Health Protection Committee, 2016/17
Interim Report (Jan - Sept 2016)

Lead Directorate: People and Communities

North Somerset COUNCIL

Contents

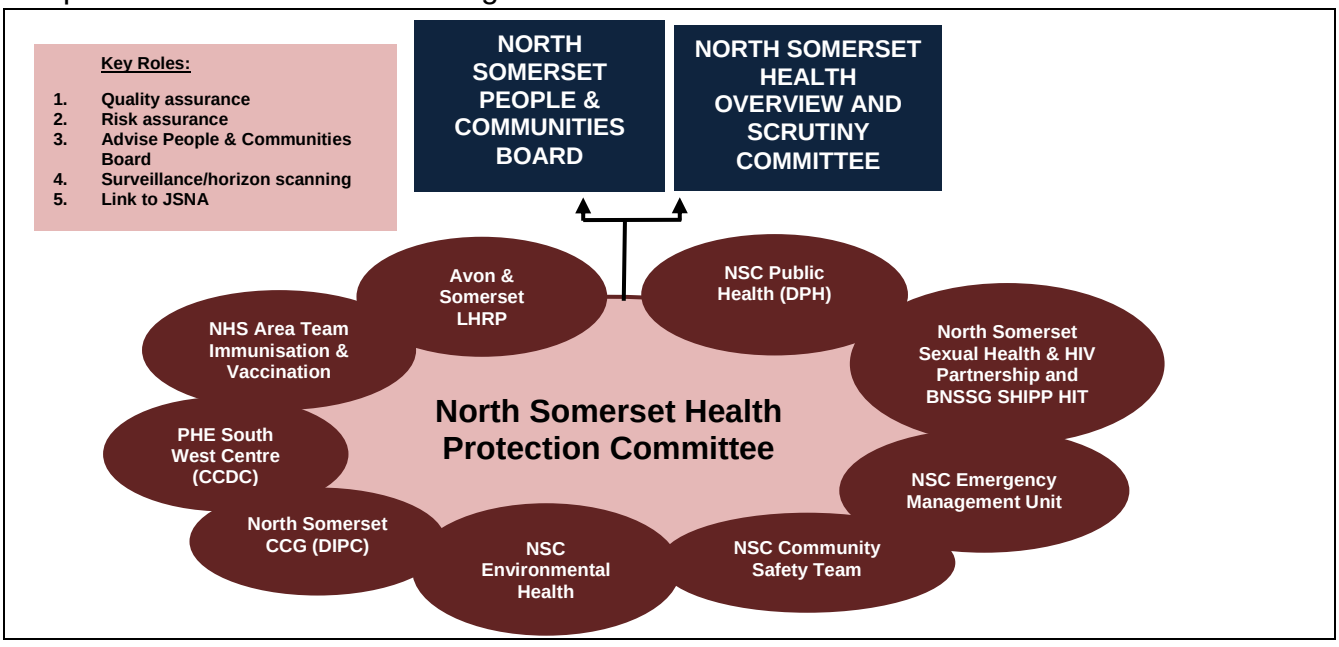
1.0 BACKGROUND

The North Somerset Health Protection Committee (HPC) was established in September 2013. The HPC provides a mechanism to assure the Director of Public Health (as required by the Health and Social Care Regulations), the Health Overview and Scrutiny Panel and the People and Communities Board, on behalf of the population of North Somerset, that there are safe, effective and well-tested plans in place and appropriate activity to protect the health of the population. The scope of the Health Protection Committee is:

- communicable disease control;
- infection prevention and control;
- emergency planning;
- sexual health;
- environmental health/hazards;
- screening and immunisation programmes.

1.1 Purpose of the report: This report provides an update on progress against priorities identified in the last Health Protection Committee Annual report and to highlight key performance indicators, risks, challenges and priorities going forward. In 2016, the Committee agreed to change its' reporting period to financial years in order to be in line with other Council reporting systems. Previous HPC reports have been compiled on a calendar year basis (up to December 2015). Therefore this report covers the 9 month period January to September 2016; a subsequent full annual report will cover the financial year April 2016 to March 2017.

1.2 Health Protection Committee Membership: The membership, relationships and key roles of the North Somerset Health Protection Committee are outlined below (see glossary for acronym definitions). The Committee is grateful for all member contributions given the imperative for strong partnership working to protect population health and ensure robust responses to incidents and emergencies.



2.0 UPDATES ON PRIORITIES IDENTIFIED IN THE 2015 ANNUAL REPORT

Priorities from the 2015 (Jan-Dec 2015) Annual Report have been addressed through implementation of the 2016/17 Action Plan:

- **Improve the uptake of seasonal influenza and pneumococcal (PPV) immunisation:** The seasonal flu coverage rate for September 2015-January 2016 are presented in section 5.2 below. Levels of vaccination coverage among eligible population groups (those aged 65 and over; at risk individuals from age six months to under 65 years, e.g. patients with diabetes or chronic heart disease; pregnant women and carers) were similar in 2015/16 to 2014/15, with a slight decrease in coverage among carers. Coverage of frontline healthcare workers among local provider's benchmarks well against those in other areas although there is still room for improvement. Improving the uptake of seasonal flu coverage remains a priority for North Somerset for the 2016/17 programme which commenced in September 2016.

