Doncaster
Metropolitan Borough Council

15 March 2017

To the Chair and Members of the

HEALTH & ADULT SOCIAL CARE OVERVIEW & SCRUTINY PANEL

HEALTH PROTECTION ASSURANCE ANNUAL REPORT FOR 2016/17

Relevant Cabinet Member(s)	Wards Affected	Key Decision
Councillor Pat Knight - Portfolio holder for Public Health and Wellbeing	All	Yes

EXECUTIVE SUMMARY

1. This is the annual report on health protection assurance in Doncaster covering the financial year 2016/17.

2. There has been sustained progress in ensuring that the health protection assurance system in Doncaster is robust, safe, effective, and meets the statutory duty placed on local government to protect the health of the people of Doncaster. This has been achieved through effective health protection governance structures and service plans.

3. This report has been developed taking into account best practice and guidance on health protection, including evidence from:

   - The Public Health Outcomes Framework, Public Health England
   - Local Air Quality Management Policy Guidance 2016, Department for Environment, Food and Rural Affairs.
   - NICE Guideline (draft for consultation Dec 2016): Air Pollution, Outdoor air quality and health.
   - Health Protection reports to Doncaster Health Protection Assurance Group and the South Yorkshire Screening and Immunisation Oversight Group.

This report is structured as follows:

1. Background
2. Progress from 2015/16 to 2016/17
3. Specific areas of focus for 2017/18:
   a. Air Quality
   b. Vaccines and Immunisations
4. Recommendations

EXEMPT INFORMATION

4. None

RECOMMENDATIONS

5. 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 2016/17; and the specific areas of focus for 2017/18.
- **Support** the recommendations made in the report.

Recommendations

The Overview and Scrutiny Panel is asked to:

a. Note the progress made from 2015/16 to 2016/17 on addressing health protection matters in Doncaster;
b. Support the following recommendations in relation to Air Quality:
    i. The Directorate of Regeneration and Environment working in conjunction with Public Health Team will explore the possibility of monitoring PM 2.5 and work to reduce the emission and ambient concentrations of PM2.5 in Doncaster.
    ii. Continue to progress the work of Doncaster Active Travel Alliance.
    iii. Establish an air quality Steering Group with respect to producing and progressing the Council's air quality action Plan.
c. Support the following recommendations in relation to immunisations:
    i. Continue to work with local partners to monitor in particular the uptake of flu vaccinations and MMR.
d. Support continued work in monitoring and reporting on progress on health protection indicators in the borough.

BACKGROUND

6. 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.

7. The scope of health protection is broad and includes:

- Emergency preparedness, resilience and response (EPRR)
- Management of communicable (infectious) diseases, including managing of outbreaks.
- Management of other health protection Incidents e.g. environmental hazards
- 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
- Vaccines and 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).

The Responsibilities for Local Authorities in relation to Public Health

8. The responsibilities of 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).

9. 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).

10. 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.

11. 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.

Who else is responsible for health protection?

12. 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.

13. 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".

