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Doncaster
Metropolitan Borough Council

To all Members of the

HEALTH AND ADULTS SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

AGENDA

Notice is given that a Meeting of the above Panel is to be held as follows:

VENUE: Council Chamber - Civic Office
DATE: Wednesday, 16th March, 2016
TIME: **10.00 am**

Members of the public are welcome to attend

Items for Discussion:

1. Apologies for Absence

2. To consider the extent, if any, to which the public and press are to be excluded from the meeting.

3. Declarations of Interest, if any

4. Minutes of the Health and Adult Social Care Overview and Scrutiny Panel held on 26th January, 2016. *(Pages 1 - 8)*

5. Public Statements

   [A period not exceeding 20 minutes for Statements from up to 5 members of the public on matters within the Panel's remit, proposing action(s) which may be considered or contribute towards the future development of the Panel's work programme].

A. Items where the Public and Press may not be excluded

Jo Miller
Chief Executive
If you require any information on how to get to the meeting by Public Transport, please contact (01709) 515151 – Calls at the local rate

Issued on: 8th March, 2016

Senior Governance Officer for this meeting: Christine Rothwell
Tel. 01302 735682

6. Health Protection Assurance Annual Report 2015/16. *(Pages 9 - 42)*

MEMBERSHIP OF THE HEALTH AND ADULTS SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

Vice-Chair – Councillor Cynthia Ransome

Councillors Elsie Butler, Rachael Blake, Jessie Credland, Linda Curran, George Derx, Sean Gibbons and David Nevett

Invitees:

Lorna Foster, UNISION

DONCASTER METROPOLITAN BOROUGH COUNCIL

HEALTH AND ADULTS SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

TUESDAY, 26TH JANUARY, 2016

A MEETING of the HEALTH AND ADULTS SOCIAL CARE OVERVIEW AND SCRUTINY PANEL was held at the COUNCIL CHAMBER - CIVIC OFFICE, DONCASTER on TUESDAY, 26TH JANUARY, 2016 at 10.00 AM

PRESENT:

Acting Chair – Councillor David Nevett

Councillors Rachael Blake, Jessie Credland, Linda Curran, George Derx, and Sean Gibbons

ALSO IN ATTENDANCE:

Councillor Nick Allen, Neil Gethin and James Hart
Councillor Pat Knight - Cabinet Member for Public Health and Wellbeing

Officers:
Laurie Mott, Head of Research, Evaluation and Intelligence
Rupert Suckling, Director of Public Health
Pat Higgs, Assistant Director of Adult Social Care
Rosemary Leek, Commissioning Manager – Commissioning and Contracts

APOLOGIES:

Apologies for absence were received from Councillors Tony Revill, Cynthia Ransome and Elsie Butler.

	NOMINATION OF CHAIR	ACTION
23	In the absence of the Chair and Vice Chair of the Health and Adult Social Care Overview and Scrutiny Panel, nominations were sought for the position of Chair for the duration of the meeting.	
	Resolved that: Councillor Nevett be appointed as Chair for the duration of the Health and Adult Social Care Overview and Scrutiny Panel meeting on the 26th January 2016.	
24	DECLARATIONS OF INTEREST, IF ANY	
	There were no declarations of interest made.	
25	MINUTES OF THE HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL HELD ON 25 NOVEMBER, 2015	

	RESOLVED that: the minutes of the meeting be agreed as a correct record and signed by the Chair.	
26	PUBLIC STATEMENTS	
	Mr Ivan Stark attended the meeting and expressed his concern regarding abuse across the adult social care system and the effectiveness of safeguarding. Mr Stark was also worried about financial abuse taking place which may also include abuse of benefits. Mr Tim Brown attended the meeting and expressed his gratitude towards the Deputy Mayor for acknowledging the significant harm to the equalities agenda in Doncaster. Mr Brown stated that whilst grateful to this scrutiny panel for proposing to find out how BME citizens were being proportionately and meaningfully engaged in Doncaster, the task has become even more urgent given the above recent acknowledgement by the Deputy Mayor - Cllr Glyn Jones. Mr Brown continued to state that the NHS was one of the most regulated organisations in the UK with the Equality Act, Equality NHS Diversity Council, EDS1 and 2, and that workforce race equality standard in place in recognition of BME populations experiencing worse health outcomes and life expectancy than their white British counterparts. It was added that the Workforce Equality Standard was particularly focused on improving BME representation across the NHS workforce and promoting BME voice and representation on the likes of the Health and Wellbeing Board and the governing body of the respective NHS commissioner and provider organisation. Mr Brown stated that in the context of the ageing population report today, that sadly the report follows a predictable pattern of failing to even acknowledge the implications of an ageing BME population in Doncaster. Looking at Doncaster Data Observatory, the qualitative information on BME citizens and older people in particular appears non-existent. Mr Brown made reference to his parents' generation who arrived in Doncaster in the late 1950's and have paid their taxes. It was commented that as stated previously the implication for an ageing BME population was the prevalence of diabetes and co morbidities that were well documented nationally but not reflected in any work programmes in Doncaster including the disappointing Health and Wellbeing Strategy which fails to even mention the term BME. Mr Brown concluded by stating that this begged the question as to what was being done by this scrutiny panel to ensure that the significant harm to the equalities agenda in Doncaster was not	

	undermining the need to safeguard people rights that included BME's as enshrined in the NHS Constitution, Health and Social Care Act, EDS and Workforce RES. Mr Brown added that he had only recently was put forward to contribute to the Health and Wellbeing Board by Superintendent Norman from South Yorkshire Police only for this positive action to be blocked by those with the power to perpetuate racial health inequalities in Doncaster. Mr Brown questioned what the Panel was going to do to address this.	
27	<u>CHILDREN'S HEALTH EARLY YEARS 0-5 INCLUDING HEALTH VISITING AND FAMILY NURSE PARTNERSHIP (JOINT ITEM WITH CHILDREN AND YOUNG PEOPLE OVERVIEW AND SCRUTINY PANEL) - AN OUTLINE OF WHAT IS NOW IN THE CONTRACT AND RESPONSIBILITIES.</u>	
	Rupert Suckling, Director of Public Health attended the Panel Meeting to present a report on Children's Early Years 0-5 (including the transfer of health visiting and family nurse partnership). It was explained that the council had assumed new commissioning responsibilities for 0-5 public health services on the 1st October 2015, which had been viewed positively. Members were informed that at present, all public health commissioned 0-5 services were provided by Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH). It was noted that this included Health Visiting, Family Nurse Partnership and Smoking in Pregnancy Services. Members were informed that the Health Visiting service was in addition to the core service specification to deliver enhanced oral health promotion offer and coordinate the distribution of universal vitamins to pregnant, included parenthood, mental health, breast feeding. <u>Performance</u> - It was clarified that in respect of the large amount of late or no notices of antenatal bookings, steps had been taken to counteract these issues such as sending texts or booking notifications to improve communications. It was added that there had been problems with the new Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT) electronic system which had adversely affected performance. Reference was made to the reduction in the number of baby weighing clinics that had resulted in a reduction to social connections. Members were informed that the majority of health services were available by voluntary means unless an individual was referred to under the Mental Health Act. It was explained that a review was being undertaken with health visitors and staff groups in relation to how new mums were engaged with and could be motivated to use the service. It was commented that it was those individuals who did not participate in these programmes that were the ones who caused the greatest concern.	

	Members were reassured that eligible new mums were offered the Family Nurse Partnership, but if they declined they would still receive routine health visiting services. Members were informed that consideration was being given to ceasing further recruitment and using more targeted skills approach to meet needs in a different way. An example was used of gaps that existed within the current provision, such as those families who because they had more than one child, were not able to access the Family Nurse Partnership. Clarification was made that universal programmes such as those offering screening and immunisation were offered to everyone. It was explained that children from 12-18 months received an integrated assessment before being issued with an agreed joint health and social care plan if the child was in need of a health and social care input. Concern was raised about those children whose physical skills were below average standards. It was outlined that free child places were available which supported young children although it was added there were often barriers to eligible children being able to access those places. In respect of the 'whole family approach' it was recognised that when working with the whole family, there was a greater likelihood that positive changes would be made, for examples, smoking cessation. However, it was commented further that there was no local data to support this. Members were informed that further consideration was being given to how social practices influenced healthy behaviours and it was recognised that legislation preventing individuals from smoking in cars had positively affected this. Councillor Knight, Cabinet Member for Public Health and Wellbeing informed the Panel of a 'Mind the Bump' initiative launched by the Doncaster Royal Infirmary which involved mothers from across the South Yorkshire region. The Panel was further told how those mums who had stopped smoking said they had undertaken a key role by educating and encouraging family members to also give up. Panel Members were informed that collaboratives shared information about families and what was happening within communities. It was questioned how we will improve opportunities as the number of children's centres are reduced within the Borough. It was added that potential avenues that could be consider included the integration of the 0-5 offer or utilisation of the Health Visiting Offer. In terms of venues, Members were informed that the Health Visiting team was considering what could be delivered in people's homes and other venues through working with the third sector offer. Members also questioned what support could be provided by established communities and how proactive were we in facilitating that. Regarding Equality Implications within the report, Members requested further detail about how different equality traits were addressed such	Director of Public