  Pneumococcal disease is a significant cause of morbidity and mortality and infections can be non-invasive such as bronchitis and otis media, or invasive septicaemia, pneumonia and meningitis. The pneumococcal polysaccharide vaccine (PPV) is recommended for over 65s and other groups. In the three years from 2012/13 to 2014/15, 68% of over 65s received a PPV vaccination, this is similar to the England average.

- **Seek assurance that NHS organisations in North Somerset have appropriate response plans in place**
  Local multi-agency table top exercises have been held in 2016 to test and develop local plans. The exercises involved representatives from local NHS providers and the Avon and Somerset Local Health Resilience Partnership. Further discussions are planned with providers and the LHRP to ensure the detailed operational arrangements are clear e.g. in case mass vaccination or prophylaxis is required.

- **Test Airport plans and preparedness to respond to Infectious diseases in light of Ebola Outbreak**
  Multi-agency table top exercises were held with Bristol Airport (see Section 7) and Public Health England to develop robust response plans.

- **Ensure robust outbreak management measures in care homes:** A workshop to improve infection prevention and control of outbreaks was developed and delivered to care home staff in January 2016. A new "Outbreak information pack for care homes" has been developed and was also launched at the workshop. The workshop evaluated well with 96% of attendees rating the training as "good" or "Excellent" and care home staff valued the opportunity to discuss best practice and work through outbreak scenarios in a safe space. Planning is underway for a

second event in December 2016, to which all care homes in North Somerset will be invited to attend.

- **Develop a local Health Protection Incident Response Plan:** Table top exercises have been delivered and further exercises are planned to ensure robust local plans are in place by the end of March 2017(see Section 7).

3.0 HEALTHCARE ASSOCIATED INFECTIONS

Key Performance Indicators: Rates of MRSA and C. Difficile infections – *See Appendix 1*

The trend in Healthcare associated infections for the North Somerset CCG area and Weston Area Health Trust is presented in Appendix A. Performance in regards to MRSA cases appointed to Weston Area Health Trust (WAHT) is good with a rate of 0 per 100,000 occupied bed days having been maintained since January 2015. There have however been two community acquired cases of MRSA in 2016, these cases were identified to be injecting drug users. Both cases were successfully treated and followed up.

There appears to have been an overall decline in C. Difficile cases appointed to WAHT since 2013, with rates per 100,000 bed days during July 2015 to March 2016 lower than the previous year. However there has been a slight increase in the last quarter to a rate of 20.8 per 100,000 bed bays in April to June 2016. Rates of community acquired cases of C. Diff have been relatively stable over recent years with a rate of 5.3 per 100,000 in April-June 2016, similar to the rate for the same period in 2015.

The North Somerset Clinical Commissioning Group (NSCCG) has a health care associated infection (HCAI) strategy group which includes the Director of Nursing and Quality, GP Clinical Quality lead, Quality & Patient Safety Manager and Medicines Management representatives from NSCCG, North Somerset Council Health Protection lead and Commissioning Lead for care homes, Microbiologist from Weston Area Health Trust and Infection control leads from both the acute Trusts and community services. This group brings a multi-disciplinary approach to tackling HCAIs and shares learning across the health and social care economy. The group has developed a work programme in line with the "Infection Prevention and Control Commissioning Toolkit", a document which is designed to provide a focused approach and provides direction for future priorities, which impact on health, public health and antimicrobial resistance. The group also requires assurance from the provider representative that they have robust work plans in place to ensure compliance with the criteria and elements of the Health and Social care Act 2008; Code of Practice on the prevention and control of infections and related guidance (DH 2015), and the CQC Fundamental Standards which were introduced in April 2015.

Addressing anti-microbial resistance is a priority area for the NSCCG medicines management team. NSCCG are currently meeting the two quality premium targets of reducing overall antibiotic prescribing/STAR PU and reducing the percentage of prescriptions that are cephalosporins, quinolones and co-amoxiclav. During the summer the "Map of Medicine", an online tool to support GPs, was updated to include a pop up leaflet for GPs to give to patients to explain why antibiotics had not been prescribed. Anecdotal information from practices suggests that these leaflets have been well received by patients. Additionally, GP practices have been requested to nominate a lead GP for antibiotic stewardship, who will undertake two audits including one to review broad spectrum antibiotic prescribing. The learning from these local audits will assist in the continued improvement in antibiotic prescribing.

Following the success of the infection prevention and control workshops for Care Homes events to promote good infection control in school settings have been prioritised. An event was held in September to highlight the importance of immunisation and good infection control practices, particularly in relation to preventing and controlling Norovirus outbreaks. The event evaluated very well and highlighted an issue in relation to cleaning products in schools. This has now been addressed. Staff who attended were given a practical hand washing session and were supplied with a range of resources to take back to their school, including an audit tool.

4.0 ENVIRONMENTAL HEALTH AND COMMUNICABLE DISEASE CONTROL

Key Performance Indicator	North Somerset	South West	England
TB Incidence rate (per 100,000 population) 2013-15	4.0	5.7	12.0

Source: Public Health England Outcomes Framework

4.1 Reported Communicable Disease Incidents:

Between January to September 2016 PHE were notified of 442 confirmed cases of infectious diseases among North Somerset residents, of which the local Environmental Health (EH) team dealt with 288 reports. The majority of reported infections were gastrointestinal, predominantly Camplyobacter. This period saw an increase in scarlet fever notifications, including a small outbreak in a primary school.