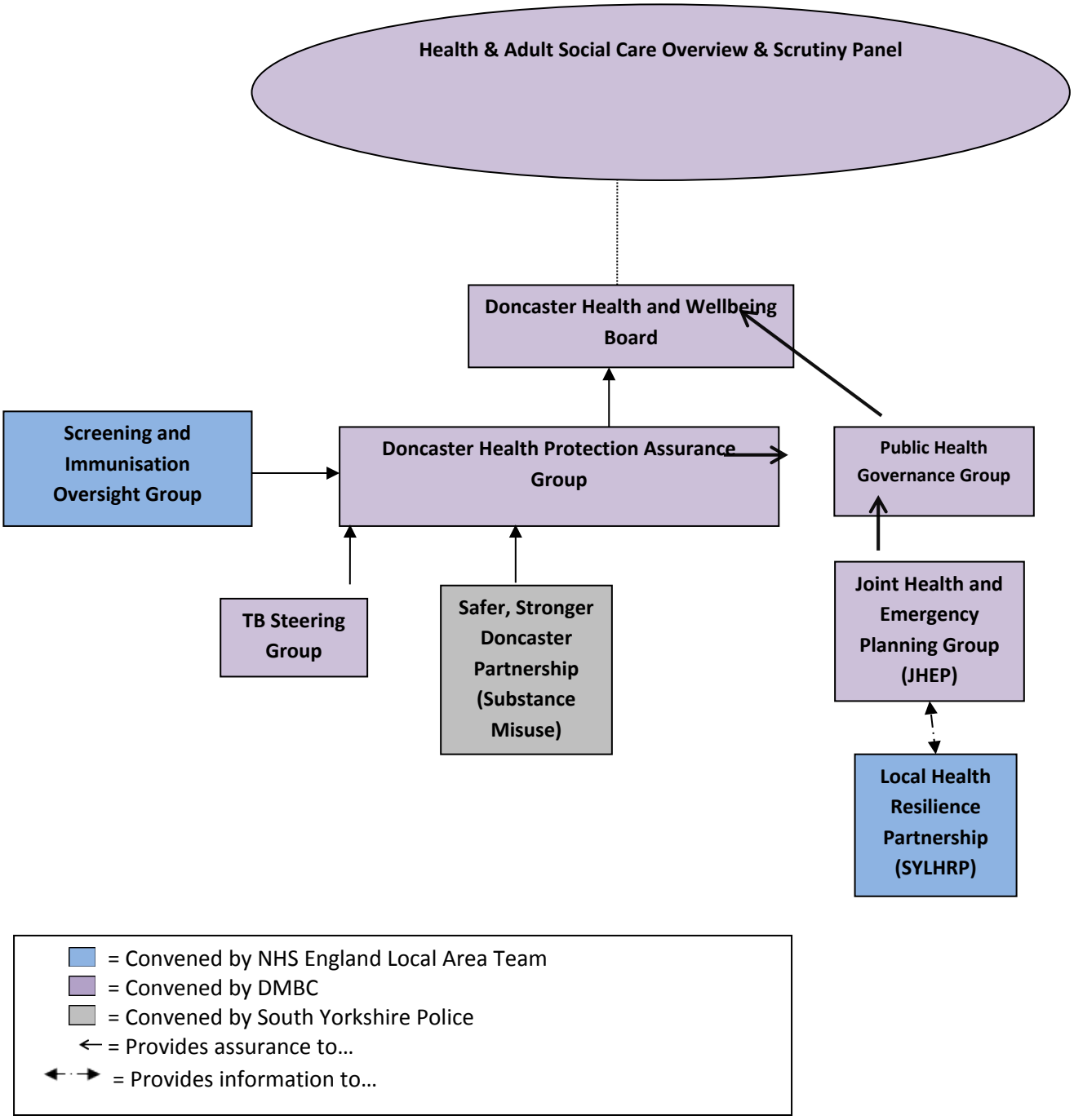
Monitoring and Assurance

14. At a national level, within the Public Health Outcomes Framework (PHOF), there is a health protection domain. Within that domain there are indicators on immunisations, screening and infectious disease which allow for comparisons with other areas and the England average. Doncaster's performance is highlighted in this report.

15. 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. A full list of the membership for the HPAG is included in Appendix 1 of this paper (Terms of Reference).

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

Figure 1: Governance Structures for Health Protection in



Progress from 2015/16 to 2016/17

Progress on recommendations made in 2015/16 annual report

17. The health protection annual report in 2015/16 recommended a number of actions for 2016/17 and progress on these is summarised in Table 1 below.

Table 1: Progress on recommendations in 2015/16 Health Protection Report

RECOMMENDATIONS FOR ACTION IN 2016/17	PROGRESS
1. Further work could be undertaken to raise the profile of Health Protection and how this integrates with other functions across the local authority.	Public Health Team has a programme of work (Plan on a Page) across all the Directorates of the Council, with identified leads working with each Directorate. The work programme aims to add value to functions of the Directorates of the Council and to improve health of the people of Doncaster. A section of this year's report covers air quality in Doncaster.
2. Work with environmental health to provide updates on air quality to the Health and Adult Social Care Overview and Scrutiny committee when required.	
3. Continue to strengthen and develop existing joint working between Public Health and Environmental Health as a whole.	
4. Address air quality in Doncaster wards.	
5. Review the roles and responsibilities for organisations involved in the District Infection Prevention and Control Committee	The District Infection Prevention and Control Committee, which was formerly chaired by Doncaster CCG has been incorporated as part of Doncaster Health Protection Assurance Group (HPAG). A revised terms of reference of the HPAG was reviewed and adopted on 2 August 2016 (See Appendix 1).
6. Continue work on the Mass Treatment plan for Doncaster.	The Doncaster Multi-agency mass treatment plan was developed through the JHEP (Joint Health and Emergency Planning Group) and signed off by strategic level representatives from each organisation in November 2016
7. Complete and get sign-off of Doncaster TB strategy and service specifications in view of new national	The national strategy for tackling TB has been adopted locally, with a local profile of TB in Doncaster. A local TB service

RECOMMENDATIONS FOR ACTION IN 2016/17	PROGRESS
TB strategy and NICE guidance.	specification was developed and approved by Doncaster TB Steering Group on 30 November 2016. Doncaster CCG is working towards embedding the service specification into contract.
8. Continue to review contingency plans as appropriate according to national and local guidance, and ensure further testing response arrangements.	The following contingency plans were reviewed in 2016/2017: • Doncaster Council Pandemic Flu Contingency plan • Doncaster Council Heat Wave contingency plan; • Doncaster Council Public Health Cold weather contingency plan; • Doncaster Multi-agency outbreak plan; • Doncaster Multi-agency Mass treatment plan; • The Management of Sexually Transmitted Infection (STI) Outbreaks and Incidents in Doncaster In 2016/2017 a number of exercises have taken place that Doncaster Council has been involved in, including but not limited to: • Exercise Cygnus (National, strategic level pandemic flu table top exercise; October 2016); • Exercise Swan (South Yorkshire, tactical level pandemic flu table top exercise; October 2016) • Exercise Cygnus Mortus (Doncaster table top management of excess deaths exercise; November 2016) Lessons identified and recommendations are incorporated into subsequent plan reviews.
9. Ensure that there is an on-going approach to learning from experience and that issues identified from real events are acted upon.	Learning from experience and incidents continues to be facilitated through the JHEP, LHRP and the South Yorkshire Health Resilience group (sub-group of the LHRP) South Yorkshire Health Protection Network has been established with a reporting mechanism to the Directors of Public

