Derby City Council

Health and Wellbeing Board
19th November2015

ITEM 11a

Report of the Acting Director of Public Health

Health Protection Board Update

SUMMARY

1.1 This report provides an overview of the key messages arising from the Derbyshire Health Protection Board which met on the 12th October 2015.

1.2 Immunisation performance for the first quarter of this year shows a slight decline in coverage, with the lowest levels of uptake in the pre-school boosters. The screening and immunisation team continues to work to improve these rates. There has been a change to the national immunisation schedule with the addition of Meningitis ACWY for teenagers and Meningitis B for babies. A new provider, Nottingham City Care, has been commissioned to provide the school aged immunisation service in Derby.

1.3 The East Midlands TB control Board has now been established and will be overseeing the implementation of the National TB strategy. This will include the introduction of testing for latent TB.

1.4 Performance of the national screening programmes remains good locally, however work is underway to consider those groups who may not access screening and how uptake could be improved. There are a number of changes to the national programmes including the introduction of bowel scope for bowel screening; screening for further chromosomal abnormalities, in addition to Down's Syndrome, is being added to the antenatal screening programme.

RECOMMENDATION

2.1 The Health and Wellbeing Board is asked to note the update report.

2.2 To consider if the board requires further information at a future meeting on any of the areas discussed.

REASONS FOR RECOMMENDATION

3.1 To ensure that the Health and Wellbeing Board is kept updated on health protection issues affecting residents of Derby.

SUPPORTING INFORMATION

Immunisation

4.1 Quarter 1 performance data for childhood vaccinations in Derby City was presented by NHS England and showed a decline in uptake against Q1 2014/15. Uptake rates remain predominately between 90-95% with the exception of vaccination at 5 years.Target performance is 95%. The screening and immunisation team within NHS England continue to work to improve the uptake rates of all immunisations, and the Health Protection Board will continue to review performance. Clarification on the coverage of these programmes that is required to prevent an outbreak (herd immunity) is provided within appendix 2.

Table 1 Summary of Childhood Immunisation Performance in Derby Q1 2015/16

Childhood Immunisation Performance Derby City						
	DTap/IPV/Hib age 1 year	PCV booster aged 2 years	Hib and MenC aged 2 years	MMR aged 2 years	DtaP/IPV booster aged 5 years	MMR 2nd dose aged 5 years
2013/14	95.4%	94.6%	94.3%	94.2%	90.3%	88.9%
2014/15	94.9%	92.8%	92.9%	92.8%	89.9%	89.4%
2015/16 Q1	95.0%	92.2%	91.2%	92%	88.2%	88%

4.2 The Health Protection Board was advised regarding the following changes to commissioned immunisation services. Meningitis C vaccination is currently delivered to Year 9 pupils (aged 13/14 years). From September 2015 this has been changed to vaccination for Meningitis ACWY due to an observed change in the circulating strains.Vaccination for Meningitis B commenced from 1st September 2015, for babies born on or after 1st May 2015. A National Pharmacy Flu Specification has been implemented from September 2015 to increase access for the “at risk” population aged 18 years and over. Nottingham CityCare have been commissioned to deliver school-age vaccination services in academic year 2015-16, including HPV (Human Papilloma Virus), Td/IPV (tetanus, diphtheria and polio), Meningitis C and Seasonal flu immunisation annually in line with national roll out plans.

Infectious Disease and Outbreaks

4.3 Public Health England (PHE)noted a recent cluster of secondary care Clostridium difficile cases. Records and pathway reviews had been undertaken to identify any common link. Work is underway to remove any potential environmental factors.

4.4 A summary of recent TB cases were provided to the Board.

Tuberculosis

4.5 The East Midlands TB Control Board has now been established. PHE provided an overview the proposal to implement latent TB testing within Derby City. The work is part of a working group undertaken by PHE, Southern Derbyshire CCG and Derby City Public Health.

