Our Ref JG
Your Ref HSC/JG
Date 23 February 2018
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Legal & Democratic Services Division

Jayne Hammond LLB (Hons)
Solicitor
Assistant Director of Legal & Democratic Services

TO: All Members of Health Scrutiny Committee

Councillors : P Adams, N Bayley, M D'Albert, J Grimshaw, S Haroon, K Hussain, S Kerrison (Chair), O Kersh, J Mallon, A McKay, Susan Southworth and R Walker

Dear Member/Colleague

Health Scrutiny Committee

You are invited to attend a meeting of the Health Scrutiny Committee which will be held as follows:-

Date:	Monday, 5 March 2018
Place:	Meeting Rooms A&B, Bury Town Hall
Time:	7.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

1 **APOLOGIES FOR ABSENCE**

2 **DECLARATIONS OF INTEREST**

Members of Health Scrutiny Committee are asked to consider whether they have an interest in any of the matters on the agenda and if so, to formally declare that interest.

3 **PUBLIC QUESTION TIME**

Questions are invited from members of the public present at the meeting on any matters for which this Committee is responsible.

4 **MINUTES** (Pages 1 - 6)

Minutes of the meeting held on the 18th January 2018 are attached.

5 **URGENT CARE REDESIGN** (Pages 7 - 24)

Dr K. Patel, Chair Bury CCG and Stuart North, Chief Operating Officer Bury CCG will provide members with a verbal update. Presentation attached.

6 **HEALTH PROTECTION ANNUAL REPORT** (Pages 25 - 118)

Lorraine Chamberlin & Anne Whittington will provide members with a verbal update at the meeting, report and presentation attached.

7 **URGENT BUSINESS**

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

Agenda Item 4

Minutes of: **HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 18th January 2018

Present: Councillor S Kerrison (in the Chair)
Councillors P Adams N Bayley, M D'Albert, J Grimshaw S Haroon, K Hussain, O Kersh, J Mallon, and R Walker

Also in attendance: Dr K, Patel, Chair Bury Clinical Commissioning Group (CCG)
Stuart North, Chief Operating Officer, Bury Clinical Commissioning Group (CCG)
Deborah Yates Provider Relationship Manager
Lesley Jones, Director of Public Health
Marcus Connor, Head of Corporate Policy
Julie Gallagher, Principal Democratic Services Officer

Public Attendance: 4 members of the public were present at the meeting.

Apologies for Absence: Councillors A McKay and Susan Southworth

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HSC.340 DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

HSC.341 PUBLIC QUESTION TIME

There were no questions from members of the public present at the meeting.

HSC.342 MINUTES

With reference to minute number HSC.237 Adults Safeguarding Board Annual Report, Councillor Mallon enquired if progress has made with regards to the future scrutiny arrangements of the Adult's Safeguarding Board. The Principal Democratic Services Officer reported that a new Chair of the Adults Safeguarding Board had recently been appointed. A meeting will be arranged between the Chair of the Health Overview and Scrutiny Committee and the Board Chair in the near future to discuss scrutiny arrangements going forward.

It was agreed:

That the minutes of the meeting held on 14th November 2017 be approved as a correct record.

It was agreed that further to the published agenda the items will be re-arranged.

HSC.343 URGENT CARE UPDATE

Dr Patel, Chair Bury CCG and Stuart North, Chief Operating Officer, Bury CCG attended the meeting to provide an overview of the proposed plans for a new model of Urgent Care within the Borough. An accompanying report had been circulated to members prior to the meeting and contained information about the context, the engagement and consultation already undertaken, the original proposal, the new proposal, the preferred model and the next steps.

The CCG Chair provided members with an overview of the proposals, proposals will include plans for a new Urgent Treatment Centre located at Fairfield General Hospital in Bury, running alongside the accident and emergency department; initially three integrated health and social hubs in Bury, Radcliffe and Prestwich, to offer a range of services, including GP led walk-in services. NHS 111 service will remain and patients requiring urgent care will be advised to contact the GP in the first instance.

The integrated health and social care hubs will provide a range of services, initially it is propose that they will deliver:

- GP-Led (including nurse) Walk-In Services
- Urgent GP appointment requests
- Access to Bury patient notes (currently not available in WICs)
- GP Extended Working Hours appointments
- Wound Care Services
- Sign posting advice to other services
- Social Care advice and services
- Co-ordination of the other services to support patients in the community

Those present were invited to ask questions and the following issues were raised.

Members sought assurances in respect of mental health provision the CCG Chair reported that it is envisaged there will be access to mental health services within the new hubs.

Responding to a Member's question, the Chief Operating Officer acknowledged that the CCG have responded to public concerns with regards to the NHS 111 service. The 111 centre is operated by Northwest Ambulance Service, the nearest call centre is based at the Middlebrook, near Bolton, clinical triage will be undertaken in Bury and calls will be forwarded to Bardoc, a Bury service.

In response to a Member's question, the Chief Operating Officer reported that it is the CCGs intention to expand the number of HUBs from three to five to include sites in the north of the Borough and appropriate accommodation/premises is currently being sourced. The CCG Chair reported that the HUBs will offer a holistic range of services, which will include, social workers, nurses, doctors and pharmacy services; staff will also be able to access patient notes. The HUBs will be able to triage and

treat patients will long term conditions, it is envisaged this will relieve pressure from over-stretched A&E departments.

Following feedback from the initial Urgent Care engagement exercise; the CCG Chair reported that there will remain a "walk in" facility at the HUBs in Prestwich and Radcliffe.

In response to a Member's question the Chief Operating Officer reported that any member of the public can access the walk in facility at the HUBs and access treatment, however if follow up treatment or additional treatment is required if they are registered with a GP out of Borough they will be referred back to their registered GP.

The CCG Chair reported that existing services will remain operational until the new HUBs are established. The staffing issue at the Prestwich walk in centre has now stabilised. The CCG Chair reported that proposals rely on GPs identifying resources within their practices, working together to share staff, to help change and shape how services are delivered.

The Chief Operating Officer reported that the Urgent Care Centre at FGH is currently staffed by locums and out of area GPs, conversations are ongoing with GPs within the Borough in respect of them providing the support to provide the service.

Members of the Committee expressed their concern that the changes are proposed at a time of financial constraint and dire staff shortages in the NHS. The Chief Operating Officer reported that there is a large financial challenge across the NHS, doing nothing is not an option, these proposals coupled with the development of the Local Care Organisations will be the most effective and efficient use of resources.

The CCG Chair reported that newly qualified GPs want more variety in their workload and want to work in wider teams with more opportunities to develop their talents and research skills; these new proposals will provide greater opportunities and will help to retain and recruit GPs.

It was agreed:

1 Stuart North, Chief Operating Officer, Bury CCG and Dr Kiran Patel, Chair Bury CCG be thanked for their attendance.
2 The Urgent Care Redesign public consultation will commence on the 29th January 2018, for six weeks.
3 Representatives from Bury CCG will attend the next meeting of the Health Overview and Scrutiny Committee scheduled to take place on the 5th March and will provide an update with regards to the progress of the Urgent Care Redesign consultation.

HSC.344 CARE AT HOME SERVICE

Deborah Yates, Provider Relationship Manager, Bury Council, attended the meeting to provide members with an update with regards to the recently procured Care at Home Contract. An accompanying report was circulated

to members prior to the meeting, the report contained the following information:

- Why the change in Care at Home services is necessary
- Previous Contract
- New Care at Home Contract
- Progress made so far
- What is working well?
- What needs to work better and actions in place to address this?
- Future plans and priorities

Those present were invited to ask questions and the following issues were raised:

In response to a Member's question the Provider Relationships Manager reported that all providers are required to pay the National Living Wage, as well an annual uplift amount. The contracts negotiated with the providers specify the monies that are to be paid for travel and mileage. Regular audits are undertaken to ensure that staff receive these monies.

Responding to a member's question, the Provider Relationship Manager reported that that the Council has a very robust Quality Assurance team that undertakes an annual programme of visits as well as cause for concern visits. The staff work as part of a neighbourhood team and operate in that locality. To help facilitate an improved partnership working between providers and localities less formal visits will also be undertaken.

The Provider Relationship Manager reported that there has been an introduction of six zoned areas of work, with two providers per zone. Work is to be allocated on an 80%/20% split on a rotating two week basis. This enables providers to concentrate their resources in that zone and reduce travel time and costs. As providers in each zone are required to pick up no less than 80%/20% of work depending on which week delays when placing packages in the community should be reduced which will also lead to a reduction in the number of delayed discharges and unnecessary placements in respite.

The Provider Relationship Manager reported that all commissioned providers must be at least CQC inspected good. A client may still choose to remain with a previous provider if they services are procured as part of a personal budget.

In response to a Member's question, the Provider Relationship Manager reported that once a client is assessed they will be re-assessed six weeks later and then routinely re-assessed every 12 months. The service is provided to all ages, if the client deteriorates and requires a different package of care, a complex package of care can be commissioned, these will be provided by a different providers and can be spot purchased.

The new model of care as detailed, will help to facilitate hospital discharge and patient flows through the system. Previously if a patient was in

hospital for 24 hours a re-assessment of their care package would need to be undertaken, this has now been extended to 72 hours.

It was agreed:

1. The Provider Relationships Manager would provide members of the committee with additional information in respect of:
   a. What percentage of the overall budget is the identified savings amount of between £80 and £580?
   b. The number of hours commissioned previously compared with those commissioned as a result of the new contract arrangements.
   c. A list of all providers.
2. Deborah Yates, Provider Relationships Manager be thanked for her attendance.
3. A further update will be provided in respect of the care at home contract in 12 months.

HSC.345 URGENT BUSINESS

There was no urgent business reported.

Councillor S Kerrison
In the Chair

(Note: The meeting started at 7pm and ended at 8.55pm)

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Bury Urgent Care System

Consultation on proposed new system

What is Urgent Care?

This is the definition we have used

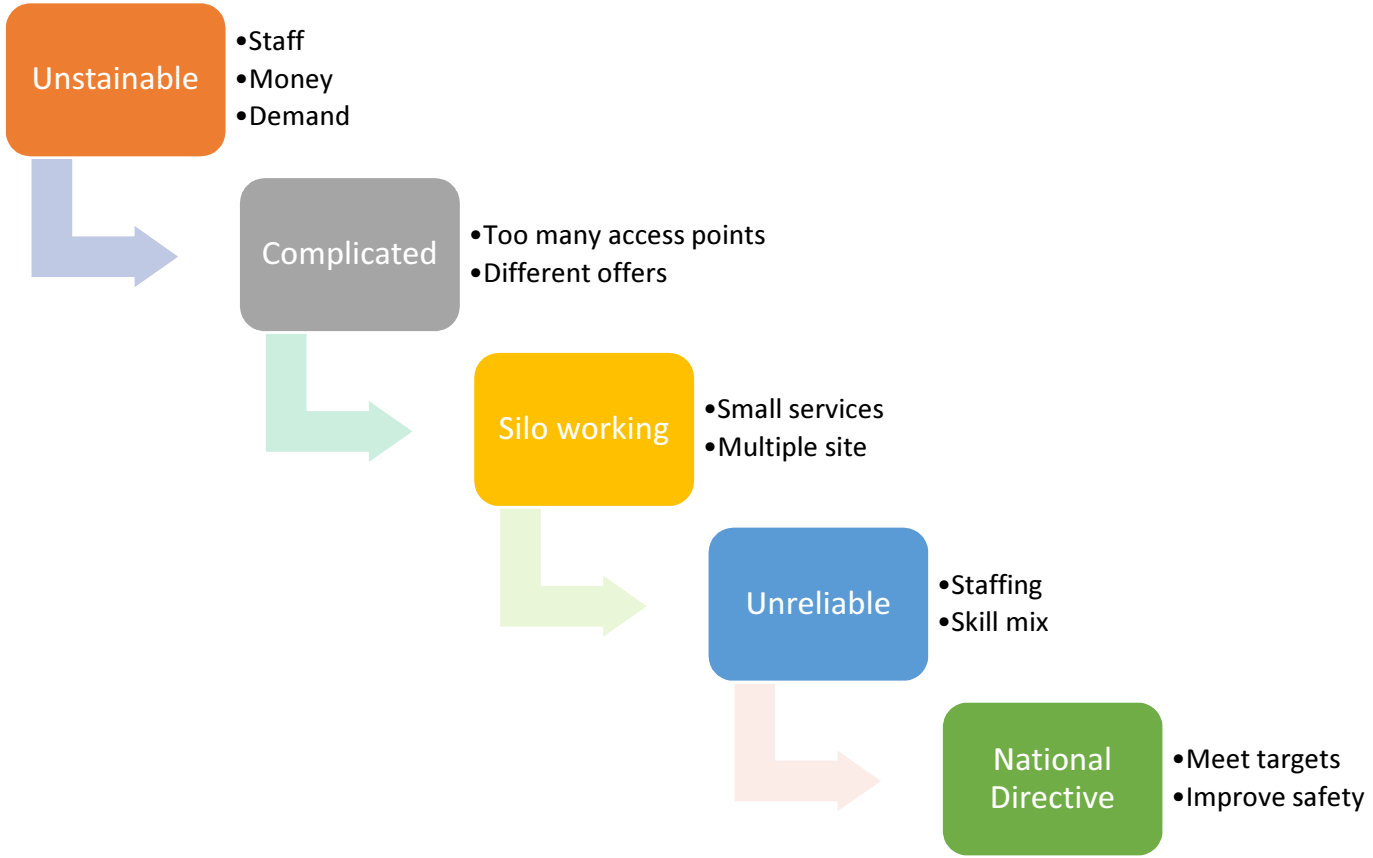
Urgent care services are services that are designed to assist patients with an illness or injury that does not appear to be an emergency, but is considered too urgent to wait for routine care

Process to decision

- 6 week consultation from – 29th January to 11th March 2018
- Range of public meetings – being arranged
- One public meeting to be arranged – Early March
- Sector engagement through February meetings

- **Decision at CCG Board – 28th March 2018**

Why change



These proposals

- Are as presented and engaged on before – through the previous Urgent Care Redesign & Consultation and build in:
  - Proposals in the locality plan (integrated hubs; neighbourhood working and teams)
  - National & GM guidance (UTC)

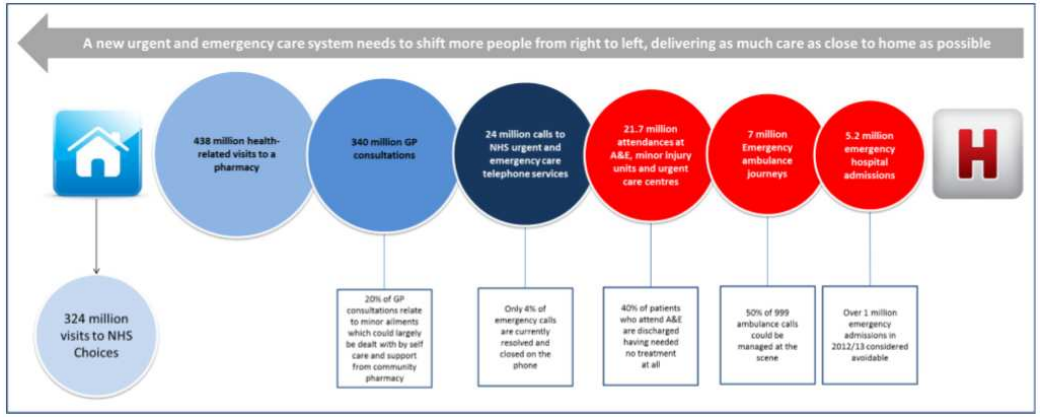
What has changed

- Promote GP Telephone Number – 24/7
- Retained walk-in services
- New Service – Urgent Treatment Centre

What has remained the same

- Reduce utilisation of emergency services
- Promoting self care
- Encourage initial phone contact
- Develop integrated services at hubs
- Multidisciplinary teams at hubs
- Access to medical records

National utilisation and ask



Proposals need to:

- Reduce utilisation of urgent care services
- Deliver more care closer to home (shift to the left)
- Reduce urgent care need by having more responsive integrated planned care

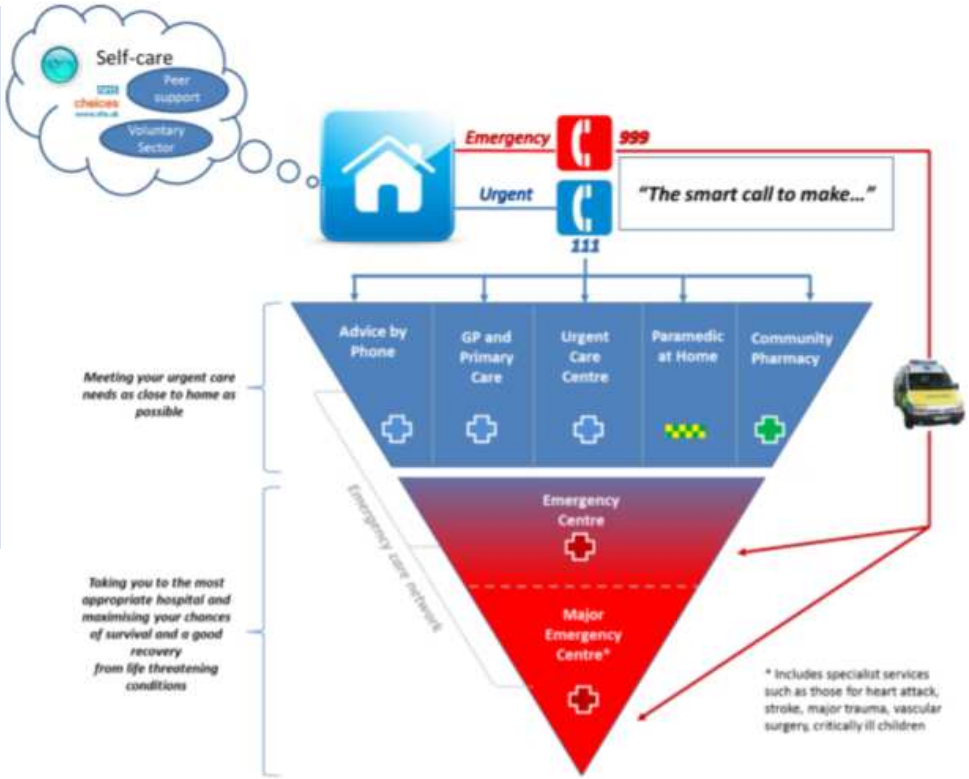
But more importantly

- ***Reduce overall demand by promoting self care***

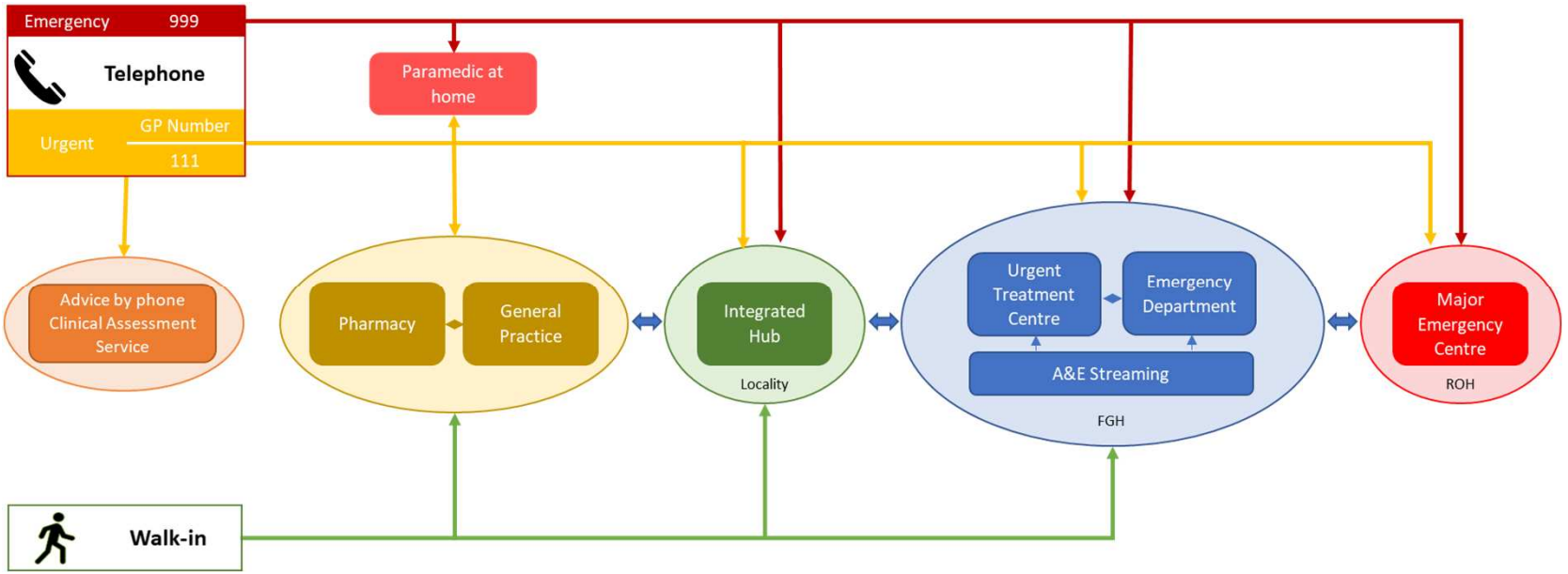
National model

The proposed model is:

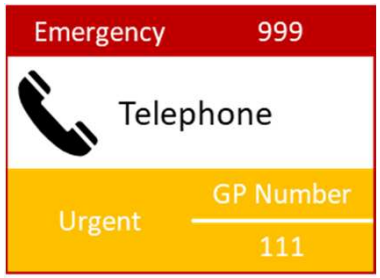
- Consistent with National recommendations
- Builds in GM variations
- Aligned with developments in other CCGs



Proposed – Bury Urgent Care System



Access to services



- Promote GP number as first contact point (GM)

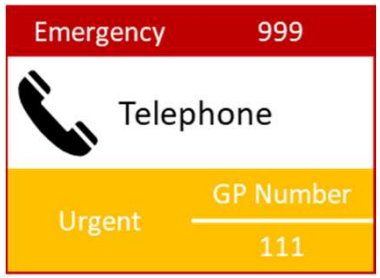
Except

- 999 – for emergencies (define these for the public)
- 111 – will continue to be promoted nationally

- Walk-in service will be built into integrated hubs

- No change to other access points
- Promote increase use of Pharmacist
- Will not be promoting walk-in to UTC/Hubs

Access to services



999 — For life threatening emergencies

GP Number — For all GP Urgent care

111 — For general advice

Pharmacy — Minor ailments

GP Surgery — GP Urgent care, Minor injuries, Non-emergencies

Integrated Hub — GP Urgent Care, Minor injuries, Non-emergencies

A & E Streaming — Serious illness, Major injuries, Emergencies

Each A & E Centre – FGH & NMGH

Each A&E Dept must implement **Streaming** and facilitate GP care where appropriate

