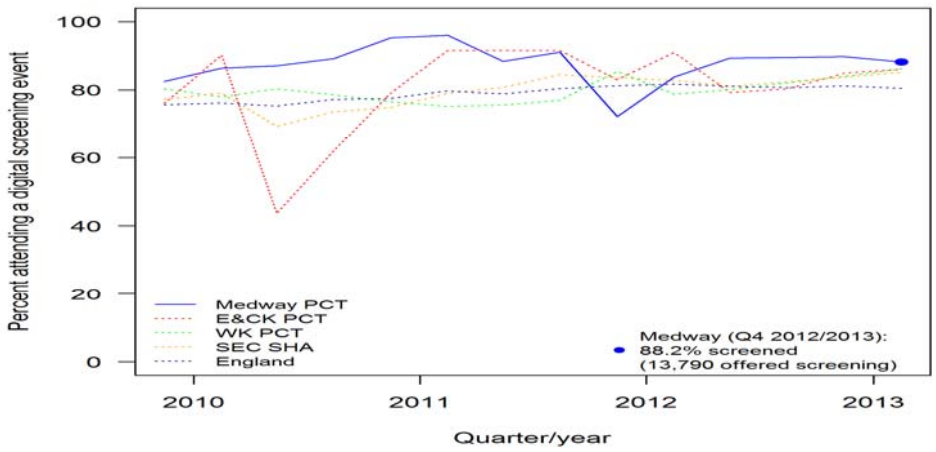
9.15 Recommendations:

- Increase bowel cancer screening uptake particularly through engaging community groups with low uptake.

Diabetic Eye Screening

9.20 People with diabetes aged twelve and over are invited annually for eye screening (retinal photography). The image is graded and if appropriate, they are then referred directly for specialist assessment and treatment. In Medway, diabetes eye screening is provided by Medical Imaging UK. The proportion of people offered and who attend is higher in Medway when compared with other areas (Figure 6).

Figure 6 – Diabetic retinopathy screening

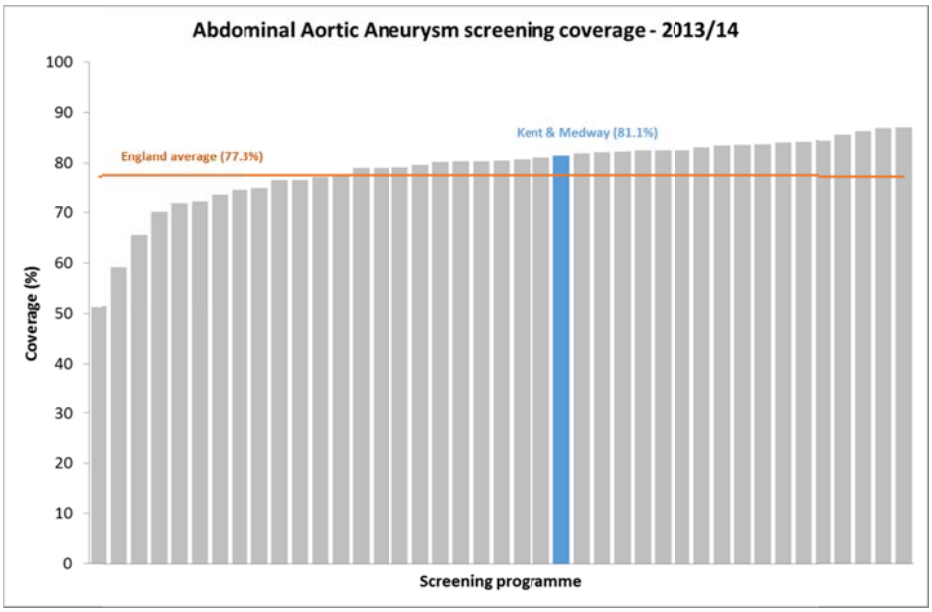


Abdominal Aortic Aneurysm Screening (AAA)

9.21 The Kent and Medway AAA programme which started in 2011, invites men on their 65th birthday to attend abdominal ultrasound examination. Those with an enlarged abdominal aorta are either monitored or referred if appropriate for surgery at Kent and Canterbury Hospital (the only accredited site in Kent and Medway). The programme aims to reduce AAA related deaths among men aged 65 to 74 years, through early detection, appropriate follow-on tests and treatment.