Screening

4.6 A detailed report of performance was provided by the Screening and Immunisation Lead. Key messages include coverage for Breast and Cervical screening locally is amongst the highest in England. However, work is being undertaken to consider which groupsmay not be accessing screening and how uptake in key groups could be improved. There will be a national transfer of the cervical screening programme call and recall system to Capita with effect from April 2016. The bowel screening programme is due to be extended to Bowel scope screening (sigmoidoscopy)from April 2016, with appointments at Royal Derby Hospital to start June 2016. A change in National guidance means all eligible pregnant women will be offered first trimester (under 13 weeks of pregnancy) screening for the chromosomal abnormalities Edwards' Syndrome (Trisomy 18) and Patau's Syndrome (Trisomy 13), in addition to Down's Syndrome (Trisomy 21) screening, by March 2016.

Bowel Cancer screening report

4.7 A report was presented of a review of the impact of Bowel Cancer screening within Derbyshire. The report highlighted that whilst uptake was significantly higher than England, variation in uptake was noted between Clinical Commissioning Groups (CCGs) and GP practices. The greatest variation was in Southern Derbyshire CCG, with uptake by GP practice ranging from 17.5% to 68.8%. The report noted the work underway by the Screening and Immunisation Team as part of a Bowel Cancer Screening Health Improvement Strategy and Action Framework, 2014-2016 and supported the completion of a Health Equity Audit to understand the population groups in Derby City with lower rates of access to the NHS Bowel Cancer Screening Programme.

Additional agenda items

4.7 Other agenda items discussed included the workunderway by the Health Protection team to map outbreak vaccination service provision and BCG vaccination services locally. There was a proposal agreed for annual equity audit or inequalities reviews to be undertaken of Screening and Immunisation programmes.

OTHER OPTIONS CONSIDERED

5.1 Not Applicable

This report has been approved by the following officers:

Legal officer **Financial officer** **Human Resources officer** **Estates/Property officer** **Service Director(s)** **Other(s)**	Dr Robyn Dewis, ActingDirector of Public Health

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Background papers:	None
List of appendices:	Appendix 1 – Implications Appendix 2 – Clarification regarding herd immunity

Appendix 1

IMPLICATIONS

Financial and Value for Money

1.1 None

Legal

2.1 Scrutiny and assurance of the local Health Protection system is a statutory function of the Director of Public Health.

Personnel

3.1 None

IT

4.1 None

Equalities Impact

5.1 It is known that certain groups, e.g. those from certain ethnic backgrounds and those with learning disabilities, are less likely to feel able to access screening services. Work is underway to understand and address these issues.

Health and Safety

6.1 None

Environmental Sustainability

7.1 None

Property and Asset Management

8.1 None

Risk Management

9.1 None

Corporate objectives and priorities for change

10.1 None

Appendix 2

Herd immunity

Herd immunity is the term used to describe the level of vaccination required in order to prevent the circulation of the disease in the community, and describes the indirect protection offered by vaccination. Herd immunity is particularly important in protecting those who can't be vaccinated due to contraindications or those for whom vaccination may be less effective. Herd immunity does not apply to all vaccinations, only those spread by person to person transmission.

The level of uptake required to provide herd immunity varies depending on how easily the disease spreads and the effectiveness of the vaccine. The figure of 95% is usually given as the gold standard for ensuring herd immunity as this is the highest figure required to provide herd immunity in the case of measles, for other diseases such as diphtheria much lower levels are required.

Whilst vaccination rates are generally high in the UK, overall uptake can mask lower rates within specific communities or groups. This may mean that whilst an outbreak may be very unlikely in the general community, some particular populations who have low levels of vaccination may be at risk.

A summary of herd immunity levels by disease is given below;

Disease	Transmission	Herd Immunity level
Diptheria	Saliva	83-86%
Pertussis	Airborne	92-94%
Polio	Faecal oral	80-86%
Measles	Airborne	92-95%
Mumps	Airborne	75-86%
Rubella	Airborne	83-86%