Leeds Health & Wellbeing Board

Report author: Dawn Bailey
Health Improvement Principal,
Public Health - Health Protection
Tel: 07712 214797

Report of: **The Director of Public Health**

Report to: **Leeds Health and Wellbeing Board**

Date: **30th September 2015**

Subject: **Health Protection Board –: Annual Report**

Are there implications for equality and diversity and cohesion and integration?	x Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	x No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	x No

Summary of main issues

This paper provides the Health and Wellbeing Board with the first annual report of the progress of the Health Protection Board since it was established in June 2014.

The Health Protection Board has identified emerging health protection priorities for Leeds and has developed an annual work plan endorsed by members of the Board. The role of the Health Protection Board is to undertake the planned new duties to protect the health of the population as laid out in national guidance and in the local West Yorkshire Health Protection Specification (April 2014).

The Health Protection Board has been assured to date that robust arrangements are in place to protect the health of communities, meeting local health needs across Leeds through the development of robust assurance frameworks, including a health protection indicators report, associated reporting systems, strengthened governance arrangements and the formation of the Leeds Health & Social Care Resilience Group.

Recommendations

The Health and Wellbeing Board is asked to:

a. Endorse the Health Protection Board's Annual report.
b. Note the key priorities identified in the Health Protection Board Annual report.
c. Consider how the board can contribute and/or support the Health Protection Board.
d. Consider the priorities of the Health Protection Board in their planning for the refresh of the Joint Health and Wellbeing Strategy.

1 Purpose of this report

1.1 This purpose of this report is to provide the Health and Wellbeing Board with the first annual report of the Health Protection Board since it was established in June 2014.

1.2 The Health Protection Board has identified emerging health protection priorities for Leeds and has developed an annual work plan and dashboard endorsed by members of the Board. This report does not cover all areas under the jurisdiction of the Health Protection Board but only those that have been identified as priorities. The Board does however gain assurance from lead organisations on all health protection priorities and monitors performance through a health protection indicators report. A summary of which, based on national outcomes indicators, is provided in this report as appendix 1.

2 Background information

2.1 In March 2014, the Leeds Health and Wellbeing Board agreed to establish the Leeds Health Protection Board. The first meeting took place in June 2014 and the terms of reference were agreed by the Health and Wellbeing Board also in June 2014. The role of the Health Protection Board is to undertake the duties to protect the health of the population as laid out in national guidance and in the local West Yorkshire Health Protection Specification (April 2014). These arrangements are in line with Department of Health recommendations.

2.2 The Board meets bi-monthly to undertake the Leeds City Council duties under the Health and Social Care Act 2012 to:

- Be assured of the effective and efficient discharge of its health protection duties;
- Provide strategic direction to health protection work streams in ensuring they meet the needs of the local population;
- Provide a forum for the overview of the commissioning and provision of all health protection duties across Leeds.

2.3 The Board is chaired by Dr Ian Cameron, Director of Public Health. Members from the Leeds City Council, Public Health England, Leeds CCGs, Leeds Teaching Hospitals, Leeds and York Partnership Foundation Trust, Leeds Community Health Trust, and NHS England attend regularly. Each organisation has a responsibility and accountability for the city's health protection risks, the key performance indicators and provide regular updates on the key areas covered by the Board;

- Communicable Disease Control
- Infection Prevention & Control
- Environmental Health
- Emergency Preparedness, Resilience and Response
- Screening
- Immunisation

2.4 In addition, the Board has identified seven priorities which require focused partnership activity to improve performance in Leeds. A subgroup has been established for each priority and reports to the Health Protection Board with the exception of surveillance and communication which is being addressed through existing systems. The priorities identified by the Board are:

- Tuberculosis
- New migrant screening
- Antimicrobial resistance
- Seasonal death
- Pandemic flu
- Air quality
- Surveillance and case finding

2.5 The Health Protection Board has been established for a full year and is going well, with energy and commitment from all partners, the work programmes are progressing with the identified priorities, through the subgroups of the Board, and progress made to date is positive. The Health Protection Board has been included within the Partnership Governance Review Project being undertaken by PwC covering Boards and groups under the Health & Well Being Board. The conclusions of that review are expected in the autumn and will be taken into account in future work.