	as translations used. The Director of Public Health offered to provide further information on equality implications. In relation to financial implications, Members expressed their concern about the planned reductions in the public health grant of £2.5 million. RESOLVED that Members note the report.	Health
28	<u>IMPLICATIONS OF AN AGEING POPULATION (NOT JUST DEMENTIA).</u>	
	The Panel welcomed Laurie Mott, Head of Research, Evaluation and Intelligence for attending the meeting to present information around Implications of an Ageing Population. It was explained to Members that the report presented a high level summary of some of the key implications for Doncaster resulting from its ageing population. Some of the key points highlighted included that: - • In 2015, there were around 56,500 people aged 65+ living in Doncaster and by 2020 this figure was expected to have reached 61,100 and by 2030 it could have reached 74,700. • Each year Doncaster will add an average of around 1,200 to the 65 plus population. • Doncaster has an ageing population. • Life expectancy has improved over the last 25 years. • Older people are at greater risk of becoming lonely and many are also carers. • That Doncaster people might be living longer with long standing illnesses or disabilities than similar areas around the country. • That the numbers of clients with personal care needs could increase from around 4,000 in 2015 to 6,000 by 2030. A Member of the Panel commented that there needs to be a change in attitudes and language used towards and about people getting older, to help create a change of how they view themselves. It was added that there needs to be a change of mind-sets and more of a celebratory approach towards living longer. It was commented that social interactions played an important role in positively influencing good health. The Assistant Director of Adult Social Care commented that in Doncaster we were typically reliant on paternal and traditional approaches to service provision which needed to change. Also, that with added pressure on GPs and A&E departments that there was more of a shift towards a self-help approach and more responsibility becoming based within supported communities. It was added that there was a need to reduce dependency on services. Reference was made to the Social Prescribing programme and Members were informed of a case study that had experienced	

	successful outcomes. Members also discussed Extra Care Housing Schemes linked accommodation with care such as Charles Court, Armthorpe and Rokeby Gardens, Kirk Sandall. Members were informed that work was being undertaken with care providers to see how opportunities can be opened up and it was recognised that the Extra Care Housing Schemes were areas for best practice. Concern was raised regarding what was available for those who did not choose to go to social clubs etc. It was questioned what was available in terms of no-fee educational opportunities for older people. Comments were made that older people also looked for their own aspirations and that these was key in addressing mental health issues such as depression. Reference was made to the University of the Third Age (U3A) movement which provides through its organisations, opportunities for its retired and semi-retired people. Recognition was also given to opportunities that had been brought about following advancements in technology although it was acknowledged that increasing usage of smart/android phones and tablets can also result in social isolation. The following health conditions associated with living longer were highlighted; • Bronchitis and Emphysema – respiratory disease often caused by smoking. • Hearing impairment. • Dementia – based on ageing population increase. The Panel RESOLVED to note the implications outlined in the report resulting from its ageing population.	
29	<u>REVIEW OF ARRANGEMENTS TO DELIVER HIGH QUALITY CARE FOR PEOPLE IN CARE HOMES AND A REVIEW OF ADMISSIONS INTO LONG TERM CARE.</u>	
	Pat Higgs, Assistant Director of Adult Social Care and Rosemary Leek, Commissioning Manager – Commissioning and Contracts attended the meeting to provide an overview of the current arrangements for people living in Care Homes in Doncaster and how the Council was ensuring that the Care Home market was fit for purpose for the future needs of the people. It was explained that the Doncaster Clinical Commissioning Group (DCCG) and DMBC Care Home Strategy was currently in its draft format and would be finished summer 2016. It was explained that the strategy was essential in supporting the steps being undertaken for DMBC and DCCG to work with the Care Home market in order to transform the current provision and develop a sustainable market that responds to the changing needs and demand. Members were informed that Care Home providers had sought a clearer direction in	

	understanding what the Council was seeking, it was added that the market was looking to involve the Council to find out more and come up with solutions. It was reported that there was a fragile domiciliary care market; and that for example, staff retention could prove difficult such as during the Christmas period when individuals were often attracted to other better paid positions resulting in pressures around staff resources. Managing Risk and Quality Improvement - Members were informed about weekly multi-agency risk meetings that were held and represented by Health, Care Quality Commission and Council representatives. It was explained that at these meetings the Care Home provision within Doncaster was discussed and reviewed. Members were informed that the meetings had been successful in identifying risks at an early stage. Education and Training – Members were informed that the quality of education and training deliver to staff was key to the quality of care experienced by residents. Members were told how that one of the key barriers was access to training and the expense incurred by care homes to pay for cover as well as paying for the staff on training as most of the training was external. It was explained that often a course with a high take-up from staff would then experience a low attendance when a crisis within the home needed staffing. Care Homes Executive Group - It was clarified that there were no representatives from finance attend the Care Homes Executive meeting. Following a discussion around the work of the Executive Group it was recognised that this could provide additional benefits such as developing a stronger collaboration within the group, a better understanding of the direction of travel and finally, to be able to address fee issues more easily rather that work in silos. Management of Long Term Admissions into Residential Care - It was reported that at the end of October 2015, there were 48 placements per month leaving residential care which was a net increase of 7 per week. Members were informed that since that time figures were now reducing. It was emphasised that there was a need to utilise the care homes sector in a more efficient way such as using care homes facilities for more rehabilitative purposes before carefully integrating the client back into the community. For example, Members were informed that some people who are in poor health or need rehabilitation could have a few weeks support in a care home and once their health etc, has improved can return to living in the community. It was noted that the right system to support people to go back home following a short rehabilitative stay was not currently in place and this needed to be addressed.	

	RESOLVED that the Panel recommended for consideration to be given to a representative from finance being included on the Care Homes Executive group.	
30	HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL WORK PLAN REPORT 2015/16.	
	The Senior Governance Officer highlighted progress with the work plan and themes for consideration throughout 2015/16. This included correspondence attached to the report in respect of Sexual Health following a joint informal meeting with Children and Young People Overview and Scrutiny Panel and a reminder of a future Health and Wellbeing Board workshop around Loneliness. In respect of the Yorkshire Ambulance Service, CQC Inspection Outcome Action Plan progress, Councillor George Derx provided a detailed update to Members. This followed his attendance at a recent Caring for Our People Overview and Scrutiny Committee meeting at Wakefield Council on the 14th January 2016. Regarding the Working Together Programme (a collaboration across the health services to consider how to improve health of communities), Members were informed that a report was going to Council to establish and appoint a representative (and substitute) to a new Joint Health Overview and Scrutiny Committee. It was outlined that the aim of the Working Together Programme was 'to support health service changes in South and Mid Yorkshire, Bassetlaw and North Derbyshire.' Members were assured that updates would be made on the progress of this Committee through the Panel's workplans. Resolved that the Panel note the workplan and updates provided.	

Doncaster
Metropolitan Borough Council

16 March 2016

To the Chair and Members of the

HEALTH & ADULT SOCIAL CARE OVERVIEW & SCRUTINY PANEL

HEALTH PROTECTION ASSURANCE ANNUAL REPORT FOR 2015/16

Presented by: **Victor Joseph (Consultant in Public Health) and Sarah Smith (Public Health Specialty Registrar)**

Relevant Cabinet Member(s)	Wards Affected	Key Decision
Councillor Pat Knight	All	Yes

EXECUTIVE SUMMARY

1. This is the third annual report on health protection assurance in Doncaster presented to the Health & Adult Social Care Overview and Scrutiny Panel covering the financial year 2015/16. This report has been presented annually since March 2014, the first year when Public Health moved from the NHS to the Local Authority following the introduction of the Health and Social Care Act (2012).

2. This report has been developed taking into account best practice and guidance on health protection, including evidence from:
   a. The Centre for Public Scrutiny
   b. The Department of Health statement on assurance;
   c. The Developing Excellence in Local Public Health, with a focus on the health protection component (a tool developed by Public Health Directors in Yorkshire and the Humber);
   d. The Health Protection reports to Doncaster Health Protection Assurance Group.

3. As part of the Health and Social Care Act (2012), the organisations that were established are now coming into their third year of existence. They include Clinical Commissioning Groups, NHS England, and Public Health England. The roles of these organisations and that of Public Health in the Local Authorities are becoming clearer. However, there are areas that require on-going clarifications between and among the agencies

4. There has been sustained progress in ensuring that the health protection assurance system in Doncaster is robust, safe, effective, and meets the new statutory duty placed on local government to protect the health of the people of Doncaster. This has been achieved through the meeting of the Health

Protection Assurance Group that provides assurance on various elements of health protection.

7. An annual Health Protection report has been presented since 2013/14 to the Health and Adult Social Care Overview & Scrutiny Panel. Prior to the Scrutiny Panel meeting in the first year (2013/2014), a series of 10 health protection scrutiny questions were agreed with the Chair and Vice Chair of the panel. Two more questions have since been added; one on performance of health protection against the Public Health Outcomes Framework and the second on smoking. This makes a total of 12 questions, updates on these 12 questions are provided in this report.