Each locality must have an **Urgent Treatment Centre**

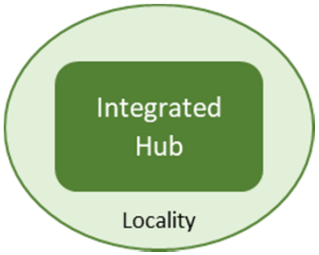
A & E Streaming	• Patients will be directed to most appropriate service
Urgent Treatment Centre	• GP Led Service for patients with minor injuries and illnesses
Emergency Department	• Emergency services

Urgent Treatment Centre

Must Do's

- Open for 12 hours a day
- Clinically led by primary care staff including GPs and nurses
- Staff will have access to patients' medical records to help with their care
- Pre-booked / same day appointments accessible by health care professionals
- Walk-in appointments – for A&E streamed patients
- Access to diagnostic tests inc X-ray

Integrated health & social care centre



Integrated health & social care team:

- GP Lead
- Community lead
- Social care lead

Also consider:

- VCS Lead

As per locality plan

- The Integrated Hubs would evolve
- Starting with a pilot in 2018/19
- Initially 3: Moorgate, Radcliffe, Prestwich (then Whitefield, North)

Current services

- EWH – Evening and weekend appointments
  - Routine & Urgent
- Walk-in services (GP, nurse)
- Specialist community clinics eg wound care

Over time, services would include:

- Services for older people & people with advanced LTC (Urgent & Planned)
- Paediatric care (Urgent and Planned)
- Social care services
- Voluntary sector services
- Some could have specialist services

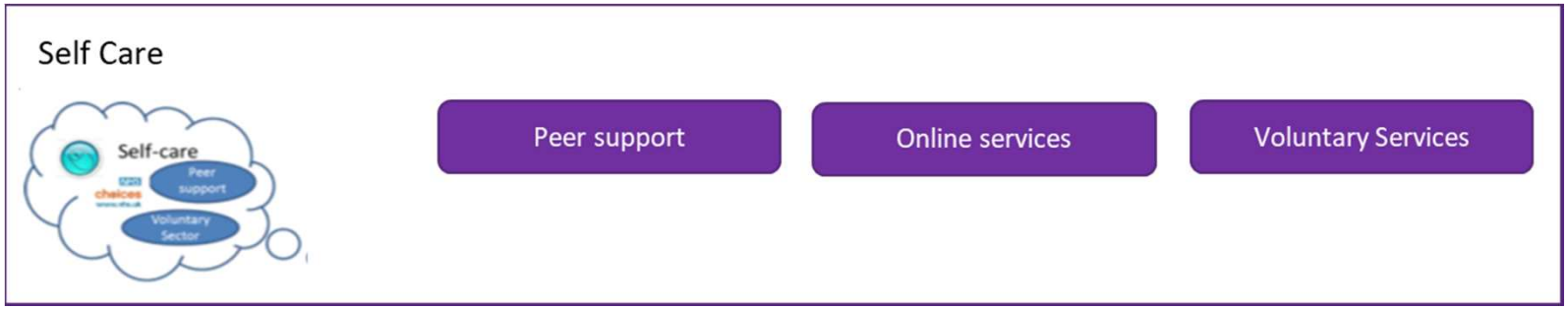
Sites, opening times and access

	Pharmacist	GP Surgery	Integrated Hub	Urgent Treatment Centre	Emergency Department	Major Emergency Centre
Time	Various	8.00 – 18.30	6 – 12 hours	12 hours	24 hours	24 hours
Locations	Multiple	30 Practices	Moorgate	Fairfield General Hospital	Fairfield General Hospital	Royal Oldham
			Radcliffe			Salford Royal
			Prestwich	North Manchester General Hospital	North Manchester General Hospital	MRI
			Whitefield			Stockport Infirmary
			North			
Staff	Pharmacist	GP, Nurse, Pharmacist	GP, Nurse, Social Care & Specialist teams	GP, Nurse, Social Care	ED Team	ED Specialist Teams
Access	Phone	Phone	Health Referrals	Walk-in (Streamed)	Walk-in (Streamed)	Ambulance
	Walk-in	Walk-in	Phone	Ambulance	Ambulance	
			Walk-in			

Services available

	Pharmacist	GP Surgery	Integrated Hub	Urgent Treatment Centre	Emergency Department	Major Emergency Centre
Services	Self care advice Minor ailment assessment	Routine GP Care Long Term Conditions Care Urgent Care	Frail elderly care Advanced long term conditions care Specialist Community Clinics Extended access GP Urgent GP Care Social care services	Minor Injuries Minor illnesses Patients with care plans	Injuries Serious illnesses Emergencies	• Strokes • Heart attacks • Major Trauma • Emergency Abdominal surgery • Emergency Vascular surgery
Examples	• Coughs & Colds • Minor sprains and injuries • Minor Infections • Minor bites and grazes • Diarrhoea • Emergency contraception	• All conditions other than those under pharmacist • Not for suspected strokes, heart attacks and emergencies	• Routine extended hours GP care • Urgent GP Care • Minor injuries	• Minor sprains and strains • Suspected broken bones • Cuts and grazes • Minor burns • Cough & colds • Feverish children and adults • Abdominal pain • Headaches • Vomiting	• Major injuries • Significant Trauma • Moderate to severely distressed patient • Medical and surgical emergencies	• Patient would be directed there by health professional
Diagnostics		Off site • Blood tests • Urine tests	Off site • Blood tests • Urine tests • Specialist Test • COPD & Asthma	• Blood test • Urine testing • X-rays • ECG	• Full diagnostic service	• Full diagnostic service

Self Care



- Help the professionals by reducing demand
- Need to do much more work on this and all need to contribute
- Working with Local Authority and VCS

- ***But everyone needs to promote and support!***

Format of the Consultation

- An online survey / paper copies are available
- A public meeting will be held during the consultation period – details to follow
- Views can be sent to the CCG by letter or e-mail

- The consultation will run from **Monday 29th January 18**, for a period of six weeks (ending on Sunday 11th March 18)

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Agenda Item 6

REPORT TO HEALTH SCRUTINY COMMITTEE

TITLE:	**Bury Health & Environmental Protection Annual Report**
DATE OF MEETING:	**5th March 2018**
REPORT FROM:	**Lesley Jones**
CONTACT OFFICER:	**Lorraine Chamberlin & Anne Whittington**

1. PURPOSE AND SUMMARY

This is the first Health and Environmental Protection Annual Report for Bury and aims to provide a means of assurance for the Council in relation to its Health & Environmental Protection Duties. The report covers a wide range of work being done to safeguard the people of Bury from the hazards presented by communicable diseases and the environment. The report highlights many areas of achievement and excellence in Bury and also provides recommendations for areas of focus in the coming year and beyond, to ensure we maintain a high standard.

2. INTRODUCTION

Health protection is an essential part of achieving and maintaining good public health. It involves planning, surveillance and response to incidents and outbreaks. Health protection prevents and reduces the harm caused by communicable diseases and minimises the health impact from environmental hazards such as chemicals and radiation. It also includes the delivery of major programmes such as national immunisation and screening programmes and the provision of health services to diagnose and treat infectious diseases.

3. BACKGROUND

The Health and Social Care Act 2012 defines the new health protection duty of Local Authorities (LAs). The Act states that public health teams, on behalf of Directors of Public Health (DPHs) are responsible for a LA's contribution to health protection matters, including responses to incidents and emergencies. Public Health England (PHE) is required to provide specialist support and has a complementary role to play. Both PHE and LA public health should work as a single unit when addressing health protection

issues. NHS organisations including NHS England and the local Clinical Commissioning Group (CCG) have a legal responsibility under the NHS Act 2006 to mobilise resources to manage incidents and emergencies. They also have a legal duty to co-operate with LA public health teams in delivering local and national health protection priorities.

4. WHAT IS WORKING WELL?

- MRSA bacteraemia infections were lower than national rates and there none were assigned to Bury CCG in 2016/17. The Bury Infection Prevention & Control (BIPCIP) Group works extremely well overseeing and managing Healthcare Associated Infections.
- Bury is performing well both regionally and nationally with regards to uptake of the flu vaccine and there are clear plans in place to ensure this continues to improve.
- Uptake of other vaccines is also generally good, particularly for the childhood vaccinations of MMR and 5-in-1.
- Coverage of the cervical screening programme is above regional and national levels, which is good.
- HIV late diagnosis has reduced significantly in recent years and is now below national levels.
- Neighbourhood working embraced by assigning two Environmental Health officers to the trailblazer Radcliffe and Bury East Hubs
- Digital mobile working introduced in Pest Control to be rolled out to all Environmental health services
- 87% of our Food businesses are broadly compliant and 68% have been awarded the highest Food Hygiene rating of 5 with only 5% having a rating of 2 or less

5. WHAT NEEDS TO WORK BETTER AND WHAT ACTIONS ARE IN PLACE TO ADDRESS THIS?

- Bury has not yet achieved the Cervical screening 80% uptake target. We will continue to work with PHE and Bury CCG to increase uptake.

- We need to develop a better understanding of our local TB prevalence and ensure prevention and treatment are optimised.

- There have been issues with data collection for HIV diagnosis in women and this needs further exploration.

- Environmental quality issues around fly tipping, accumulations and nuisance continue to dominate the reactive workload and a new Environmental Quality strategy is to be implemented

- Food Hygiene inspections are increasingly being carried out by consultants as a result of job cuts within environmental health - there was a drop in

total interventions in 2016 which has come to the attention of the Food Standards agency for monitoring in 2017/18. We will continue to monitor and manage the situation as effectively as possible within available resources.

6. FUTURE PLANS AND PRIORITIES

Whilst we have good arrangements in place for Health & Environmental Protection, the standards being achieved are increasingly challenged by organisational change which causes disruption to established systems and processes, e.g. creation of the Locality Care Organisation and One Commissioning Organisation and by the on-going financial challenges which impact on capacity to deliver. A Transformation programme reviewing all aspects of Public Protection, Regulation and Enforcement across the Council is underway to meet challenge of maintaining protection of the public & environment whilst also delivering challenging savings targets. This will include further development of the Neighbourhood Working approach and exploration of efficiency through technologies.

Air quality is a priority in Greater Manchester (GM) and Bury will continue to work with Transport for Greater Manchester (TfGM) and other GM Councils to deliver the GM Air Quality Action Plan 2016-2020, the GM Climate Change and Low Emissions Strategy Implementation plan 2016-2020 and develop a local Action Plan in response to DEFRA identifying Bury and 6 other GM areas as likely not to meet EU NO2 targets in the next 3 years

Communicable disease prevention and control requires constant and ongoing vigilance and responsiveness. For example, the launch of E.coli bacteraemia monitoring in 2017 will require careful consideration by the BIPCIP group going forward and we will need to take account of and respond to the ever changing and expanding vaccination programme and ensuring standards are maintained.

The Greater Manchester Population Health Plan includes action on Sexual Health and an ambition to eradicate HIV in a generation. We are proactively working with colleagues across GM to deliver these actions and ambition. There is a strong emphasis in the plans on the role of Primary Care which will require collaboration with Bury CCG and the emerging LCO.

List of Background Papers:-
See references in the report and Food Service Plan below:

Food Service Plan 2017-18.docx

Contact Details:-

Lorraine Chamberlin
Head of health & Environmental Protection
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Anne Whittington
ST2 Public Health / Public Health Registrar
0161 253 6138

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Health & Environmental Protection Annual Report

2016/17

Bury Council
Health & Environmental Protection Annual Report 2016/17

Foreword

I am delighted to present the first Health and Environmental Annual Report for Bury. This report covers many aspects of the work being done to safeguard the people of Bury from the hazards presented by communicable diseases and the environment. This work is very varied and wide-reaching and is carried out so efficiently that we may often be unaware of its presence. It covers our legal and moral duties and requires close working with partners such as Public Health England.

This report highlights many areas of achievement and excellence in Bury that we can be very proud of. It also provides recommendations for areas of focus in the coming year and beyond, to ensure we maintain a high standard. On reading it, I hope that you, like me, will rest assured that we remain well protected from these threats, as a result of the day-to-day hard work of the health and environmental protection teams.

Highlights and Key Challenges:

- *MRSA bacteraemia infections were lower than national rates and none were assigned to Bury CCG in 2016/17. The launch of E.coli bacteraemia monitoring in 2017 requires careful consideration going forward.*
- *Bury is performing well both regionally and nationally with regards to uptake of the flu vaccine and there are clear plans in place to ensure this continues to improve.*
- *Uptake of other vaccines is also generally good, particularly for the childhood vaccinations of MMR and 5-in-1. Future challenges are presented by the ever changing and expanding vaccination programme and ensuring standards are maintained.*
- *Coverage of the cervical screening programme is above regional and national levels, which is good, but there is still some work to do to achieve the intended target of 80%.*
- *HIV late diagnosis has reduced significantly in recent years and is now below national levels. There have been issues with data collection for HIV diagnosis in women and this needs further exploration.*
- *Neighbourhood working embraced by assigning two Environmental Health Officers to the trailblazer Radcliffe and Bury East Hubs.*
- *Digital mobile working introduced in Pest Control to be rolled out to all environmental health services.*

- *Environmental quality issues around fly tipping, accumulations and nuisance continue to dominate the reactive workload and a new Environmental Quality strategy is to be implemented.*
- *Food hygiene inspections are increasingly being carried out by consultants as a result of job cuts within environmental health - there was a drop in total interventions in 2016 which has come to the attention of the Food Standards Agency for monitoring in 2017/18.*
- *87% of our food businesses are broadly compliant and 68% have been awarded the highest Food Hygiene rating of 5, with only 5% having a rating of 2 or less.*
- *Air quality is a priority in Greater Manchester and Bury will continue to work with Transport for Greater Manchester (TfGM) and other GM Councils to deliver the GM Air Quality Action Plan 2016-2020, the GM Climate Change and Low Emissions Strategy Implementation plan 2016-2020 and develop a local Action Plan in response to DEFRA identifying Bury and 6 other GM areas, as likely not to meet EU nitrogen dioxide targets in the next 3 years.*

Lesley Jones
Director of Public Health

Acknowledgements

Authors:

Anne Whittington

Lorraine Chamberlin

This report would not have been possible without contributions from the following people, to whom we are very grateful:

Gary Brown

Natasha Franklin

Jon Hobday

Chris Horth

Steve Hoyle

Felicity Keeling

Julie Parker

Shenna Paynter

Michelle Foxcroft

Laura Spencer

Table of Contents

Health Protection

1.0 Introduction

1.1 Background

1.1.1 Health protection is an essential part of achieving and maintaining good public health. It involves planning, surveillance and response to incidents and outbreaks. Health protection prevents and reduces the harm caused by communicable diseases and minimises the health impact from environmental hazards such as chemicals and radiation. It also includes the delivery of major programmes such as national immunisation and screening programmes and the provision of health services to diagnose and treat infectious diseases.

1.1.2 The Health and Social Care Act 2012 defines the new health protection duty of Local Authorities (LAs). The Act states that public health teams, on behalf of Directors of Public Health (DPHs) are responsible for a LA's contribution to health protection matters, including responses to incidents and emergencies. Public Health England (PHE) is required to provide specialist support and has a complementary role to play. Both PHE and LA public health should work as a single unit when addressing health protection issues. NHS organisations including NHS England and the local Clinical Commissioning Group (CCG) have a legal responsibility under the NHS Act 2006 to mobilise resources to manage incidents and emergencies. They also have a legal duty to co-operate with LA public health teams in delivering local and national health protection priorities.

1.1.3 The key roles necessary to provide effective health protection include: -

- planning and responding to incidents and emergencies;
- carrying out surveillance of communicable and notifiable diseases;
- reducing the negative impacts of communicable and non-communicable diseases including preventing infection and infectious diseases;
- minimising the health impact of environmental hazards;
- reducing premature mortality and morbidity by improving environmental sustainability.

INFECTION PREVENTION AND CONTROL

Infection prevention and control involves working to prevent and control the spread of infection among the population. Communicable diseases are diseases that you can"catch" from someone or something else, often via airborne viruses or bacteria, but also through bodily fluids or contact with contaminated objects in the environment.

Infection and Prevention Control Audits

75%

Care homes scoring green from audits and re-audits Aug 2015-Mar 2017

None scored **Red**

None scored **Red**

Of the GP Practices audited

Work being undertaken to raise awareness and reduce Antibiotic prescribing by **50%** by **2021**

38 number of disease outbreaks that the Infection Prevention and Control team helped to manage

Key Points

MRSA (**M**eticillin-**R**esistant **S**taphylococcus **A**ureus)

Infections lower than national rates - 0 for Bury in 2016/17

E.coli (**E**scherichia **coli**)

Launch of monitoring in 2017/18, consideration needed going forward

MMR (**M**easles **M**umps and **R**ubella)

Uptake rates are good over 95% for 1 dose by 5 years old, and are comparable or better than the national average

FLU (in**flu**enza)

Good uptake when compared against regional and national uptake, plans to ensure this continues

DTaP/IPV/Hib (5-in-1)

Uptake rates are good over 95% at 2 years old, and are comparable or better than the national average

(**D**iphtheria, **T**etanus, **a**cellular **P**ertussis /**I**nactivated **P**olio **V**irus /**H**aemophilus **i**nfluenzae type **b**)

Focus group research conducted in Bury around pre-school vaccine - Informing methods to increase uptake

FLU

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Infection Prevention & Control

2.0 Introduction & Overview

2.1 Background

2.1.1 A substantial role of health protection involves working to prevent and control the spread of infection among the population. This can occur in the community and in health and social care settings. Communicable diseases are diseases that you can "catch" from someone or something else. They are spread from person to person or from an animal to person. The spread often happens via airborne viruses or bacteria, but also through blood or other bodily fluid or contact with contaminated objects in the environment. Some people may use the words contagious or infectious when talking about communicable diseases.

2.2 Outbreaks

2.2.1 An outbreak occurs when there are more cases of a disease than would normally be expected in a community, area or season. Health protection input aims to minimise the impact and contain the infection, wherever outbreaks occur. Outbreaks occurring in care facilities can have a significant impact both on the individuals affected and the wider health economy. Management of outbreaks has involved interagency approaches which have tested emergency preparedness. Learning identified has been fed into the local health economy outbreak plans.

2.2.2 In Bury in 2016/17 there were 31 outbreaks of gastroenteritis, affecting a total of 270 care home residents and 57 staff and resulting in 163 days of care home closure. There were 4 respiratory outbreaks affecting a total of 63 residents and 18 staff and closing care homes for 50 days. There were 3 outbreaks of other undefined types, affecting a total of 30 individuals.

2.3 Significant Cases

2.3.1 The Infection Prevention and Control (IPC) team are available to offer advice and help to manage cases that could be of significance to health protection. There were 19 cases

(not including C.diff, see section 3.3 below) that were handled by the team, requiring IPC advice. These covered a variety of different situations including tuberculosis, scarlet fever, and vaccinations.

2.4 Audits

2.4.1 Infection prevention and control audits are carried out in care homes and GP surgeries to monitor practice and processes in place, and provide assurance on quality. They allow identification of any required improvements so that targeted support can be provided.

2.4.2 Care home audits and re-audits were completed for all care homes in Bury between Aug 2015 and May 2017. In the initial audits, the majority of care homes scored 'amber' for their IPC and no care homes scored 'red', as show in Chart 1 below. By comparison, improvement was shown through the re-audit of some care homes, with the majority then scoring 'green' (75%) and still none scoring 'red' (Chart 2).

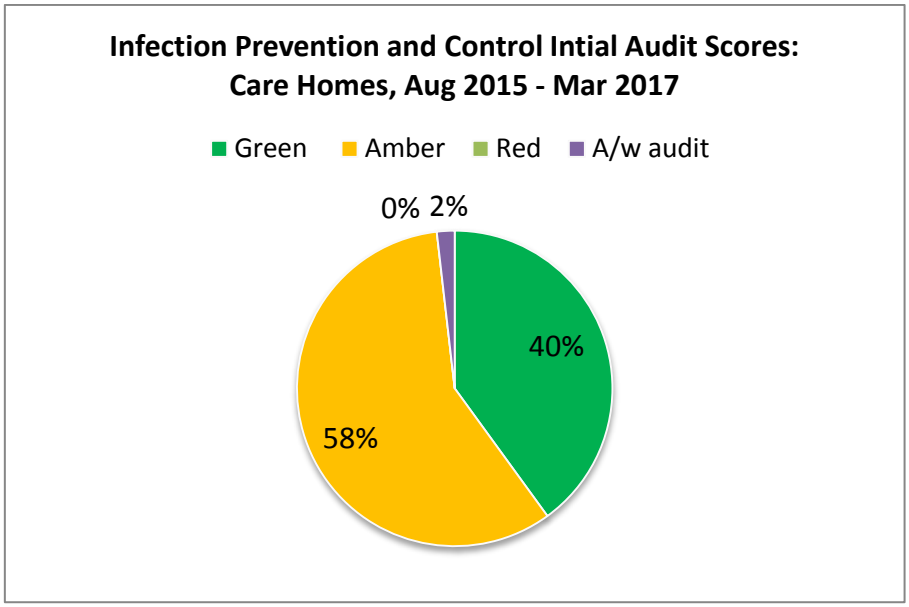

Chart 1 – Pie chart of IPC initial audit scores in Bury care homes, Aug 2015 – Mar 2017

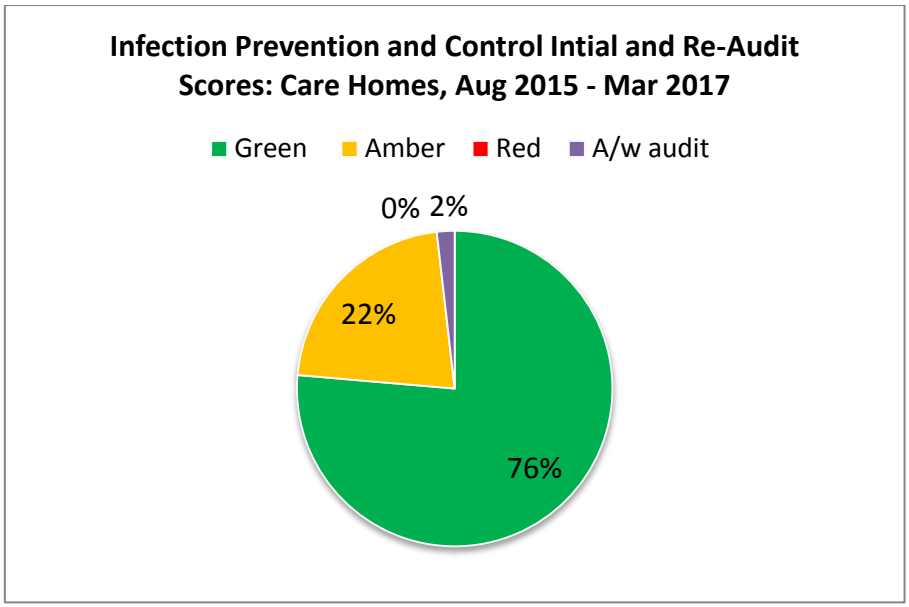

Chart 2 – Pie chart of IPC re-audit scores in Bury care homes, Aug 2015 – Mar 2017

2.4.3 Audits of the 33 general practices are scheduled to be carried out 2 yearly. The audit consists of a general IPC audit of the practice and a further audit for minor surgery accommodation. The general IPC audits are red, amber or green (RAG) rated. The minor surgery audits are only rated red or green.