Five cases of Vero cytotoxin-producing Escherichia-Coli 0157 were reported and investigated by North Somerset Environmental Health Officers between January to September 2016. One case appeared to be associated with the handling and consumption of venison burgers sold through an internet based company and cooking instructions were not in line with current food safety advice. Liaison with the company and advice from the Food Safety team led to the cooking instruction being altered to ensure thorough cooking of the product. Two cases were linked by a household setting but the source of infection was

not identified in the primary case. The remaining two cases were linked a national increase in E-coli 0157 during the summer. The majority of cases associated with this outbreak were resident in the South West, particularly in Gloucestershire and South Gloucestershire. Investigations found the likely source to be mixed salad leaves, bagged or consumed in restaurants. The outbreak was declared over in August 2016. Two further e-coli cases were investigated by the local EH team between July to September, these were not thought to be part of the national outbreak.

Two Legionella cases were investigated by the local EH team in this reporting period. The surveillance questionnaire and environmental sampling associated with one case resulted in the service of a prohibition notice against a local business and liaison with the Primary Authority in relation to the lack of legionella controls in place at a business centre in the district. Another business failing in their duty to control the risks from legionella bacteria were referred to the HSE for enforcement.

Notification of two cases of cyclospora were received and enhanced surveillance questionnaires were completed as both cases were returning travellers from Mexico. Enhanced surveillance is not routine for cyclospora cases in the UK but since June 1 2016 there have been an increase in cases associated with travel from Mexico. Various hotels and resorts have been identified and PHE Travel and Migrant Health section are leading on investigations.

From January to September the EH team has investigated 44 outbreaks of gastrointestinal infections (mainly Norovirus) including 9 in schools, 24 in care homes and 11 associated with food related businesses).

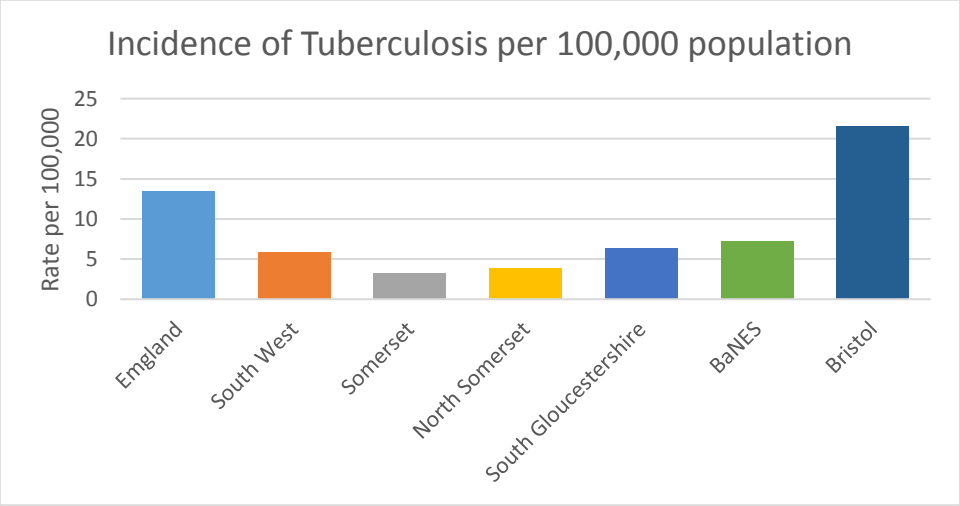
Tuberculosis: Tuberculosis (TB) is a serious infectious disease which can have major social impacts for those affected. TB is associated with marked inequalities in health; with deprived populations more likely to get TB and suffer worst outcomes. While most cases of TB are currently curable there are increasing numbers of drug-resistant cases that require more lengthy and complex treatment, associated with increased side effects, higher treatment costs and worse outcomes.

Individuals with drug and alcohol problems have a greater risk of both contracting TB and the infection developing in to active disease. This increased risk is associated with these individuals typically being in poorer general health, living in poor quality overcrowded conditions, experiencing other concurrent diseases, sharing drug using paraphernalia, and spending time in prison.

In the 2011 Annual Report of the Chief Medical Officer the health inequalities related to TB and antimicrobial resistance were highlighted as key priorities for England.

North Somerset has a low incidence of TB (see chart below). In 2012-14 there were 3.9 new cases per 100,000 population.

Chart 1: TB incidence in 2013-15



Source: Public Health England Outcomes Framework

TB inpatient and outpatient care for local TB cases and contact tracing activity is undertaken by the respiratory service at Weston Area Health Trust (WAHT) as numbers do not justify having a dedicated community service. The respiratory consultant-led service at WAHT has 1x Whole Time Equivalent (WTE) respiratory consultant vacancy and lacks administrative support for contact tracing; the administrative workload is undertaken by the respiratory nurse specialist herself.

WAHT has no definite arrangement for the provision of Directly Observed Therapy (DOT) because of scarce need. However the service provider is confident that provision could be arranged on a case-by-case basis if required, either through inpatient or ambulatory care, or through healthcare staff in primary care (i.e. community nurses). The local respiratory nurse specialist links with Public Health England and the Bristol community TB Nurse Service for support with contact tracing activities.

4.2 Environmental Sampling

Water Sampling: During January to September sampling under the private water supply regulations was carried out at a national yogurt producer and water quality at the airport was monitored. Non conformities were dealt with in line with legislation. Samples were also taken from the private water distribution system which was put in at the Balloon Fiesta at Ashton Court. Over the course of the event (11-14th August) 500,000 people could consume or use water whilst on site so it was imperative to ensure that it was safe.