5. This report is structured as follows:
    a. Background
    b. Updates on the 12 areas of health protection including:
        i. Current progress for Doncaster
        ii. Update on actions set for 2015/16
        iii. Recommendations for future health protection work – identified through progress on previous actions and through the Health Protection Assurance Group.

EXEMPT INFORMATION

6. None

RECOMMENDATIONS

7. The Health and Adult Social Care Overview and Scrutiny panel is asked to:

- **Note** and comment on the progress made against areas identified for development in 2015/16; and note update on assurance of health protection system in Doncaster
- **Support** the recommendations made in the report.

a. BACKGROUND

11. Health protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation.

The Responsibilities for Local Authorities in relation to Public Health

12. The new responsibilities of the Local Authorities for Public Health functions (including health protection) since 1 April 2013 are underpinned by legislation under the Health and Social Care Act 2012. There are also associated Regulations - Regulation 8 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, made under section 6C of the National Health Service Act 2006. This is in addition to the existing health protection functions and statutory powers

delegated to Local Authorities under the Public Health (Control of Disease) Act (1984), the Health and Social Care Act (2008), the Health and Safety at Work Act (1974) and the Food Safety Act (1990).

13. The Secretary of State (SoS) for Health has the overarching duty to protect the health of the population. This duty is generally discharged by the SoS to Public Health England (PHE).

14. According to the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, the Local Authority Director of Public Health (DPH) has responsibility for strategic leadership of health protection in a unitary/upper tier authority. This should be exercised by:

    - Chairing a local Health Protection Committee (accountable to the Health and Wellbeing Board);
    - Preparing a multi-agency health protection agreement and forward plan.

    The DPH, on behalf of their Local Authority, should be absolutely assured that the arrangements to protect the health of their local communities are robust and are implemented appropriately.

What is meant by health protection?

16. The scope of health protection is broad. The scale of work undertaken by local government to prevent and manage threats to health will be driven by the health risks in the Local Authority area. The key areas of health protection are:

    - Emergency preparedness, resilience and response (EPRR)
    - Communicable diseases management, including Tuberculosis (TB) and Hepatitis
    - Management of other health protection Incidents e.g.
        - Environmental hazards
        - Chemical, biological, radiological, nuclear (CBRN) and terrorist incidents
    - Infection prevention and control (IPC) in health and social care, including healthcare acquired infections (HCAI), communicable disease and infection prevention and control standards in community settings;
    - Screening
    - Immunisation including routine and targeted programmes
    - Contraception and Sexual Health
    - Surveillance, Alerting and Tracking
    - Port Health (e.g. airport health)

There are areas of health improvement that overlap with health protection. They include the following:

- Suicide prevention
- Drugs and substance misuse (in relation to infection with blood-borne viruses)
- Smoking (protection of the public from harm of tobacco).

Who else is responsible for health protection?

17. In addition to the Local Authority, there are a number of agencies which exercise health protection functions in relation to the borough either as a commissioner or provider. The key agencies include:

    - Public Health England: Communicable disease control, Infection prevention and control, environmental, chemical, biological, radiological, nuclear, terrorist hazards/incidents; health improvement, and healthcare Public Health.
    - Doncaster Clinical Commissioning Group: Infection prevention and control (in hospitals), immunisation, communicable disease control, screening.
    - NHS England Local Area Team: Screening and Immunisation Programmes.
    - Health care providers; General practice, pharmacies, Doncaster and Bassetlaw NHS Foundation Trust, Rotherham Doncaster and South Humberside NHS Foundation Trust.

18. The 6C Regulations require each Local Authority to;

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

Monitoring and Assurance

19. At a national level, within the new Public Health Outcomes Framework (PHOF), there is a health protection domain. Within that domain there is a placeholder indicator; *'Comprehensive, agreed inter-agency plans for responding to Public Health incidents.'* Public Health England measures progress by Local Authorities against this indicator. Doncaster has fully met this requirement (100%) for the year 2015/16 (compared with 92.3% for Yorkshire and the Humber Region, and 95.2% for England).

20. At a sub-regional there is a Local Health Resilience Partnership, chaired by a representative of the Directors of Public Health in South Yorkshire, and a Screening and Immunisation Advisory Board chaired by NHS England.

21. At a local level the Health Protection Assurance Group reports to the local Health and Wellbeing Board. Health Protection reports are also submitted to the Public Health Governance group (within the Public Health Team in DMBC) on a regular basis. The Health Protection Assurance Group meets quarterly and is chaired by a Consultant in Public Health.

22. Overview and scrutiny of the new health protection functions in DMBC is provided by the Health & Adults Social Care Overview and Scrutiny Panel on an annual basis.

b. SCRUTINISING DMBC's HEALTH PROTECTION FUNCTIONS

Q1. Does the Local Authority have a clear understanding of the pathways and providers involved in the delivery of health protection in Doncaster?

23. Pathways: There are a number of pathways involved in the delivery of health protection in Doncaster. They include the following:
    a) Routine activities, which encompass:
        1. Routine delivery and surveillance of vaccination and screening programmes.
        2. Infection Prevention and Control (IPC). Monitoring of HCAI cases, and IPC activity in hospitals commissioned by Doncaster CCG.
        3. Community IPC. Provided by RDaSH, commissioned by DMBC.
        4. Disease surveillance by Public Health England e.g. Meningitis, Mumps etc.
        5. Community TB service. Provided by RDASH, commissioned by Doncaster CCG.
        6. Drugs and substance misuse service. Delivered by RDaSH, commissioned by DMBC.
        7. Sexual Health Service provided by primary care and secondary care providers, commissioned by DMBC

    b) Outbreaks and emergencies: activity undertaken in response to health protection incidents (may involve multi-agencies).

        1. Outbreak reporting e.g. norovirus, measles etc.;
        2. Escalation systems – see question 7 for more detail;
        3. Targeted Vaccination programmes e.g. MMR catch up.

    c) Future planning: Activity undertaken to plan for potential future health protection incidents.
        1. Emergency plans e.g. Pandemic Influenza, Cold Weather, Heat Wave etc., Public Health contribution to DMBC Corporate Emergency plan;
        2. Business continuity.

Question 1.
PROGRESS ON 2015/16 ACTIONS
None identified
RECOMMENDATIONS
• Further work could be undertaken to raise the profile of Health Protection and how this integrates with other functions across the local authority.

Q2. What are the local governance structures and responsibilities for Health Protection in the Borough?

Providers

24. Table 1 provides an overview of the agencies involved in Health Protection in Doncaster and what their responsibilities are.

Table 1 Providers involved in the health protection system in Doncaster during 2015/16 and their key roles.