2.4.4 14 GP audits, 5 re-audits and 10 minor surgery audits were carried out in Bury between Apr 2015 and Mar 2017. These concentrated on practices not audited since 2013 or 2014. In the minor surgery audits, 6 practices scored 'green' for their IPC and 4 practices scored 'red', as shown in Chart 3 below.

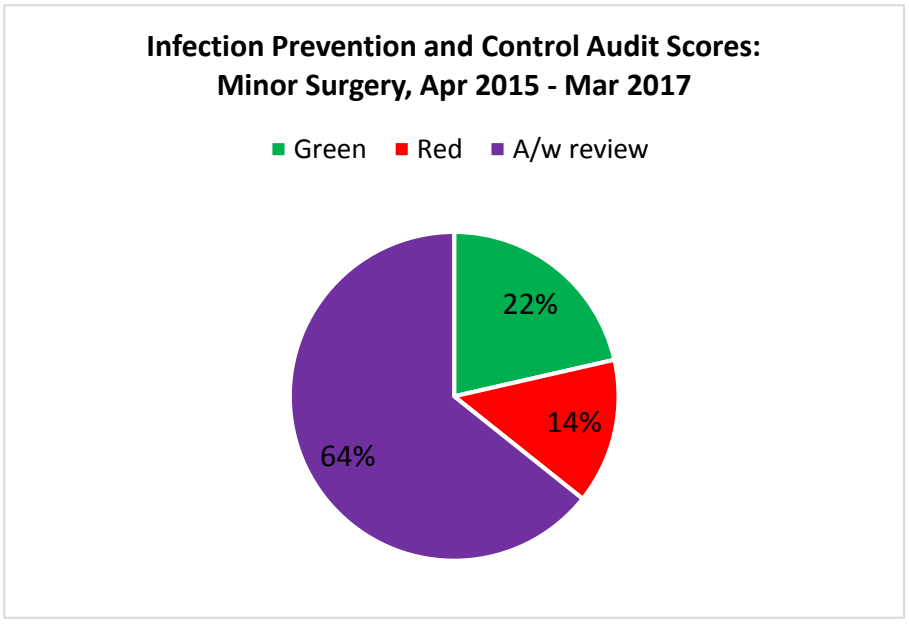

Chart 3 – Pie chart of IPC audit scores in Bury GP's minor surgery accommodation, Apr 2015 – Mar 2017

2.4.5 In the general IPC audits, 7 practices scored 'green', 7 practices scored 'amber' and no practices scored red, as shown in Chart 4 below.

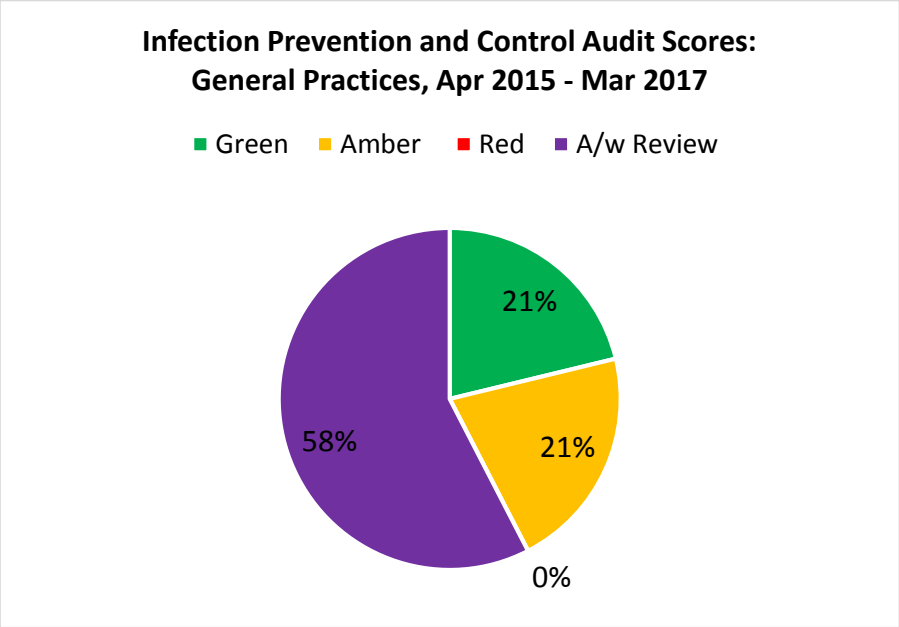

Chart 4 – Pie chart of IPC audit scores in Bury general practices, Apr 2015 – Mar 2017

2.5 Recommendations

2.5.1 It will be important to continue to monitor outbreaks, to aid prevention and control as far as possible. Support will continue to be offered to care homes to address IPC, in line with Health & Social Care Act guidance (1), and this should be reflected in an increase in care homes and GPs achieving 'green' ratings on initial audit.

3.0 Health Care Associated Infections (HCAIs)

3.1 Background

3.1.1 Health care associated infections (HCAIs) cover a wide range of infections. They can be the result of healthcare interventions or contact with a healthcare setting. There are two infections that are currently monitored at a national level: Meticillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (C.diff).

3.2 Meticillin-Resistant Staphylococcus aureus (MRSA)

3.2.1 MRSA is a bacterium that is resistant to many antibiotics. MRSA lives harmlessly on the skin of around 1 in 30 people but if it gets deeper into the body can cause infection. The Staphylococcal group of bacteria, including MRSA, can cause a variety of problems ranging from skin infections and sepsis to pneumonia to blood stream infections (BSIs, also known as bacteraemias), which can be very serious or even fatal. MRSA infection is treated with specific antibiotics.

3.2.2 There was 1 case of MRSA bacteraemia in 2016/17 that occurred in the first quarter of the year and was ultimately not assigned to Bury CCG. The annual trajectory target was for no cases. There were a small number of more superficial MRSA infections but these are not recorded within national data because they are not as usually as serious, and only a few required input from the IPC team.

3.2.3 The trend data for Bury shows there has been significant annual variation, although the overall numbers do appear to be falling, in line with the national data trend, shown in Chart 5. For the last 4 years, Bury has had a lower or similar case rate to the national average and in 2016/17 the Bury rate (0.5 per 100,000 population) was lower than both the North West (NW) (2.1 per 100,000 population) and national rates (1.5 per 100,000 population).

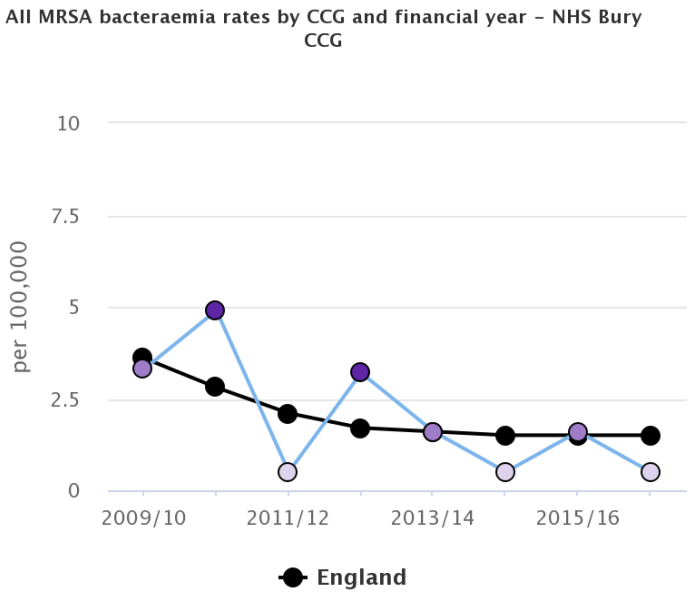

Chart 5 – MRSA rates in Bury CCG compared to the England average, 2009-2017 (2)

3.3 Clostridium difficile (C.diff)

3.3.1 C.diff is a bacterium found in some people's intestines that can cause disease by producing a toxin, usually associated with taking antibiotics. Infection can cause diarrhoea and more serious bowel problems in some cases, which can be life threatening. C.diff is common in places such as hospitals where people are within close contact with one another and may be being treated with antibiotics. Some people carry the bacterium in their bowel without producing toxin (carriers) or having symptoms but can represent an infection risk if they have diarrhoea. A robust process is in place for notifying GPs of both toxin positive cases and carriers, to ensure appropriate management to prevent full blown infection or reoccurrence.

3.3.2 There were 61 toxin positive cases in 2016/17, which overshot the trajectory target of 45 that was predicted in the 4th quarter of the year. The largest number of cases occurred in the 3rd quarter and the fewest cases occurred in the 2nd quarter. There were 97 cases of carriers in the same year. Community root cause analysis was performed for 32 cases to determine the potential reason for infections and 2 lapses in care were identified. Feedback is provided to GPs and the CCG, working closely with Medicines Optimisation to address any issues with prescribing that are identified. The Health Protection Nurses are also involved in the process for reviewing cases occurring in acute care, and ensure that any issues identified are fed back.

3.3.3 As can be seen in Chart 6, C.diff rates were following a downward trend between 2009-2013, but have plateaued in recent years, with some annual variation. In 2016/17 the rate in Bury (32.4 per 100,000 population) was higher than both the NW (28.4 per 100,000 population) and England average (23.4 per 100,000 population).

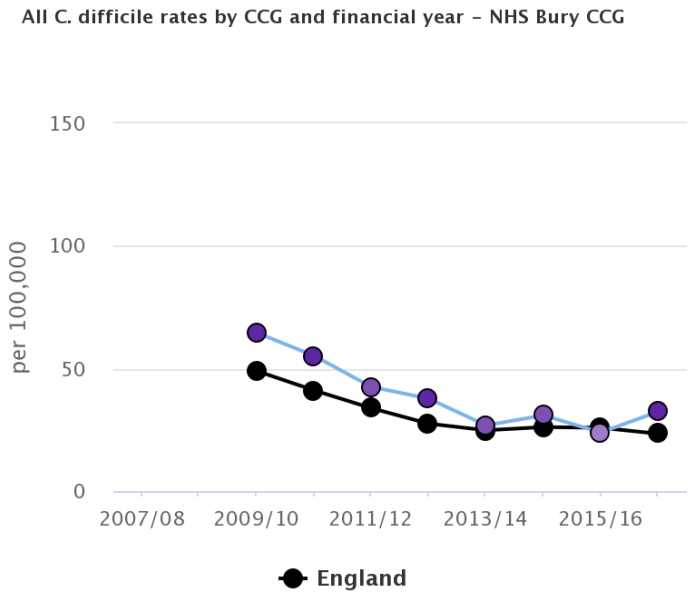

Chart 6 – Annual C.diff rates in Bury CCG compared to the England average 2009-2017 (2)

3.4 Recommendations

3.4.1 The work done to monitor and investigate community acquired HCAIs and share learning with health and care providers should continue.

3.4.2 In early 2017, the Secretary of State for Health launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections (GNBSIs) by 50% by 2021, and reduce inappropriate antimicrobial/antibiotic prescribing by 50% by 2021. This is because of an increase in the numbers of E.coli BSIs, which make up 55% of all GNBSIs, across the health system. 'Gram-negative' refers to bacteria with a specific cell structure that can sometimes cause serious infections. In Bury, the processes required for delivering this important target are being addressed to ensure a whole health economy approach as part of a North East sector (of the North West) approach. It will be important to monitor the incidence of GNBSIs with a focus on E. coli BSIs, work with the North East Sector economy to develop processes for monitoring E.coli BSI, and implement once defined.

3.4.3 Anti-microbial resistance (AMR) is a global issue which has been added to the national risk register by the chief Medical Officer for England and Wales, and which members

of the United Nations (UN) have pledged to address. Locally, as well as highlighting prescribing issues identified as part of the programmes described above, a core theme of the work being carried out is making the most of opportunities to raise awareness of the problem and action that can be taken to reduce the need for antibiotics. The health protection team in Bury will support and deliver initiatives to address AMR, complementing work being carried out across the local health economy.

4.0 Tuberculosis (TB)

4.1 Background

4.1.1 Tuberculosis (TB) is an infectious disease, caused by bacteria belonging to the Mycobacterium tuberculosis complex. TB usually causes disease in the lungs (pulmonary), but can also affect other parts of the body (extra-pulmonary). The three year average incidence rate for TB in England was 12.0 cases per 100,000 of population in 2013-15 (2). Those most at risk are migrant populations and vulnerable groups, particularly the homeless. The UK currently has the second highest rate of TB among Western European countries. Some cases of TB are vaccine preventable and vaccination is offered to those at risk.

4.2 Incidence

4.2.1 The three year average incidence rate of TB in Bury was 10.3 cases per 100,000 population, which was the 8th highest rate in the North West (NW). This was slightly higher than the NW regional average (9.0 cases per 100,000 population). Between 2000-2011 the three year average incidence rate in Bury was significantly lower than the national rate. Since 2012 to the most recent data however, the national rate has been declining, whereas the local rate in Bury has risen and reached a plateau, meaning there is no longer a significant difference between the two, shown in Chart 7 (2).

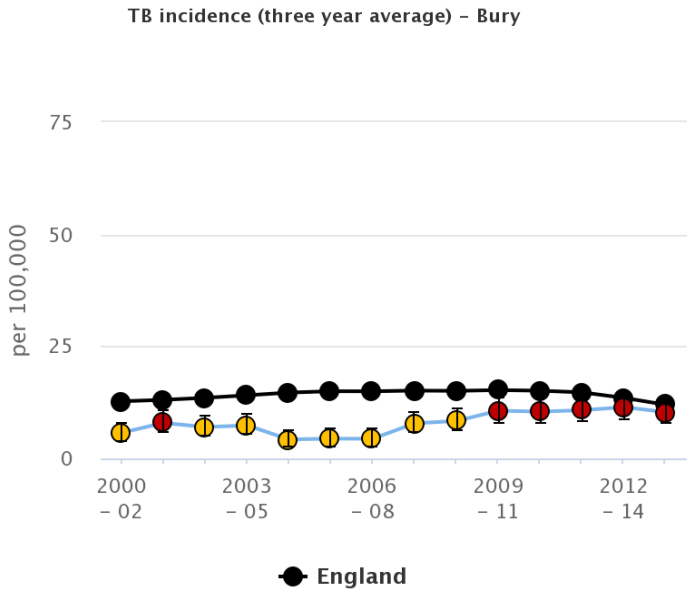

Chart 7 – TB Incidence (three year average) in Bury 2000-2014 (2)

4.3 Treatment Completion

4.3.1 The standard treatment for TB lasts between six and nine months. At a national level, there is increasing concern around multi drug resistant (MDR) TB, which doesn't respond to the standard treatment. The indicators reported by PHE only include drug sensitive cases of TB. In 2014, only 79.2% of cases completed a full course of treatment within 12 months of starting it in Bury. This makes Bury the second lowest in the NW, among Local Authorities (LAs) with available data, and lower than both the NW (83.9%) and national (84.4%) averages (2).

4.4 Prevention

4.4.1 In the UK, BCG vaccination is offered to babies born in families at higher risk for TB. There is no data available for the coverage of BCG vaccination. Other prevention measures include contract tracing confirmed cases of TB to identify other at risk individuals and offer them testing and treatment as necessary.

4.5 Recommendations

4.5.1 Bury should continue to monitor rates of TB and provide treatment and implement prevention measures where possible. Improvement could be made with regards to ensuring a full course of treatment is completed within 12 months.

4.5.2 For the 2017/18 report, work should be done with partners working in TB prevention, detection and treatment to greater understand the local picture, including current issues and work being done in this area.

5.0 Seasonal Influenza (Flu)

5.1 Background

5.1.1 Influenza (commonly known as flu) is a viral respiratory illness, transmitted readily between people via respiratory droplets. Symptoms include: fever, cough, tiredness, nasal congestion, aches and pains, diarrhoea and vomiting. Flu cases can range from asymptomatic to fatal, with certain at-risk populations being affected more frequently and severely (3,4). Between 3 and 5 million people across the world suffer from severe flu every year, resulting in up to 500,000 deaths annually. Influenza can be responsible for outbreaks, epidemics and pandemics; annual seasonal influenza epidemics are a recognised phenomenon in temperate regions, usually occurring December to March in the UK (3,5). Up to 21,000 excess winter deaths have been caused by flu in the UK during years with pandemics because these are caused by a mutated virus to which people lack immunity. However even during normal epidemic seasons, the estimated average death rate is still around 5,000 in the UK (3,6,7).

5.1.2 A vaccine against seasonal influenza is available to people in Bury in certain at risk groups: -

- those aged 65 years or over;
- pregnant women;
- people with certain medical conditions;
- residents of long-stay care homes or other long-stay care facilities;
- those in receipt of a carer's allowance, or are the main carer for an elderly or disabled person whose welfare may be at risk;
- children aged 2 to 11 years old.

5.1.3 Bury was an original pilot site for the children's school vaccination programme and so whilst most other areas of the country only offered the vaccine to children in school years 1-3, children in school years 1-6 are eligible in Bury. In the 2016/17 season, children aged 2-4 years were offered the vaccine via their GP and older children received it at school. For the 2017/18 season, it has been decided nationally that children aged 4 years will be included in the school vaccination programme through inclusion of reception classes and only children aged 2 and 3 years will continue to receive the vaccine via their GP.

5.1.4 A Bury seasonal influenza vaccination locality group was established in September 2013. This group has representation from: -

- Bury Public Health Department (who chair the meeting);
- Bury Clinical Commissioning Group (CCG);
- Communication – Bury CCG and Council;
- Pennine Acute Foundation Trust – including district nurse representation;
- Greater Manchester Screening and Immunisation Team;
- practice managers;
- Bury Council children's services;
- Bury Local Pharmaceutical Committee;
- IntraHealth (school programme);
- maternity services.

5.2 Incidence

5.2.1 There is no incidence data for flu available for Bury. This is because of technical incompatibilities between the systems used by GPs in Bury and the national flu surveillance programme. In England, in the 2016/17 winter season, cases of influenza-like-illness requiring some form of medical input (GP consultations in and out of hours and NHS 111 calls) peaked at 18.0 per 100,000 population, in the 1st week of 2017. These rates are not a true representation of actual cases of flu as there will be many that do not seek medical attention and some of those cases included will not have been caused by the seasonal influenza virus, just presented with similar symptoms.

5.3 Community vaccination uptake

5.3.1 The majority of vaccinations outside the school programme are delivered via GPs, with only 0.1-2.9% being delivered by pharmacies or other healthcare providers, depending on patient group. All of the 29 GP surgeries in Bury responded to the mandatory uptake survey monitored by ImmForm. Excluding school-aged children and carers, there were approximately 68,107 registered patients eligible for flu vaccination in 2016/17. A total of 42,508 (62.4%) seasonal influenza vaccinations were recorded and administered to these patients, which was a slight increase of 957 patients from 2015/16. Uptake varied across practices and approximately 25,599 (37.6%) eligible people registered at a GP practice in Bury CCG were not vaccinated, of which 6,190 (14.56%) patients declined it. Uptake increased or remained relatively stable within each at risk group, as shown in Chart 8 and Table 1. The highest uptake was in the '65 and over' group and the lowest was in the '4 years' group.

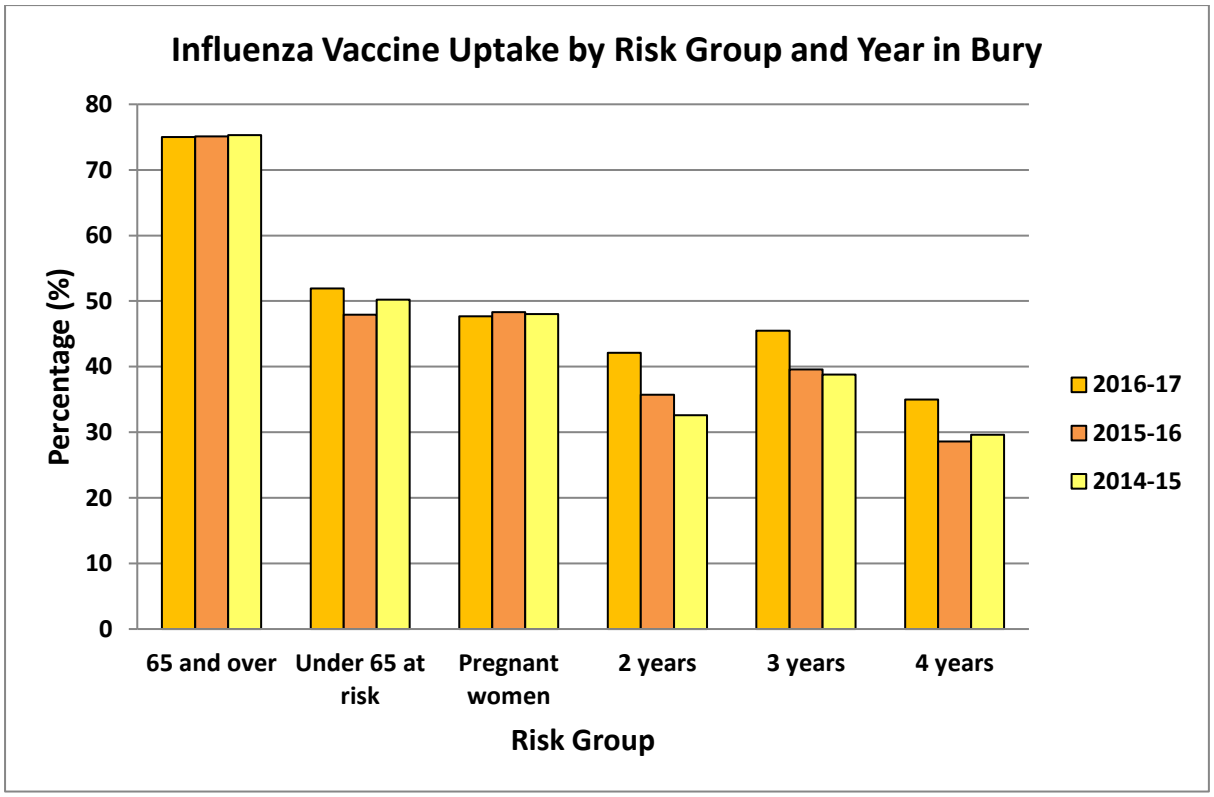

Chart 8 – Influenza vaccine uptake by risk group and year in Bury (8)

5.3.2 As can be seen in Table 1, Bury failed to achieve the minimum target uptake in those aged 6 months to 65 years in at risk groups, pregnant women and 4 year olds. However, improvement was made from the previous year across all of these groups. Uptake reached lower target levels in the 2 year and 3 year age groups, which was not achieved in the previous year. Even though the 4 year old group failed to achieve the target, uptake increased by more than 20% of the previous rate. The target level was just maintained in the 65 and over age group.