RECOMMENDATIONS FOR ACTION IN 2016/17	PROGRESS
	Health. The Network provides a forum for sharing learning from real events across South Yorkshire. In addition, a learning set consisting of heads of health protection in each of the South Yorkshire local authority. The learning set also provides opportunity to learn lessons on prevention and control of health protection incidents / outbreaks.
10. Work with NHS England to improve areas of performance where Doncaster is not meeting national targets.	Continue to work with NHS England to review the performance of health protection related to vaccination & immunisation; and screening in Doncaster.
11. Review performance indicators to determine the measure are relevant to Health Protection.	
12. Review local data to explore inequalities in uptake of cancer screening and stage of cancer diagnosis.	
13. 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/.	There has been a continued work and support from Yorkshire and the Humber to address the common challenge of tobacco control. In addition, a collaborative work among public health leads on tobacco across local authorities in South Yorkshire is on-going.
14. Finalise local Tobacco Strategy following the release of the National Strategy later in 2016.	A draft local tobacco strategy is in place. We are still awaiting for the publication of Tobacco Control plan for England.
15. Demonstrate the impact specific interventions have had on reducing smoking prevalence in Doncaster.	The latest statistics appear to show that the prevalence rate of smoking is decreasing; at 19.6% in 2015 (from 22.7% in 2014). This represents a welcome steady decline in smoking rate among adults. However, the rate is still significantly higher than that seen in England (16.9%).
16. Embedding Making Every Contact Count (MECC) or very brief advise into routine practice among Health and Wellbeing partner organisations	Limited progress has been made. An e-learning for MECC has been produced by the Council; and primary care service specification has been produced by CCG to enable primary care staff use MECC for

RECOMMENDATIONS FOR ACTION IN 2016/17	PROGRESS
in Doncaster. (Q12)	patients with multiple long-term conditions.

Progress on Public Health Outcome Indicators for Health Protection (from 2015/16 to 2016/17)

Vaccines and Immunisations (Area of Focus)

17. Doncaster generally performs well in relation to vaccines and immunisations but there is scope for improvement. Doncaster is better or similar to national targets in 14 out of 18 indicators. Four indicators require significant improvement; these are in relation to flu vaccination (over 65s, 2-4 years olds and at risk individuals) and MMR (uptake of 2 doses at 5 years old). Details of the performance against the relevant health protection indicators of the Public Health outcome framework (PHOF) are shown in Table 2 overleaf.

18. Work is underway with relevant partners and the NHSE screening and immunisation oversight group. Concerns have been raised across the South Yorkshire and Bassetlaw region with regards to the number and management of persistent patients who do not attend (DNAs) appointments. A multi-stakeholder task and finish group has been convened to consider the issue and potential problems. Specific concerns regarding uptake are included in local improvement plans.

19. The four indicators where Doncaster is not meeting the national target for immunisation are:

    a) MMR (uptake of two doses at 5 years old):
    Doncaster achieved 86.5% against a national target of 95% (European region of the WHO target). This is based on 2015/16 data in the Public Health Outcomes Framework. It is worth noting that the rate for 1 MMR dose before the age of 5 years exceeds the 95% target.
    However the 86.5% coverage rate for (two doses) 2015/16 is below target and in need of improvement. It is not a significant change from the previous year's rate.

    b) Flu (aged 65+)
    Doncaster achieved 72.3% against a national target of 75% (WHO target). This is based on 2015/16 data in the Public Health Outcomes Framework. The 72.3% coverage rate for 2015/16 is a decrease on the coverage rate of 73.4% that Doncaster achieved in 2014/15

    c) Flu (at risk individuals)
    Doncaster achieved 46.8% in 2015/16 against a national target of 55%. This is a decrease on the coverage rate of 51.4% achieved in 2014/15.

    d) Flu (aged 2-4 year olds)
    Doncaster achieved 35.4% in 2015/16 against a national target of 65%. This is the first year this indicator has been reported.

Table 2: Public Health Outcomes Framework Immunisation Indicators [1]

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) - %	2015/16	94.4*	93.6	*95%*
Population vaccination coverage – DTAP/ IPV / HiB (2 years old) - %	2015/16	95.7*	95.2	95%
Population vaccination coverage – MenC (Group C Meningooccal vaccine) %	2015/16	96.5*	N/A	95%
Population vaccination coverage – PCV (pneumoccal conjugate vaccine) %	2015/16	94.2*	93.5	*95%*
Population vaccination coverage – Hib / MenC booster (2 years old) %	2015/16	90.8	91.6	*95%*
Population vaccination coverage – Hib / MenC booster (5 years old) %	2015/16	93.6	92.6	*95%*
Population vaccination coverage – PCV booster %	2015/16	91.1	91.5	*95%*
Population vaccination coverage – MMR for one dose (2 years old) %	2015/16	90.8	91.9	*95%*
Population vaccination coverage – MMR for one dose (5 years old) %	2015/16	96.0	94.8	*95%*
Population vaccination coverage – MMR for two doses (5 years old) %	2015/16	86.5	88.2	*95%*
Population vaccination coverage – HPV %	2014/15	89.1	89.4	*90%*
Population vaccination coverage – PPV (Pneumococcal Polysaccharide Vaccine) %	2015/16	72.0	70.1	*75%*
Population vaccination coverage – Flu (aged 65+) %	2015/16	72.3	71.0	*75%*
Population vaccination coverage – Flu (at risk individuals)	2015/16	46.8	45.1	*55%*
Population vaccination coverage – Flu (2-4 year olds)	2015/16	35.4	34.4	*65%*
Population vaccination coverage – Shingles (70 years old)	2015/16	53.6	54.9	*60%*

*Value estimated from former primary care organisations covered by the LA.
**Value suppressed for disclosure control due to small count

Screening

20. Doncaster has performed well compared to the England average in measures for cancer screening and Abdominal Aortic Aneurism or AAA screening.