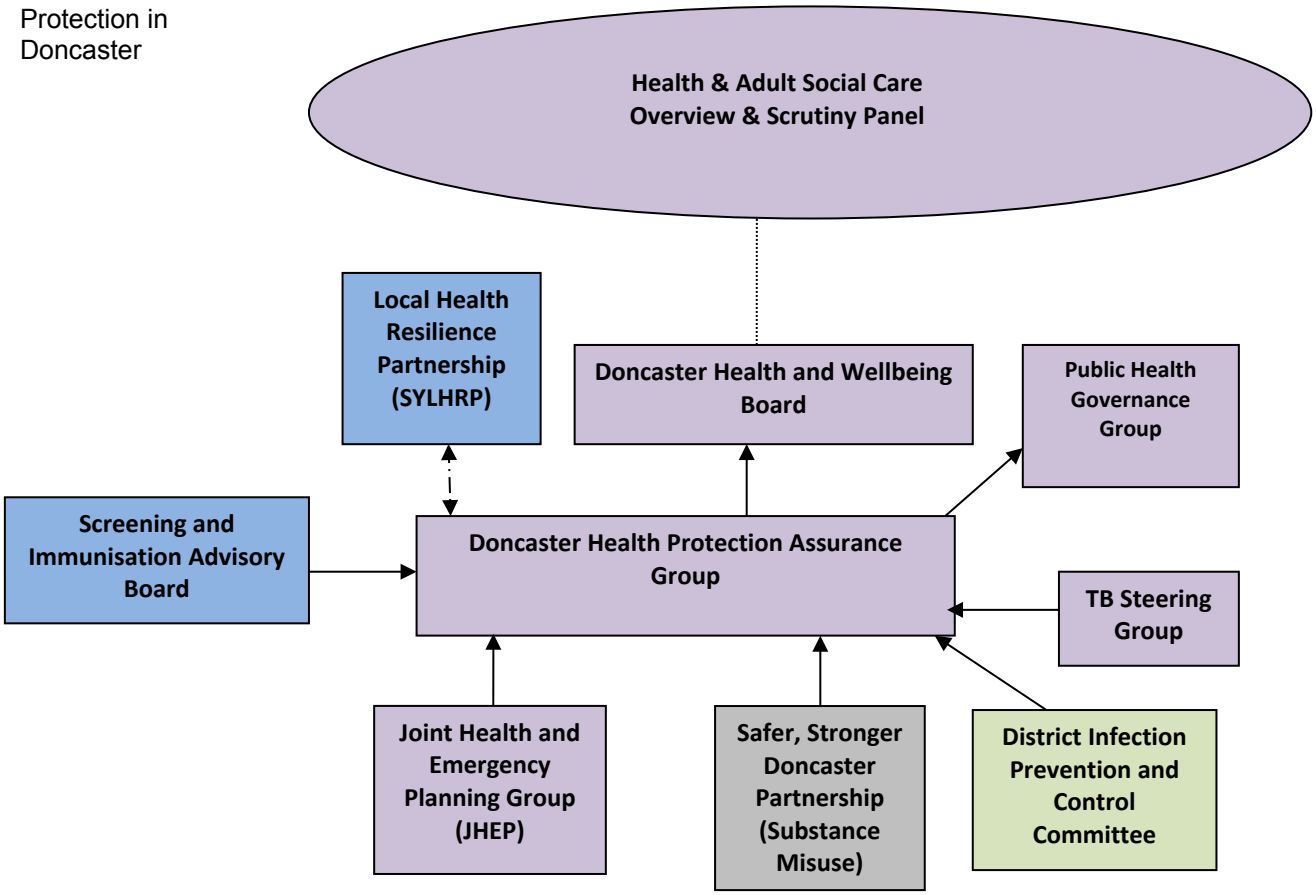
Agency	Roles and responsibilities	Lead Officer
Doncaster Metropolitan Borough Council	Overall assurance of the Health Protection System, Emergency Planning, Resilience and Response. Environmental Health	Dr Rupert Suckling, Director of Public Health Peter Dale, Director of Regeneration and Environment
	Commissioning of community infection prevention and control	Dr Rupert Suckling, Director of Public Health; Victor Joseph, Consultant in Public Health
Public Health England	Communicable disease control and monitoring, expert advice on environmental, chemical, biological and radiation hazards, HCAI monitoring.	June Chambers, Senior Health Protection Specialist/Lead Nurse, South Yorkshire Team, Public Health England
NHS England Local Area Team	Commissioning routine vaccination, immunisation and screening programmes, commissioning primary care, responsibility for some closed communities, e.g. prisons Emergency planning	Fiona Jorden, Consultant in Public Health
Doncaster CCG	A duty to make available to LAs, CCG services or facilities so far as is reasonably necessary to enable LAs to discharge their functions relating to social services, education and Public Health HCAI monitoring and control, commissioning secondary care services, infection control commissioning (hospital)	Wendy Feirn, Senior Nurse / Clinical Commissioner – Quality & Patient Safety
Primary Care Providers	Reporting notifiable diseases, administering vaccination and screening programmes	GPs
Secondary Care Providers	Managing HCAI's, responding to emergencies, communicable disease notification and control	DBHFT – Director of Infection Prevention and Control; RDASH; YAS – Head of Safety.
Voluntary Sector Organisations	Infection Prevention Control where applicable	Lead Manager/staff

Governance Structures

25. The Doncaster Health Protection Assurance Group (HPAG) is the key group that is responsible for receiving assurance from a range of local and sub-regional committees involved in health protection. The HPAG provides assurance to the Doncaster Health and Wellbeing Board and the DMBC Public Health Governance group.

Figure 1 below sets out the governance structures for health protection in Doncaster.

Figure 1: Governance Structures for Health Protection in Doncaster



= Convened by NHS England Local Area Team

= Convened by DMBC → = Provides assurance to…

= Convened by Doncaster CCG ⇠⇢ = Provides information to…

= Convened by South Yorkshire Police

All of the above groups are multi-agency. A full list of the membership for the HPAG is included in Appendix 1 of this paper (Terms of Reference).

26. In terms of monitoring arrangements for health protection, a report is produced regularly (quarterly) to the Public Health Governance Group using an agreed standard template on health protection assurance during each quarter. There is also an agreed system of exception reporting to the Health and Wellbeing Board in the event that a health protection incident should occur between statement periods.

Question 2.	
PROGRESS ON 2015/16 ACTIONS	
Health Protection to be included as a standing item on Health & Wellbeing Board meetings. This will demonstrate the strategic importance of health protection agenda.	An annual report on health protection will be presented to Health protection will be on Health and Wellbeing Board on 4th March 2016, and annually thereafter. A survey of practice in a number of local authorities in the region showed that majority of Health and Wellbeing Boards receive health protection report once a year.
RECOMMENDATIONS	
• Review the roles and responsibilities for organisations involved in the District Infection Prevention and Control Committee	

Q3. Are clear, up to date SLA's/MOU's in place between the Local Authority and all partner agencies involved in the local health protection system?

27. Existing agreements or MOU between DMBC and partner agencies have been maintained. These include:

- An MOU between DMBC and Doncaster CCG;
- A 'Local Ways of Working Agreement' between DMBC, PHE and NHS England;
- The Local Health Resilience Partnership (LHRP) has signed agreements in place with each NHS organisation across South Yorkshire.

28. As part of the changes in health protection on-call arrangements, PHE now runs its own health protection on-call system; Public Health Consultants employed by Local Authorities no longer take part in this on-call system. Instead, each Local Authority has its own on-call arrangements.

29. 'Ways of Working Agreement' between PHE and Local Authorities at a national level has not been agreed due to re-organisation and re-structuring within PHE. It is expected that this is still on going.

30. The mechanisms for the review of Memorandum of Understandings (MOUs) / agreements are carried out through existing mechanisms e.g. partnership meetings and business processes.

Question 3.
PROGRESS ON 2015/16 ACTIONS
• None identified
RECOMMENDATIONS
• None identified

Q4. How well does DMBC understand the potential and existing risks to health in the borough, and how do we ensure that partners also know and understand?

31. We have maintained a health protection assurance framework to update on health protection risks in Doncaster over the year.

32. In addition, there is a system for receiving timely surveillance and alert information from PHE, both at national and sub-regional levels by Public Health officers in the Council. For example, through the South Yorkshire PHE Team, a regular daily situational report is provided to the Local Authority and this information is also cascaded to partner organisations in Doncaster for information and action where appropriate. They include information on outbreaks of infectious diseases in Doncaster.

33. Through the quarterly Health Protection Assurance Group, a report is received on individual elements of health protection from the lead officer for the area e.g. sexual health, vaccination, screening, infection prevention and control, etc. The report covers key risks in the subject area, and what is being done to address them. A forward plan containing all elements of health protection is in place, and all the elements are discussed in the course of the year.

34. As part of the process of managing potential risks, there is an on-going process of EPRR in relation to health protection. The following plans were reviewed and updated in 2015/16:
- Pandemic Influenza;
- Heat Wave;
- Cold weather;
- Multi-agency outbreak plan
- The Management of Sexually Transmitted Infection (STI) Outbreaks and Incidents in Doncaster

35. There are areas still for further development, which include:

- Mass Treatment plan: these are on-going pieces of work with health partners across Doncaster being undertaken through the Joint Health and Emergency Planning Group (JHEPG).

36. A South Yorkshire Health Protection local Memorandum of Understanding for roles and responsibilities in health protection incidents and emergencies was has agreed through the LHRP and is in place.

Question 4.	
PROGRESS ON 2015/16 ACTIONS	
Develop the Mass Treatment plan for Doncaster	Work is in progress to develop this. A multi-agency plan has been drafted through JHEPG.
Develop a multi-agency outbreak plan.	This has been developed and signed off.
RECOMMENDATIONS	
• Continue work on the Mass Treatment plan for Doncaster	

Q5. What system is in place to provide assurance to the DPH, on behalf of the Local Authority, that arrangements to protect the health of the people of Doncaster are robust and being implemented appropriately?

37. The Health Protection Assurance Group (HPAG) continues to meet at quarterly intervals and it receives assurance that health protection duties are discharged effectively in the borough from various groups, as described in Figure 1. The terms of reference of HPAG can be found in Appendix 1. The HPAG regularly receives information and reports on a range of health protection areas. The Chair of the HPAG provides a regular report to Public Health Governance Group meetings on health protection matters in the borough. The Public Health Governance Group is chaired by the DPH.

38. The Health Protection Assurance Framework continues to provide a comprehensive tool to manage risks across all areas of health protection. This document is owned by the HPAG and regularly reviewed. There is an active programme of risk management in place.

39. The DMBC Scrutiny Committee also has a key role in assuring the health protection system by taking an overview and scrutinising the systems and procedures in place to ensure that they are, and will remain, fit for purpose. This is the third year the DMBC Scrutiny panel will receive an annual report on health protection functions in the borough.

40. A national TB control strategy for England was published in January 2015. This emphasises the need for local work in order to realise the Governments long-

term ambition of eliminating TB as a Public Health problem by 2050. New NICE guidance on the management of TB was published in January 2016. Therefore, an updated TB strategy for Doncaster is needed to incorporate national strategy and guidance.

41. During the course of the year, a self-assessment exercise has been undertaken, using a regional tool (Delivering Excellence in Local Public Health). The health protection section was completed for Doncaster, and an action plan developed to guide improvement to protect the health of the people of Doncaster.