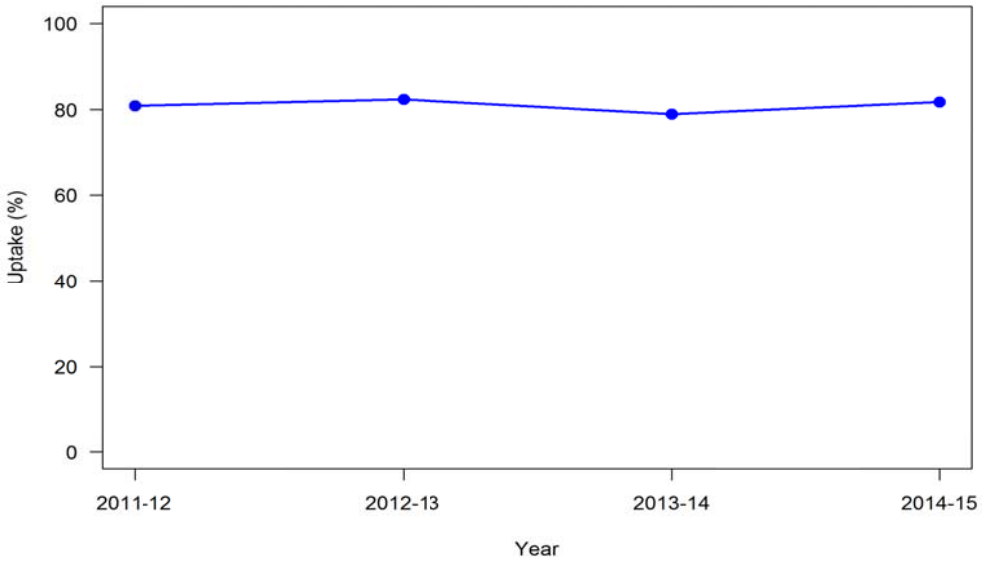
9.22 Figure 7 shows that coverage in Kent and Medway in 2013/14 was above the average for England.

Figure 7 – Abdominal Aortic Aneurysm screening coverage by screening programmes – 2013/14



9.23 In Medway, AAA screening uptake has remained fairly stable from 2011-12 to 2014-15 (Figure 8).

Figure 8: AAA Screening uptake in Medway, 2011-12 to 2014-15



10. Emergency Preparedness, Resilience and Response (EPRR)

10.1 NHS England established the Kent and Medway Local Health Resilience Partnership (LHRP) in 2013 in line with national requirements. The LHRP is co-chaired by the Director of Public Health (DPH) for Medway and the NHS England Director of Operations and has representation from all CCGs and NHS providers in Kent and Medway. It facilitates the production of local sector wide health plans to respond to emergencies and contribute to multi-agency emergency planning. It also provides the DsPH with assurance that the health sector has well tested plans and capability and capacity across all member organisations to respond to major incidents impacting on health and health services. To ensure there is a linkage between the LHRP and Kent Resilience Forum, the co-chairs are members of the KRF Strategic Group.

10.2 During 2014/15, the LHRP produced its plan for responding to Pandemic Flu which remains one of the most significant threats locally and nationally. The KRF will participate in a multiagency exercise for pandemic flu in 2016. Plans have also been produced for the mobilisation of NHS resources in response to health protection incidents. This includes responding to outbreaks of infectious disease including the provision of immunisation and antibiotics. Further work is required to ensure that effective plans are in place so that urgent treatment can be mobilised by the NHS to respond to outbreaks in a timely fashion.