3 Main issues for the Health Protection Board – one year on

3.1 Ebola

3.1.1 The benefits of having a partnership Board became clear when a response was needed to the Ebola outbreak in West Africa. At the November 2014 meeting of the Health Protection Board a significant amount of time was dedicated to discussing the Ebola outbreak and its implications for national and local planning. Subsequently, Leeds Ebola Planning Group was formed, chaired by the Director of Public Health, to outline the partnerships and key requirements to developing a local response. Membership of the group included; PHE, NHS England, YAS, LTHT, Emergency Planning Officer for Health Protection, Leeds CCGs\Primary Care, Local Care Direct\NHS 111, LA and CCG Comms. A priority was to ensure consistent communication routes across Leeds, at a time when information was pouring out from the centre and which at times was causing confusion for front line staff. Effective links were made with the West Yorkshire Local Resilience Forum and the West Yorkshire Local Health Resilience Partnership.

3.1.2 LTHT formed an internal Ebola group and developed clear guidance which was available to staff via the LTHT intranet. LTHT had a number of patients suspected for Ebola and therefore staff were able to use the systems set up to isolate and test. All patients were negative for Ebola. These cases though have led to invaluable learning which has been incorporated into LTHT emergency planning arrangements. The learning from Ebola has also been shared amongst partner organisations.

3.2 Tuberculosis

3.2.1 Following a major decline in the incidence of TB during most of the 20th century, the incidence of TB in England increased steadily from the late 1980s to 2005, and has remained at relatively high levels ever since. Although there has been a small decline in incidence in the past two years, it is too early to tell whether this is the start of a downward trend.

3.2.2 In 2013, there were 7,290 cases reported in England. Whilst the majority of cases are a reactivation of latent infection (LTBI), the transmission, infection and potential outbreaks are a national and local public health priority as late diagnoses are associated with worse outcomes for the individual and in the case of pulmonary TB a transmission risk to the public.

3.2.3 In Leeds there has been a small decline in cases from 125 in 2009 to 116 in 2013 and 94 in 2014. This has been helped by previous investment in TB services by Leeds Primary Care Trust. TB cases cover all ages, with a consistent 78% being non-UK born.

3.2.4 TB services in Leeds are extremely busy in 2014. For example, the Leeds TB service screened 634 people as new entrants. 117 were referred to the Leeds Chest Clinic. 74 of these had latent TB Infection (LTBI) with 39 having TB treatment and the remaining 35 having chest x-ray follow up. In addition the service carries out “contact tracing and screening” with all active cases identified in 2014. 436 people were screened as contacts resulting in a further 6 active cases who all went on to receive treatment. A further 29 cases of LTBI were identified and all went onto have treatment, 19 were adults and 10 were children. Such work is important because TB is treatable and Leeds has a greater than 90% treatment completion rate in latent cases.

3.2.5 South & East CCG is an area with a higher incidence. New NHS funding has been made available for such CCG’s to enhance screening latent TB. South & East CCG has worked with Public Health England and Leeds City Council and submitted a proposal for funding for an enhanced latent TB service in Leeds. The outcome for this proposal is expected shortly.

3.2.6 This additional funding is linked to the launch in March 2015 of the Collaborative TB Strategy for England 2015 – 2020, which seeks to make significant advance in TB control. While the intended regional collaborative arrangements for the new strategy have been slower to develop than expected, Leeds Health Protection Board partners are already engaged in this process.

3.3 New migrant health screening

3.3.1 Migration to the UK has risen dramatically in the past decades, with implications for public health services. Migrants have increased vulnerability to infectious diseases (70% of TB cases and 60% HIV cases) and face multiple barriers to healthcare.

3.3.2 There is currently considerable debate as to the best approach to infectious disease screening in this hard-to-reach group, and there is an urgent need for

innovative approaches. There is a lack of research focused on the specific experience of new migrants or seeking views of new migrants in identifying ways forward.

3.3.3 Recent research of new migrant groups in London has indicated that there are significant barriers to screening, acceptability of screening, and innovative approaches to screening for four key diseases (HIV, TB, hepatitis B, and hepatitis C). Current screening models are not perceived to be widely accessible to new migrant communities. Dominant barriers that discourage uptake of screening include disease-related stigma present in their own communities and services being perceived as non-migrant friendly. New migrants are likely to be disproportionately affected by these barriers, with implications for health status.

3.3.4 Screening is certainly acceptable to new migrants, however, services need to be developed to become more community-based, proactive, and to work more closely with community organisations; findings that mirror the views of migrants and health-care providers in Europe and internationally. Awareness raising about the benefits of screening within new migrant communities is critical.