Question 5.	
PROGRESS ON 2015/16 ACTIONS	
In view of membership changes to the Health Protection assurance group. The membership of the group should be reviewed to ensure the appropriate level of staff is represented on the group.	Membership of the Health Protection Assurance Group has been reviewed by Public Health Governance Group.
Continual review of the function of the Health Protection Assurance Group should be carried out.	The Public Health Governance Group reviewed the function of the Health Protection Assurance Group and it was felt it should continue as it is.
Review local TB strategy (plan) and services in light of national TB strategy for England.	The local TB strategy is currently being reviewed, along with service specifications, in consultation with relevant partners. This is expected to be completed by March 2016.
RECOMMENDATIONS	
Complete and get sign-off of Doncaster TB strategy and service specifications in view of new national TB strategy and NICE guidance	

Q6. Is DMBC assured that the system can respond appropriately in the event of an outbreak/incident?

Emergency Plans

42. There are a range of multi-agency contingency plans in place, along with strategic agreements allowing agencies and organisations to work together. Plans are tested through exercises and actual incidents, and multi-agency groups are in place which allows learning from each other. Multi-agency plans held by South Yorkshire Local Health Resilience Partnership (SY LHRP) are in

place, or in development, for across the South Yorkshire region, and assurance is also sought through this group for across South Yorkshire.

43. Internal to the Council, PH input has been made into the DMBC Corporate Emergency Plan as part of its annual review, ensuring the ability of DMBC specifically to respond. Joint plans have been developed between PH and DMBC Resilience and Emergency Planning for events such as Pandemic Flu, and these compliment multi agency plans developed by the LHRP, and the Local Resilience Forum (LRF), as appropriate.

44. Assurance on plans and the ability to respond in Doncaster is sought through the JHEP group which has representatives from across the local health community. The overall aim of this group is to provide the main local strategic focus for health sector emergency planning and resilience to ensure a co-ordinated approach in EPRR locally.

Testing the System

45. The system remains vigilant in ensuring that plans in place are regularly tested and lessons learnt from them. Lessons identified from exercises are shared at multi-agency meetings by those who attended, for members across the system to be aware of any issues/areas that need addressing and further attention. On-call systems, both internal to DMBC and wider are regularly tested during real incidents and exercises.

Learning from Experience

46. The system continues to learn from real events in order to improve response to future events.

Infection Prevention and Control

47. IPC specifications are embedded in contracts of all relevant LA commissioned services and an IPC standard paragraph is embedded in all relevant local authority contracts.

Question 6.	
PROGRESS ON 2015/16 ACTIONS	
Continue to review emergency plans as appropriate according to national and local guidance and ensure further testing of plans.	A review of emergency plans has been undertaken and tested. DMBC participated in a tactical level table top pandemic flu exercise (Exercise Alberio) held on a South Yorkshire level. Recommendations from this exercise have been incorporated into relevant

	plans.
Ensure there is an on-going approach to learning from experience and that issues identified from real events are acted upon.	Lessons learned from experience of incidents have been built into actions for future improvement.

RECOMMENDATIONS
•Continue to review contingency plans as appropriate according to national and local guidance, and ensure further testing response arrangements. •Ensure that there is an on-going approach to learning from experience and that issues identified from real events are acted upon.

Q7. What accountability structures would be used by the DPH to escalate health protection concerns as necessary, and can current arrangements ensure a timely response?

49. As described in Figure 1, there are established governance arrangements for managing and escalating health protection concerns in Doncaster. If a health protection incident could not be managed within Doncaster the DPH could escalate concerns to other key groups and agencies including the LHRP and PHE. The HPAG can also escalate concerns through the Public Health Governance Group, which in turn can ensure that risks are placed onto the DMBC corporate risk register as necessary. These arrangements remain active and are working well. They are embedded in the relevant governance structures such as Public Health Governance Group and HPAG.

Question 7.
PROGRESS ON 2015/16 ACTIONS
• None identified
RECOMMENDATIONS
• None identified

Q8. What arrangements are in place to manage cross-border incidents and outbreaks?

51. There are plans in place and under review/development that take into account cross border incidents and outbreaks that are held by the SYLHRP e.g. pandemic influenza. PHE is the key link to support management of cross border outbreaks and incidents. They will notify DMBC and other local authorities as necessary, and would establish cross-border incident/outbreak meetings as required.

52. In addition, arrangement for the management of TB cases in secondary care, in both Doncaster and Bassetlaw is being delivered by the same trust. Through the local TB Steering Group, we have included members from Bassetlaw to ensure the pathway of care is standardised between the two areas. This arrangement is captured in the terms of reference of Doncaster's TB Steering Group.

Question 8.
PROGRESS ON 2015/16 ACTIONS
• None identified
RECOMMENDATIONS
• None identified

Q9. How are we developing new joint working arrangements between Public Health / the wider health protection system and environmental health within DMBC?

53. Environmental health is part of the Health Protection Assurance framework. There has been extensive work on the framework with collaboration and contribution from staff from across the DMBC directorates, in particular Regeneration and Environment. Risks will be reviewed on a regular basis. There has been more integration between PH Health Protection functions and environmental health which will continue to develop. Joint plans have been developed with each directorate to allow for joint working where appropriate and where beneficial. This also applies to environmental health issues.

54. Since the move of Public Health into DMBC, EPRR plans have been harmonised and are being jointly updated and produced together with the Resilience and Emergency Planning team. Examples of these include the Heat Wave Plan, Pandemic Flu Contingency Plan, and Cold Weather Plan. These have been prioritised based on the perceived risk from the SY risk register, and timed to new national guidance being issued. This is particularly relevant to the new structure of the health system. Joint work priorities/plans have been developed between Public Health and the Resilience and Emergency Planning team to highlight what needs to be developed next e.g. Mass Vaccination.

55. Public Health has worked with the air quality team to develop a process for issuing joint warnings about fluctuations in air quality that could have an impact on health, specifically respiratory health. This includes factsheets and information being shared with health partners and schools, amongst others. Information and advice will also be shared with the public through the use of social media. Public Health and the air quality team meet on a regular basis to review progress and identify further opportunities for joint working. There is a joint action plan for Air Quality between Public Health and Environmental

Health. Public Health works with Environmental Health to ensure the health implications of poor air quality are considered.

56. The HPAG has representatives from across health protection system including DMBC Environmental Health/Environmental Protection, Public Health England, DBHFT, Doncaster CCG and DMBC Public Health. This allows for regular updates from all areas responsible for health protection and enables joint working where appropriate through developing stronger working relationships. The purpose of the HPAG is to ensure co-ordinated action across all sectors to protect the health of the people of Doncaster from health threats, including major emergencies.

Question 9	
PROGRESS ON 2015/16 ACTIONS	
Continue to strengthen and develop existing joint working between Public Health and Environmental Health as a whole.	There is continued joint work between Public Health and Environmental health on a range of health protection areas, including air quality, control of infectious diseases, tobacco control, and EPRR. We envisage this collaborative work will continue into the future.
RECOMMENDATIONS	
•Continue to strengthen and develop existing joint working between Public Health and Environmental Health as a whole.	

Q10. What formal agreements are in place between PHE and DMBC to determine the specialist health protection support, advice and services PHE will provide to DMBC?

57. The following agreements remain in force between DMBC and partner agencies. These include:

- An MOU between DMBC and Doncaster CCG;
- A South Yorkshire Health Protection Local Memorandum of Understanding for roles and responsibilities in health protection; the Local Health Resilience Partnership (LHRP) has signed agreements in place with each NHS organisation across South Yorkshire.

58. However, PHE now runs its own health protection on-call system, without the input of Local Authority Public Health Consultants.

59. It is uncertain whether or not there will be national guidance on “Ways of Working”, however, local arrangements are in place.

Question 10.
PROGRESS ON 2015/16 ACTIONS
• None identified
RECOMMENDATIONS
• None identified

Q11. How is Doncaster performing in relation to health protection matters?

60. Doncaster generally performs well in relation to Health Protection. Doncaster is meeting national targets in 13 out of 15 indicators and performing significantly better than the England average in a further two indicators. Details of the performance against the health protection indicators of the Public Health outcome framework (PHOF) are shown in Table 2 below.