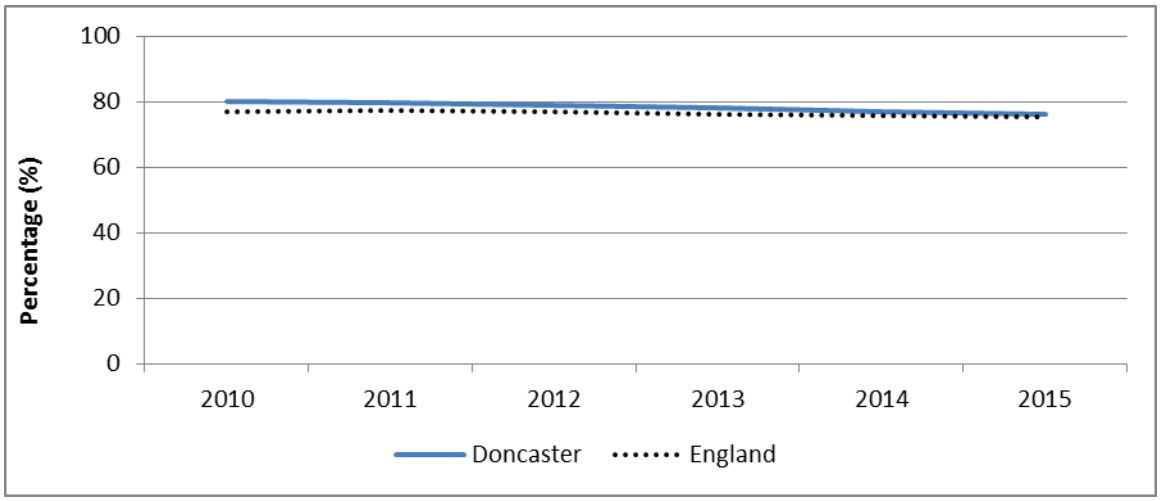
1. Source (Based on Published PHOF by Public Health England, 7th February 2017): http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000043/pat/6/par/E12000003/ati/102/are/E08000017/iid/30301/age/30/sex/4

Performance on new born screening indicators shows improvement from last year and is not statistically different from the England average. See Table 3 and Figure 2 below.

Table 3: Public Health Outcomes Framework Screening Indicators

Indicator	Period	Doncaster value	England value	Target
Cancer screening coverage – breast cancer - %	2016	76.2	75.5	Significantly better than England average
Cancer screening coverage – cervical cancer - %	2016	75.0	72.7	Significantly better than England average
Cancer screening coverage – bowel cancer - %	2016	60.7	57.9	Significantly better than England average
New born bloodspot screening coverage - %	2015/16	95.6	95.6	Significantly better than England average
New born hearing screening coverage - %	2013/14	98.5	98.7	Significantly better than England average
Abdominal aortic aneurysm Screening - %	2014/15	84.2	79.9	Significantly better than England average

Figure 2: Breast cancer screening coverage in Doncaster: 2010-2015



Smoking

21. Smoking is a major Public Health problem in Doncaster, but improvements are being made. Currently, 19.6% of adults aged 18 years and over smoke in Doncaster, compared with 18.6% in Yorkshire and Humber and 16.9% in England. This is a reduction from 22.7% of smokers in 2014 and equates to approximately 7,374 less smokers in 2015 than in 2014. Further work is required to reduce the rate below the Y&H and England rates. See Table 4 and Figure 3 overleaf.

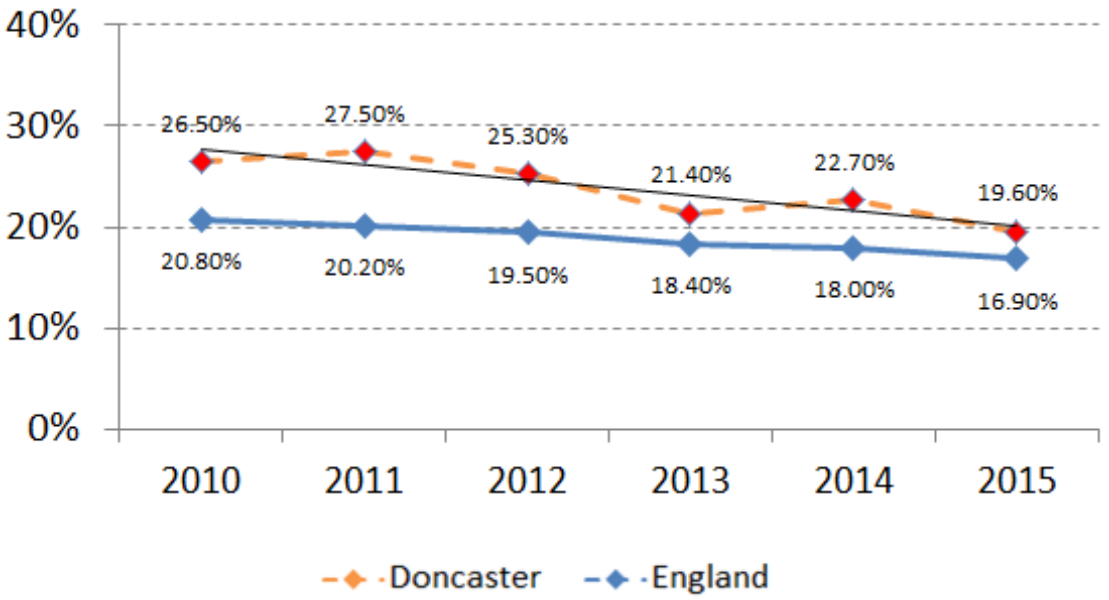
22. Whilst Doncaster is significantly higher than the national average figure for women smoking at the time of delivery this figure, 12.9%, is a significant improvement and demonstrates persistent reductions from previous years, 20.5% in 2014/15, 22.1% in 2013/14 and 22.5% in 2012/13.