3.3.5 Locally work is being progressed to identify high prevalence areas for Hep B, Hep C and TB to plan a targeted integrated approach of identification and screening. This work is in the early stages of development and is a priority for the Health Protection Board in 2015/16.

3.4 Antimicrobial Resistance

3.4.1 Antimicrobial resistance threatens the effective prevention and treatment of an ever-increasing range of infections caused by bacteria, parasites, viruses and fungi. This is now a government priority as it is an increasingly serious threat to global public health. The UK government now has a Antimicrobial Resistance Strategy and Antimicrobial Resistance is now on the Department of Health's risk register Action is required across all government sectors and society.

3.4.2 As an example, nationally of antimicrobial resistence, since 2003, there has been a sustained increase in the numbers of Carbapenemase Resistant Enterobacteriaceae (CPE) which is a relatively new and highly resistant infection. Identification of CPE in England by PHE has risen from fewer than 5 patients in 2006 to over 600 in 2013. In England, approximately two thirds of NHS trusts have had between 1 and 20 patients identified with CPE carriage or infection over the past 5 years. Two Trusts in Manchester have had more than 100 patients identified with CPE during the same period, while in comparison Leeds, so far, has only had a handful of positive cases.

3.4.3 Antimicrobial stewardship is a national programme to take action to address drug resistant infections. Led by the Leeds Clinical Commissioning Groups, partners in the city are working proactively to ensure that antimicrobial stewardship is a priority and that prescribing trends continue to improve by:

- ensuring antibiotics are only prescribed when clinically needed
- ensuring all prescribing is in line with local and national guidance

- CCGs working with individual practices that have above average antibiotic prescribing
- CCG's working with individual practices that have C.Difficile or MRSA cases where the practice's prescribing is a contributing factor
- To increase patient and public awareness of when antibiotics are useful.

3.4.4 Leeds has historically had high levels of the Healthcare Associated Infections Meticillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C.difficile). C.difficile is most closely linked with antimicrobial prescribing, as the infection most commonly occurs following a course of antibiotics. Steady progress is being made to reduce C.difficile infection in Leeds. In 2014/15, Leeds North and Leeds West CCG's completed the year within their NHS England allocated threshold. Leeds South and East CCG exceeded their threshold by 5 cases. However all the Leeds CCGs maintained a reducing trend, whilst nationally there was a 6% increase in C.difficile infection.

3.4.5 Work has been progressed by the CCGs and Leeds Teaching Hospitals across the City, which has ensured that prescribers in Leeds, including GPs, are engaged in preventative action to reduce the burden of C.difficile through changes in prescribing practices. The prescribing data collected locally indicates that the prescribing of broad spectrum antibiotics has reduced to below the national target which is an important positive indicator for reducing the burden of drug resistant infections.

3.5 Seasonal deaths and seasonal flu

3.5.1 In Leeds, as in the rest of the country, more people die in the winter than in the summer. Nationally, there has been concern for many years over the number of excess deaths occurring in winter – although in 13/14 England and Wales had the lowest number of such deaths since records began in 1950/51.

3.5.2 In Leeds there are 380 extra winter deaths on average per year (based on a 3 year rolling average) (Public Health England 2014). Many of these deaths are avoidable and are primarily due to heart and lung conditions from cold temperatures rather than hypothermia. The reasons why more people die in winter are complex and interlinked with fuel poverty, poor housing and health inequalities as well as circulating infectious diseases, particularly flu and norovirus, and the extent of snow and ice. The winter period not only sees a significant rise in deaths but also a substantial increase in illnesses – which adds to the pressures on health and social care services.

3.5.3 The response by Leeds in 2014/15 was through the Leeds Cold Weather Plan. This was based in the Department of Health's Cold Weather Plan for England and aimed to firstly raise the public's awareness of the harm to health from cold and secondly to provide support to the most vulnerable.

The Leeds Cold Weather Plan for 2014/15 was also based on the evaluation by Leeds Metropolitan University of the 2012/13 Plan. The evaluation had highlighted how schemes represented value for money, that beneficiaries experienced improved levels of emotional and physical comfort, less susceptibility to cold related illnesses and felt less socially isolated.

3.5.4 The Department of Health announced that the usual Warm Homes Healthy People Fund would not be available for 14/15 and so LCC Public Health funded this shortfall.