Table 2: Public Health Outcomes Framework Immunisation Indicators
[1] (Based on Published PHOF by Public Health England, 10th February 2016)

Indicator	Period	Doncaster value	England value	Target
Population vaccination coverage – Hepatitis B (1 year old) - %	2014/15	100*	N/a	N/A
Population vaccination coverage – Hepatitis B (2 years old) - %	2014/15	0*	N/a	N/A
Population vaccination coverage – DTAP/ IPV / HiB (1 year old) - %	2014/15	94.6*	94.2	*90%*
Population vaccination coverage – DTAP/ IPV / HiB (2 years old) - %	2014/15	96.7*	93.2	90%
Population vaccination coverage – MenC (Group C Meningooccal vaccine) %	2012/13	95.0*	93.9	90%
Population vaccination coverage – PCV (pneumoccal conjugate vaccine) %	2014/15	94.2*	93.9	*90%*
Population vaccination coverage – Hib / MenC booster (2 years old) %	2014/15	93.4.	92.1	*90%*
Population vaccination coverage – Hib / MenC booster (5 years old) %	2014/15	95.1	92.4	*90%*
Population vaccination coverage – PCV booster %	2014/15	93.7	92.2	*90%*
Population vaccination coverage – MMR	2014/15	93.0	92.3	*90%*

1. Source: http://www.phoutcomes.info/public-health-outcomes-framework#page/1/gid/1000043/pat/6/par/E12000003/ati/102/are/E08000017/iid/30101/age/230/sex/4

for one dose (2 years old) %				
Population vaccination coverage – MMR for one dose (5 years old) %	2014/15	94.5	94.4	*90%*
Population vaccination coverage – MMR for two doss (5 years old) %	2014/15	89.0	88.6	*90%*
Population vaccination coverage – HPV (Previous years) %	2013/14	90.0	86.7	*> previous years England average*
Population vaccination coverage – PPV (Pneumococcal Polysaccharide Vaccine) %	2014/15	71.4	69.8	*70%*
Population vaccination coverage – Flu (aged 65+) %	2014/15	73.4	72.7	*75%*
Population vaccination coverage – Flu (at risk individuals)	2014/15	51.4	50.3	*Better than England average*

61. The two indicators where Doncaster is not meeting the national target for immunisation are:

•Population vaccination coverage – MMR for two doses (5 years old):
Doncaster achieved 89.0% against a national target of 90% (WHO target). This is based on 2014/15 data in the Public Health Outcomes Framework. The 89.0% coverage rate for 2014/15 is however an increase on the coverage rate of 88.2% that Doncaster achieved in 2013/14.

•Population vaccination coverage – Flu (aged 65+)
Doncaster achieved 73.4% against a national target of 75% (WHO target). This is based on 2014/15 data in the Public Health Outcomes Framework. The 73.4% coverage rate for 2014/15 is however an increase on the coverage rate of 73.0% that Doncaster achieved in 2013/14; it is also the PHOF target.

Table 3: Public Health Outcomes Framework Screening Indicators
(Based on Published PHOF by Public Health England, 10th February 2016)

Indicator	Period	Doncaster value	England value	Target
Cancer screening coverage – breast cancer - %	2015	76.2	75.4	Significantly better than England average
Cancer screening coverage – cervical cancer - %	2015	75.6	73.5	Significantly better than England average
Cancer screening coverage – bowel cancer - %	2015	61.3	57.1	Significantly better than England average
New born bloodspot screening coverage - %	2014/15	94.8*	95.8	Significantly worse than England average

New born hearing screening coverage - %	2013/14	98.7	98.5	Not statistically different from the England average
Access to non-cancer screening programmes – diabetic retinopathy %	2012/13	88.6	79.1	Significantly better than England average
Abdominal aortic aneurysm Screening - %	2014/15	99.9	97.4	Significantly better than England average

*New born bloodspot screening achievements in Doncaster for 2015/16 quarter 2: 95.0% (PHOF acceptable level). Issues identified by NHS England related to timely receipt of specimen in to laboratory. NHS England is reviewing this.

62. Doncaster has performed well compared to the England average in measures for cancer screening, diabetic retinopathy and AAA screening. Performance on new born screening indicators could be improved.

Table 4: Public Health Outcomes Framework Smoking Indicators

(Based on Published PHOF by Public Health England, 10th February 2016)

Indicator	Period	Doncaster value	England value	Target
Smoking status at time of delivery - %	2014/15	20.5	11.4	Significantly worse than England average
Smoking prevalence at age 15 - current smokers (WAY survey) - %	2014/15	8.9	8.2	Not statistically different from the England average
Smoking prevalence at age 15 - regular smokers (WAY survey) - %	2014/15	6.8	5.5	Not statistically different from the England average
Smoking prevalence at age 15 - occasional smokers (WAY survey) - %	2014/15	2.1	2.7	Not statistically different from the England average
Smoking prevalence - %	2014	22.7	18.0	Significantly worse than England average
Smoking prevalence – routine and manual	2014	29.6	28.0	Not statistically different from the England average

63. Doncaster is significantly worse than the national average figure for women smoking at the time of delivery. This figure is a decrease from previous years, 22.1% in 2013/14 and 22.5% in 2012/13.

Overall smoking prevalence in Doncaster is significantly higher than the national

average. The number of smokers in Doncaster decreased from 26.5% in 2010 to 21.4% in 2013. This number did increase to 22.7% in 2014.

Table 5: Public Health Outcomes Framework Other Health Protection Indicators

(Based on Published PHOF by Public Health England, 10th February 2016)

Indicator	Period	Doncaster value	England value	Target
Fraction of mortality attributable to particulate air pollution (PM2.5)	2013	5.7	5.3	*N/A*
Chlamydia detection rate (15-24 year olds) (per 100,000)	2014	2809	2012	*>2300*
People presenting with HIV at a late stage of infection - %	2012 -14	48	42.2	*25 – 50% average*
*Treatment completion for TB - %	2013	Not enough data	*N/A*	
Incidence of TB (rate per 100,000)	2012-14	7.7	13.5	*Better than England average*
NHS organisations with a board approved sustainable development management plan - %	2013-14	66.6	41.1	*N/A*
Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies	2014/15	100	95.2	*N/A*

Note: TB treatment completion in Doncaster for 2015/16 was 89% (national target >85%)

64. Doncaster is meeting the national target for detection of Chlamydia and is average for the proportion of people presenting with HIV at a late stage of infection.

65. Doncaster's incidence of TB is significantly below the England average. An initiative aimed at reaching hard-to-reach groups, including black and minority ethnic (BME) groups. The initiative related to early identification of TB using the Health Bus that targeted asylum seekers and migrants in Doncaster town centre. The initiatives had been effective in identifying latent TB cases among those screened. It also enabled extension of the initiatives to other services like sexual health.

66. Doncaster is performing well in relation to the corporate management of Health Protection.

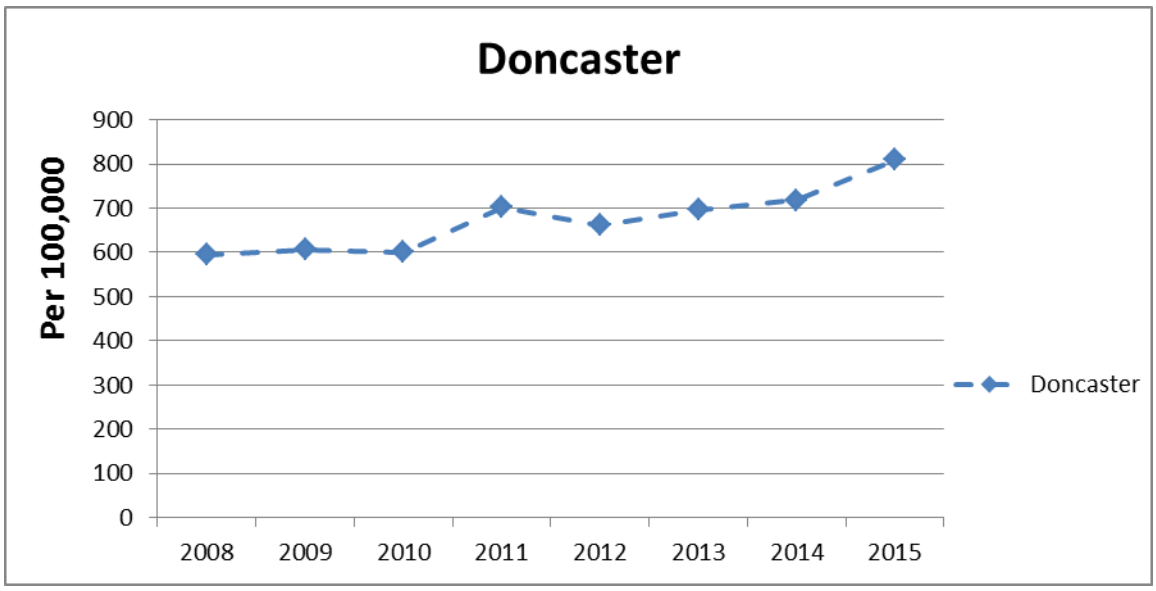
Question 11.	
PROGRESS ON 2015/16 ACTIONS	
Working with NHS England to improve areas of red performance: • Treatment completion for TB • Population vaccination coverage: ➢ MMR for two doses (5 years old) ➢ Flu (those aged >65years) Flu (at risk individuals)	Regular assurance meeting with NHS England and through Health Protection Assurance Group were held during the year to review performance of health protection related to screening and immunisations (MMR and Flu vaccination). Reviewed outcomes for TB treatment completion (Quarter 2 of 2015/16 showed that treatment completion was 89%, above the national target of 85%>
To review KPIs for Health Protection as outlined in the Public Health Outcomes Framework to determine Doncaster's national position.	Performance of health protection was reviewed quarterly through Health Protection Assurance Group, and Public Health Governance Group. Additional performance metrics have been considered in this report to account for the wider remit of Health Protection.
RECOMMENDATIONS	
•Work with NHS England to improve areas of performance where Doncaster is not meeting national targets. •Review performance indicators to determine the measure are relevant to Health Protection.	