5.3.3 Also seen in Table 1, Bury ranked well nationally and regionally in terms of uptake, improving on the previous year's ranking in most instances and sitting comfortably in the top 50% across all risk groups at a national level. Although the national ranking fell slightly for those aged 65 and over and for pregnant women, Bury still ranked in the top 10% and top 25% for these groups respectively. From a GM perspective, Bury improved its ranking across all groups except pregnant women.

Influenza Vaccine Uptake Ranking Nationally and Greater Manchester 2015/16 & 2016/17			
	2015/16	**2016/17**	**National Target**
Those aged 65 years or over			
Uptake	75.1%	75.0%	75%
National Rank (211 CCGs)	10	14	
GM rank: (12 CCGs)	9	3	
Those aged 6 months to under 65 years in a clinical at risk group			
Uptake	47.9%	51.9%	55-75%
National Rank (211 CCGs)	55	49	
GM rank: (12 CCGs)	9	7	
All pregnant women			
Uptake	47.1%	47.7%	55-75%
National Rank (211 CCGs)	39	43	
GM rank: (12 CCGs)	5	7	
All 2 year olds			
Uptake	35.7%	42.1%	40-60%
National Rank (211 CCGs)	112	75	
GM rank: (12 CCGs)	6	4	
All 3 year olds			
Uptake	39.6%	45.5%	40-60%
National Rank (211 CCGs)	91	70	
GM rank: (12 CCGs)	6	3	
All 4 year olds			
Uptake	28.6%	35.0%	40-60%
National Rank (211 CCGs)	120	80	
GM rank: (12 CCGs)	7	4	

Table 1 - Influenza Vaccine Uptake Ranking – Nationally and in Greater Manchester in 2015/16 and 2016/17 (8)

5.4 School vaccination programme uptake

5.4.1 As mentioned above, Bury was part of the pilot scheme for the school influenza vaccine programme and therefore offers the vaccine to all primary school years (1-6), unlike the majority of England, which only offered it to school years 1-3. The pilot programme started in 2013/14 with national roll out for years 1 and 2 in 2014/15. Uptake rates dropped across all school years in 2016/17 compared to 2015/16, although they remained within the target range (see Table 2). Highest uptake was in the Year 2 group (6-7 years old), closely followed by Years 1 and 3, which were all available as part of the wider national programme.

Bury Schools Influenza Vaccination Uptake in 2015/16 and 2016/17							
Season	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Target**
2015/16	67.7%	66.1%	65.4%	61.4%	63.0%	61.5%	40-65%
2016/17	58.2%	60.9%	58.1%	57.4%	54.3%	56.3%	

Table 2 – Uptake of influenza vaccination through the school programme by season and year group (8)

5.5 Vaccination uptake in other groups

5.5.1 For registered carers, Bury CCG achieved an uptake of 52.9% an increase of 9.6% from 2015/16. There was significant variation in uptake across practices, ranging from 75% to 0% (8).

5.5.2 The flu letter for 2016/17 stipulated that it was the employer's responsibility to ensure maximum uptake in frontline healthcare worker staff groups (9). An average uptake of 52.6% was reported by 8 general practices out of 29, which was an improvement from the

previous year when no practices reported any data. Pennine Acute Hospitals NHS Trust had an uptake of 53.6%, which was a 0.5% increase from 2015/16. Pennine Care NHS Foundation Trust had an uptake of 30.5%, which was a decrease of 12.5% from 2015/16 (8). Vaccination of staff in care homes was encouraged and details of uptake were requested. Only two care homes replied, reporting 100% vaccination of their staff.

5.6 Recommendations

5.6.1 Bury will be prioritising the following increases in uptake, as per the Greater Manchester Health and Social Care (GMHSC) Partnership: -

- 2-3 year olds → increase of at least 10% at each practice or uptake of 65%
    - **How?** Recent local qualitative research suggests that some parents were unware their child was eligible for vaccination, which may explain some of the low take-up. In view of this, efforts are being focused on publicity of the vaccine to this age group. In addition, the research also suggested access to GP appointments to obtain the vaccine was not always easy for parents and this has been fed back to local practices to improve the variety of appointments available, including at weekends and in the evenings. Pop-up clinics for opportunistic vaccinations are being investigated.
- 65 years and over → uptake of 75% or over at all practices
    - **How?** Promotion will be targeted at groups and centres known to be frequented by this age group and via the council reablement service.
- 6 months-65 years in at risk group → uptake of 55% minimum in all practices, with aspirations for 75%
    - **How?** For this group and the 65 years and over, national promotional campaigns, pharmacy marketing and practice contacts will be utilised to promote uptake, and reminders will be sent from GPs to eligible patients who have not attended for vaccination.
- pregnant women → uptake of 55% minimum in all practices, with aspirations for 75%
    - **How?** Flu vaccination is now part of the midwife contract and midwives have been trained to give vaccines.
- In addition, work is being done through links with the charity ADAB, to try and improve uptake among minority ethnic groups, which aims to improve uptake across all target groups.

5.6.2 In addition, it is recommended the following are considered: -

- School programme → Bury should aim to improve uptake back to 2015/16 levels or better (i.e. achieve or exceed 65% target)
- Encourage health and social care organisations to promote uptake amongst frontline workers and report on this uptake.
- Through Bury Carers Centre, those individuals in a caring role will be encouraged to register as a carer with their GP so that they are eligible for free vaccination.

6.0 Other Vaccine Preventable Diseases

6.1 Background

6.1.1 Vaccines are a way of allowing the body's natural defence system become familiar with a pathogen (bacteria or virus causing disease) so that it is ready to protect itself against the real version if it comes into contact with it naturally. Immunization against disease is a very effective way of reducing infection rates and has successfully eradicated smallpox, with the eradication of polio expected in the near future. In the UK, the majority of routine vaccinations are given in childhood and adolescence. In order to function most effectively, most vaccination programmes require the large majority of the population to be immunized (>95%). This produces 'herd immunity', which means that the disease causing pathogen cannot easily spread and even those who are not vaccinated are protected. The timeline of the introduction of each vaccine can be seen in Figure 1.

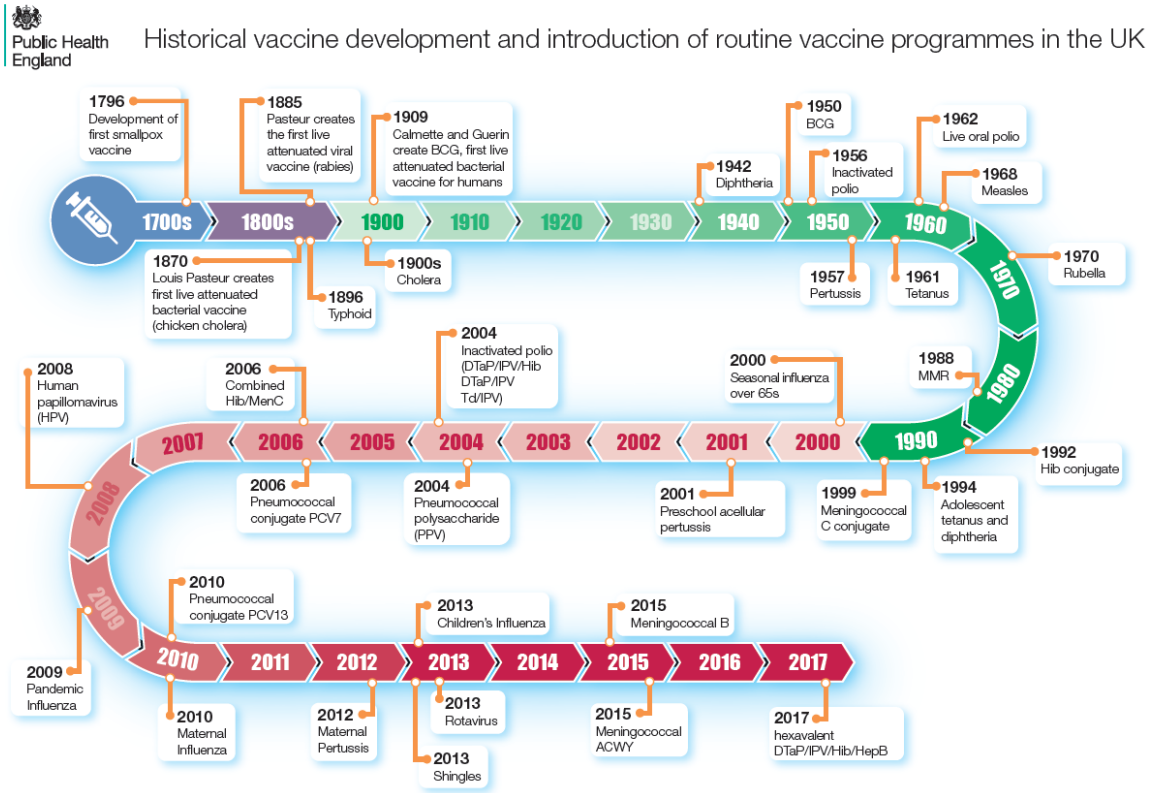

Figure 1 – Timeline of vaccination programme in the UK (2)

6.1.2 Most of the data available are from 2015/16 because this is the most recent confirmed data publically available. Most data has been taken from the Public Health Profiles 'Fingertips' resource produced by PHE (2). Where more recent data is available via GP

submissions through the ImmForm system (10), this has been included; as has provisional data from the 'Cover of Vaccination Evaluated Rapidly' (COVER) programme (11).

6.2 Human Papilloma Virus (HPV)

6.2.1 HPV vaccination is offered to all girls aged 12-13 years to protect against cervical cancer. HPV has multiple different subtypes, some of which cause warts and verrucas. The vaccine only protects against four different types of the virus, which cause 70% of cervical cancer and some cases of genital warts. In 2015/16, the coverage for one dose of the HPV vaccination was 87.0% nationally and 88.2% in the North West, and the coverage for two doses was 85.1% nationally and 87.8% in the North West.

6.2.2 The population coverage for HPV vaccination of 13-14 year old girls in Bury in 2015/16 was 87.0% for one dose and 82.0% for two doses (see Table 3). This is slightly below the intended benchmark of 90%. Across the North West (NW), Bury has the 6th lowest uptake of the vaccine for one dose and 2nd lowest for two doses, significantly lower than geographical neighbours Bolton (93.0%), Oldham (92.4%) and Rochdale (88.8%). Bury is also 5th lowest for uptake among its CIPFA nearest neighbours (2).

HPV Coverage by Number of Doses and Location in 2015/16				
Number of doses	**Bury Coverage (%)**	**NW Coverage (%)**	**England Coverage (%)**	**Benchmark**
1 dose	87.0	88.2	87.0	90%
2 doses	82.0	87.8	85.1	

Table 3 – Human papilloma virus vaccine coverage in Bury, the NW and England in 2015/16 (2)

6.2.3 Trend data is not available for two doses because the programme recently changed from three to two doses, so the indicator definition has changed. Data for the previous year suggests there has been a small, non-significant increase in uptake of one dose from 85.7%. It will be important to monitor this to determine if it is a genuine ongoing upward trend. Preliminary data for 2016/17 suggests the uptake rates may have stabilised at 87.3% for one dose and have fallen slightly to 80.3% for two doses, but this is not yet confirmed (12).

6.3 Measles, Mumps and Rubella (MMR)

6.3.1 Measles, mumps and rubella (German measles) are illnesses caused by viruses that were common in childhood prior to the introduction of vaccination. They are all very contagious and can cause serious side effects or even death in some cases. A combined triple vaccine is given against measles, mumps and rubella on or after the 1st birthday and then a booster is given pre-school (3-5 years). Uptake is measured at 2 and 5 years of age.

6.3.2 As shown in Table 4, in 2015/16, at 2 years the uptake of one dose of MMR was 93.3%, at 5 years it was 97.1% for one dose and 92.7% for two doses. Although two of these measures fall slightly below the 95% benchmark, they are all slightly higher than the England and NW average. Bury was the 8th highest in the NW (2) for 2 doses at 5 years. The provisional data for 2016/17 suggests that the coverage for one dose of MMR at 2 years was 90.3.%, at 5 years it was 95.6% for one dose and 89.1% for two doses (11). This suggests the coverage may have dropped slightly, although this may change once confirmed.

MMR Coverage by Number of Doses, Age Point and Location in 2015/16				
Doses & age measured	**Bury Coverage (%)**	**NW Coverage (%)**	**England Coverage (%)**	**Benchmark**
1 dose - 2 years	93.3	92.9	91.9	
1 dose - 5 years	97.1	96.9	94.8	95%
2 doses - 5 years	92.7	89.4	88.2	

Table 4 – Measles, mumps and rubella vaccine coverage in Bury, the NW and England in 2015/16 (2)

6.3.3 Between 2010-11 and 2012-13 the uptake of two doses of MMR at 5 years of age significantly increased from below the national average to above it. This has reached a plateau in the last 4 years, as can be seen in Chart 9 (2).

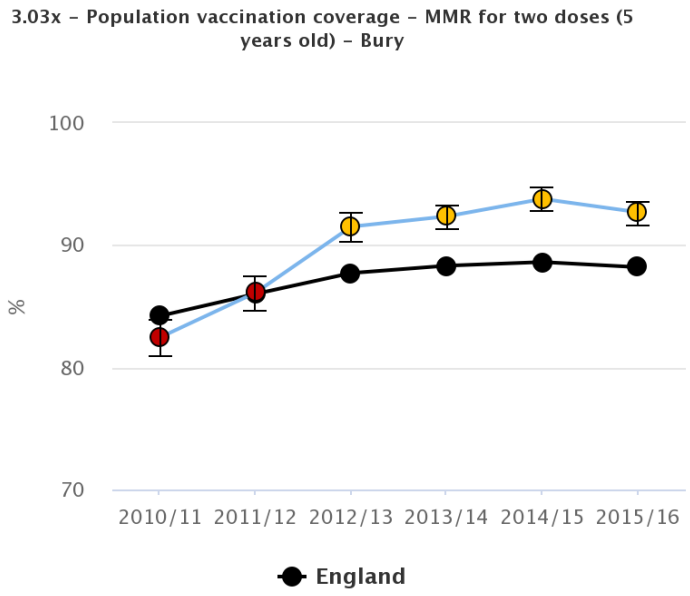

Chart 9 – Population vaccination coverage in Bury - MMR for two doses (5 years old) 2010-2016 (2)

6.4 Meningococcal Groups: A, B, C, W & Y (MenACWY, MenC & MenB)

6.4.1 The meningococcal groups are sub-groups of a bacterium called *Neisseria meningitidis* that can cause meningitis and septicaemia (blood poisoning). Although most people recover if they receive prompt treatment, these infections can be life-threatening and can cause long term complications. Different subgroups are more common at different ages and therefore the vaccinations against them are given at different times.

6.4.2 Up until July 2016, the MenC vaccination was given at 12 weeks and then again on or after a child's first birthday. The dose at one year of age (combined with the Hib booster) remains on the schedule but the earlier dose has been withdrawn because meningococcal C is a now rare cause of infection in babies and infants, due to the success of the vaccination programme. In 2015/16, the coverage in Bury was at 95.2%, just above the target, shown in Table 5 (2). The provisional data for 2016/17 suggests that at 12 months of age, 93.0% of infants in Bury were covered for MenC, as this cohort would still have been offered the vaccine at 12 weeks (11).

6.4.3 In 2015/16 in Bury, uptake of the Hib/MenC booster by 2 years of age fell slightly below the 95% target at 91.6%, which is the same as the England average (Table 5). There has been no significant variation in uptake of this vaccine over the last 5 years. Bury currently has the 5th lowest uptake in the NW and 3rd lowest compared to CIPFA nearest neighbours and slightly lower than the NW average. The provisional data for 2016/17 suggests coverage in Bury of 89.2%, but this may change when confirmed (11).

MenC Coverage by Age and Location in 2015/16				
Vaccine & age measured	**Bury Coverage (%)**	**NW Coverage (%)**	**England Coverage (%)**	**Benchmark**
Men C - 1 year	95.2	*	*	95%
Hib/MenC – 2 years	91.6	92.6	91.6	

*Data not available for quality reasons

Table 5 –Menigococcal C vaccine coverage in Bury, the NW and England in 2015/16 (2)

6.4.4 The MenACWY vaccination is offered to teenagers aged 13-14 years and young adults going to college/university (up to age 25) who aren't already immunized. It is a direct replacement of the meningococcal C (MenC) booster vaccine that used to be offered to this age group, in view of the increasing prevalence of the highly virulent meningococcal W strain among this age group. The vaccine protects against 4 strains of the meningococcal bacteria (A, C, W & Y). This vaccine was offered in both schools and via GPs in Bury, whereas some LAs only chose to use one of these two routes. There is no published target coverage for this vaccine.

6.4.5 The national school based programme for younger age groups was evaluated in Aug 2016, for the school year 2015/16, and reported coverage of 71.8%, 77.2% and 84.1% for school years 11, 10 and 9 respectively (13). The 2015/16 school based programme in Bury only covered school years 11 and 10 and achieved coverage of 82.0% and 80.6% respectively for these groups, higher than the national rates (13).

6.4.6 The average uptake of the vaccine across all the GP practices in Bury in 2016/17 was 15.7%. Uptake varied from 21.5% at the highest to 5.3% at the lowest. The highest uptake was in the 15-17 year old age groups, with 35.1% aged 15-16 years and 36.4% aged 16-17 years (12). The spread of uptake via GPs in Bury by age-group can be seen in Chart 10. Because of the method of delivery and the potential for school leavers to obtain the vaccine at a GP closer to their place of study, there is no accurate population denominator for these rates so it is difficult to comment on uptake, particularly for those aged over 17 years.

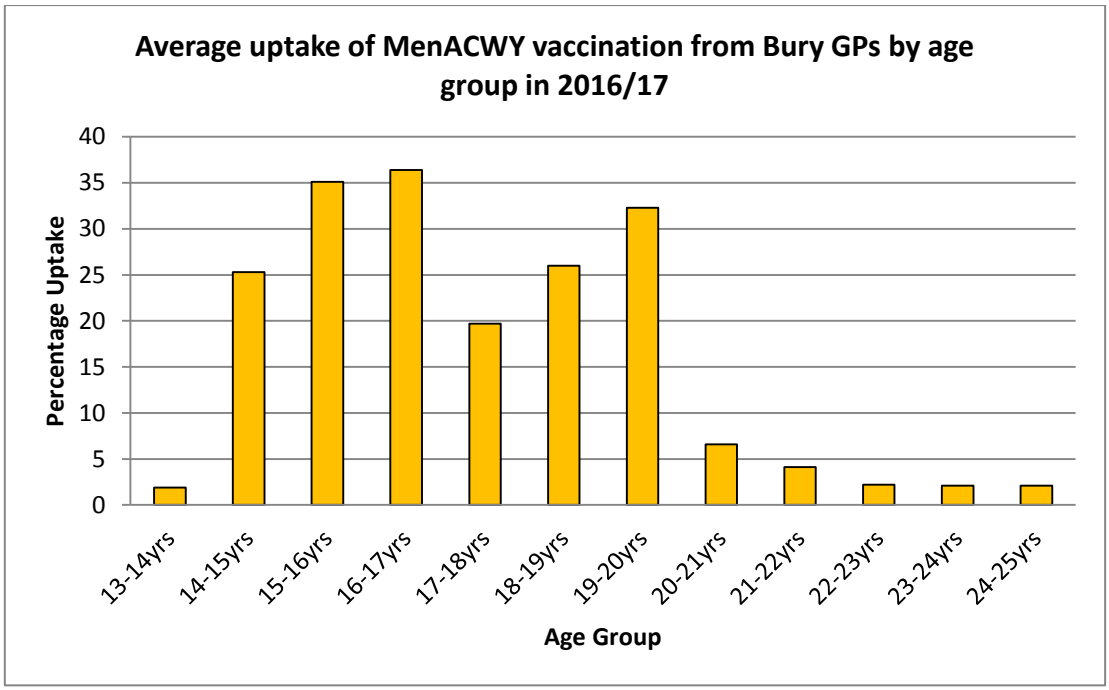

Chart 10 – Average uptake of Men ACWY vaccination from Bury GPs by age group in 2016/17 (Data from: DoH, 2017)

6.4.7 MenB was introduced to the childhood immunization programme in September 2015 and is given at 2 and 4 months and then again at 1 year. Because of its relatively recent introduction, there is not yet a full year data available on local uptake rates but national rates are good: 96.3% for one dose and 93.1% for two doses by 12 months of age in February 2017. There is data available by CCG for January – August 2016 that shows Bury CCG had an average uptake of 90.6% for one dose and 71.1% for two doses by 6 months of age (14). These are slightly lower than the national rates but these datasets cover slightly different time frames and because the most complete CCG data are collected at an earlier age (6 months versus 1 year), there is scope for catch-up doses to be given.

6.5 Diptheria, Tetanus, Pertussis (whooping cough), Polio, Haemophilus influenza type b (5-in-1, DTaP/IPV/Hib)

6.5.1 The 5-in-1/pentavalent vaccination offers protection against five different childhood diseases. These conditions are very contagious and/or can cause serious illness, but most of them are now very rare in the UK because of effective immunisation. The exception to this is pertussis (whooping cough), which had an outbreak in 2012 (9,367 cases compared to 336 in 2002) and continues to have around 3-4000 confirmed cases a year, with the most serious side-effects being in babies under 1 year.

6.5.2 The 5-in-1 vaccine was given in three doses at 2, 3 and 4 months of age, but from September 2017 this vaccine became the hexavalent (6-in-1) vaccine, to include hepatitis B

as well (more details in section 6.9 below). A booster for Haemophilus influenza is given at 1 year of age. Boosters for diphtheria, tetanus and polio are given at 3 years 4 months and 14 years. Boosters for pertussis are also given at 3 years 4 months and offered to pregnant women from 16 weeks gestation, to try and prevent infections in newborn babies. The target for uptake of all of these vaccines is >95%.