Food Safety: Establishments handling, preparing or producing products of animal origin must be approved by the competent authority. As part of the approval process several samples of food were sampled from new premises during January to September to determine end-product safety.

In January the Food Safety Service was subject to an audit by The Food Standards Agency (FSA) on the basis of under achieving our inspection programme. The FSA were informed that the reason for this was a lack of inspection resources to achieve the programme; the service were required to put in place measures to remedy this position. Additional inspection capacity has been bought in to improve the inspection numbers for the year 2016-2017. The FSA also required that steps are taken to improve the sustainability of this resource, however at the time we were unable to confirm how this would be achieved. This information led the FSA to plan an additional core service audit in October.

The additional staffing has enabled the service to improve its's inspection numbers and we are currently rated amber in terms of achieving our annual targets for 2016-17. The service has so far completed 365 of the 586 inspections required and have commenced a postal survey of the low risk food premises. The service has also given approval to a local producer who is manufacturing both haloumi and ricotta cheeses.

The Food Safety Service have recently developed an action plan to increase the provision of food safety inspections by March 2017.

Zika Virus monitoring: Bristol Airport is one of the 6 airports receiving flights directly from Zika affected areas and thus has the potential to facilitate the importation of invasive mosquitoes. Port Health Officers from the Environmental Health team have been working with PHE, Edge Hill University and the Association of Port Health Authorities to develop capability and conduct mosquito surveillance at seas and airports.

Four mosquito traps were put in place airside at Bristol Airport for surveillance of invasive mosquitoes. The traps are monitored weekly to coincide with the arrival of the flight from the Zika affected area. Insects emptied from the Bristol Airport traps were sent to PHE Porton Down for analysis. No mosquitoes of the Zika type have been identified to date.

5.0 SCREENING AND IMMUNISATION

Key Performance Indicator	North Somerset	South West	England
MMR coverage (2 doses) at age 5, 2014/15 (target 95%)	93.0%	90.9%	88.6%
HPV vaccination coverage (one-dose) in females aged 12-13), 2014/15 (aim >90%)	92.1%	88.9%	89.4%
Flu vaccination coverage in at-risk groups, 2015/16 (aim >55%)	49.3%	44.7%	45.1%
PPV (pneumococcal polysaccharide vaccine) coverage of eligible population aged 65+, 2015/16 (aim >75%)	68.8%	69.7%	70.1%

Source: Public Health Outcomes Framework

5.1 Childhood immunisations: Immunisations included in the routine childhood immunisation schedule are:

- DTaP/IPV/Hib vaccination (diphtheria, tetanus, whooping cough (pertussis), polio, and Hib (Haemophilus influenzae type b))
- MenC vaccination (meningitis C) and MenB (meningitis B)
- PCV vaccination (pneumococcal conjugate vaccine)
- MMR vaccination (measles, mumps and rubella)
- Rotavirus vaccine

The uptake of routine childhood immunisations among the North Somerset population is generally good with coverage of around 95% for most routine immunisations in Jan-March 2015/16. Coverage of MMR and DTaP/IPV boosters at age 5 needs on-going attention with coverage at around 90% throughout 2015/16.

The Meningitis B vaccine was introduced in 2015, local uptake appears to be good with 97% of eligible infants receiving 2 doses by 6 months of age in Jan-March 2016.

5.2 Adult Immunisations:

Pertussis: In 2012 there was a national outbreak of Pertussis and in the same year the Department of Health announced that a vaccine would be offered to women in pregnancy. This provides passive immunity to infants from birth, protecting them up until they receive the routine childhood immunisation at 8 weeks of age. The programme remains in place

until further notice from the Department of Health. In Jan-March 2016 75% of eligible women received the pertussis (whooping cough) vaccine during pregnancy.

Shingles: In the same period the Shingles vaccine coverage among eligible 70 and 78 year olds was 52 and 54% respectively. The Shingles vaccination programme commenced in 2013 and data quality is still improving so this should be handled with caution. Improvements in coverage are expected since the vaccine became routinely available to all 70 and 78 year olds (with provision for coverage of the eligible cohort who previously missed out on their vaccination until their 80th birthday.

Seasonal Flu: The seasonal flu immunisation programme is delivered between September and January each year and the data is broken down into a range of population groups all of which are eligible for a flu vaccination. Eligible groups and the coverage from the 2015-16 programme are listed below. Whilst there is significant room for improvement in vaccination coverage of healthcare workers it should be noted that coverage amongst those working in local healthcare providers benchmarks well against providers is neighbouring areas. The coverage of Weston Area Health Trust staff is higher than coverage of acute trust staff in Bristol and Somerset (see table below).

Flu planning for the 2016/17 programme has involved local partners and NHS England. Priorities for 2016/17 include improving uptake of children, at-risk groups and frontline healthcare workers. Individuals with impaired liver function who are in contact with the local substance misuse service have been targeted as part of the efforts to improve vaccine coverage in at risk group. The CCG is seeking assurance that robust flu planning is underway in all providers.