23. *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 2017. Once the national strategy on* tobacco is out, our local strategy will be finalised.

Table 4: Public Health Outcomes Framework Smoking Indicators

Indicator	Period	Doncaster value	England value	Position against England
Smoking status at time of delivery - %	2015/16	12.9	10.6	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 adults- %	2015	19.6	16.9	Significantly worse than England average
Smoking prevalence – routine and manual	2015	26.5	26.5	Not statistically different from the England average

Figure 3: Smoking prevalence 18+yrs - % of current smokers in the Household Survey for England (sample of 1,500-1,800 per quarter in Doncaster). (Source - PHE, Local Tobacco Control Profiles. Updated December 2016)



Other Health Protection Indicators

24. Chlamydia

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 (see Table 5).

25. Tuberculosis

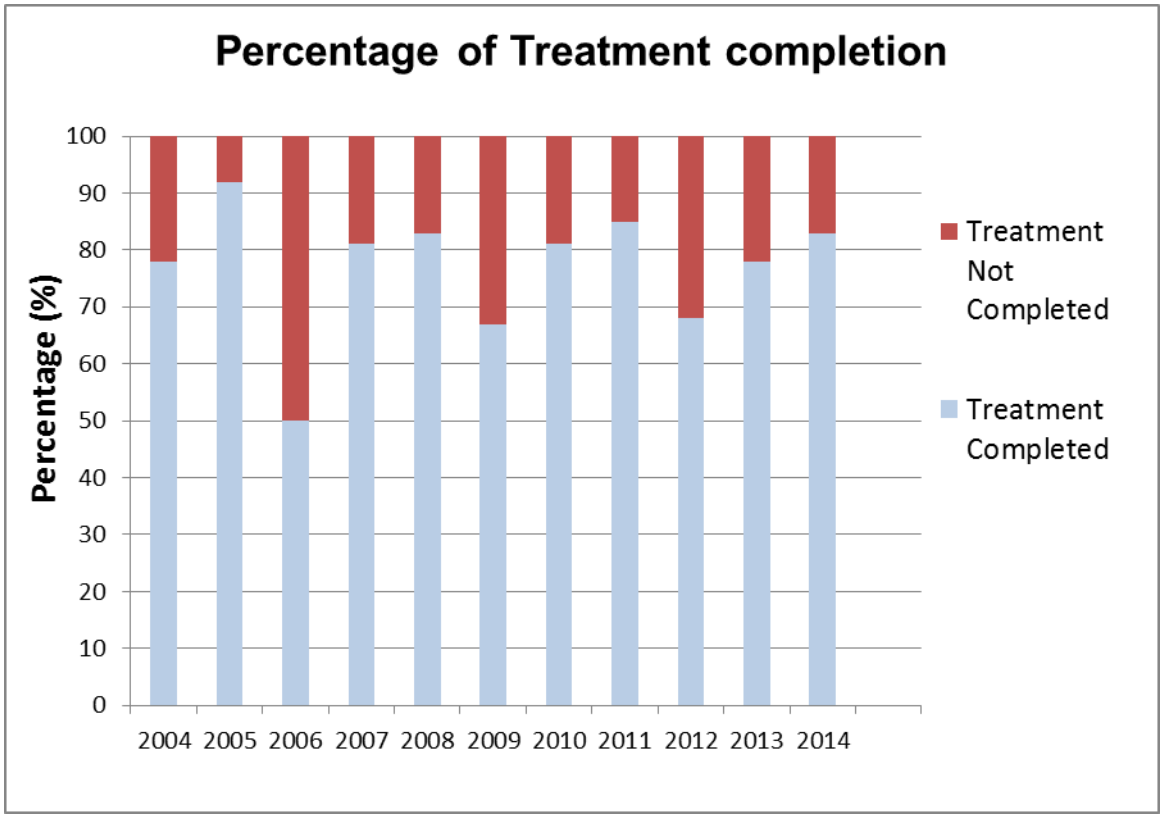
Doncaster's incidence of TB is low, and as such it is considered as a low incidence area compared with other areas in England.

The percentage of people with TB who complete treatment in Doncaster in 2014 was reported as 76.7%, according to national return. Local evidence showed that the local treatment completion rate was higher. In 2014, the total number of TB cases reported in Doncaster was 29 of which 24 (83%)[2] patients completed treatment within the year. Treatment was stopped for three[6] patients during the period as they were atypical TB cases while another patient had to stop treatment as it was thought to be medically inappropriate to continue. One[6] patient was undergoing treatment. During the period, none of the cases were lost to follow-up or death. Figure 11 showed TB treatment completion over the past decades in Doncaster.