Q12. How effective are the interventions on smoking in Doncaster to protect the health of the local population?

67. Smoking is a major Public Health problem in Doncaster. Currently, 22.7% of adults aged 18 years and over smoke in Doncaster, compared with 20.1% in Yorkshire and Humber and 18% England. This equates to around 54,000 adults who smoke.
The rate of people dying from smoke related conditions in Doncaster (389.8 per 100,000) is worse than that seen in the country (288.7 per 100,000 for England). This equates to more than 1,900 deaths between the years 2011-2013 in Doncaster. Equally, Doncaster is one of the worse areas compared to England's rates in relation to hospital admissions that can be attributed to smoking (Doncaster: 1819 versus 1420 per 100,000 for England). There are

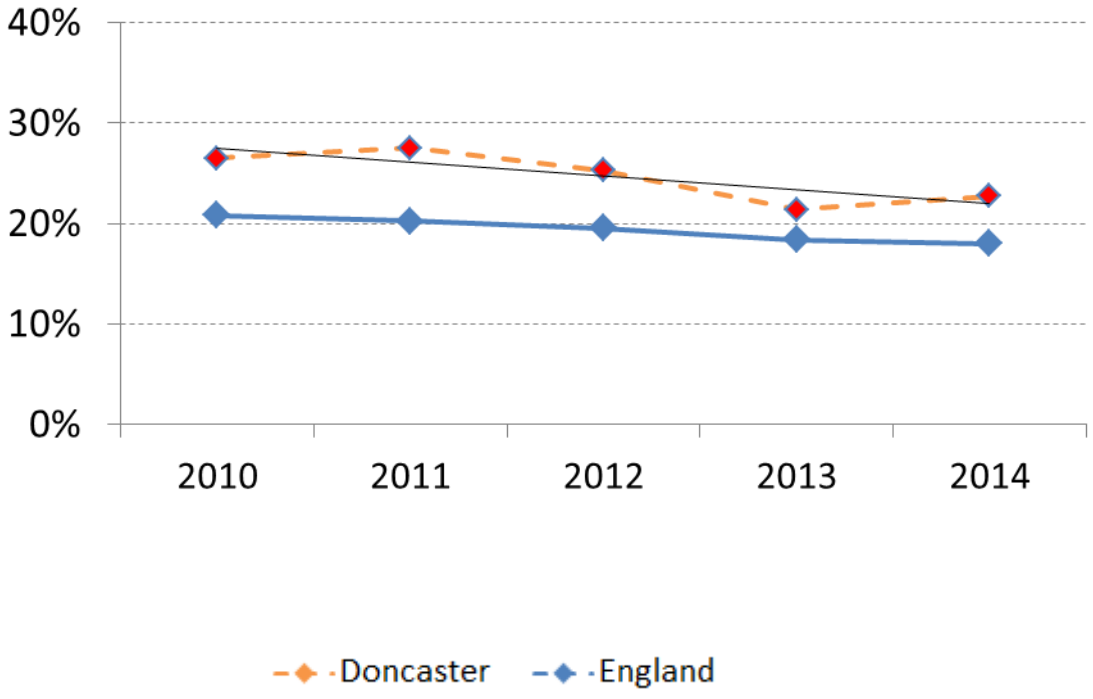
172,000 people aged 35 years and over admitted to hospital in Doncaster from smoking related causes each year and the trend is increasing (Figure 2).

Figure 2: Emergency hospital admissions for Respiratory infections among adults in Doncaster



68. There is some indication that the prevalence rate of smoking among adults aged 18 years and over is falling, and it currently stands at 22.7%, based on 2014 data (down from 26.3% in 2011), see Figure 3 below.

Figure 3: Smoking prevalence among adults aged 18 years and over - % of current smokers in the Household Survey for England: 2010-2014. (Source: PHE, Local Tobacco Control Profiles.)



69. Responding to this challenge, the Council has reviewed the approach to commissioning services to address smoking and has currently got a range of service contracts in place. Stopping smoking services are commissioned for the whole population and to targeted groups including pregnant women.

70. Doncaster Council has commissioned social marketing campaigns, which targeted illicit tobacco and smoking in pregnant women. Health campaigns have been carried out based on intelligence gathered on these groups. In addition to this a regional TV campaign was launched on 1 February for a month, focusing on raising public awareness of 16 cancers linked to smoking.

71. Doncaster Council signed a Tobacco Declaration in March 2015. This is a public statement of commitment that we are working to reduce the prevalence of smoking in Doncaster.

Illicit tobacco remains one of the major areas of public health interventions in reducing the prevalence of smoking in Doncaster. Since April 2015, there had been 85,000 cigarettes and 45kg of hand rolling tobacco seized by the Trading Standards Team at Doncaster Council.

72. The Doncaster Tobacco Control Alliance has facilitated partnership working between DMBC, RDASH, DBHFT and Doncaster CCG to encourage compliance with smoke-free premises. There is on-going work to ensure the respective premises are smoke-free.

73. Doncaster has undertaken a self-assessment on tobacco control and an action plan developed. A refresh of the Doncaster Tobacco Strategy has been drafted, awaiting national strategy due later in 2016. Once the national strategy on tobacco is out, our local strategy will be finalised incorporating the output of the tobacco control self-assessment.

Question 12.	
PROGRESS ON 2015/16 ACTIONS	
Support the Council in effort to sign Tobacco Declaration.	Doncaster Council has signed Tobacco Declaration in March 2015. This commits the organisation to take action to reduce the prevalence of smoking.
Monitor the performance of existing contracts related to smoking interventions	Regular performance monitoring of contracts on smoking had been held during the course of the year.
Explore other innovative actions that could be done to tackle smoking	There have been social marketing campaigns aimed at reducing cigarette smoking among young people and pregnant women. Also there have been actions to support the Council's premises to be smoke-free.

RECOMMENDATIONS
• Continue work on Breathe2025. A regional initiative with a vision of seeing the next generation of children born and raised in a place free from tobacco, where smoking is unusual. It is calling for people and organisations to sign up. http://www.breathe2025.org.uk/. • Finalise local Tobacco Strategy following the release of the National Strategy later in 2016. • Demonstrate the impact specific interventions have had on reducing smoking prevalence in Doncaster. • Embedding Making Every Contact Count (MECC) or very brief advise into routine practice among Health and Wellbeing partner organisations in Doncaster.

OPTIONS CONSIDERED

74. There are no specific options to consider within this report as it provides an opportunity for the Panel to receive and hold to account the progress and work undertaken as part of the Council's responsibilities for Health Protection.

IMPACT ON THE COUNCIL'S KEY OUTCOMES

	Priority	Implications
	All people in Doncaster benefit from a thriving and resilient economy. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	Health is a resource for life, and economic productivity. Healthy people contribute to the economy, and health protection functions aims to protect the health of the population, including those who are current and potential workforce.
	People live safe, healthy, active and independent lives. • *Mayoral Priority:* Safeguarding our Communities • *Mayoral Priority:* Bringing down the cost of living	Health protection impacts on how we keep our population safe from certain diseases, which are preventable by vaccination (e.g. MMR) and conditions that could be identified early by screening so that appropriate treatment can be given. Health protection is also about protecting the health of our people from risks and hazards related to major emergencies and incidents.

	People in Doncaster benefit from a high quality built and natural environment. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding our Communities* • *Mayoral Priority: Bringing down the cost of living*	
	All families thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	Health Protection contributes to healthy families and their ability to thrive and realise their full potentials.
	Council services are modern and value for money.	The health protection work is delivered within Public Health financial grant.
	Working with our partners we will provide strong leadership and governance.	The Health Protection Assurance Group provides the leaders to ensure appropriate plans are in place to protect the health of the people of Doncaster. It has appropriate governance to ensure the delivery of health protection functions.

RISKS AND ASSUMPTIONS

75. The Health Protection Assurance system in Doncaster is a risk management system. The areas for development identified in this report will further strengthen Doncaster Council's ability to manage these risks. Risks are reviewed by Health Protection Assurance Group, and reported to Public Health Governance Group on quarter basis. A report by Internal Audit identified substantial assurance related to maximizing public health outcomes within the limited resources available. The current risk assessment of health protection score is 10 (likelihood = 2; impact = 5) from original risk score of 15 (likelihood = 3; impact = 5). One of the main current risks that the Health Protection Assurance Group has identified and is working to put measures in place to mitigate relates community infection prevention and control; and tuberculosis (TB) in light of national emphasis on future eradication of the infection as a public health threat. Other risks related to low coverage of vaccination, especially Flu vaccination update among the local population.

76. These plans are based on the assumption that key agencies will continue to work together going forward.

LEGAL IMPLICATIONS

77. Supporting the recommendations in this report will enable DMBC to continue to discharge its statutory duty to protect the health of the public effectively.

FINANCIAL IMPLICATIONS

78. Managing risk effectively will reduce potential financial implications of health protection incidents to DMBC.

CONSULTATION

79. There is a mechanism in place for on-going consultation with stakeholders through HPAG and the various subgroups that report to it.