The Leeds Cold Weather Plan for 14/15 included extensions of existing services that can be scaled up at short notice targeting vulnerable people. The plan included:

- A systematic approach to cascading the Met Office alerts across health & social care. This enables health & social care workers to identify and support vulnerable people.
- Warm Homes Service in 2014/15. Leeds North and Leeds South & East CCGs and Public Health each contributed to a crisis and strategic heating fund, administered through Care & Repair's Warm Homes Service. Leeds City Council provided funding for a Warm Homes Coordinator who supported vulnerable people with health condition made worse by living in a cold, damp property with inadequate heating or insulation by providing advice and support to improve their housing conditions . The Warm Homes Service Caseworker undertakes a home visit to carry out a holistic assessment of their needs. As well as assessing their heating requirements, this may also include a benefit check, fire safety check, referrals to other agencies and accessing other Care & Repair services. Since December 2014 the Warm Homes Service has supported 364 people to remain at home by providing vital heating repairs. Work included: carry out repairs to existing heating systems, including boiler servicing; referrals for cavity wall and loft insulation measures; energy efficiency advice and referrals to other agencies; thermostatic radiator valves; draught proofing; carbon monoxide detectors; gas fire servicing; flue liners;
- An expanded Green Doctor Service, to target areas of high fuel poverty. This service included advisors supporting vulnerable clients to resolves problems with energy suppliers, help them work through the switching process and to clear debts. For example, in the winter period from December 2014 – April 2015 the Green Doctor team delivered 326 home visits, installing a total of 1333 measures. This has assisted 661 residents:

    - 23% housed a resident over the age of 60.
    - 35% housed young children
    - 59% of households received welfare support
    - 38% housed someone with a disability or long term health condition
    - 63% of households have a low income.
    - Measures installed:
        - 286 Energy Saving bulbs
        - 598 reflective radiator panels
        - 65 water saving devices
        - Draft-proofing 170 doors and windows
    - Estimated annual savings from measures £ 7,510
    - Estimated lifetime savings from measures £ 76,760
    - Estimated annual savings from advice £ 6,370

- A community small grants fund of £65k, administered by Leeds Community Foundation allowed groups to assist vulnerable people. 34 grants were awarded ranging from £500 to £4,000 with 4,158 beneficiaries. Projects included:
  - Staying Safe and Healthy clubs were run in 11 locations to increase resilience and wellbeing during winter. Topics included healthy eating, safe footwear, warm clothing, travelling safely, safety in the home.
  - Pre-pay cards were purchased so that volunteer home visitors could pay for things that were urgently needed e.g. energy bills, basic food, warm clothing in response to beneficiary need. Energy bills were the most common, often resulting in reconnection of services. Red Cross would then work with beneficiaries to create a plan to avoid being in a similar situation again where appropriate
  - Provision of thermal undergarments and warm outer wear (scarves, gloves, and snuggies) to lunch clubs beneficiaries. Many are reluctant to turn the heating on due to the cost.
- Public Health continued to fund CAB and Welfare Rights advice in Primary Care (GP practices, Health Centres) and Mental Health (inpatient wards, day centres) which contributes towards income maximisation and CAB also help clients with utility enquiries.
- The CCG Patient Empowerment Project was implemented in 2014/15 to increase awareness, support and access to existing local services including promotion of winter wellbeing messages and services.
- Leeds City Council distributed 4297 Winter Warmth packs to vulnerable people.
- The Leeds City Council Stay Winter Wise web page promotes Winter Well Being Services and provides advice including on how to stay warm at home, how to reduce energy bills, advice on flu jabs.
- In addition, the Clinical Commissioning Groups promoted winter wellbeing messages and services. Citizens Advice Bureau and Welfare Rights advices continued to be provided in a variety of health settings.
- Leeds City Council continued to engage with partners to tackle fuel poverty using three distinct approaches:
  - Improving energy efficiency in homes
  - Targeted support to households experiencing fuel poverty
  - Proactive interventions targeting vulnerable people.

3.5.5 Looking ahead, the multi-agency Leeds Adverse Weather Group (covering both hot and cold weather) is already working on the 2015/16 Winter Plan.

3.5.6 A factor in seasonal deaths and in demand for health and social services in seasonal flu – the description for influenza which is an acute highly infectious viral infection of the respiratory tract is highly infectious.

3.5.7 The risk of serious illness from influenza is higher amongst children under six months of age, older people, and those with underlying health conditions such as respiratory disease, cardiac disease, and pregnant women. It is important that

every effort is made to reduce the rate of infection and prevent the spread of the virus.