Figures for year 1 April 2014 to 31 March 2015, based on local performance indicated that the TB treatment completion in Doncaster was 100%.

Figure 11: Percentage of TB cases completing treatment (2004-14)

[2] TB SpecNRs outcomes report March 2014 and TB SpecNRs Dashboard February 2015



Source: PHE; Tuberculosis in Yorkshire and the Humber 2013, TB SpecNRs outcomes report March 2014 and TB SpecNRs Dashboard February 2015.

The national strategy for tackling TB has been adopted locally, with a local profile of TB in Doncaster. A local TB service specification was developed and approved by Doncaster TB Steering Group on 30 November 2016. This was received by Doncaster CCG to embed into service contract.

26. *Antibiotic prescribing*

Prescribing of antibiotics is a new indicator. Doncaster's prescribing rate is more than the England rate. This is an area of work for the CCG and local GP practices.

Table 5: Public Health Outcomes Framework Other Health Protection Indicators

Indicator	Period	Doncaster value	England value	Target
Fraction of mortality attributable to particulate air pollution (PM2.5)	2015	4.5	4.7	*N/A*
Chlamydia detection rate (15-24 year olds) (per 100,000)	2015	2549	1887	*>2300*
HIV late diagnosis - %	2013 - 15	47.9	40.3	*<25*

*Treatment completion for TB - %	2014	76.7	*84.4*	*Target is >90th percentile of LAs. Doncaster is <50th percentile*
Incidence of TB (rate per 100,000)	2013-15	7.3	12.0	*<10th percentile of LAs. Doncaster is between 10th and 50th percentile.*
NHS organisations with a board approved sustainable development management plan - %	2014-15	40.0	56.5	*N/A*
Adjusted antibiotic prescribing in primary care by the NHS	2015	1.25	1.1	*<England 2013/14 prescribing rate*
Suicide rate – age standardised per 100,1000 population (persons)	2013-15	10.1	10.1	*No target*
Suicide rate (males)	2013-15	16.4	15.8	*No target*
Suicide rate (females)	2013-15	*Cannot be calculated as cases too small*	4.7	*N/A*

Specific area of focus for 2017/18

Air Quality

Background to air quality monitoring

27. Air pollution is associated with a number of adverse health impacts. It is recognised as a contributing factor in the onset of heart disease and cancer. Additionally, air pollution particularly affects the most vulnerable in society: children and older people, and those with heart and lung conditions. There is also often a strong correlation with equalities issues, because areas with poor air quality are also often the less affluent areas.

28. The statutory duty for local authorities to assess the air quality in their area was first introduced by Part IV of the Environment Act 1995 and subsequent regulations.

29. The air quality across the majority of the Borough is good with respect to the current Air Quality Regulations, 2015. However there are seven areas where this is not the case and as such they have been declared air quality management areas (AQMAs).

30. Broadly speaking the areas affect properties in:- the Town centre along Trafford Way and Church Way; along the A630 from the A1(M) to the Balby Flyover; the length of Carr House Road; in Bessacarr between the M18 and Warning Tongue Lane; Conisbrough Low Road and along the A630; Skellow adjacent to the A1 and Hickleton along the A635.

31. All of these AQMAs are due to exceedances (act of exceeding standard for air quality) of the nitrogen dioxide objective attributable to emissions from road transport.

32. The regulations also require that a local authority assess the air for PM10s. This is particulate matter which has a size of 10 microns or less, essentially dust that can be inhaled but invisible. The PM10 fraction was originally selected because it is the size that is small enough to pass through the human nasal defences and reach the lungs. No exceedances of the PM10 limits have been identified within the borough.

PM 2.5

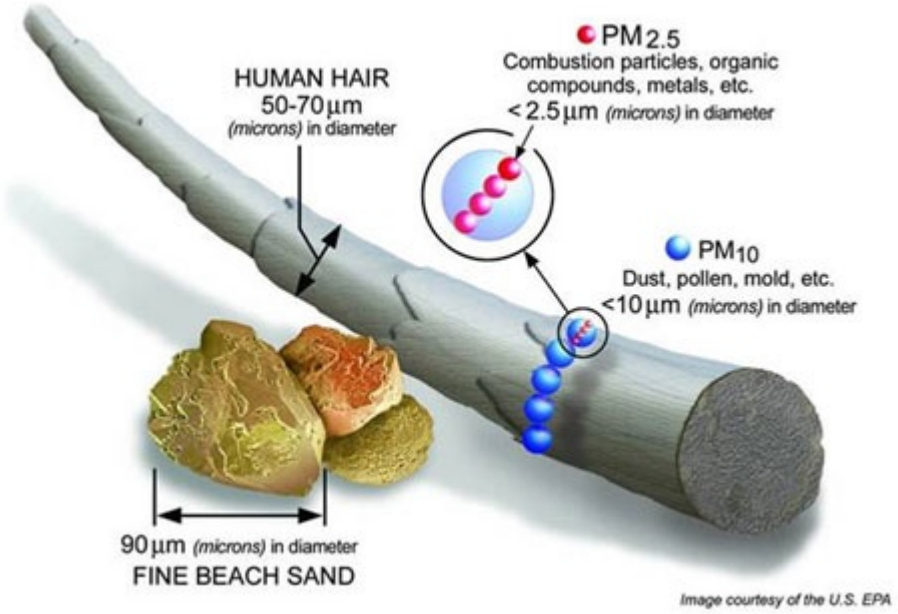
33. The Public Health Outcomes Framework (PHOF) introduced an indicator with respect to mortality attributable to PM 2.5, which is caused by human activities. This fraction is deemed small enough to pass from the lungs and into the blood stream. The intention of this indicator is to enable Directors of Public Health to prioritise action on air quality in their area and thereby reduce the burden on health. The full description of the indicator is:

    3.01 - Fraction of all-cause adult mortality attributable to anthropogenic (human-made) particulate air pollution (measured as fine particulate matter, PM2.5)

    PM2.5 is fine particular matter with a diameter of less than 2.5 micrometres.