This report has significant implications in terms of the following:

Public Health	✓	Crime & Disorder	
Human Resources		Human Rights & Equalities	✓
Buildings, Land and Occupiers		**Environment & Sustainability**	✓
ICT		Capital Programme	

BACKGROUND PAPERS

80. - Health Protection Assurance Framework
- Ways of working document between DMBC & PHE
- MOU between CCG and DMBC
- Terms of Reference of Health Protection Assurance Group
- Public Health Governance Terms of Reference
- Delivering Excellence in Local Public Health (Public Health Self-assessment tool for sector led improvement produced by DsPH Network for Yorkshire and the Humber).

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Doncaster
Metropolitan Borough Council

Doncaster Health Protection Assurance Group

Terms of Reference

Reporting to:	Doncaster Health and Wellbeing Board
Health Protection Group authorised by:	Doncaster Health and Wellbeing Board
Responsible Directorate:	Public Health Directorate, Doncaster Metropolitan Borough Council (DMBC)
Approval date of TOR:	8 October 2013
Reviewed date:	16 April 2014
Reviewed date:	17 April 2015
Next review date:	April 2016

Document history (author)

Draft Version 1.1 (VJ):	22 July 2013
1.2 (JW comments incorporated)	29 July 2013
1.3 PH DMT input	5 August 2013
1.4 Statement added on Local Health Resilience Partnership and outbreak responsibilities re: school nurses, etc. (Section 5.1)	23 September 2013
1.5 Final draft agreed by HP Assurance Group	8 October 2013
2.1 Amended frequency of meeting to be quarterly (VJ)	16 April 2014
PHE representation: South Yorkshire Health Protection Team, Public Health England (VJ).	17 April 2015

1.	Purpose:
1.1.	The purpose of the Health Protection Group is to ensure co-ordinated action across all sectors to protect the health of the people of Doncaster from health threats, including major emergencies.
1.2.	It supports the Director of Public Health (DPH) to carry out statutory responsibility to protect the health of the community through effective leadership and coordination, ensuring appropriate capacity and capability to detect, prevent and respond to threats to public health and safety.
1.3.	The Health Protection Group will provide strategic direction and assurance on matters relating to health protection policy, risks and incidents.
1.4.	All agencies will work collaboratively to exchange information and share knowledge and where appropriate pool resources for the purpose of protecting Public Health.

2.	Functions:
2.1.	To ensure that public health (PH) threats requiring local intervention are identified, analysed and prioritised for action to protect public health.
2.2.	To ensure that health threats are prevented through implementation of relevant national strategies and regulations to protect public's health.
2.3.	To ensure plans exist to coordinate responses to public health emergencies and threats.
2.4.	To ensure appropriate governance for all health protection activities.
2.5.	To ensure appropriate policies and plans associated with health protection activities are in place.
2.6.	To establish local health protection assurance system and support organisations to deliver against the health protection outcomes (part of public health outcomes framework).
2.7.	To receive annual reports that demonstrate compliance with, and progress against, health protection outcomes.
2.8.	To ensure plans are in place for prompt and effective cascade of major health protection alerts (including Chief Medical Officer cascade, Medicines and Healthcare products Regulatory Agency (MHRA) alerts, Met Office alerts, and other major alerts) to appropriate audiences and to confirm that systems are in place for responding to such alerts.
2.9.	To scrutinise incidents (including outbreaks), considering the responses of providers and commissioners so giving an overview to the Health Protection Group.
2.10.	To provide health protection (including emergency preparedness,

resilience and response (EPRR)) assurance and statements on regular (quarterly) basis to Doncaster Health and Wellbeing Board and any other relevant local bodies via the Director of Public Health.

3. Accountability

3.1. The Health Protection Group will report to Doncaster Health and Wellbeing Board (HWBB).

3.2. The DPH is accountable to the Chief Executive of DMBC on discharging health protection duties of the local authority.

4. Scope

The scope of the Health Protection Group is to minimise hazards to human health, and to ensure that any threats are promptly dealt with. Geographically, the scope covers the population of Doncaster. (Links will be established with professionals in Bassetlaw and other areas as appropriate). Thematically, the scope covers the following health protection areas in the Health Protection Assurance Framework for Doncaster:

4.1. Vaccination & immunisations

4.2. Infection prevention and control (IPC) related to healthcare associated infections

4.3. Drugs and substance misuse

4.4. Alcohol

4.5. Injury prevention (including suicide prevention)

4.6. National screening programmes.

4.7. Sexual health

4.8. Communicable disease control including TB, blood-borne viruses, gastro-intestinal (GI) infections, seasonal and pandemic influenza

4.9. Emergency preparedness, resilience and response (EPRR)

4.10. Healthy environments for living, working and recreation

4.11. Public health advice regarding the planning for and control of pollution

4.12. Climate change

4.13. Sustainable environment

4.14. Regulation and enforcement

5. Strategic Linkages: to receive minutes and update from relevant committees / groups	
5.1.	Local Health Resilience Partnership (LHRP): There will be linkage with emergency preparedness, resilience and response (EPRR) for which there is an established process for assurance through LHRP chaired by a Director of Public Health; and the Joint Health Emergency Partnership Group (JHEPG). The LHRP and the JHEPG shall provide statement of assurance and minutes of their meetings to the Health Protection Assurance Group. Among other things, the LHRP shall provide assurance that the following services are in place to respond to any major outbreak if it occurs: school nursing services, community nursing services, out-of-hours services, walk-in centres, and medicine management services.
5.2.	Safer Doncaster Partnership (SDP): for substance misuse
5.3.	Doncaster Data Observatory: for intelligence related to health protection
5.4.	Public Health England: for surveillance data and outbreak control
5.5.	District Infection and Control meeting (Doncaster CCG)
5.6.	Quality and Patient Safety meetings (Doncaster CCG)
5.7.	District Vaccination and Immunisation Committee
5.8.	NHS England: Screening and Immunisation Advisory Board for South Yorkshire and Bassetlaw
5.9.	Any other groups whose work remits are linked to the health protection assurance framework.

6. Membership of Health Protection Group:	
6.1.	Consultant in Public Health (Chair), DMBC
6.2.	Director of Public Health (Deputy Chair), DMBC
6.3.	Assistant Director of Public Health (Lead for EPRR), DMBC
6.4.	Senior Nurse / Clinical Commissioner – Quality & Patient Safety, Doncaster CCG
6.5.	Screening and Immunisation Lead, NHS England
6.6.	Chair of Doncaster Vaccination and Immunisation Committee, NHS England
6.7.	South Yorkshire Health Protection Team, Public Health England
6.8.	Director of Infection Prevention and Control, DBHFT

6.9.	Director of Infection Prevention and Control (or equivalent), RDASH
6.10.	Representative from Environmental Health, DMBC
6.11.	Representative from Adult Social Care, DMBC
6.12.	Public Health Practitioner (Health Protection and Emergency Planning), DMBC

7. Co-option of members

7.1.	Other Leads of health protection elements maybe co-opted as and when appropriate.

8. Declarations of Interest

8.1.	If any member had an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussion. The Chair will have the power to request that member to withdraw until the Health Protection Group has given due consideration to the matter.
8.2.	All declarations of interest will be minuted.

9. Deputising

9.1.	All members must make every effort to attend. If members are unable to attend they must send formal apologies, otherwise they will be recorded as 'did not attend'. Deputies should attend only when necessary.

10. Quorum

10.1.	Chair or Deputy; and at least 3 other members from different agencies.

11. Frequency of meetings:

11.1.	Quarterly as from April 2014.

12. Agenda deadlines:

12.1.	Items to be received two weeks prior to meeting
12.2.	Agenda to be circulated within two weeks of meeting.

13. Minutes:

13.1.	Minutes will be circulated within two weeks of the meeting.
13.2.	Minutes will be circulated to all members of the Health Protection Group.

14. Urgent matters	
14.1.	Any urgent matters arising between meetings will be dealt with by Chair's action after agreement from three other members of the group.

15. Administration:	
15.1.	Public Health Support Officer, Directorate of Public Health, DMBC

16. Attendance:	
16.1.	Members (or their nominated deputies) are required to attend a minimum of 4 out of 6 meetings annually.

GLOSSARY

CCG – Clinical Commissioning Group

Communicable Disease - A disease that can be spread from one person to another, by direct or indirect means.

DBHFT – Doncaster and Bassetlaw NHS Foundation Trust

DPH – Director of Public Health

EPRR – Emergency Preparedness, Resilience and Response

Healthwatch – The independent consumer champion organisation for health and social care

HCAI – Healthcare Acquired Infections are acquired as a result of healthcare interventions. They include infections such as MRSA and C.Difficile.

HPAG – Health Protection Assurance Group

HWBB – Health and Wellbeing Board

IPC – Infection Prevention and Control

JHEP – Joint Health and Emergency Planning Group

LHRP – Local Health Resilience Partnership

NHSE – NHS England

Notifiable Disease - Any disease that is required by law to be reported to government authorities.

PH – Public Health
PHE – Public Health England

PHOF – Public Health Outcomes Framework

RDaSH – Rotherham, Doncaster and South Humberside NHS Foundation Trust

SoS – Secretary of State (for Health in this paper)

STI – Sexually Transmitted Infections