Population group		**Seasonal Flu Vaccination Coverage (%)**	
		2014/15	**2015/16**
Aged 65 and over		76%	75%
At risk individuals from age six months to under 65 years (e.g. patients with diabetes or chronic heart disease)		53%	49%
Pregnant women		48%	51%
Carers		52%	46%
Healthcare Workers	**Weston Area Health Trust**	67%	55%
	GP Practices	68%	68%
	North Somerset Community Partnership	48%	44%

Source: Data from NHS England Area Team. *Data sources from Public Health Outcomes Framework (PHOF)

5.3 Antenatal and Newborn Screening

The Antenatal Screening Programme is a series of three screening programmes offered to women during pregnancy; the NHS Foetal Anomaly Screening Programme (Down's Syndrome screening and the Foetal Anomaly Scan); NHS Infectious Diseases in Pregnancy Screening (screens for HIV, Hepatitis B, Syphilis and Rubella); and the NHS Sickle Cell and Thalassaemia Screening Programme (screening for Sickle Cell Disease and other Haemoglobinopathies). No concerns regarding the ante-natal screening programmes in North Somerset have been identified and performance across all programmes are above "acceptable" targets for Weston Area Health Trust.

Three Newborn Screening Programmes are offered after a child is born; the NHS Newborn Blood Spot Screening Programme (screening in babies up to 1 year old for 5 metabolic disorders: Phenylketonuria, Medium-chain acyl-CoA dehydrogenase deficiency, Congenital Hypothyroidism, Sickle Cell Disease and Cystic Fibrosis); the NHS Newborn and Infant Physical Examination Screening Programme (screening by 72 hours post-delivery and again at 6 – 8 weeks of age for anatomical defects in the Heart, Eyes, Hips, (and Testes in male babies)); and the NHS Newborn Hearing Screening Programme (screening of a baby's hearing by five weeks of age).

Performance in the neonatal blood spot and physical examination screening programmes in 2015/16 was generally above "acceptable" targets for Weston Area Health Trust however improvements in the number of avoidable repeat blood spot screening tests are required.

University Hospitals Bristol NHS Foundation Trust provides the Newborn Hearing Screening Programme, performance was above "acceptable" targets in 2015/16.

5.4 Adult Screening Programmes

Bowel Screening: The Bowel Screening Programme that invites all men and women aged 60-74 years, who are registered with a GP, to complete a faecal occult blood test in the form of a home testing kit every two years. Those patients found to have abnormal tests are then referred to their local Screening Centre for further assessment and if necessary to have further investigation with a colonoscopy.

As of March 31st 2015 58.5% of eligible people had been screened for Bowel caner in the previous 2 and a half years. This higher than the national average (57.1%) and lower than the regional average (60.3%). Waiting time performance for Colonoscopy in quarter 4 2015/16 was poor. This was due to staff capacity issues and has since been addressed by NHS England and the provider. The Health Protection Committee has been assured that waiting times for the following quarters will show an improvement.

Breast Screening: The Breast Screening Programme is a national programme that invites all eligible women aged 50-70 years registered with a GP for mammographic (X-ray) screening every three years. Women over 70 years of age can request screening but are not routinely invited. Those women identified with abnormal changes in breast tissue (about 4 in 100 women) are referred for further assessment. Around 1 in 4 of those with abnormal changes are found to have breast cancer and will be offered treatment. The Independent Review of the Harms and Benefits of Breast Cancer Screening estimates that early detection and treatment of breast cancer by screening can reduce the risk of dying of breast cancer by 20%.

In quarter 4 of 2015/16 98% of women aged 50-70 were offered a screening appointment within 36months of their previous screen. This is against a performance target of 100%.

As of March 31st 2015 78.4% of eligible North Somerset women had been screened in the previous 3 years; this is above the England average (75.4%) and similar to the South West (78.6%), however it is lower than the target coverage of 80%.

Cervical Screening: The Cervical Screening Programme invites all eligible women registered with a GP aged between 25 to 64 years for a cervical screen every three or five years (depending on age). Screening primarily takes place in GP practice and women with an abnormal test may be referred directly to colposcopy for further investigation and/or treatment.

As of 31st March 2015 76.6% of eligible women had been screened adequately in the previous 3.5 or 5.5 years (according to age). This is similar to the regional average (75.9%) and higher than the national coverage (73.5%), however it is lower than the coverage target of 80%.

Diabetic Retinopathy Screening: The UK National Screening Committee recommends a systematic population diabetic screening programme with the aim of significantly reducing the prevalence of sight loss through the prompt identification and effective treatment of the diabetic retinopathy. Each local programme invites diabetics (Type 1 and 2) who are registered with a GP and 12 years or older for annual screening and where required more frequent monitoring or referral to the Hospital Eye Service for further assessment and treatment.

There are 3 key performance indicators for diabetic retinopathy screening; the percentage of those offered screening who attend a digital screening event; the percentage of those screened who are issued results within 3 weeks; and the percentage of those with a positive screening result who receive a timely consultation (within 4 weeks of notification). The Bristol and Weston Diabetic Eye Screening Programme achieves above “acceptable” performance on each of the performance indicators and there have been recent improvements in the percentage of those screening positive who receive a timely consultation.

Abdominal Aortic Aneurysm Screening: The national Abdominal Aortic Aneurysm (AAA) screening programme invites all men in England aged 65 who are registered with a GP to be screened for AAA. If the aneurysm is beyond a certain size it is prone to rupture, leading to an acute surgical emergency and risk of death. One in 25 men aged 65-74 have an abdominal aortic aneurysm and there are approximately 6,000 deaths each year across England and Wales as a result of rupture. Women are at a lower risk and therefore not included in the programme.

In 2015 99.9% of eligible North Somerset men were offered an AAA screening appointment.