    The difference between PM10 and PM2.5 is illustrated in Figure 4.

    Figure 4: Comparative sizes of PM10 and PM2.5



Source: https://www.quora.com/What-is-the-difference-between-PM2-5-and-PM10-with-respect-to-the-atmospheric-pollutants (Accessed online on 14 February 2017)

The % of deaths attributable to $PM_{2.5}$ is highlighted below and currently stands at 4.5% which is just below the England value (Source: Public Health England (2017).

Indicator	Period	Doncaster value	England value	Target
Fraction of mortality attributable to particulate air pollution ($PM_{2.5}$), (%)	**2013**	**5.7**	**5.3**	***N/A***
	2014	**5.5**	**5.1**	
	2015	**4.5**	**4.7**	

Statutory Policy

34. In 2016 statutory policy and technical guidance was issued by Department for Environment Food and Rural Affairs (DEFRA) within which is a requirement that local authorities (LAs) consider PM $_{2.5}$ as part of its air quality regime and thus align with the PHOF indicator.
35. DEFRA's policy guidance does not expect LAs to undertake monitoring for PM2.5, but instead make use of data from national monitoring. PM2.5 is reported annually by DEFRA.[3] However DEFRA's technical guidance encourages an increased frequency of monitoring where possible.

[3] https://uk-air.defra.gov.uk/data/pcm-data#pm25

36. The Council needs to address, to the satisfaction of both the public health and air quality perspectives, the monitoring for PM 2.5. This may have resource implications.

37. The guidance also recognises that the air quality indicator has beneficial interactions with other indicators such as active travel. Initiatives on this indicator will not only encourage more physical activity that result in reductions of excess weight, better respiratory and cardiovascular functions but also reduce transport emissions thereby contributing to improved air quality.

38. The DEFRA guidance emphasises that improving or protecting air quality requires a multi-disciplinary and integrated approach. Such an approach is ideally provided by LAs with their planning, transport, highways, public health and environmental departments along with their Health and Well-Being Boards and an overarching management structure.

Actions

39. Achieving a significant, long-term improvement in air quality by reducing emissions from traffic is a tremendous challenge, not just for Doncaster, but for the country, Europe or indeed wherever air aspirated, carbon fuelled combustion engines are used to power motor vehicles.

40. To quantify the issue, it is estimated that there are 35 million vehicles on the UK roads alone.

41. The following actions have been taken:

    a) Public Health Team has established the Doncaster Active Travel Alliance, upon which the Council's air quality officers are active member. The purpose of Doncaster Active Travel Alliance is to bring together partners to work collectively to increase and promote active travel across Doncaster. The main functions are to develop, implement and deliver a joint Active Travel Action Plan, implement and monitor the Doncaster Cycling Strategy 2014/15 action plan, and inform and involve relevant partner organisations of the Active Travel agenda as it evolves. This Alliance contributes to air quality by providing an overview of infrastructure for low- and zero-emission travel and encourage and walking and cycling.

    b) Air quality officers are actively promoting the use of low emission vehicles:

        - Ian Kellett, Senior Pollution Control Officer organised a presentation to the Directorate Leadership Team of Regeneration and Environment on the air quality and sustainability advantages of using hydrogen fuel cell vehicles (HFCV). As a follow up, a visit to a local hydrogen generator/supplier was undertaken on 31January 2017. Hydrogen fuel cell vehicles have no emission other than water vapour.
        - In conjunction with the Council's fleet management, the Council has obtained an electric car for a trial use.
        - An Air Quality Technical Planning Guidance document is at the draft stage. The aims of the guidance are to integrate air quality

considerations into the planning system whilst providing clarity and consistency for developers, planners and communities.

c) The Chief Executive of the Council has been briefed on the 2016 guidance and DEFRA's expectations as indicated within a letter from the Head of Local Air Quality Policy, Atmosphere and Industrial Emissions Team from DEFRA.

OPTIONS CONSIDERED

42. 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.

43. This report provides the Panel with an opportunity 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 PRIORITIES

	Priority	**Implications**
	We will support a strong economy where businesses can locate, grow and employ local people. • *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.
	We will help people to 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.
	We will make Doncaster a better place to live, with cleaner, more sustainable communities. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding*	

	our Communities • *Mayoral Priority: Bringing down the cost of living*	
	We will support all families to thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	Health Protection contributes to healthy families and their ability to thrive and realise their full potentials.
	We will deliver modern value for money services.	The health protection work is delivered within Public Health financial grant.
	We will provide strong leadership and governance, working in partnership.	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

44. The Health Protection Assurance system in Doncaster is a risk management system.

45. The areas for development identified in this report will further strengthen Doncaster.

46. Council's ability to manage health protection risks. Risks are reviewed by Health Protection Assurance Group, and reported to Public Health Governance Group on quarter basis.