10.3 The NHS and Medway Council have participated in exercises run by the Kent Resilience Team to test preparedness to respond to Ebola, severe weather

and terrorism. All exercises were useful in informing further development of local plans. A workshop has also been held in response to chemical, biological, radiological and nuclear incidents for acute trusts.

10.4 NHS England lead an annual assurance process on EPRR in the NHS each November. The LHRP chairs both participate in this process which builds on the assurance process led by the CCGs of the NHS providers in their locality. In Kent and Medway, in common with Kent, Surrey and Sussex, the finalisation of plans to respond to health protection incidents is an outstanding action. This has been escalated by the DPH and Public Health England are now co-ordinating the completion of the plan.

10.5 Exercise Brook was held at Medway Council in June 2015, to test the Council's arrangements to comply with its duties under the Civil Contingencies Act 2004. The scenario selected was a road traffic collision involving a chemical tanker.

10.6 A Medway Council Extreme Weather Group was established in August 2013 to oversee the planning for extreme weather events. This group is attended by officers from a range of Council services (emergency planning, housing, adult social care, children's services and communication) and is chaired by a Public Health Consultant. This group will also convene when triggers in extreme weather plans are met, to ensure Council Services are aware of the event, the impact on service delivery and that appropriate actions are taken. This has ensured that mechanisms are in place across Council services for a coordinated response to an Extreme Weather Event. In 2014/15, Medway Council heatwave and cold weather incident plans were updated in line with national plans. These were approved by the Council's Corporate Management Team.

10.4 An audit conducted in August 2014, by Public Health following a Heatwave Level 2 Alert highlighted internal communications as an area for further improvements. Forecasts are received by the emergency planning team and circulated to services via appropriate officers within the Council when agreed triggers are reached. Within the emergency plans, services have agreed the actions they would take when they receive the warning and alerts.

10.5 Recommendation:

- Ensure that plans for the mobilisation of NHS resources in response to a health protection incident are completed in 2015.

11. Air quality

11.1 Good air quality is essential for human health and the environment as a whole. Poor air quality has a negative impact on health from both short and long term exposure.

11.2 Under the Environmental Act 1995, Local Authorities have a statutory duty to regularly monitor the air quality in their area. Medway reports the results of its monitoring, and progress on action plan measures, to the Department of Environment Food and Rural Affairs (Defra) annually. These reports are made publicly available at www.kentair.org.uk/library.

11.3 As with the majority of the UK, the largest source of urban air pollution in Medway is from road transport. Medway Council declared Chatham Central; High Street, Rainham and Pier Road, Gillingham in 2010, as Air Quality Management Areas (AQMA).

11.4 Air quality monitoring of pollutants (particulate matter: PM_{10} and $PM_{2.5}$; ozone (O_3); sulphur dioxide (SO_2) and nitrogen dioxide (NO_2) is carried out routinely by automatic and non-automatic methods, and the data are reported by the Kent and Medway Air Quality Monitoring Network (www.kentair.org.uk). The Network provides a free email forecast service of predicted air quality for Kent and Medway, in the likely event of moderate to high pollution levels (in accordance with the health based national Daily Air Quality Index).The service allows users to take steps to modify their behaviour and take action to help reduce the health impact of the pollutants, for example by reducing their exposure.

11.5 Air pollution expressed as a fraction of mortality attributable to long term exposure to particulate air pollution is one of Public Health Outcomes Framework indicators. Table 5 shows that the mortality burden from long term exposure to air pollution in 2010 in Medway was equivalent to about 125 deaths and 1,359 years of life lost to Medway population.