6.0 SEXUAL HEALTH

Key Performance Indicator	North Somerset	South West	England
HIV late diagnosis, 2013-15 (aim <25%)	56.3%	41.1%	40.3%
Chlamydia detection rate per 100,000 population aged 15-24, 2015 (target >=2,300)	1,850	1,716	1,887

Update on the procurement of Sexual Health Services across Bristol, North Somerset and South Gloucestershire (BNSSG): A decision on award is due in November subject to approval from full Council. Mobilisation of the new contract (if awarded) will begin soon after formal approval.

Performance: Nationally new sexually transmitted infection figures show continued increases among gay men and sustained high rates in young people. The latest version of the PHE Sexual and Reproductive Health Profile (July 2016) shows performance in North Somerset is generally close to or better than regional averages across most indicators. Areas to note for North Somerset compared to national averages continue to be:

- Low HIV testing coverage within genitourinary medicine services (48.6%)
- High population coverage for HPV vaccination (92%)
- Low Chlamydia detection rate (1,850 per 100,000 population aged 5-24yr), despite high levels of screening uptake (27.7%)
- Higher rate of hospital admissions for Pelvic Inflammatory Disease (PID) (356 admissions per 100,000 females aged 15-44)
- High rate of LARC provision from GPs (62 per 1,000 females age 15-44)

7.0 EMERGENCY PLANNING AND COMMUNITY RESILIENCE

7.1 Emergency Response Exercises

Bristol Airport Exercise: A number of HPC members attended an exercise at Bristol Airport, supported by Public Health England, to review arrangements and capabilities to deliver a coordinated response against two credible scenarios.

There were two scenarios worked through to test preparedness s at the airport and their supporting plans. The first involved a “white powder” substance being distributed, and secondly an incoming flight with a patient who was suspected of having a significant infectious disease. The exercise was well organised and identified a number of areas that will need further work to provide partners with the necessary re-assurances. Learning and actions to be taken forward will be monitored through the North Somerset Health Protection Committee.

Community Mass Response Exercises: In July the Deputy Director of Health Protection for Public Health England (PHE) South West facilitated a table-top exercise with multi-agency partners to work through the local response to an infectious disease outbreak. The exercises considered scenarios involving mass prophylaxis and vaccination of school children following an outbreak of meningococcal disease and mass screening of university students following diagnosis of a student with infectious pulmonary Tuberculosis. Engagement during the exercises was good and important operational issues were addressed, however the discussions highlighted the need to broaden the membership of the group and work up further detail for local operation guidance on a communicable disease mass response to be incorporated in to the Local Health Resilience Plan. A follow-up meeting has been scheduled for December 2016, facilitated by a Consultant in Communicable Disease Control (CCDC) from PHE, with a further meeting scheduled for January. Both meetings will explore additional scenarios and clarify operational details to be included in the final outbreak response plans.

7.2 Emergency Management and Business Continuity

During 2016 an Emergency Management & Business Continuity Coordination Group (EM&BCCG) was established and tasked with reviewing directorate roles and responsibilities and reporting on their capacity and capability to deliver the necessary functions. This work is progressing and EMU continue to support directorates in this undertaking. The results of this exercise will be used to inform development of subsequent recruiting, training and planning.

A formal bid was submitted to the European Commission for funding to develop an *‘Intelligent Mapping & Prioritisation of Vulnerability in Emergencies and Linkages to Disaster Risk Reduction’* (IMPROVE-DRR) to support effective local emergency responses.

Following the referendum the success of the EU funding bid may well be in doubt. Support from the Cabinet Office (Resilience Direct) may be available to progress the programme.

7.3 Community Resilience

The 'Community Resilience North Somerset' (CRNS) website is now live and will act both as an information tool, a means of promoting volunteering, and a commercial site supporting fund raising and commercial activity of the Community Interest Company.

The Resilient Communities Board meets quarterly to discuss and agree both the wider resilience agenda and joint outcomes between Flood Risk Management and CRNS. Executive meetings have also been established to ensure a Community Resilience Strategy can be successfully implemented.

The Community Resilience a Framework for Practitioners has recently been published by the Cabinet Office and outlines the collective best practice from across the country. The desired outcomes and deliverables outlined in the document align well with the current North Somerset model.

An initial application to the National Lottery, Big Fund, has been submitted for consideration. The bid is for some £480,000 over a five year period. Additionally a bid to Nesta under "Resourceful and Resilient Places" working with ppeople aged 50 and over. Potential partners for such a bid include, Heart of Weston and Our Neighbourhood in Weston-Super-Mare; up to £250,000 is potentially available.

8.0 SUBSTANCE MISUSE SERVICES AND REDUCING COMMUNICABLE DISEASES

Key Performance Indicators	North Somerset	South West	England
Hepatitis C Virus (HCV) testing among service users, 2014/15	93.9%	85.2%	81.5%
Completion of Hepatitis B Virus (HBV) vaccination course among service users, 2014/15	7.9%	12.3%	8.7%
IDUs responding to a consultation to state they are at least happy with local exchange provision[1]	90%	-	-

Source: Public Health Outcomes Framework. [1]North Somerset Community Safety Drug Action Team.

8.1. Introduction

Injecting drug users (IDUs) are at increased risk of transmission of blood-borne viruses (BBVs) including Hepatitis B (HBV), Hepatitis C (HCV) and HIV. HBV and HCV are the leading cause of liver disease worldwide.