47. One of the main risks identified and treated in the past year related to infection prevention and control in care homes in Doncaster. This risk was addressed by commissioning an infection prevention and control service, which is now in place. The risk of tuberculosis poses a threat to the local population and this is being managed through TB steering Group to ensure that the national plan is implemented locally.

48. Other risks related to low coverage of vaccination, especially Flu vaccination update among the local population.

LEGAL IMPLICATIONS

49. 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

50. Managing risk effectively will reduce potential financial implications of health protection incidents to DMBC. There is potential financial implication to the council if a system is set up to monitor air quality in relation to PM2.5.

CONSULTATION

51. 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

51. Background papers include;

- 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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Peter Dale
Director of Regeneration and Environment

Doncaster
Metropolitan Borough Council

Appendix1: 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:	Adult Health and Wellbeing, Doncaster Metropolitan Borough Council (DMBC)
Approval date of TOR:	8 October 2013
Reviewed date:	16 April 2014
Reviewed date:	17 April 2015
Reviewed date:	6 April 2016
Reviewed	2 August 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
Reviewed linkages and membership of the Group	64 April 2016
Reviewed to incorporate essential functions from District IPC (VJ and WF)	2 August 2016
Amended titles of representation from RDASH in 6.7; and clarified who are core members (6.6-6.8).	12 December 2016

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 incidents and emergencies) and any Infection Prevention and Control (IPC) issues.

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. The Health Protection Assurance Group will obtain assurance from Healthcare providers that they are compliant with the Health & Social Care Act (2015). The group will oversee and monitor all matters pertaining to Infection Prevention and Control across the Doncaster health economy.

1.5. 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 inform agencies about any serious problems or potential risks relating to Infection Prevention and Control

2.3. To monitor progress against annual infection prevention & control annual work programmes

2.4. To monitor progress against national, regional, and local IPC requirements

2.5. To ensure that health threats (including IPC) are prevented through implementation of relevant national strategies and regulations to protect public's health e.g. zero tolerance – MRSA blood stream infection.

2.6. To ensure plans exist to coordinate responses to public health / IPC outbreaks, emergencies and threats.

2.7. To ensure appropriate governance for all health protection activities.

2.8. To ensure appropriate policies and plans associated with health protection, including Infection Prevention & Control activities, are in place.

2.9. To establish local health protection assurance system and support organisations to deliver against the health protection outcomes (part of public health outcomes framework).

2.10. To receive quarterly reports, and annual reports from Provider Infection Prevention & Control committees, that demonstrate compliance with, and progress against, Infection Prevention & Control outcomes.

2.11. To receive reports from health protection areas other than IPC based on forward plan.

2.12. 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.

2.13. To scrutinise incidents (including outbreaks of infection), considering the responses of providers and commissioners so giving an overview to the Health Protection Group as well as their respective Trust board / Governing body.

2.14. To provide health protection 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.

2.15. Approve the IPC Training, Education and Audit programme for each of the healthcare providers. Share this information with commissioners

2.16. The Health protection Assurance group will receive and monitor routine alert organism surveillance data from the providers. This will be discussed and recommendations will be made where and when appropriate.

2.17. The Health Protection Assurance Group will receive and discuss (where required) the minutes from the Decontamination and Waste Management groups from respective provider organisations

3. Accountability and Reporting Arrangements

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.

3.3. The minutes of the Health Protection Assurance Group will be shared with Doncaster Clinical Commissioning Group, Doncaster & Bassetlaw NHS Foundation Trust, and Rotherham Doncaster and South Humber Trust

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. National screening programmes

4.3. Infection prevention and control (IPC) related to healthcare associated infections (Core);

4.4. Drugs and substance misuse; & Alcohol

4.5. Injury prevention (including suicide prevention)

4.6. Sexual health

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

4.8. Public health advice regarding the planning for and control of pollution; Climate change; Sustainable environment.

4.9. Regulation and enforcement (core related to IPC).

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, which is co-chaired by a Director of Public Health; and the Joint Health Emergency Planning Group (JHEPG). The LHRP and the JHEPG shall provide statement of assurance and minutes of their meetings to the Health Protection Assurance Group. Locality areas provide assurance to the LHRP 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. NHS England: Screening and Immunisation Advisory Board for South Yorkshire and Bassetlaw

5.6. Strategic Intelligence and Quality Team (Adults Health and Wellbeing, DMBC)Doncaster Children Trust

5.7. 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. Senior Nurse Quality & Patient Safety, Doncaster CCG

6.4. Representative from Screening and Immunisation, NHS England

6.5. South Yorkshire Health Protection Team, Public Health England

6.6. Director of Infection Prevention and Control and Lead IPC Nurse, DBHFT. **(Core member)**

6.7. Head of Nursing (RDASH); and Senior Clinical Nurse Specialist Infection Prevention & Control (RDASH). **(Core member)**

6.8. Representatives (2) from Regulation and Enforcement, DMBC; with Environmental Health as **core member** attending at all meetings.

6.9. Representative from Strategic Intelligence and Quality Team, (Adults, Health and Wellbeing Directorate, DMBC)

7. Co-option of members

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

7.2. Doncaster Children Trust

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, including core members.

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, Public Health Team, 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