6.5.3 In 2015/16, by 1 year of age, Bury had 93.9% population coverage with the 5-in-1 vaccine, which rose to 95.6% by 2 years of age (Table 6). These values were very similar to both the NW (93.5-95.5%) and England (93.6-95.2%) averages, but 5th lowest in the NW (2). Early data for 2016/17 suggests similar levels of uptake, but these have yet to be confirmed. Provisional GP reported data at September 2017 suggests that the 3rd and final dose of the 5-in-1 is what brings down the average, as by 8 months 95.5% of the population had received two doses of the vaccine but only 88.5% had received three doses.

5-in-1 Coverage by Age and Location in 2015/16				
Age	**Bury Coverage (%)**	**NW Coverage (%)**	**England Coverage (%)**	**Benchmark**
1 year	93.9	93.5	93.6	95%
2 years	95.2	95.5	95.2	

Table 6 – Coverage with 5-in-1 vaccination by age and location in 2015/16 (2)

6.5.4 Recent trend data, shown in Chart 11, suggests that Bury was previously achieving coverage of >95% at 1 year but experienced a fall in uptake in 2015/16, although this was not statistically significant. If this trend continues, it is possible Bury will slip below the national average.

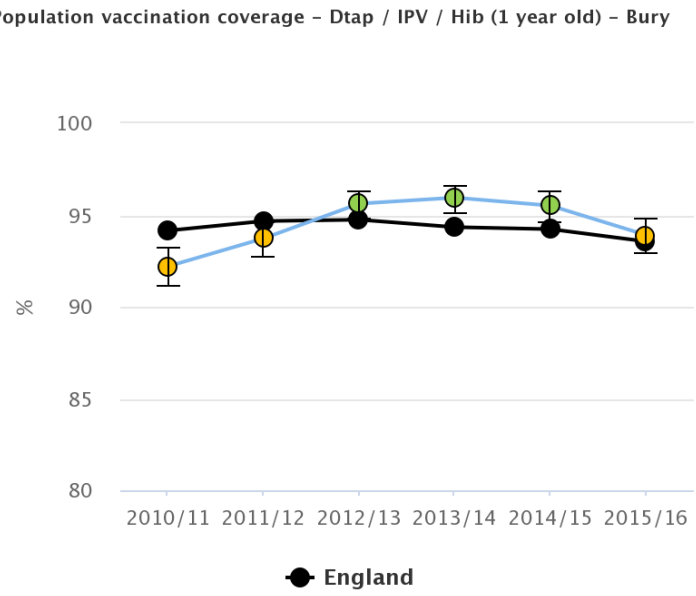

Chart 11 – Population vaccination coverage with DTaP/IPV/Hib at 1 year of age in Bury (2)

6.6 Pneumococcal (PCV & PPV)

6.6.1 The pneumococcal vaccine prevents against infections caused by the bacterium *Streptococcus pneumonia*, which can lead to pneumonia (lung infection), meningitis and septicaemia (blood poisoning). It can cause very serious illness and can be fatal. There are two types of pneumococcal vaccine: the pneumococcal conjugate vaccine (PCV) given to infants and protecting against 13 different strains; and the pneumococcal polysaccharide vaccine (PPV) given to people with certain long term health conditions or those over the age of 65, protecting against 23 different strains. In 2015/16 the national coverage rate for PCV was 93.5% and for PPV was 70.1%.

6.6.2 The PCV is given at 8 and 16 weeks and 1 year of age. In 2015/16 in Bury, the population coverage for the PCV was 92.7%, close to the 95% benchmark but the 5th lowest rate in the NW. The population coverage for the PCV booster was 92.6% in the same year, which was 6th lowest in the NW. The population coverage for PPV in over 65 year olds in Bury in 2015/16 was 68.3%, which is slightly below the 75% target. These values are shown in Table 7.

Pneumococcal Coverage by Age and Location in 2015/16				
Vaccination & Age	**Bury Coverage (%)**	**NW Coverage (%)**	**England Coverage (%)**	**Benchmark**
PCV – 1 year	92.7	92.5	93.5	95%
PPV – >65 years	68.3	71.4	69.8	75%

Table 7 – Coverage with pneumococcal vaccination by age and location in 2015/16 b

6.6.3 The recent trend for PCV uptake in Bury suggests that coverage peaked in 2013/14 at 95.6% and has gradually fallen until it is now significantly lower than that peak. This trend can be seen in Chart 12.

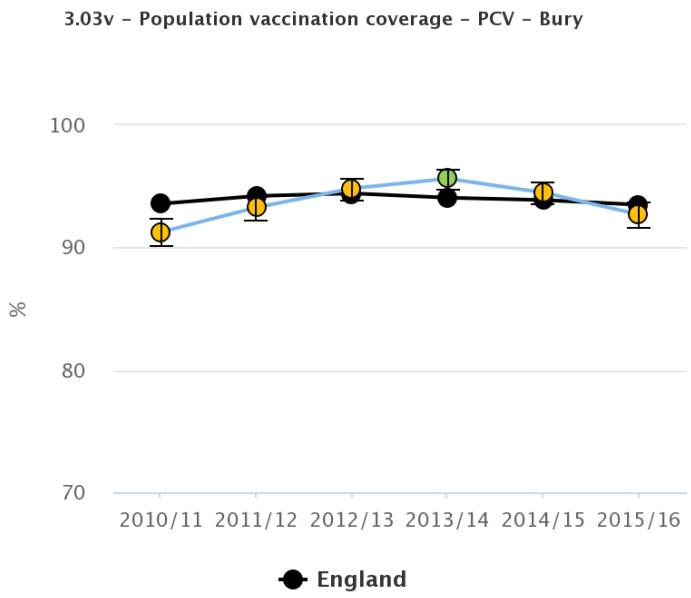

Chart 12 – Trend of population coverage for pneumococcal conjugate vaccine (PCV) in Bury 2010-2016 (2)

6.6.4 Conversely, the trend of coverage for PPV has been gradually improving over the last 5-6 years, getting closer to the national rates, as shown in Chart 13. These improvements have been statistically significant and so are unlikely to be due to chance.

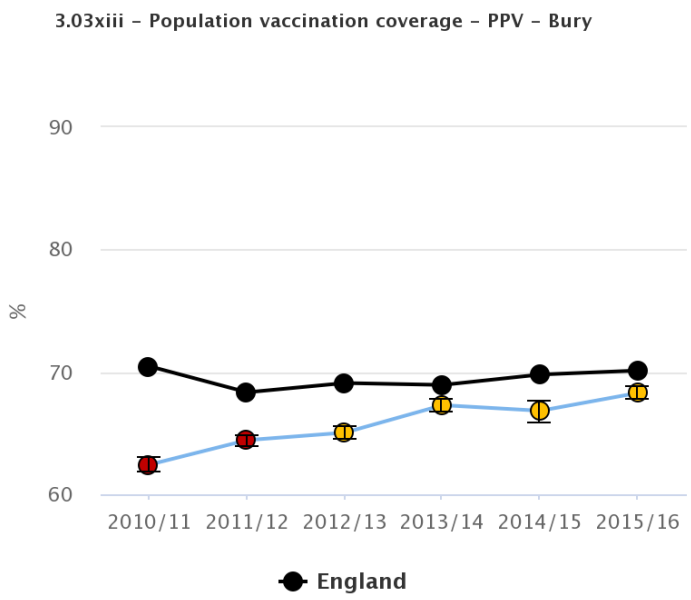

Chart 13 – Trend of population coverage for pneumococcal polysaccharide vaccine (PPV) in Bury 2010-2016 (2)

6.7 Rotavirus

6.7.1 Rotavirus causes gastroenteritis (diarrhoea and vomiting) and can be particularly severe in babies and young children. The oral rotavirus vaccination is given in two doses, at 2 and 3 months of age.

6.7.2 Estimated coverage rates are available at CCG level up until July 2016. Between August 2015 and July 2016, the estimated average coverage rate for 6 month olds having one dose of rotavirus vaccine in Bury CCG was 95.3% and for the second dose was 89.4%. These are slightly higher than the estimate average coverage for England during the same period: 93.3% for one dose and 89.3% for the second dose. Because these are only estimates without confidence intervals, it is impossible to comment on the significance of the difference between the different CCGs in the NW or nationally (15).

6.8 Shingles (Herpes zoster)

6.8.1 Shingles (herpes zoster) is a nerve infection that causes skin pain and a rash. It is caused by the varicella-zoster virus, which also causes chicken pox. Shingles is more common in older people or those with immune deficiency. Because of this, in 2013 a shingles vaccine was introduced for 70 year olds.

6.8.2 The population coverage for the shingles vaccine was 52.6% in 70 year olds in 2015/16. This was significantly lower than the NW coverage rate (55.5%) and lower than the national rate (54.9%) but not significantly so (2). Although this is a relatively new vaccine, recent trend data shows that uptake has fallen slightly, although this also reflects the national trend and suggests that the coverage has fallen less in Bury than nationally (see Chart 14).

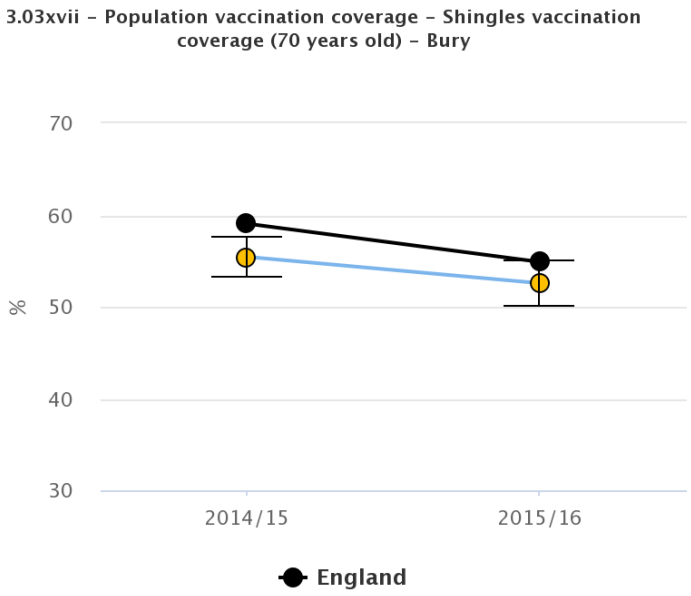

Chart 14 – Population coverage for the shingles vaccination in Bury for people aged 70 years old 2014-16 (2)

6.9 Hepatitis B (Hep B)

6.9.1 In 2016/17, Hep B immunisation was only offered to individuals at high risk of contracting the infection, such as babies born to mothers who are Hep B positive and people working in certain occupations, such as healthcare. For this reason, because the number of people requiring the vaccination is unknown, it is very difficult to comment on uptake.

6.9.2 As mentioned above, from September 2017, Hepatitis B has been included in the routine immunisation schedule at 2, 3 and 4 months of age, as part of the new 6-in-1 vaccination. Hepatitis B can cause serious liver disease, leading to scarring (cirrhosis) and cancer. It is spread through contact with infected blood or bodily fluids.

6.10 Summary & Recommendations

6.10.1 From the most recent confirmed data for the year 2015/16, Bury was higher than the NW uptake for MMR, PCV and the 5-in-1 at 1 year, but was lower than the NW average uptake

for HPV, Hib/MenC, PPV, Shingles and the 5-in-1 at 2 years. Rotavirus uptake was only estimated but was slightly higher than national estimates. Whilst PPV coverage was slightly lower than NW and national rates, it has shown significant improvement over the last few years and if it continues to improve at the same rate, may be higher than the regional and national average soon. Trend data for PCV, MMR and 5-in-1 suggest that uptake rates in Bury may be starting to decline and so it will be important to monitor this and act accordingly if this is the case.

6.10.2 Based on provisional data for 2016/17 from the COVER (cover of vaccination evaluated rapidly) programme, for most vaccine preventable diseases, Bury is similar to, or slightly below, the North West average uptake of immunisations (see Chart 15). The biggest difference is in the uptake of rotavirus at 12 months (75.1% in Bury compared to 87.3% in NW). Uptake of the 5-in-1 vaccine (DTaP/IPV/Hib) is slightly higher in Bury than the NW (94.9% compared to 94.0%). It will be important to continue to monitor uptake of the new 6-in-1 vaccination and compare it to uptake of the 5-in-1 in previous years to ensure uptake remains high. The COVER data do suggest some decline from previous years for many vaccination programmes in Bury, but this data is not yet confirmed so should be treated with caution.

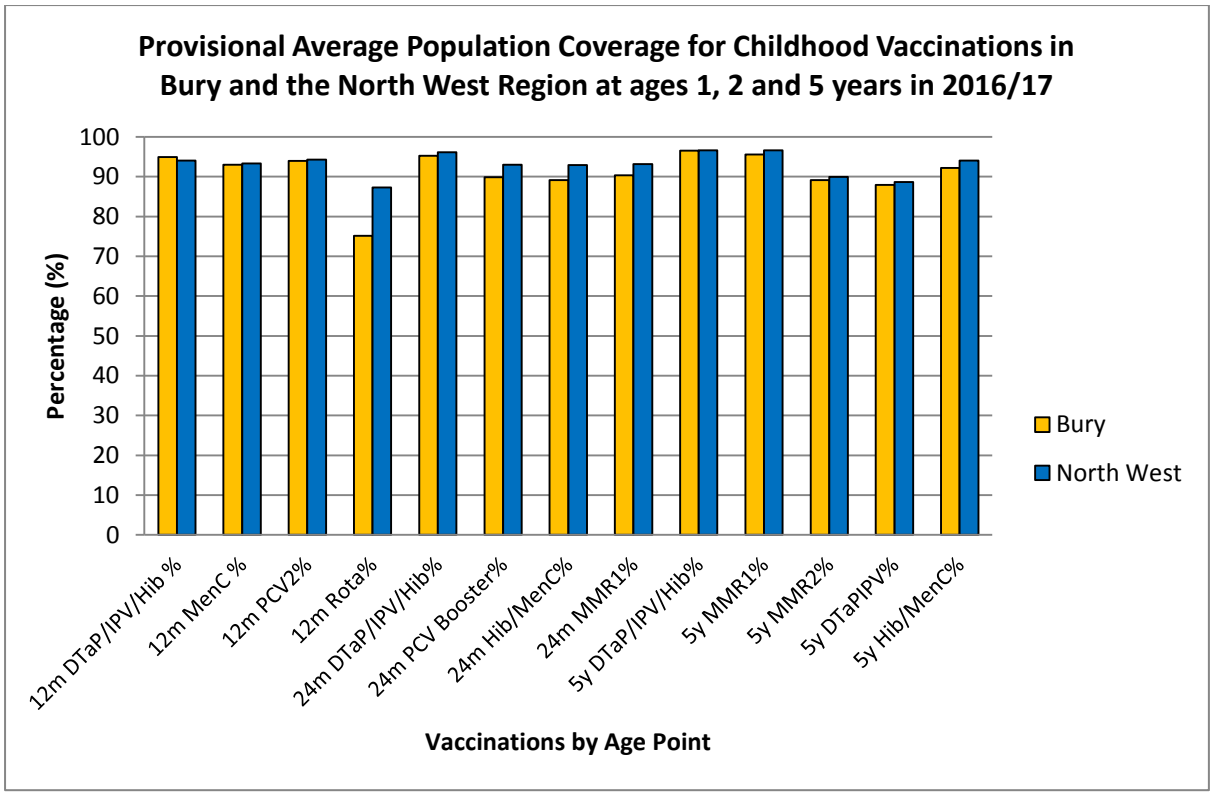

Chart 15 – Provisional Average Annual Population Coverage for Childhood Vaccinations in Bury and the North West Region at 12 months, 24 months and 5 years in 2016/17 (11)

SCREENING AND SEXUALLY TRANSMITTED INFECTIONS

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition, or in asymptomatic early stages of the condition. In England there is a range of screening programmes and these can lead to a reduction in late diagnosis and preventable deaths.

Sexual health is an issue that concerns the majority of the population. Good surveillance of trends in key measures of sexual health, such as rates of sexually transmitted infections (STIs) are a good measure of a comprehensive and high-quality sexual healthcare service, health promotion and educational opportunities achieved.

81% **Coverage for - Abdominal Aortic Aneurysm Screening**

Diabetic Eye Screening
>70%
Target

Bowel cancer screening toolkits are being made available to Bury Residents and development of a social movement of cancer champions

FREE STI home testing kits now available in Bury via:
www.thesexualhealthhub.co.uk

Key Points

Screening

Bury is above regional and national averages for all England screening programmes

Although coverage is above national averages for Cervical Screening, work to be done moving forward to achieve 80% target.

STI's

HIV Late Diagnosis has reduced significantly in recent years and is now below national levels

Bury will be taking part in the national HIV PrEP trial

Bury public health are to organise stakeholders to complete a Chlamydia Care Pathway Review with PHE North West colleagues, to increase screening rates.

96%
Uptake of HIV testing among men who have sex with men

Created by: Performance & Intelligence, Bury Council

Screening Programmes

6.11 Screen Programmes - Background

6.11.1 Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition, or in asymptomatic early stages of the condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. In England there is a range of screening programmes including breast, cervical and bowel cancer, abdominal aortic aneurysm (AAA) and diabetic retinopathy. Screening can lead to a reduction in late diagnosis and preventable deaths.

6.11.2 To maximise the benefits of a screening programme it is important that as many of the eligible population take up the screening as possible, ideally 100%. Screening rates can be affected by a number of factors including socioeconomic group, ethnicity, knowledge, health literacy and service provision. For all of the cancer screening programmes, many of the low uptake GP practices are in areas with high black and minority ethnic groups (BME) and new and emerging communities, and higher deprivation levels.

7.0 Breast Screening

7.1 Background

7.1.1 Breast cancer screening aims to reduce mortality from breast cancer by early detection. The Breast Screening Programme invites eligible women every three years (age 50-70). Because the rolling programme invites women from GP practices in turn, not every woman receives an invitation as soon as she is 50 but will receive her first invitation before her 53rd birthday. Women above the upper age cohort are able to opt in to be screened. The coverage of the screening programme is the proportion of resident eligible women who have had a mammogram with a recorded result at least once in the previous 3 years. The performance threshold (achievable) is 70% or over.

7.2 Current situation

7.2.1 The data shows the percentage of residents in the population eligible for breast screening (females aged 50-70) who were adequately screened within the last 3 years (2015/16 data). In Bury this was 73.2%, which was slightly higher than both the regional and national rates (GM 66.8%, England 72.5%).

7.2.2 In the trend data, Bury's coverage reduced significantly in 2015 when compared to 2014. The coverage increased again in 2015/16 but not to the higher levels that Bury has seen in previous years (see Chart 16). There is a similar decreasing trend in GM and nationally over the past 6 years. Currently Bury's coverage is not significantly different to the national average. Drilling down further into the GP practice level data, there is clear variation in coverage data, ranging from 50% to 82.6% coverage (see p.37 for possible reasons).

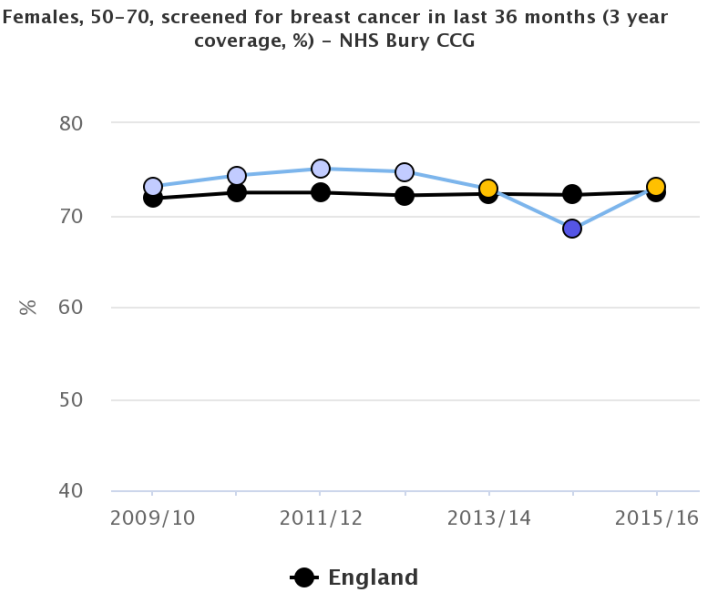

Chart 16 – 3 year coverage of breast screening programme in females aged 50-70 years in Bury, 2009-2016 (11)

8.0 Bowel Screening

8.1 Background

8.1.1 The Bowel Cancer Screening Programme (BCSP) aims to reduce bowel cancer mortality by detecting and treating bowel cancer, or pre-cancerous growths (adenomas), at an early stage. It does this by looking for hidden blood or 'faecal occult blood' (FOB) in stool samples. FOB testing kits are posted out by a screening hub every two years to people aged 60-74 (aged 75+ can opt in) to collect samples at home.

8.1.2 If hidden blood is found (usually in less than 2% of those taking part), Bury registered patients are referred onto Pennine Bowel Screening Centre, a service provided by Pennine Acute NHS Hospitals Trust (PAT). If fit to proceed, the person will be offered colonoscopy (camera test looking at the large bowel). Usually around one in ten of these people will be found to have a cancer, with around four in ten having adenomas in their bowel, which are removed during the procedure.

8.2 Current situation

8.2.1 The data shows the uptake for persons 60-74 years eligible for bowel cancer screening, who were adequately screened within 6 months of invitation. In Bury in 2015/16, the uptake was 54.8%, which was slightly higher than the GM uptake (52.9%) and slightly lower than England (56.4%). There are significant differences in uptake of the BCSP between the GP practices in Bury, ranging from 37.9% to 66% (see p.37 for possible reasons).

8.2.2 When looking at Bury compared to the national average in Chart 17, the trend pattern is broadly similar, however at this point Bury's uptake is lower than the national average.