3.5.8 During the 2014/15 seasonal flu campaign a total of 156951 vaccinations were delivered. As can be seen in Appendix 1 each of the three Clinical Commissioning Groups achieved greater coverage then the national target of 75% for the over 65yrs.

3.5.9 Although GP practices are primarily responsible for offering the vaccine to their eligible patients in 14/15, NHS England worked with Community Pharmacy West Yorkshire to commission pharmacies to deliver to over 65s, at risk patients and pregnant women to increase uptake and offer more patient choice. Pharmacies delivered 2,726 vaccinations across the 3 CCG areas in 14/15, including for those who'd never previously had flu vaccination.

The seasonal flu campaign also targets those under 65yrs and at clinical risk e.g. chronic health conditions, those immunosuppressed. Appendix 1 shows that the uptake rates has dropped for all three CCG's and are just below the national figures. However, there has been a huge increase in the number classified being "at risk" – 15,000. One CCG has gone from 700 at risk patients with liver disease to 4,500. This is being investigated by NHS England.

Each of the CCG's has shown a small improvement in uptake for pregnant women compared to the previous year to – Leeds West (55.4%), Leeds North (57.4%), Leeds South & East (56.5%).

The 2014/15 uptake for flu vaccination for 2, 3, & 4 year olds are set out below. As can be seen each CCG has greater uptake rates than for England as a whole.

	Aged 2	Aged 3	Aged 4
NHS Leeds North CCG	46.4%	47.7%	39.8%
NHS Leeds West CCG	42.7%	48.3%	34.0%
NHS Leeds South & East CCG	42.4%	46.4%	36.8%
England	38.5%	41.3%	32.9%

3.5.10 Work has already commenced between all parties on the Health Protection Board for the 2015/16 seasonal flu vaccination programme including to increase staff uptake, improve data reporting systems, developing the role of pharmacists. For example Leeds City Council plans to increase the availability of the vaccine to 1200 identified front line staff from 850 last year. There is also work to assure parents about the porcine content to improve uptake of the children's nasal flu vaccine.

3.5.11 Because of the changing nature of influenza viruses, the World Health Organisation monitors the viruses and each year it makes recommendations about the strains to be included in vaccines. In most recent years, the vaccines have closely matched the influenza. In 2014/15, however, a drift in the viruses was observed and the vaccine did not provide optimal protection. Mismatches between the vaccine and circulating viruses do occur from time to time and explains the variation in estimates of vaccine effectiveness. The Leeds seasonal

flu communications plan is being developed to challenge the negative press on the vaccine.

3.6 Pandemic Flu

3.6.1 The potential for an outbreak of Pandemic Influenza has been highlighted as a risk by the UK government. Following changes in the local health and social care economy the Local Authority and partner organisations have, in 14/15 revisited local pandemic influenza response plans to ensure that the roles and responsibilities of each organisation are clearly identified and recognised as part of the citywide approach to tackling an influenza pandemic .

3.6.2 To progress this work the Leeds Pandemic Influenza Task and Finish Group has been formed to support partner organisations in the development of both their own individual plans and an overarching Pandemic Influenza Response Plan for the city. This group includes Resilience Managers and Infection Control staff from the three Leeds Health Trusts and representatives from; Adult Social Care, Children's Services, Public Health, St Gemma's Hospice (on behalf of the three Leeds Hospices), Nuffield Leeds, the Leeds CCGs Urgent Care Team, NHS England and Public Health England.

3.6.3 Alongside the health response to an Influenza Pandemic there is the requirement for the Council to mobilise a range of Directorates to support the overall response. Each service highlighted as critical within the Council has a Business Continuity Plan in place outlining how that service will be maintained in the event of a pandemic outbreak. Some departments have also been flagged up as having wider specialist roles to play in support of the wider city pandemic response for example Adult Social Care and Children's Services. The Local Authority is responsible for the development of a Management of Excess Deaths Plan. This plan is in the process of being developed with key directorates including Bereavement Services and Registrars.

3.6.4 On Friday, 15th May 2015 a Leeds Pandemic Influenza Exercise – Sekhmet was hosted by the Local Authority Health Protection and Resilience and Emergencies Teams. The Exercise was well attended and received by a broad range of regional and local organisations. A lessons learned\feedback document is to be compiled and shared with participants with the intention that these will be incorporated into local plans for submission to respective Executive Boards for ratification.

The over-arching Leeds Pandemic Influenza Response Plan will be presented to the Leeds Resilience Health & Social Care Group for agreement prior to submission to the Leeds Health Protection Board in Autumn 2015 and from then to the Leeds Health & Well Being Board.