Table 5: Mortality estimates for Medway, Kent, South East and England, 2010-2012

Local authority area	Attributable fraction* (%) 2010	Associated life –years lost ** 2010	Attributable fraction* (%) 2011	Attributable fraction* (%) 2012
Medway	6.1	1,359	5.8	5.5
Kent	**5.6**	**7,436**	**5.6**	**5.0**
South East	**5.5**	**41,729**	**5.5**	**5.1**
England	**5.6**	**264,749**	**5.4**	**5.1**

* Attributable fraction: the proportion (%) of deaths estimated as due to long-term exposure to anthropogenic particulate air pollution

** Associated life–years lost: the years of life lost to the population due to increased mortality risk attributable to long-term exposure to anthropogenic particulate air pollution

11.6 Public Health is supporting Kent and Medway Air Quality Partnership in developing an air quality monitoring/website service specification. Public health is working with environmental health colleagues to improve local air quality and has engaged with them in producing Medway's draft air quality action plan.

11.7 The plan, which is aimed at improving air quality in Medway to below objective levels, as specified in the legislation went out to public consultation between 8 June and 30 August 2015.

11.8 Recommendation:

- Implement measures to reduce concentrations of local air pollutants including $PM_{2.5}$ and reduce the population's exposure to air pollution, which in turn will lead to improvements to public health.

12 Summary and Assurance

12.1 The health protection challenges in Medway are similar to other areas and the performance indicators are generally above the England average.

12.2 Medway has health protection system which effectively prevents and controls harm to the health of its population. However, further improvements can be made as outlined in this report. Of particular importance are the need to

- Complete the plans for mobilisation of NHS resources in response to health protection incidents
- Improve the accuracy of immunisation data, particularly childhood immunisations) and improve uptake in groups with low uptake rates.
- Improve the coverage of cancer screening programmes, particularly for colorectal cancer.

12.3 It is crucial that Medway continues to invest in and improve its health protection services in order to enable further improvements in screening uptake, reduction in infectious diseases and robust planning in response to emergencies.

13. References

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. Available:https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199773/Health_Protection_in_Local_Authorities_Final.pdf

Directors of Public Health in Local Government: Roles and Responsibilities and Context October 2013. Available: www.fph.org.uk/uploads/DPH_Guidance_Final_v6.pdf Accessed 13.07.2015.

Performance Report for National Screening Programmes for Kent and Medway Quality Committee June 2015.

Public Health England, Public Health Outcomes Framework http://www.phoutcomes.info/

Public Health England (2014) Estimating Local Mortality Burdens associated with Particulate Air Pollution https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332854/PHE_CRCE_010.pdf

Appendix 1

The complete routine immunisation schedule from summer 2014

When to immunise	Diseases protected against	Vaccine given	Immunisation site[1]
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib)	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)[2]	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
Three months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	Meningococcal group C disease (MenC)	Men C (NeisVac-C or Menjugate)[2]	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
Four months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
Between 12 and 13 months old – within a month of the first birthday	Hib/MenC	Hib/MenC (Menitorix)	Upper arm/thigh
	Pneumococcal disease	PCV (Prevenar 13)	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR (Priorix or MMR VaxPRO)[2]	Upper arm/thigh
Two, three and four years old[3]	Influenza[4] (from September)	Flu nasal spray (Fluenz Tetra) (annual) (if Fluenz unsuitable, use inactivated flu vaccine)	Nostrils Upper arm
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	DTaP/IPV (Infanrix IPV or Repevax)[2]	Upper arm
	Measles, mumps and rubella	MMR (Priorix or MMR VaxPRO) (check first dose has been given)[2]	Upper arm
Girls aged 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (Gardasil)	Upper arm
Around 14 years old	Tetanus, diphtheria and polio	Td/IPV (Revaxis), and check MMR status	Upper arm
	MenC[5]	MenC (Meningitec, Menjugate or NeisVac-C)[2,5]	Upper arm
65 years old	Pneumococcal disease	PPV Pneumococcal polysaccharide vaccine (Pneumovax II)	Upper arm
65 years of age and older	Influenza[4]	Flu injection (annual)	Upper arm
70 years old	Shingles (from September)	Shingles (Zostavax)	Upper arm (subcutaneous)