North Somerset Council commissions a range of services which when combined form the local adult community substance misuse treatment system (*hereafter* the treatment system). The services within the treatment system are delivered by specialist substance misuse treatment providers and/or primary care providers. The treatment system delivers interventions which cover primary, secondary and tertiary prevention. These interventions are an important element of the North Somerset's health protection work and contribute to reducing communicable disease transmission (namely blood borne viruses) among the high-risk group of injecting drug users.

The largest single service within the treatment system is the Substance Misuse Service, through which the majority of interventions (for both drug and/or alcohol problems) are provided. Hence some points in sections below refer to the Substance Misuse Service in isolation from the other elements of the treatment system.

8.2 Performance of the North Somerset Treatment System

Included below are some of the many measures used to monitor the effectiveness of the North Somerset community substance misuse treatment system, which provide a useful context in which the substance misuse related health activity work can be viewed:

- Between April to June 2016 949 individuals were registered with the Substance Misuse Service; 695 of these were receiving structured treatment and 254 were receiving some form of unstructured service.
- April to June 2016 the proportion of individuals completing treatment successfully increased for all of the treatment types (i.e. opiates, non-opiates, alcohol, alcohol and non-opiate). The rate of successful completions for opiate users was within the national top quartile range.

8.3 Health protection initiatives delivered through the North Somerset Treatment System.

This section describes the elements of the treatment system which directly deliver health protection functions:

8.3.1 Needle exchange.

Needle exchanges are an important mechanism for controlling the spread of blood borne viruses, especially hepatitis C (injecting drug users are the highest risk group in relation to HCV infection with about 80% of new infections in the UK being attributed to injecting drug use.

The most recent estimate (from 2011/12) of the number of injecting drug users in North Somerset is 418 (95%CI 315-521) this equates to a per 1,000 rate which is higher than both the South West and England (NS = 3.33 per 1000, SW = 2.99 and England = 2.49). Users of the local needle exchange services are provided with 10,000 to 16,000 needles per month.

8.3.2 Hepatitis C Virus (HCV)

Injecting drug use (IDU) is the most common route of HCV transmission. 80% of new cases in the UK during 2009 being associated with IDU. 2 in 5 of IDUs are living with HCV with "about half being undiagnosed". Figures produced by North Somerset Public Health estimate that in 2014 there were 686 local cases of HCV with 363 being linked to IDU.

The provision of HCV services, with these now mainly being delivered by or in partnership with the Substance Misuse Service, have steadily improved over the last few years with the most recent performance (Q1 16/17), relating to HCV tests, being better than the national average.

8.3.3 Hepatitis B Virus (HBV)

It is estimated that 1 in 200 injecting drug users are living with HBV. Nationally the level of vaccination uptake has stopped increasing and may have begun to decline.

HBV interventions, whilst achieving better outcomes than the national average, are lower than that achieved for HCV. Work is being undertaken to improve the provision and uptake of HBV vaccinations.

8.3.4 HIV testing

It is estimated that 1 in 100 IDUs are living with HIV[1]. A snapshot as of 20th January 2016 showed 503 of the 963 (53%) individuals receiving structured treatment from Addaction had undergone an HIV test, less than 1% of tested individuals were HIV positive.

Addaction complete HIV testing for both their own service users as well as local sex-workers.

8.3.5 High risk groups

Whilst all substance use (especially injecting drug use) is inherently risky there are some sub-groups of users that present a greater risk and may require enhanced health protection attention. These are: steroid users, amphetamine users, and men that have sex with men.

[1] *Primary Prevention of Hepatitis C among injecting drug users, Home Office, 2009.*

In 2016 the Community Safety Drug Action Team (CSDAT) implemented a system to enable them to receive alerts of MRSA cases related to injecting drug users given the increased risk in this population.

8.4 Other health protection problems resulting from substance misuse

In addition to spread of disease, preventable deaths related to substance use, and accidental consumption of medication, substance misuse also results in accidents, violence, self-harm and suicide. It also affects individuals at a pre-birth (in utero) stage. In response to these challenges the CSDAT has:

- Commissioned a service (Addaction) which treats the physical health needs of service users.
- Facilitated the presence of the (CCG commissioned) Community Outreach Practitioners in Addaction
- Commissioned a programme to increase the provision of alcohol brief interventions across North Somerset
- Commissioned Addaction to support service users in receiving home fire safety checks
- Led partnership actions targeted at the local night time economy
- Commissioned a family focussed substance misuse treatment service
- Commissioned a naloxone scheme

8.5 Key areas of focus for the substance misuse treatment system in relation to health protection and communicable disease control

- **Ensure provision of needle exchange services and HCV testing and treatment is maintained in order to contain and reduce HCV infections.**
- **Develop programmes in response to high risk sub-groups within the substance misusing population,**

9.0 SUMMARY

At this stage in the year the HPC considers good progress to have been made against the priorities laid out in the 2015-16 Health Protection Committee Action Plan. The five priorities laid out in the action plan continue to be priorities for the remainder of this financial year (until March 2017).

The emergency response exercises held this year have provided useful learning points which are being taken forward operationally and in further developing local response plans.

A key focus of coming months will be on maximising the uptake of the seasonal flu and pneumococcal vaccinations among key groups.