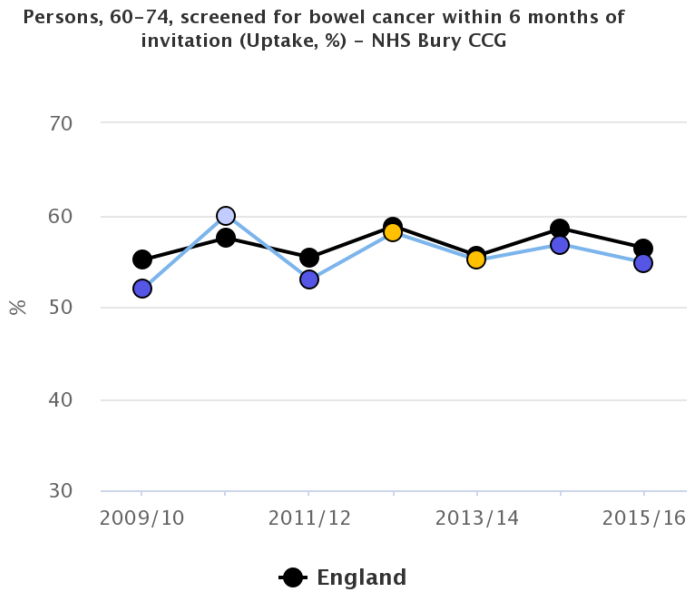

Chart 17 – Coverage of bowel cancer screening programme in people aged 60-74 years in Bury, taking the test within 6 months of invitation, 2009-2016 (11)

9.0 Cervical Screening

9.1 Background

9.1.1 Cervical screening aims to detect and treat early abnormalities which, if left untreated, could lead to cancer in a woman's cervix. All women aged 25 to 64 are invited for a screening test every 3 or 5 years dependent upon age (25-49 are screened 3 yearly, 50-64 year olds 5 yearly). Coverage is the percentage of eligible women (25-64 years old) who have a recorded adequate test result within the last 5 years. The achievable performance threshold is 80% and over.

9.2 Current situation

9.2.1 Females aged 25-64 attending for cervical screening within the target period in 2015/16 was 74.5% in Bury, which was slightly higher than both the GM (72.0%) and England (73.3%) average. The data shows that Bury has a higher cervical screening coverage than GM and England and coverage has gradually been decreasing since 2010, in line with national trends (Chart 18). There is however, inter-practice variation with coverage ranging from 65.1% to 83.4%.

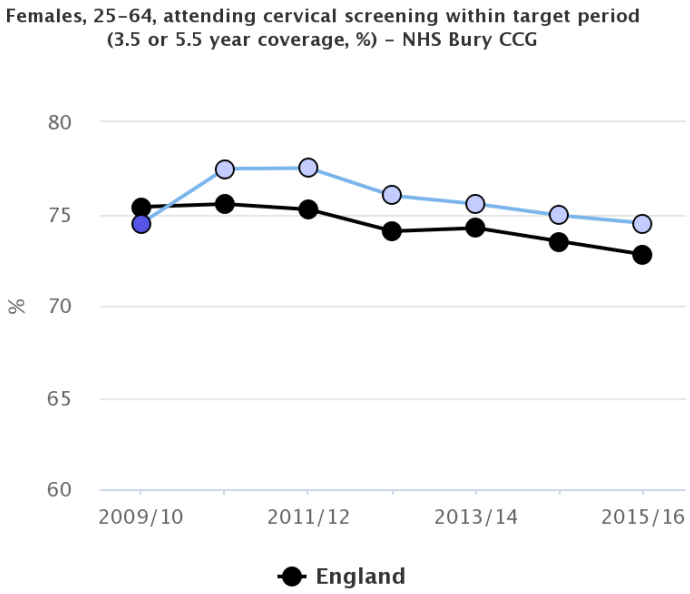

Chart 18 – Coverage or cervical screening programme in females aged 25-64 attending within target period in Bury, 2009-2016 (11)

10.0 Cancer Screening Programmes: Recommendations

10.1.1 Cancer screening features within the 2017/18 Bury Quality in Primary Care scheme (QiPC – a local contract between Bury CCG and all GP practices in Bury). Practice staff will offer support to vulnerable groups to take part in screening programmes, including those with mental ill health, a learning disability and military veterans. GP surgeries will work with the learning disabilities team, where appropriate, to offer and facilitate screening including: cervical smear tests, breast self-examinations and mammography. This should continue.

10.1.2 There is also a standard around bowel cancer screening and education for non-clinical GP practice staff, with higher performing practices sharing best practice with cluster practices. At GM level, there is introduction of a bowel cancer screening toolkit and development of a social movement of cancer champions, which Bury will be part of (16).

10.1.3 Bury will be building capacity by encouraging conversations around cancer screening- education, myth busting and behaviour change support. This will be through new programmes such as 'Making Every Contact Count', 'Healthy Living Framework' and any new link worker/enabling roles developed through the Locality Plan.

10.1.4 A multi-disciplinary group of stakeholders will be meeting to look at barriers to cervical screening in BME communities in Bury (this may extend to other screenings) including practice nurses from low coverage surgeries, public health, CCG, third sector, NHS England and charities e.g. Cancer Research UK and Jo's Trust. Bury Public Health will also use the learning from the GM wide Cancer Screening Health Equity Audits and Qualitative research on barriers to screening (due March 2018).

10.1.5 The local integrated sexual health service will continue to offer opportunistic cervical screening appointments for females who are overdue a cervical screen and would not access cervical screening from within general practice.

11.0 Abdominal Aortic Aneurysm (AAA) Screening

11.1 Background

11.1.1 AAA screening is a way of checking if there is a swelling (aneurysm) in the aorta – the main blood vessel that runs from the heart to the rest of the body. If the swelling isn't identified early on, it could grow and eventually burst. Approx. 80% of people who have a burst AAA will die. Men in their 65th year (this target group are most at risk of AAA) and registered with a GP, are identified and invited to attend a screening location. Men over 65 years who are registered with a GP may self-refer.

11.2 Current situation

11.2.1 The quality standard for coverage in the AAA programme is a minimum of 75% and an aspirational level of 85%. In Bury, for screening year 2015/16, coverage was 81.1% – a slight increase from previous years. This is above the GM average of 76.5% and national average of 79.9%. Trend data is only available for the last 3 years but uptake in Bury has remained relatively stable, although it was previously significantly higher than the national average and now this difference is no longer significant (see Chart 19).

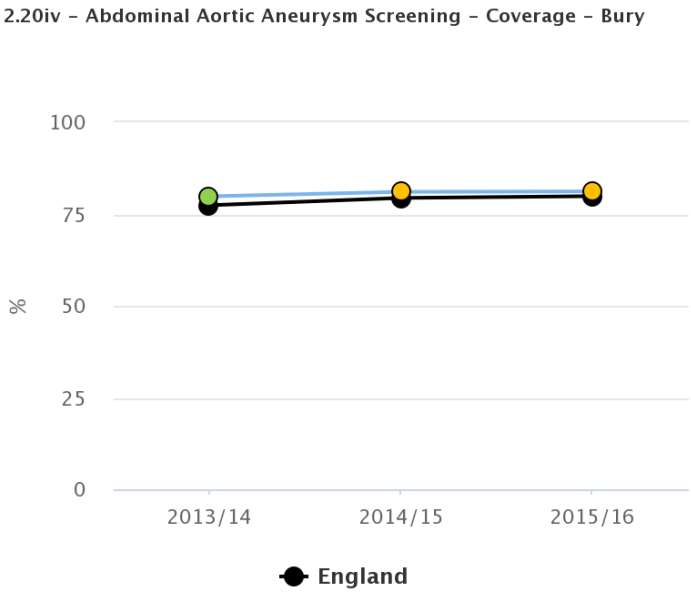

Chart 19 – Abdominal aortic aneurysm screening coverage in Bury 2013-2016 (11)

11.2.2 Currently the AAA screening programme for Bury is delivered by Manchester University NHS Foundation Trust (MFT) on a community model. A total of 37 venues are in use across GM & East Cheshire, 4 of which are in Bury. Men are invited to a venue close to their postcode of residence, however they are free to choose an alternate venue to the one allocated.

11.3 Recommendations

11.3.1 Bury will continue to liaise with the commissioners of this programme (GM Health and Social Care Partnership) for assurances around quality and inequalities, and support any issues that arise.

12.0 Diabetic Eye Screening

12.1 Background

12.1.1 The diabetic eye screening programme (DESP) aims to reduce the risk of sight loss among people with diabetes, by prompt identification and effective treatment of diabetic retinopathy. This is a condition that affects the blood vessels at the back of the eye and can lead to loss of sight. Screening is offered annually to people aged 12 years and over with diabetes. The programme is delivered in Bury by the North East Manchester Diabetic Eye Screening Programme, hosted by PAT.

12.2 Current situation

12.2.1 Throughout 2015/16 11,398 people were invited for DESP, with 9,093 people attending for screening. Uptake within the Bury CCG area for 2015/16 is 79.8%, which is above the acceptable >70% threshold but just below the aspirational >80% threshold (17).

12.3 Recommendations

12.3.1 In 2015/16, the North East Manchester programme undertook a number of patient engagement sessions and held patient focus groups. As a result of this engagement, a number of initiatives have been introduced, for example: piloting evening screening clinics and additional information in the invitation packs, relating to accessing the screening sites. Service improvement plans are addressing health inequalities within the programme and targeting non-attenders to improve uptake and access. Bury Public Health will continue to liaise with the commissioners of the DESP (GMHSCP) to monitor quality and inequalities.

Sexually Transmitted Infections

12.4 Background

12.4.1 Sexual health is an issue that concerns the majority of the population. The World Health Organization (WHO) defines sexual health along these main parameters: -

- enjoyment of sexual relations without exploitation, oppression or abuse;
- safe pregnancy and childbirth, and avoidance of unintended pregnancies;
- absence and avoidance of sexually transmitted infections, including human immunodeficiency virus (HIV).

12.4.2 To ensure these parameters can be achieved, a comprehensive and high-quality sexual healthcare service, as well as health promotion campaigns and educational opportunities (especially for young people) are required. In addition, good surveillance of trends in key measures of sexual health, such as rates of sexually transmitted infections (STIs), should be used to measure this. Under the Public Health Outcomes Framework (PHOF) the main areas of focus for sexual health are HIV and chlamydia.

13.0 Human immunodeficiency virus (HIV)

13.1 Background

13.1.1 HIV is a virus that attacks the immune system and weakens its ability to fight infections and disease. It is most commonly caught through unprotected sex. It can also be passed on by sharing infected needles and other injecting equipment, and from an HIV-positive mother to her child during pregnancy, birth and breastfeeding.

13.1.2 Around one in every 360 people in the UK has HIV, but the two groups with highest rates of HIV are men who have sex with men (MSM) and Black African heterosexuals, where the rates are approximately one in 17 and one in 18 respectively.

13.2 Diagnosed prevalence rate

13.2.1 A high HIV prevalence is 2-5 diagnosed cases of HIV per 1,000 people aged 15-59 years, per year. In 2016, Bury had a HIV prevalence of 1.83 per 1000. The upward trend in prevalence seen in Chart 20 can largely be attributed to the increased life expectancy of individuals with HIV, meaning numbers are increasing cumulatively.

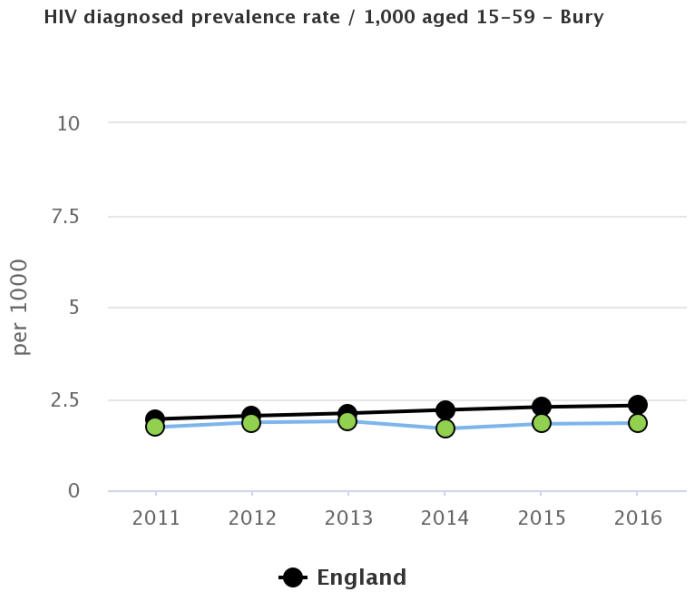

Chart 20 – Prevalence rate of diagnosed HIV per 1,000 people aged 15-59 in Bury, 2011-2016 (11)

13.3 HIV testing uptake in men who have sex with men (MSM)

13.3.1 In Bury in 2015/16, 95.9% of MSM accepted HIV testing when offered during an eligible new episode. This is higher than both the GM (75.3%) and national (94.2%) uptake rates. The trend for this data has remained relatively stable at these levels over the last 7 years, as shown in Chart 21.

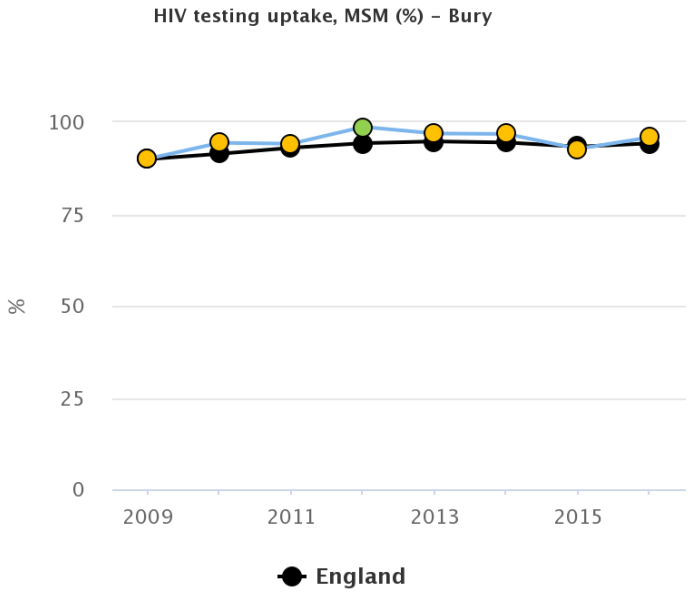

Chart 21 – HIV testing uptake among MSM in Bury 2009-2016 (11)

13.4 HIV testing in women

13.4.1 Only 38.9% of women accepted HIV testing when offered it as part of a eligible new episode. This clearly substantially lower than the uptake rates for MSM and lower than both GM (47.3%) and national (69.2%) rates. The data shows that uptake is significantly lower in Bury compared to England and has decreased by more than 40% in the last four years, being equivalent to national rates in 2013/14 and above them in 2009-2012 at >75%, shown in Chart 22.

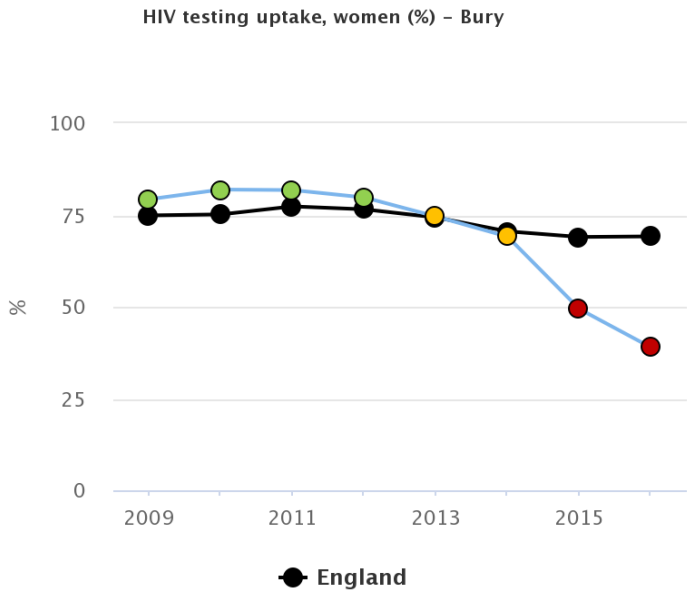

Chart 22 – HIV testing uptake among women in Bury in 2009-2016 (11)

13.4.2 The HIV testing coverage is from uptake among people attending specialist sexual health services. Women attending for standard contraceptive and sexual health (CASH) services only should not be included in the figures; however it is likely that this has been the case. The HIV testing uptake in women looks low for most of Greater Manchester; however it is higher for MSM and men in general. This is currently being investigated as a long term coding error related to the CASH patients and a look back exercise is taking place.

13.5 HIV late diagnosis

13.5.1 Late diagnosis for HIV is associated with increased morbidity and mortality and therefore early diagnosis is a priority. As a consequence, HIV late diagnosis has been made an indicator on the PHOF. LAs are monitored against the percentage of people presenting with HIV at a late stage of infection. Using 3 year rolling averages, the rate of late diagnosis in Bury has decreased from 69.7% to 39.1% in the last 8 years and is now lower than the England and GM averages (see Chart 23).

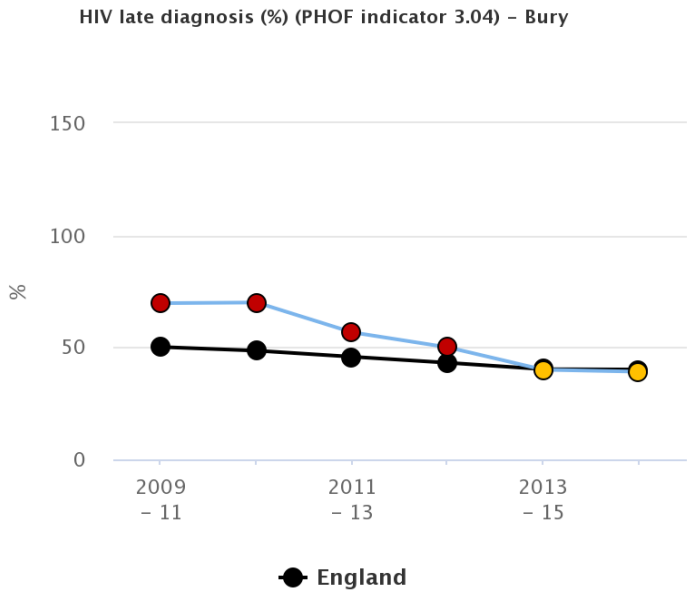

Chart 23 – Percentage of HIV late diagnoses in Bury in 2009-2016 (11)

13.6 Pre exposure prophylaxis (PrEP) IMPACT trial

13.6.1 PrEP is a course of HIV drugs taken by HIV negative people before sex, to reduce the chance of getting HIV. Results in trials have been very successful, with PrEP significantly lowering the risk of becoming HIV positive, and without major side effects.

13.6.2 PrEP will be available to 10,000 people in England as part of the IMPACT trial which commenced on 1 October 2017 for 3 years. NHS England wants to get an idea about the numbers of people who could benefit from using PrEP; how people will choose to use PrEP and for how long; and if it is cost-effective. NHS England will also look at the impact on incidence (new cases) of HIV and other STIs.

13.6.3 340 trial places have been allocated to Greater Manchester. These places are being shared across the sexual health clinics in our region. Bury genitourinary (GU) clinic will be partaking in this national trial. Clinic attendees aged 16 and over considered to be at high risk of acquiring HIV will be eligible to participate in the trial. Heterosexual, transgender individuals and gay men will be clinically risk-assessed and those at high risk offered PrEP.

14.0 Chlamydia

14.1.1 *Chlamydia trachomatis* is one of the most common sexually transmitted infections (STIs) in the UK. It's a bacterial infection passed on from one person to another through unprotected sex (sex without a condom). The PHOF includes an indicator to assess progress in controlling chlamydia in sexually active young adults. This recommends local areas achieve an annual chlamydia detection rate of at least 2,300 per 100,000 15-24 year old resident population, to detect and treat sufficient asymptomatic infections to effect a decrease in incidence.

14.1.2 The chlamydia detection rate reflects both screening coverage levels and the proportion of tests that are positive at all testing sites, including primary care, sexual and reproductive health and specialist sexual health services. Areas achieving or above the 2,300 detection rate should aim to sustain or increase, with areas achieving below it aiming to increase their rate.

14.1.3 Bury currently has a chlamydia detection rate of 1,862 per 100,000, which is significantly below the target goal of ≥2,300. However it appears to be following the national trend and is currently at a similar rate, but much lower than the GM rate of 2,207 per 100,000 (see Chart 24).

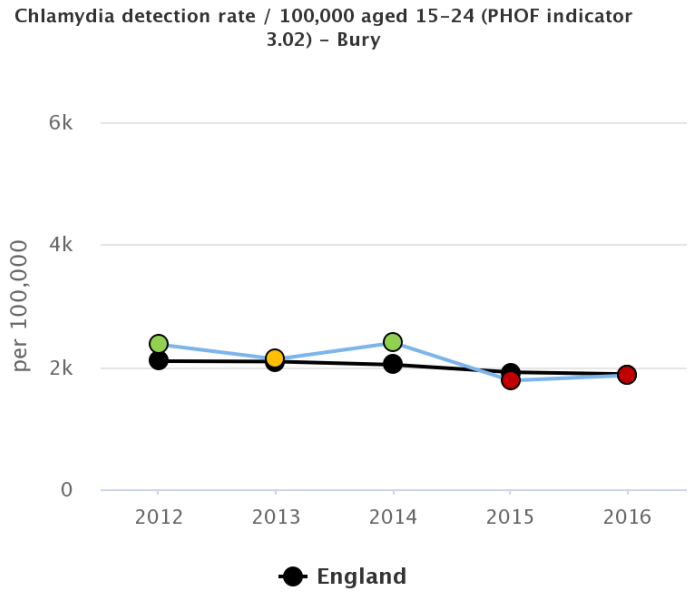

Chart 24 – Chlamydia detection rate per 100,000 people aged 15-24 years in Bury, 2012-2016 (11)

14.1.4 Bury Public health will be working with Public Health England (PHE) and integrated sexual health providers to explore this drop in detection rate.

15.0 Other STIs

15.1.1 Syphilis, gonorrhoea, genital herpes and genital warts are other bacterial and viral infections that are predominantly passed through sexual contact. They have a range of signs, symptoms and complications and are more common in young adults. For all conditions it is important to both identify and treat the infections in a timely manner to prevent onward transmission. Bury public health continues to monitor the levels of these infections through liaison with the Integrated Sexual Health Provider and also through annual reports from PHE.

15.2 Hepatitis A (Hep A) outbreak

15.2.1 Hepatitis A is a liver infection caused by a virus that's spread in the faeces of an infected person. It can cause an acute illness with symptoms such as fever, aches and pains, nausea, vomiting, jaundice and pale-coloured stools. The first symptoms may last for up to two weeks but jaundice and fatigue may persist for up to six months. Bury GU health providers will be highlighting the importance of Hep A vaccination for MSM at risk or travelling to destinations where Hep A outbreaks have been reported among MSM.

15.2.2 There has been a recent increase in cases of hepatitis A infection in the UK, including the North West throughout 2017. PHE are currently working with local partners to monitor this. Earlier this year there were outbreaks in Europe, the USA and Asia predominantly amongst MSM.

16.0 Sexually Transmitted Infections: Recommendations

16.1.1 With regard to monitoring, Bury should continue to closely monitor STI levels and identify and take relevant action following confirmation of confirmed outbreaks. HIV prevalence should be monitored at MSOA level.