Immunisations for those at risk[6]

At birth, 1 month old, 2 months old and 12 months old	Hepatitis B	Hep B	Thigh
At birth	Tuberculosis	BCG	Upper arm (intradermal)
Six months up to two years	Influenza[4]	Inactivated flu vaccine (annua)	Upper arm/thigh
Two years up to under 65 years	Pneumococcal disease	PPV Pneumococcal polysaccharide vaccine (Pneumovax II)	Upper arm
Over two up to less than 18 years	Influenza[4] (from September)	Flu nasal spray (Fluenz Tetra) (annual) (if Fluenz unsuitable, use inactivated flu vaccine)	Nostrils Upper arm
18 up to under 65 years	Influenza[4]	Inactivated flu vaccine (annua)	Upper arm
At any stage of pregnancy	Influenza[8]	Inactivated flu vaccine	Upper arm
From 28 weeks of pregnancy[7]	Pertussis	dTaP/IPV (Boostrix-IPV)[8]	Upper arm

[1] Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5cm apart. For more details see Chapters 4 and 11 in the Green Book. All vaccines are given intramuscularly unless stated otherwise.

[2] Where two or more products to protect against the same disease are available, it may on occasion be necessary to substitute an alternative brand.

[3] This is defined as children aged two, three or four year (but not five years) on 1 September 2014.

[4] The vaccine is given prior to the flu season – usually in September and October.

[5] Meningitec and Menjugate are currently not available to order through ImmForm – only NeisVac-C is available at the moment.

[6] See individual chapters of the Green Book for clinical risk groups.

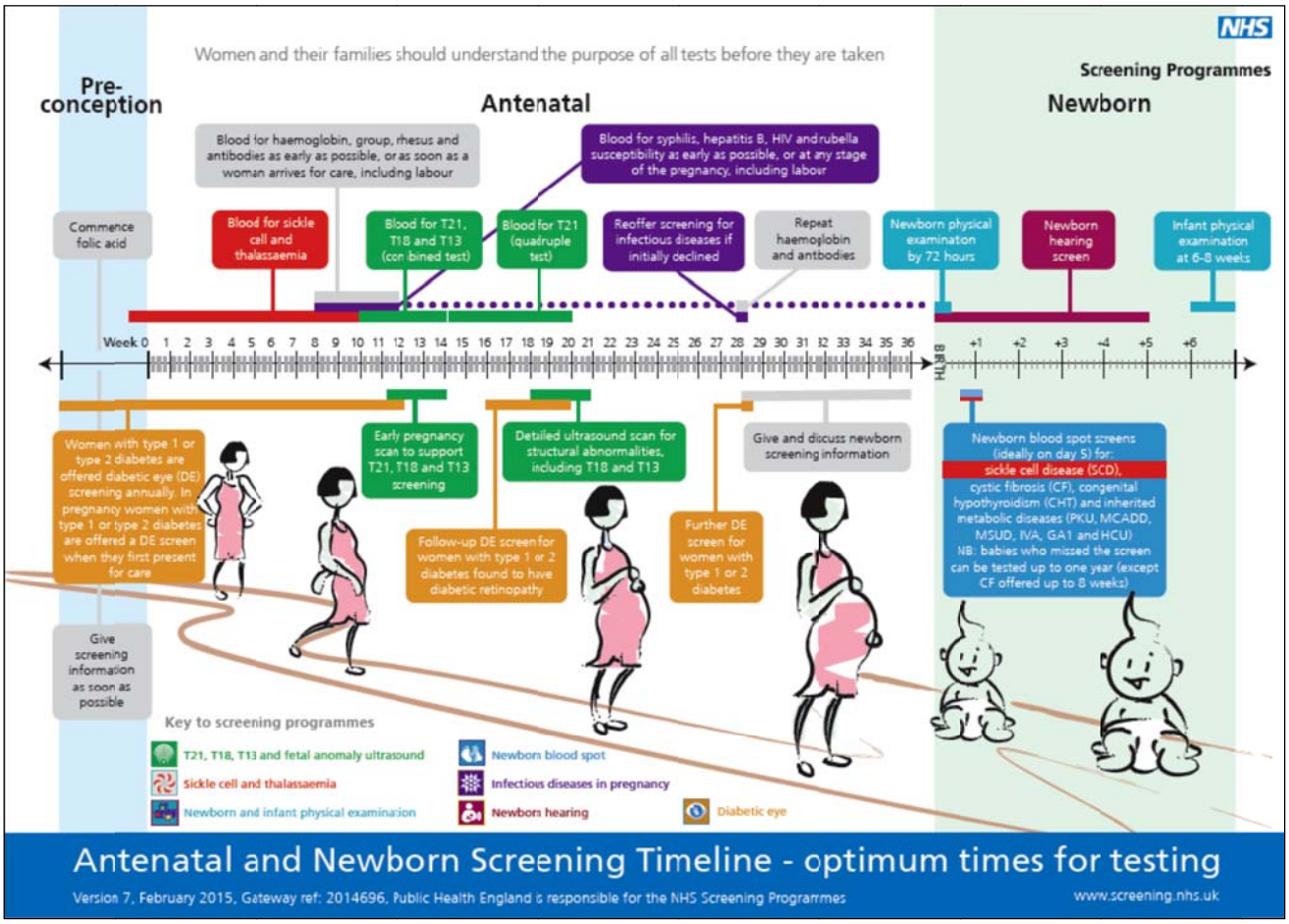
[7] See CMO letter of October 2012.