Health Protection Committee Priorities for 2016/17:

- **Improve the uptake of seasonal influenza and pneumococcal (PPV) immunisation**
- **Seek assurance that NHS organisations in North Somerset have appropriate response plans in place**
- **Test Airport plans and preparedness to respond to Infectious diseases in light of Ebola Outbreak**
- **Ensure robust outbreak management measures in care homes**
- **Develop a local Health Protection Incident Response Plan**

APPENDIX 1: NORTH SOMERSET INFECTIOUS DISEASE REPORTS TO PUBLIC HEALTH ENGLAND, UP TO JUNE 2016

Healthcare associated infections (HCAI)^

^Rates for the acute Trusts and CCGs within the local authority are presented. Rates are per 100,000 occupied bed days. Cases of *E. coli* bacteraemia are not subject to apportioning.

		Rate per 100,000 occupied bed days													
Trust	Infection	2013		2014				2015				2016		Trend	Comparison to A-J 2015
		J-S	O-D	J-M	A-J	J-S	O-D	J-M	A-J	J-S	O-D	J-M	A-J		
Weston Area Health NHS Trust	Trust assigned MRSA bacteraemia	0.0	0.0	4.5	0.0	4.8	5.1	0.0	0.0	0.0	0.0	0.0	0.0		→
	Trust apportioned C. *difficile* Infection	15.1	31.5	27.0	14.2	24.0	30.6	28.4	0.0	18.4	10.1	16.6	20.8		↑

		Rate per 100,000 population													
CCG	Infection	2013		2014				2015				2016		Trend	Comparison to A-J 2015
		J-S	O-D	J-M	A-J	J-S	O-D	J-M	A-J	J-S	O-D	J-M	A-J		
NHS North Somerset CCG	CCG assigned MRSA bacteraemia	0.0	0.0	1.0	0.0	0.0	0.0	0.5	1.0	0.0	0.5	0.5	0.0		↓
	Non-trust apportioned C. *difficile* Infection	6.3	7.8	6.2	9.6	8.6	6.2	7.2	5.3	9.6	5.8	5.8	5.3		→
	All reports of *E.coli* bacteraemia	24.3	12.6	22.1	20.2	23.5	22.1	18.3	17.3	20.2	20.2	18.3	18.7		↑

	Infection	Rate per 100,000 population												Trend	Comparison to A-J 2015
		2013		2014				2015				2016			
		J-S	O-D	J-M	A-J	J-S	O-D	J-M	A-J	J-S	O-D	J-M	A-J		
	Scarlet Fever	0.5	0.5	4.3	17.3	2.9	5.3	10.0	4.3	2.4	2.9	11.0	9.1		↑
	Invasive group A streptococcal infection	0.5	1.0	1.4	1.0	0.5	1.0	1.4	1.0	1.4	0.5	0.5	1.0		→
Vaccine Preventable Diseases	Measles	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		→
	Mumps	0.5	0.5	1.0	0.0	0.0	1.0	0.0	1.4	0.0	1.4	0.0	0.0		↓
	Pertussis	4.9	2.9	0.5	5.3	6.7	5.8	1.9	1.9	4.8	6.7	6.2	2.4		↑
	Meningococcal infection*	0.0	0.5	1.0	0.0	1.0	0.0	1.0	0.5	0.0	0.0	0.0			↓**
Gastrointestinal Infections^	Campylobacter	53.4	35.4	38.9	51.4	40.4	32.2	24.3	33.8	43.3	30.0	25.2	30.5		↓
	Cryptospondium	0.5	3.4	0.0	1.9	2.9	3.8	1.0	1.4	9.5	13.3	0.5	1.0		↓
	Escherichia coli VTEC	0.5	0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0	0.0	0.0	1.4		↑
	Giardia	3.4	1.9	4.8	3.4	2.4	3.4	2.4	1.9	6.2	6.7	4.3	7.1		↑
	Salmonella Enteriditis	0.5	0.5	0.0	0.0	2.9	1.9	0.0	0.0	2.4	1.4	1.0	0.5		↑
	Salmonella Typhimurium	0.5	0.0	0.0	0.0	0.5	0.5	1.0	1.0	1.9	0.5	0.0	1.4		↑
	Shigella	1.0	0.5	0.5	1.0	0.0	0.5	0.5	0.0	0.5	0.0	0.5	0.0		→

* Data for April to June 2016 is currently undergoing validation and is therefore not yet available.

**For meningococcal infection this comparison is between the January to March 2015 and January to March 2016 quarters.

^ The rates for Campylobacter, Cryptosporidium, Giardia, Salmonella Enteriditis, Salmonella Typhimurium and Shigella include data extracted from the Southmead Laboratory LIMS system. A LIMS extract for Cryptosporidium and Giardia was not available prior to January to March 2015, and therefore rates prior to this should be treated with caution.

GLOSSARY OF ACRONYMS

AGW	Avon, Gloucestershire and Wiltshire
BNSSG	Bristol, North Somerset and South Gloucestershire
CCDC	Consultant in Communicable Disease Control
CCG	Clinical Commissioning Group
CSDAT	Community Safety Drug Action Team
DIPC	Director of Infection Prevention and Control
DPH	Director of Public Health
EH	Environmental Health
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HPC	Health Protection Committee
NHS	National Health Service
NSC	North Somerset Council
LHRP	Local Health Resilience Partnership
MRSA	Methicillin Resistant Staphylococcus Aureus bacteria
PHE	Public Health England
PCV/PPV	Pneumococcal Conjugate Vaccine (for children) /Pneumococcal Polysaccaride Vaccine (for adults)
SHHIP HIT	Sexual Health Improvement for Population and Patients Health Integration Team
TB	Tuberculosis
WAHT	Weston Area Health Trust