16.1.2 Bury public health are to organise stakeholders to complete a Chlamydia Care Pathway Review with PHE North West colleagues. Work should be undertaken with the Integrated Sexual Health Services and Young People's services to produce an action plan for boosting chlamydia screening coverage in young people.

16.1.3 There should be continued investment in preventative services that support reduction in STI levels. Bury public health recently co-commissioned 'Passionate About Sexual Health' (PASH) sexual health improvement programme, provided by an alliance of Black Health Agency, LGBT Foundation and George House Trust. The locality-specific action plan is awaited for 2018. This will include targeted work around early identification in populations at highest risk of HIV and STI infection – for example the MSM and transgender populations, BME and new and emerging communities.

16.1.4 To further reduce the percentage of late HIV diagnosis through working with the sexual health service providers in Bury and the GM sexual health system reform agenda, to promote early diagnosis through primary and secondary care. Identifying indicator conditions where HIV testing should be considered.

16.1.5 Clinicians should be taking every opportunity to recommend that: -

- Sexually active under 25 year olds should be screened for chlamydia every year, and on change of sexual partner. Services should include a routine offer of a re-test at around 3 months after treatment completion for patients who test positive initially, as this group is at high risk of re-infection.
- MSM having unprotected sex with casual or new partners should have a HIV/STI screen at least annually, and every 3 months if changing partners regularly. MSM should also avoid having unprotected sex with partners believed to be of the same HIV status (serosorting), as there is a high risk of STI and hepatitis infection and, for the HIV negative, a high risk of HIV infection as 12% of MSM are unaware of their HIV infection.
- Black African and Caribbean men and women should have an HIV test, and a regular HIV and STI screen if having unprotected sex with new or casual partners.

16.1.6 Campaigns should be supported - in December 2017, the PHE sexual health campaign will be amplified locally, which will include World AIDs Day and testing/early identification of HIV. The ability to order HIV home testing kits online will be promoted. Bury residents can order HIV home testing kits from the website www.thesexualhealthhub.co.uk.

ENVIRONMENTAL PROTECTION & EMERGENCY PLANNING

We have an integrated Environmental Health and Health protection team comprising EHO's, Nurses and Enforcement officers unique in GM. The complementary skills provide greater resilience in emergencies, particularly for outbreak control.

1700 Year 6 children were given **litter and dog fouling talks** as part of the 'Crucial Crew' initiative

Environmental Health Officers (EHO's)

- Planning application consultancy provided on:
  - 265 general environmental health issues
  - 209 contaminated land issues
- Provided support to neighbourhood working

12 private water supply premises audited to ensure safe water

Key findings

Pest control **over-achieved** their income target by over **£51,000**. This is through improved efficiency, and new contracts gained

Bury achieved a **22% reduction** in carbon emissions from 2008/9

2492 requests for services dealt with covering various areas including noise nuisance, fly-tipping etc.

493 legal notices and **28 fixed penalties notices** were served for various Environmental Enforcement offences, with **2 successful prosecutions**

Risk assessments carried out for:

- **Severe weather**
- **Pandemic Influenza**
- **Emerging infectious diseases**
- **Environmental hazards**

4 **Multi agency training exercises completed**

16 emergency plans reviewed or produced

Created by: Performance & Intelligence, Bury Council *All data correct as at January 2018*

Environmental Protection

17.0 Introduction

17.1 Background

17.1.1 Bury Council Environmental Health practitioners form a critical part of the public health workforce. The functions falling under environmental health are diverse and overlap with some of the issues reported elsewhere in this document. Officers are empowered to take legal action where matters cannot be resolved informally. Bury Council's Environmental Protection duties cover: -

- investigation and resolution of statutory nuisance, including noise, odour, pollution, waste accumulations, hoarding, pests and other health risks;
- education and enforcement of environmental crimes – fly tipping, stray dogs, fouling, litter, smoking ban;
- consultation on environmental matters for new planning applications and licensing;
- managing unauthorised Gypsy and Traveller encampments;
- permitting of prescribed businesses with the potential to pollute;
- providing a pest control service and keeping council land free from pests;
- managing contaminated land issues – mainly through the planning process.

17.1.2 In 2016 two Environmental Health Officers (EHOs) were assigned to the trailblazer Bury East and Radcliffe 'Neighbourhood Hubs' and are providing valuable support for the shaping of neighbourhood working across the borough. The team are developing new digital mobile working across the service piloted by Pest Control. More information is being provided on the Bury Directory and Bury Council website to encourage self-help and manage demand for the services. Complaints about fly-tipping and other waste issues continued to rise, prompting closer working with waste management and police and more enforcement for environmental quality issues. The number of planning consultations requiring environmental control measures is increasing due to growth in development across the borough.

17.2 Achievements in 2016/17

17.2.1 There was training and development of staff into new areas of work to fill in gaps in expertise, including: pest control, acoustics, environmental permitting, private water supplies, air quality, food hygiene competency and neighbourhood hub working,

17.2.2 In 2016/17 the team responded to 2,492 requests for services over a variety of areas, mostly: accumulations, fly-tipping, noise nuisance, drainage and dog fouling. A total of 46 Environmental Permit sites were inspected and risk assessed, 20 variation notices were issued for permitted processes. The water quality of 12 premises with a private water supply was audited. Litter and dog fouling talks were delivered to 1,700 Year 6 children as part of the 'Crucial Crew' initiative.

17.2.3 With regards to Environmental Enforcement work, 493 legal notices for various offences were served (264 in 2015/16) as well as 28 fixed penalties notices (14 in 2015/16). There were 2 successful prosecutions with 2 more pending (3 prosecutions in 2015/16).

17.2.4 Pest Control over-achieved their income target of £185k by being more cost efficient, gaining new contracts and identifying new business areas. The total income for environmental protection was £238,622.

17.2.5 An integrated service has been developed and pest officers now supporting air labs, dog fouling and neighbourhood enforcement. Public health business support team is recording new food business registrations, financial transactions and providing administrative support for the whole of Environmental Health.

17.2.6 There was consultancy on 265 planning applications for all environmental health issues (181 in 2015/16). The team carried out 1,054 property searches to aid house and land transactions (1,113 in 2015/16). There was also consultancy on 209 planning applications for contaminated land and the team responded to 270 reports from developers in relation to contaminated land and air quality.

17.2.7 From a carbon management perspective, the team completed the CRC Energy Efficiency Scheme (formerly known as the "Carbon Reduction Commitment") submission and allowance purchases on time. A feasibility study for a heat network in Bury town centre was completed. Bury secured £62k of Salix funding towards comprehensive energy efficiency measures to be installed at Killelea residential care home (Salix Finance Ltd. provides interest-free Government funding to the public sector to improve their energy efficiency,

reduce carbon emissions and lower energy bills). The team helped the council achieve a reduction in carbon emissions of 22% from baseline of 2008/09.

17.3 Recommendations

17.3.1 In 2017/18, the environmental protection team will: -

- continue to support neighbourhood working;
- have active participation in the 2017/18 regulatory services review;
- develop an Environmental Quality strategy with partners to tackle fly-tipping;
- continue to explore potential income streams and grow existing ones.

18.0 Emergency Planning & Major Incident Response

18.1 Background

18.1.1 Emergency planning and major incident response comprises actions that are taken to reduce the chances of emergencies occurring. If incidents do occur, the response includes ensuring the impact on residents and the environment is kept to a minimum.

18.1.2 Bury Council has a wide range of responsibilities which relate to emergency planning and response. This includes meeting the requirements of the Civil Contingencies Act 2004 and the Health and Social Care Act 2012. Both Acts require plans to be put in place for responding to public health emergencies, such as pandemic influenza and other significant outbreaks of disease; as well as a range of other incidents that have the potential to impact on public health, for example flooding, incidents of terrorism and accidents at chemical production sites.

18.1.3 At a borough level, the Council works closely with a range of partners through the Health Economy Resilience Group (HERG) and the Borough Resilience Forum (BRF) which is chaired by the Director of Public Health (DPH). Both meet quarterly, with the HERG focusing solely on health related issues e.g. flu, communicable disease outbreaks and heat waves. Membership comprises:

- health protection nurses;
- representation from the CCG;
- Pennine Care & Pennine Acute Hospitals NHS Trusts;
- other health providers such as private hospitals, out of hours GP services (BARDOC) and North West Ambulance Service (NWAS).

18.1.4 The BRF has a broader focus on planning and preparedness for localised incidents and catastrophic emergencies. It works to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities. BRF includes representation from various agencies including LA, Greater Manchester Police, Greater Manchester Fire and Rescue Service, CCG, NHS England (NHSE), Public Health England (PHE) and community organisations.

18.1.5 At a Greater Manchester (GM) level, the council collaborates through the GM Directors of Public Health Group (GMDsPH), GM Health Protection Confederation, GM Local

Authority Civil Contingencies Chief Officers Group, the Greater Manchester Resilience Forum and Local Health Resilience Partnership.

18.1.6 The Chief Executive of Bury Council is the lead GM Chief Executive for civil contingencies and resilience, which includes leadership and oversight of health protection issues at a GM level. In this capacity, the lead Chief Executive is chair of the GM Local Authority Civil Contingencies Chief Officers' Group and is also a member of the GM Resilience Forum which is responsible for overseeing and co-ordinating emergency preparedness activity in GM.

18.1.7 Since 2011, the local authority Civil Contingencies Chief Officers Group has collectively commissioned the Association of Greater Manchester Authorities (AGMA) Civil Contingencies and Resilience Unit (CCRU), a shared GM-wide service, to deliver services in relation to emergency planning, response and resilience. Following the transition of public health into local government in 2013, Directors of Public Health have also commissioned the AGMA CCRU to help address their health protection needs. This joint commissioning has been key to ensuring an efficient and integrated approach to system-wide health protection planning at both a local and regional level.

18.1.8 Bury Council, as part of GM, is recognised as a UN role model for disaster risk reduction and was recently accepted into the Rockefeller Foundation's 100 Resilient Cities Network.

18.2 Achievements in 2016/17

18.2.1 Working locally and through GM governance and delivery arrangements, Bury Council has ensured delivery of a comprehensive work programme to ensure emergency preparedness. Key activity over the past 12 months includes:

- The completion of various risk assessments in relation to public health risks, including severe weather, Pandemic Influenza, emerging infectious diseases and environmental hazards.

- The production and / or review of emergency plans including:
    - GM Vulnerable People Guidance and List of Lists
    - GM Resilience Direct Protocol
    - Borough Multi-Agency Outbreak Plan

- GM Emergency Water Distribution and Sanitation Guidance
- GM Strategic Flood Plan
- GM Generic Offsite Reservoir Emergency Plan
- GM Strategic Recovery Guidance
- GM Generic Response Plan
- GM Pandemic Influenza Response Plan
- STAC Activation Plan for Greater Manchester
- GM Chemical, Biological, Radioactive or Nuclear emergency (CBRNe) Strategic Response plan
- GM Animal Disease (Generic) Plan
- GM Mass Fatalities Plan
- Bury Town Centre Evacuation Plan
- Bury Council Generic Response Plan
- Bury Council Evacuation and Shelter Guidance

- Design and delivery of a range of internal and multi-agency training and exercising, including:
  - Exercise Ferranti: testing the response to large scale power outage across the NW of England;
  - Exercise Sherman: testing the response to a terrorist incident in Bury;
  - Exercise Triton: a GM wide live-play exercise testing the response to flooding;
  - Exercise Vapour: a table top exercise to test the Bury town centre evacuation plan.

18.3 Recent incidents

18.3.1 There were no major incidents declared in Bury 2016/17. The borough continued the recovery phase following storm Eva on Boxing Day 2015 with the council assisting residents and businesses to access government funding to assist recovery and develop climate resilience.

18.3.2 The Bury Resilience Forum delivered a flood resilience workshop to raise awareness of flood risk in Bury as well as work undertaken to improve resilience in Bury following flooding on Boxing Day 2015. The meeting including presentations from the local authority, United Utilities, the Met Office, Electricity Northwest, the Environment Authority and University of Manchester. The meeting was also attended by members of the Radcliffe Flood Action Group and a number of other partners.

18.3.3 The session helped responders to gain a better understanding of flood hotspots in Bury, different types of flooding and how responders work together in response, including processes for identifying vulnerable people. The expertise of those involved will be used to collectively review the Bury Multi-Agency Flood Plan over the coming months.

18.3.4 A multi-agency response to a proposed large scale campsite unrelated to but prompted by the Parklife festival was prevented due to lack of preparation and public safety fears in June 2016.

18.4 Manchester Arena terrorist attack: May 2017

18.4.1 The Manchester Arena terrorist attack had a devastating impact on individuals and communities cross GM. Residents of Bury were amongst those who were killed and injured and many others could potentially suffer from long-term psychological impacts.

18.4.2 Given the widespread impacts of the attack, the response and recovery efforts were led and co-ordinated at a GM level. The council's Chief Executive was a member of the GM Recovery Co-ordination Group and also chaired the emergency local authority Civil Contingencies Chief Officers' Group. In this capacity, the Chief Executive played a key role in leading recovery activity which included the establishment of new services for the provision of mental health support, e.g. the GM Resilience Hub and the Manchester Attack support website.

18.5 Recommendations

18.5.1 The broad suite of emergency plans maintained by Bury Council and partners collectively addresses the public health outcomes framework's requirement to have a 'comprehensive and agreed inter-agency plan for responding to health protection incidents and emergencies.' Furthermore, a rolling programme of multi-agency training and exercises

drives continuous improvement and development of knowledge and expertise amongst responders.

18.5.2 During 2017/18 Bury Council will continue to work with other agencies and communities through existing partnership structures to ensure that health protection arrangements remain robust and fit for purpose. Key activity will include review of emergency plans, such as the GM Excess Deaths Plan and Bury Multi-Agency Flood Plan, as well as continued training and exercising.

18.5.3 Bury Council will also contribute to Greater Manchester's participation in the '100 Resilient Cities' programme (18) to identify further opportunities to build resilience in Bury.

FOOD HYGIENE, HEALTH & SAFETY AT WORK & AIR QUALITY

Bury Council's health and safety regulators are required by law to make adequate arrangements for enforcement. The council is required to evidence that it can deliver high quality investigations and enforcement work. The food safety annual inspection programme is designed to give consumers in Bury confidence that food produced and sold in Bury is safe to eat.
Air quality is the largest environmental health risk to public health in the UK, with more than 2000 people in GM dying prematurely as a result of poor air quality.

Food Hygiene

87% of registered food premises in Bury achieved a rating of 3, 4 or 5

Inspections

- 450 inspections carried out in 2016/17
  - 178 written warnings issued
  - 3 voluntary closures of food premises
- 24 food complaints dealt with
- 68% of registered food premises in Bury awarded a top score of 5 on the Food Hygiene rating scheme
- Only 5% scored a rating of 2 or less

Air Quality

The fraction of mortality attributable to air pollution in Bury is 4.1 - below the North West and national average

270 reports dealt with from developers on Air Quality and contaminated land

The rate of carbon emissions from domestic properties, Business and Transport are lower in Bury than GM

46 Environmental Permit sites inspected and risk assessed

20 variation notices issued for permitted processes to prevent air pollution

Health & Safety at work

49 Health and safety inspections carried out and 52 workplace accidents investigated

1294 service requests on commercial premises dealt with

Created by: Performance & Intelligence, Bury Council

19.0 Food Hygiene

19.1 Background

19.1.1 Bury has approximately 1500 registered food businesses which are inspected according to the Food Law Code of Practice risk rating scheme. The programme is designed to give consumers in Bury confidence that food produced and sold in Bury is safe to eat. The annual inspection programme targets the highest risk and least compliant businesses. In recent years because of in-house resource issues, we have employed food safety consultants to assist with satisfying our statutory obligations.

19.1.2 In 2016/17 Bury Council carried out 450 Food inspections and 19 Food Hygiene Rating Scheme rescore inspections. We issued 178 written food warnings, 3 voluntary closures of food premises, 1 Emergency prohibition food premises, 4 food improvement notices and dealt with 24 food complaints.

19.1.3 At present, 87% of food businesses in Bury are broadly compliant with food safety legislation. 68% of food businesses in Bury have been awarded a rating of 5 on the Food Hygiene Rating scheme (highest in Greater Manchester (19)) and only 5% have been awarded a rating of 2 or less.

19.2 Recommendations

- Continue to monitor the quality of food produced and sold in Bury taking part in the PHE North West region microbiological food sampling programme.
- Continue to investigate food complaints, food borne incidents and outbreaks in partnership with PHE and other relevant organisations.
- Work with businesses and partners to offer consumers in Bury healthier choices in catering establishments through the Healthier Catering Award Scheme.
- Contribute to improving the health of young children in Bury by continuing to implement the Golden Apple Award in 57 nursery settings.
- Participate in the GM Better Business for All initiative in partnership with other GM authorities and the GM Growth hub.

- Watching brief on Food Standards Agency's 'Regulating our Future' review of Food Law enforcement.
- Continue to audit food premises in line with the annual Food Service plan – see appendix 1.

20.0 Health and Safety at Work

20.1 Background

20.1.1 Bury Council's health and safety regulators are required by law to make adequate arrangements for enforcement in line with the Section 18 Standard issued under the Health and Safety at Work Act 1974. The standard requires the council to evidence that it can deliver high quality investigations and enforcement work. Whilst the primary responsibility for managing health and safety risks lies with the business and those who create the risk, Bury's health and safety regulators have an important role in ensuring the effective and proportionate management of risks, supporting business, protecting their communities and contributing to the wider public health agenda. In delivering the priorities we ensure planned regulatory activity is focussed on outcomes to deliver national priorities set by the Health and Safety Executive (HSE), work to deliver local priorities, and be accompanied by an inspection programme that meets the requirements of the LA National Enforcement Code. These priorities fit within the wider national health and safety strategy, 'Helping Great Britain Work Well' (19). This sets out six themes for the whole of the GB health and safety system and Bury's workplace health and safety regulators are a key part of that system. The six strategic themes are:

- *Acting together*: Promoting broader ownership of health and safety in Great Britain.
- *Tackling ill health*: Highlighting and tackling the costs of work-related ill health.
- *Managing risk well*: Simplifying risk management and helping business to grow.
- *Supporting small employers*: Giving small and medium sized enterprises simple advice so they know what they have to do.
- *Keeping pace with change*: Anticipating and tackling new health and safety challenges.
- *Sharing our success*: Promoting the benefits of Great Britain's world-class health and safety system.

20.2 Current situation

20.2.1 In 2016/17 Bury EHO's carried out 49 health and safety (H&S) inspections, issued 52 H&S warning letters, 2 prohibition notices, 2 improvement notices, investigated 52 workplace accidents and dealt with 1,294 service requests. 3 full-time-equivalent (FTE) officers carry out all food and H&S work supported by 0.8 FTE unit manager.

20.3 Recommendations

20.3.1 The following priorities are set by HSE at a national level and Bury will be focusing on them in 2017/18:

- Electrical supplier joint visits to premises identified as stealing electricity (generally very poor/dangerous health and safety standards). As part of joint enforcement visits with the Police, Trading Standards, Immigration Services, Inland Revenue, Electricity North West and Environmental Health.
- Warehouse inspections: focusing on loading and unloading safely, manual handling in warehouses and distribution centers, using HSE's MAC (manual handling assessment charts) tool and RAPP (risk assessment for pushing and pulling) tool for pushing and pulling pallets (20). The target is 42 H&S inspections (14 per FTE).
- Gas safety in commercial catering premises*:* to check during all food inspections, and enforce as issues are identified.
- Dough roller guarding in pizza and other catering premises, which has been identified regionally as a major concern.

21.0 Air Quality

21.1 Background

21.1.1 Air quality is the largest environmental health risk to public health in the UK. It is estimated that more than 2000 people die prematurely in Greater Manchester (GM) as a result of poor air quality and its impacts are felt more severely by vulnerable groups such as the elderly, those with pre-existing conditions and those in deprived areas. In Bury and across GM we have areas that are not likely to meet national and European Union (EU) health based targets for the pollutant nitrogen dioxide (NO2). The main source of nitrogen dioxide in our area is road transport. The burning of fossil fuels to heat our homes, run our cars, produce electricity and manufacture products are adding greenhouse gases to the atmosphere. Release of carbon dioxide and other greenhouse gases is causing the Earth's temperature to rise and other changes to our climate. These changes pose serious threats to the health of our communities and in particular our elderly and vulnerable residents.

21.2 Current Situation

21.2.1 In 2017 Bury took part in the National Clean Air Day 2017 by having a public engagement stand in the Millgate shopping centre and encouraging Bury Council staff and the public to pledge actions to improve air quality. In addition, energy efficiency was encouraged in the council and schools by holding a "Switch off Fortnight" in December 2017.

21.2.2 Bury's per capita carbon emissions are less than the national and North West (NW) average but slightly higher than the GM average. These emissions have decreased significantly since 2005 but the rate of decline has reduced from 2014 to 2015, as shown in Chart 25.

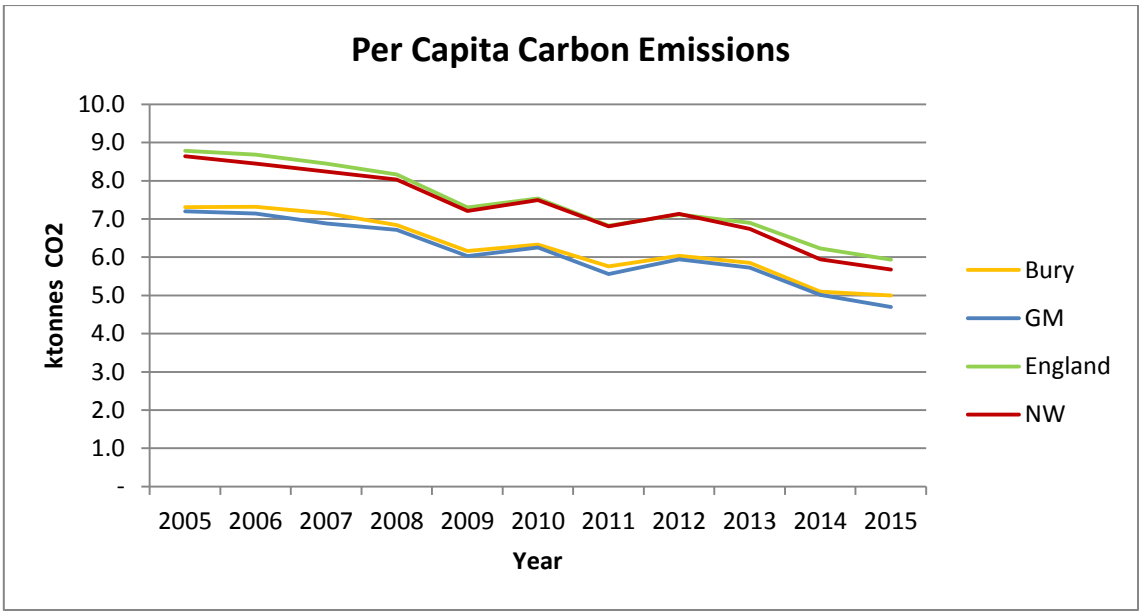

Chart 25 – Bury's per capita carbon emissions compared to Greater Manchester, the North West and England

21.2.3 Bury's carbon emissions from the domestic, business and transport sector are lower than the GM averages. However the rate of decline in the domestic and business sector has been small from 2014 to 2015 (see Chart 26 and Chart 27). In the transport sector both Bury and GM emissions showed a small increase for 2014 to 2015 (see Chart 28).