[8] Repevax should continue to be used until 1 July 2014.

[8] Between September and March or later at GP's clinical discretion.

Source: www.gov.uk

Appendix 2


NHS
Screening Programmes
Women and their families should understand the purpose of all tests before they are taken
Pre-conception
Antenatal
Newborn
Blood for haemoglobin, group, rhesus and antibodies as early as possible, or as soon as a woman arrives for care, including labour
Blood for syphilis, hepatitis B, HIV and rubella susceptibility as early as possible, or at any stage of the pregnancy, including labour
Commence folic acid
Blood for sickle cell and thalassaemia
Blood for T21, T18 and T13 (combined test)
Blood for T21 (quadruple test)
Reoffer screening for infectious diseases if initially declined
Repeat haemoglobin and antibodies
Newborn physical examinaton by 72 hours
Newborn hearing screen
Infant physical examination at 6-8 weeks
Week 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36
BIRTH
+1 +2 +3 +4 +5 +6
Women with type 1 or type 2 diabetes are offered diabetic eye (DE) screening annually. In pregnancy women with type 1 or type 2 diabetes are offered a DE screen when they first present for care
Early pregnancy scan to support T21, T18 and T13 screening
Detailed ultrasound scan for structural abnormalities, including T18 and T13
Give and discuss newborn screening information
Newborn blood spot screens (ideally on day 5) for:
sickle cell disease (SCD),
cystic fibrosis (CF), congenital hypothyroidism (CHT) and inherited metabolic diseases (PKU, MCADD, MSUD, IVA, GA1 and HCU)
NB: babies who missed the screen can be tested up to one year (except CF offered up to 8 weeks)
Follow-up DE screen for women with type 1 or 2 diabetes found to have diabetic retinopathy
Further DE screen for women with type 1 or 2 diabetes
Give screening information as soon as possible
Key to screening programmes
T21, T18, T13 and fetal anomaly ultrasound
Sickle cell and thalassaemia
Newborn and infant physical examination
Newborn blood spot
Infectious diseases in pregnancy
Newborn hearing
Diabetic eye
Antenatal and Newborn Screening Timeline - optimum times for testing
Version 7, February 2015, Gateway ref: 2014696, Public Health England is responsible for the NHS Screening Programmes
www.screening.nhs.uk