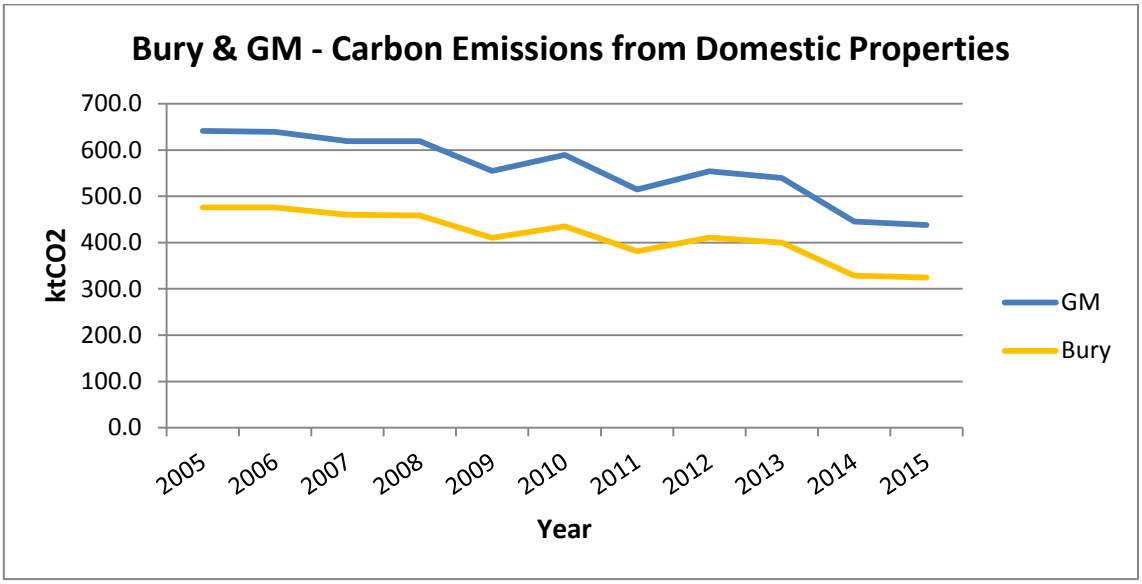

Chart 26 – Bury's carbon emissions from domestic properties compared to Greater Manchester

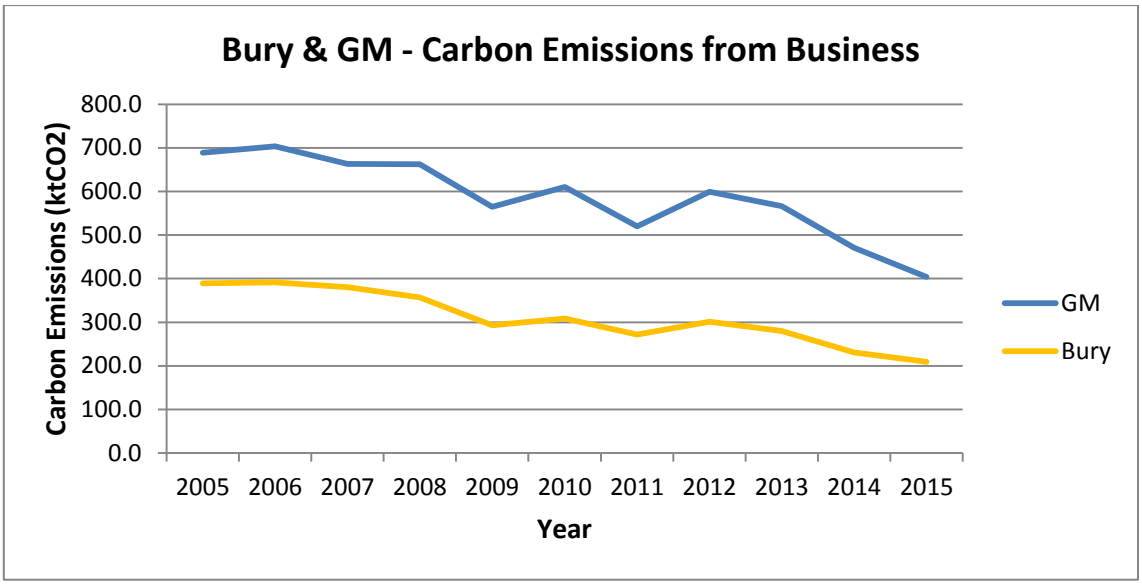

Chart 27 – Bury's carbon emissions from businesses compared to Greater Manchester

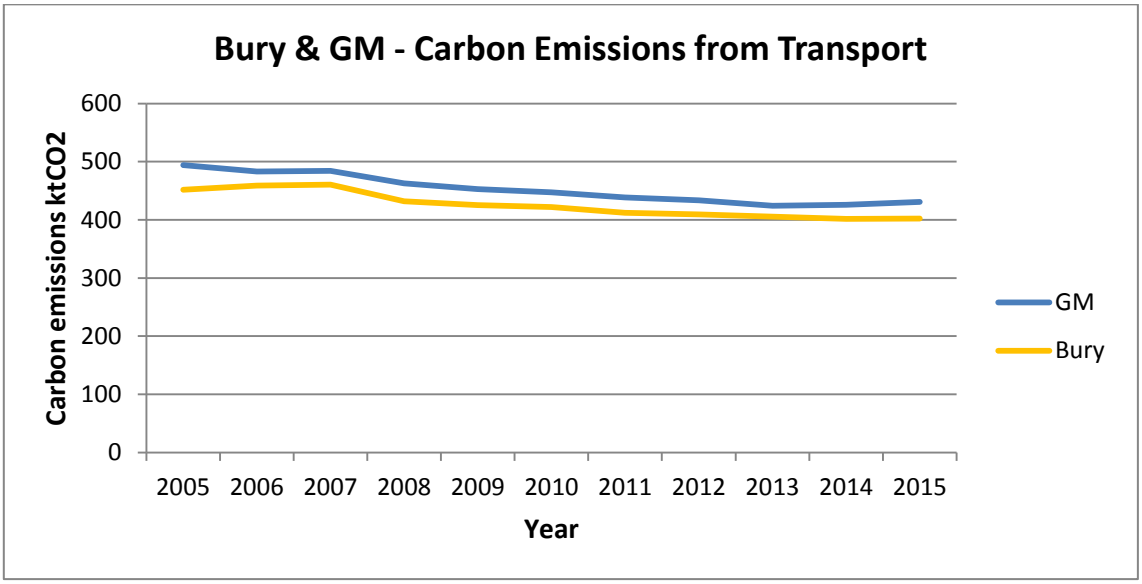

Chart 28 – Bury's carbon emissions from transport compared to Greater Manchester

21.2.4 Particulate matter air pollution considers the concentration of small particles in the air, which can contribute to health and environmental problems. Measurements for fine particles (PM10) show that all Bury's monitoring stations meet the national and EU targets but from 2015 to 2016 there were minimal or no improvements (see Chart 29). Although we have been making progress, it is recognised that there is a need to do much more. Proposed actions are included in the Greater Manchester Climate Change and Low Emission Strategy Implementation Plan 2016-2020, and the Greater Manchester Air Quality Action Plan 2016-2020.

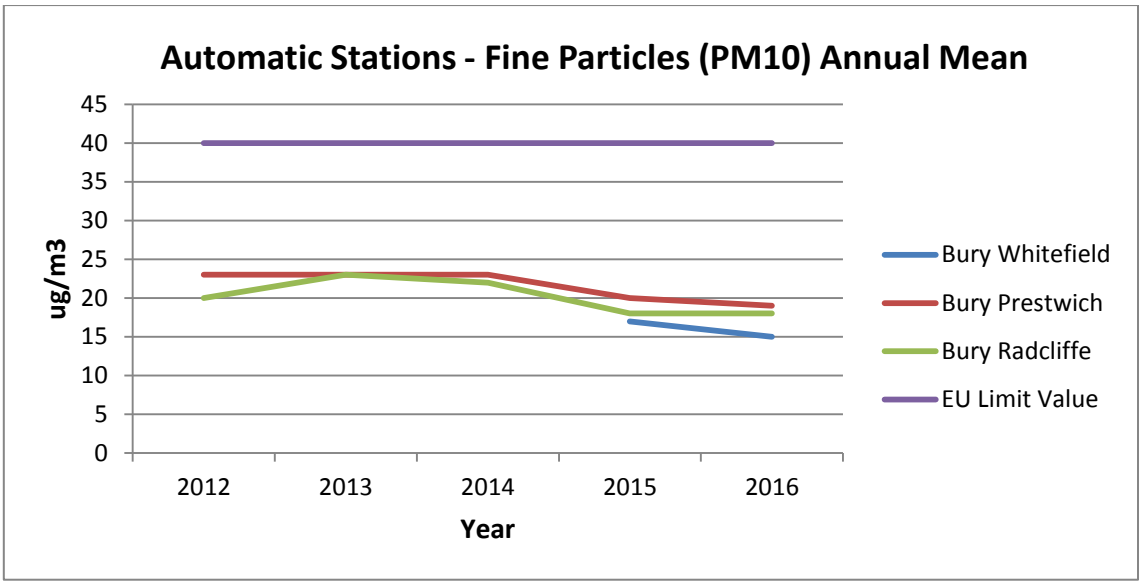

Chart 29 – Fine particle (PM10) air pollution annual mean measurements in the townships of Whitefield, Prestwich and Radcliffe, alongside the EU limit value.

21.2.5 In Bury, the fraction of mortality attributable to particulate pollution is reducing and is below the NW and national average (see Chart 30).

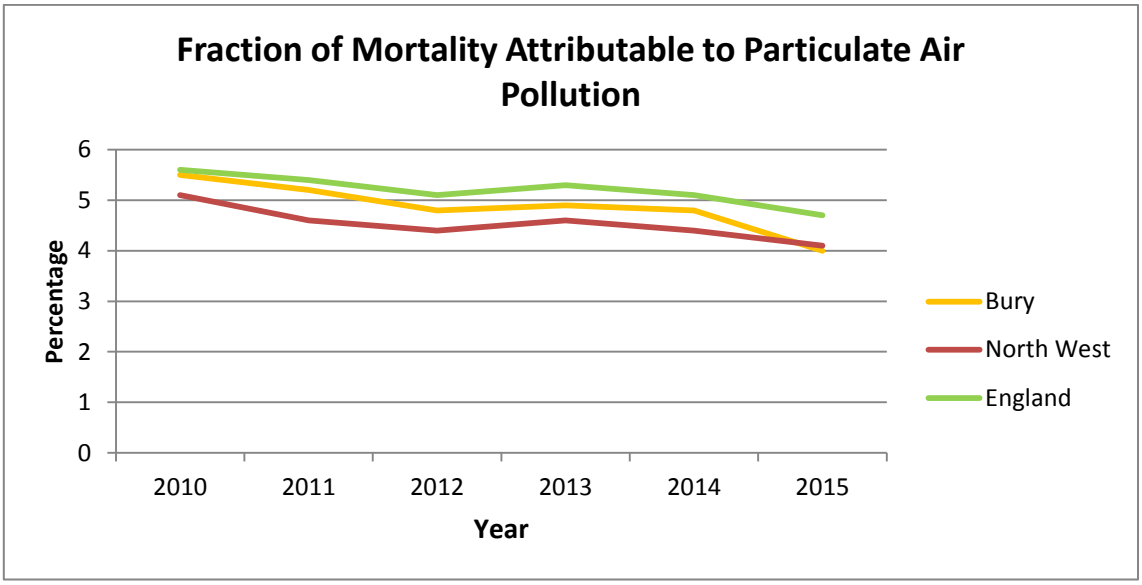

Chart 30 – Fraction of mortality attributable to particulate air pollution in Bury, the North West and England

21.2.6 Chart 31 shows that our automatic measurement for NO2 at the Prestwich monitoring station is not meeting the national and EU health based NO2 target. The measurements for the other 2 stations are well below the target but it is noticeable that the levels at Whitefield increased from 2015 to 2016. 2015 was the first year of operation of this site and the NO2 measurements only began in April 2015. The results for that year are therefore not for a full annual average and will not reflect a full year of results. This could

account for the large increase observed on 2016. 2017 results will show 2 full years of monitoring and will be more valuable in judging trends at this site.

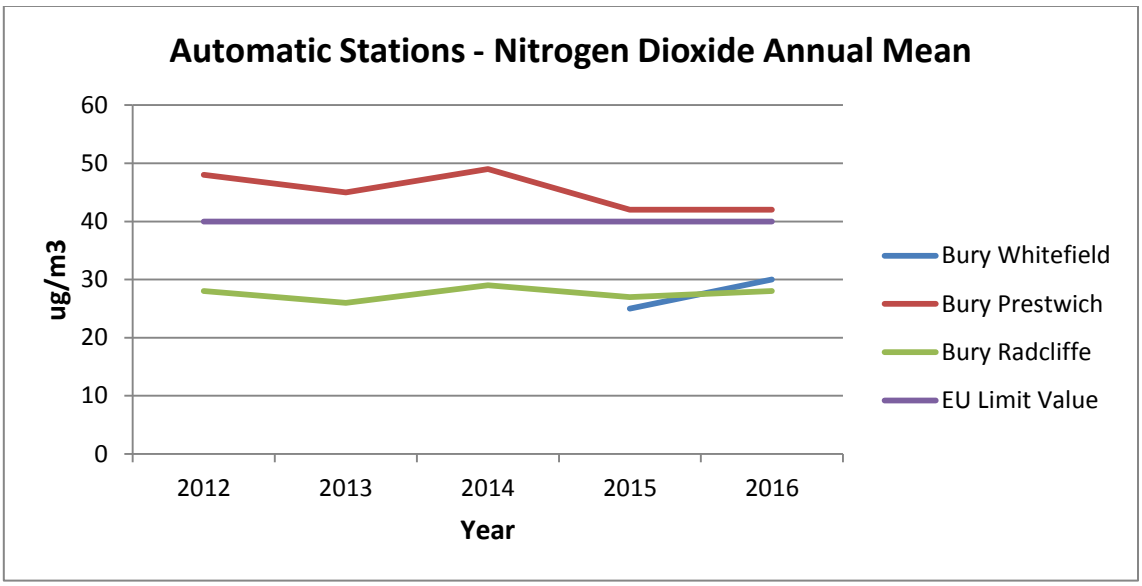

Chart 31 – Nitrogen dioxide (NO2) annual mean measurements in the townships of Whitefield, Prestwich and Radcliffe, alongside the EU limit value.

21.2.7 The Department for the Environment, Food and Rural Affairs (DEFRA) have identified Bury and 6 other GM LAs as areas that are not likely to meet national and EU targets for NO2 in the next 3 years. The area of concern is the Bury Bridge road junction near Bury town centre. As a result we are required to produce a Local Action Plan to describe how we will meet the NO2 target in the shortest time possible. Transport for Greater Manchester (TfGM) will be leading on the production of a Greater Manchester Local Action Plan. To complement these plans, Bury Council are in the process of producing a Climate Change and Low Emissions Plan 2018 – 2023 which will describe all the actions that will be taken to combat climate change and improve air quality.

21.3 Recommendations

21.3.1 As above, there are plans to produce a Climate Change and Low Emissions Plan and implement actions. Close work with TfGM will be required to produce and deliver our Local Action Plan for air quality within DEFRA deadlines.

21.3.2 Specific highlight actions for 2017 will be: -

- gather intelligence regarding the important demographics relating to air quality and health in the Bury area;

- complete the Energy Path Network programme to show how Bury's energy delivery and use will change as we decarbonise to 2050;
- complete the NEDO (Japanese Government Department for New Energy and Industrial Technology Development) project to deliver air source heat pumps and trial demand response in Six Town Housing properties;
- run the Clean Energy Switch Campaign;
- continue to deliver our Fuel Poverty Strategy and Action Plan;
- continue our programme to install LED (low energy) street-lighting;
- publicise the DEFRA advice on wood-burning stoves;
- ensure that measures to improve air quality, tackle climate change and improve health are integrated into Bury's new developing Local Plan.

21.3.3 Work with Bury's Active Travel and Healthy Workplace groups is planned to increase the use of low emission alternatives to the traditional car. Actions to include: -

- introduce a low emission vehicle car club;
- introduce council pool bikes;
- implement council "Bike to Work" scheme;
- investigate feasibility of a Public Bike Share Scheme;
- implement a pilot "Cycling by Prescription" scheme.

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Appendix 1

Food Service Plan 2017.docx

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INFECTION PREVENTION AND CONTROL

Infection prevention and control involves working to prevent and control the spread of infection among the population. Communicable diseases are diseases that you can"catch" from someone or something else, often via airborne viruses or bacteria, but also through bodily fluids or contact with contaminated objects in the environment.

Infection and Prevention Control Audits

75%

Care homes scoring green from audits and re-audits Aug 2015-Mar 2017

None scored **Red**

None scored **Red**

Of the GP Practices audited

Work being undertaken to raise awareness and reduce Antibiotic prescribing by **50%** by **2021**

38 number of disease outbreaks that the Infection Prevention and Control team helped to manage

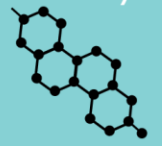
Key Points

MRSA (**M**eticillin-**R**esistant **S**taphylococcus **A**ureus)

Infections lower than national rates - 0 for Bury in 2016/17

Launch of monitoring in 2017/18, consideration needed going forward

E.coli (**E**scherichia **coli**)



MMR (**M**easles **M**umps and **R**ubella)

Uptake rates are good over 95% for 1 dose by 5 years old, and are comparable or better than the national average

Good uptake when compared against regional and national uptake, plans to ensure this continues

FLU (in**flu**enza)

DTaP/IPV/ Hib (5-in-1)

Uptake rates are good over 95% at 2 years old, and are comparable or better than the national average

(**D**iphtheria, **T**etanus, **a**cellular **P**ertussis /**I**nactivated **P**olio **V**irus /**H**aemophilus **i**nfluenzae type **b**)

Focus group research conducted in Bury around pre-school vaccine - Informing methods to increase uptake

Created by: Performance & Intelligence, Bury Council

SCREENING AND SEXUALLY TRANSMITTED INFECTIONS

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition, or in asymptomatic early stages of the condition. In England there is a range of screening programmes and these can lead to a reduction in late diagnosis and preventable deaths.

Sexual health is an issue that concerns the majority of the population. Good surveillance of trends in key measures of sexual health, such as rates of sexually transmitted infections (STIs) are a good measure of a comprehensive and high-quality sexual healthcare service, health promotion and educational opportunities achieved.

81% **Coverage for - Abdominal Aortic Aneurysm Screening**

Diabetic Eye Screening
>70%
Target

Bowel cancer screening toolkits are being made available to Bury Residents and development of a social movement of cancer champions

Key Points

Screening

Bury is above regional and national averages for all England screening programmes

Although coverage is above national averages for Cervical Screening, work to be done moving forward to achieve 80% target.

STI's

HIV Late Diagnosis has reduced significantly in recent years and is now below national levels

Bury will be taking part in the national HIV PrEP trial

Bury public health are to organise stakeholders to complete a Chlamydia Care Pathway Review with PHE North West colleagues, to increase screening rates.

FREE STI home testing kits now available in Bury via:
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96%
Uptake of HIV testing among men who have sex with men

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ENVIRONMENTAL PROTECTION & EMERGENCY PLANNING

We have an integrated Environmental Health and Health protection team comprising EHO's, Nurses and Enforcement officers unique in GM. The complementary skills provide greater resilience in emergencies, particularly for outbreak control.

1700 Year 6 children were given **litter and dog fouling talks** as part of the 'Crucial Crew' initiative

Environmental Health Officers (EHO's)

- Planning application consultancy provided on:
  - 265 general environmental health issues
  - 209 contaminated land issues
- Provided support to neighbourhood working

12 private water supply premises audited to ensure safe water

Key findings

Pest control **over-achieved** their income target by over **£51,000**. This is through improved efficiency, and new contracts gained

Bury achieved a **22% reduction** in carbon emissions from 2008/9

2492 requests for services dealt with covering various areas including noise nuisance, fly-tipping etc.

493 legal notices and **28 fixed penalties notices** were served for various Environmental Enforcement offences, with **2 successful prosecutions**

Risk assessments carried out for:

- **Severe weather**
- **Pandemic Influenza**
- **Emerging infectious diseases**
- **Environmental hazards**

4 **Multi agency training exercises completed**

16 emergency plans reviewed or produced

Created by: Performance & Intelligence, Bury Council *All data correct as at January 2018*

FOOD HYGIENE, HEALTH & SAFETY AT WORK & AIR QUALITY

Bury Council's health and safety regulators are required by law to make adequate arrangements for enforcement. The council is required to evidence that it can deliver high quality investigations and enforcement work. The food safety annual inspection programme is designed to give consumers in Bury confidence that food produced and sold in Bury is safe to eat.
Air quality is the largest environmental health risk to public health in the UK, with more than 2000 people in GM dying prematurely as a result of poor air quality.

Food Hygiene

87% of registered food premises in Bury achieved a rating of 3, 4 or 5

Inspections

- 450 inspections carried out in 2016/17
  - 178 written warnings issued
  - 3 voluntary closures of food premises
- 24 food complaints dealt with
- 68% of registered food premises in Bury awarded a top score of 5 on the Food Hygiene rating scheme
- Only 5% scored a rating of 2 or less

Air Quality

The fraction of mortality attributable to air pollution in Bury is 4.1 - below the North West and national average

270 reports dealt with from developers on Air Quality and contaminated land

The rate of carbon emissions from domestic properties, Business and Transport are lower in Bury than GM

46 Environmental Permit sites inspected and risk assessed

20 variation notices issued for permitted processes to prevent air pollution

Health & Safety at work

49 Health and safety inspections carried out and 52 workplace accidents investigated

1294 service requests on commercial premises dealt with

Created by: Performance & Intelligence, Bury Council

Health & Environmental Protection Annual Report 2016/17

Lorraine Chamberlin - Head of Health and Environmental Protection
&
Anne Whittington - Public Health Specialty Registrar

Bury COUNCIL

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Any questions?

Bury COUNCIL