3.7 Air Quality

3.7.1 Poor air quality causes the equivalent of 350 deaths per year in Leeds. It is now known that there are no safe levels of the main pollutants of concern, meaning that any reduction will achieve health benefits. Reducing particulate matter by 10µg/m would extend life expectancy in the UK by five times more than

eliminating casualties on the roads, or three times more than eliminating passive smoking. The main outcomes of air pollution are cardiovascular and respiratory diseases, and it has been listed as a Class 1 carcinogen. There is therefore a clear public health case for local action to improve air quality.

3.7.2 In 2014-15, on behalf of the Health Protection Board Public Health in Leeds City Council has worked to understand the current City and region-wide status of air quality, to engage a number of partners, and to ensure that public health is able to effectively influence the air quality agenda at a local and regional level.

3.7.3 In December 2014 the results of the DEFRA funded Leeds City Council Low Emission Zone (LEZ) Feasibility Study were published. This reported found that although significant reductions in emissions could be achieved by a LEZ, these could also be achieved through alternative measures and policies that will not require the additional resources necessary to enforce a LEZ. The study found that no single intervention will deliver compliance with air quality objectives, and that we need a combination of measures to achieve a significant reduction. In particular it reported that:

- Deprived inner city areas, and areas adjacent to major roads are the most likely to be affected by poor air quality and to suffer health effects.
- Intervention is required: The natural replacement of the “Leeds Vehicle Fleet” will not be sufficient on its own to enable us to meet air quality objectives.
- Interventions to reduce emissions will have both direct (reduction in number of deaths attributable to air quality), and indirect (improvements to physical and mental health from a shift to active travel) impacts on health.
- Measures to improve bus and HGV emissions, and measures to reverse the increasing use of diesel cars will give the best improvements in air quality.
- Promoting a modal shift to active travel is cost effective.

3.7.4 Leeds City Council together with the West Yorkshire Combined Authority and other partners, is committed to translating the evidence from the LEZ Study into action. This includes public health playing a key role in the development of the West Yorkshire Low Emission Strategy (that will go out for consultation and adoption within the five West Yorkshire local authorities in Summer 2015) and developing specific actions for Leeds. As a minimum we must meet our legal obligations to improve air quality to within the objectives set by the Air Quality Regulations. But we want to go beyond this to minimise the negative health impacts of air pollution by providing the cleanest air that we can.

3.7.5 In addition, through the Adverse Weather Group, the Health Protection Board will review the impacts on health and health & social care services from a prolonged episode (or up to 20 days) of poor air quality. This will include plans to communicate risk; to support those people at risk and to manage surge and demand.

3.8 Tour de France and TdY

3.8.1 On Saturday, 5th July 2014 Leeds hosted the Grande Depart for the Tour de France. The event provided a series of challenges to the safe delivery of health and social care services over the weekend of 5th\6th July and led to the formation

of the Leeds Resilience Health & Social Care Group and the Adult Social Care Project Group. The Leeds Resilience Health & Social Care Group combined Leeds City Council with partner organisations in a joint approach to the planning and delivery of critical services over that weekend. The Adult Social Care Project Group membership consisted of representatives from each department of ASC likely to be impacted by the event. Key challenges set by the event included:

- eight hour road closures
- maintaining blue light\emergency routes
- maintaining access to Leeds General Infirmary
- access to clients for social care
- access to day centres
- access for meals at home and the equipment service
- communication to staff, both NHS, ASC and Commissioned Services
- information shared with hospitals, nursing homes, day centres
- health advice and communication to the general public

Following the Tour a debrief meeting was held for both the Health & Social Care Resilience Group and the Adult Social Care Project Group. This event generated valuable feedback which has been incorporated into a lessons learned and recommendations document.

3.8.2 In May 2015 Leeds hosted the day 3 finish of the first ever Tour de Yorkshire. Once again this became the main focus of the Leeds Health & Social Care Resilience Group and the Adult Social Care Project Team was re-formed in order to undertake the planning for the day. The Finish line was in Roundhay Park, an area with a high proportion of nursing and care homes. Once again a full risk assessment was carried out for health and social care services and appropriate actions were put in place to mitigate the risks highlighted.

One area of health concern was the amateur Sportive which took place on the morning of the Tour de Yorkshire and attracted over 5,000 riders. The race was divided into three routes of varying difficulty and set off and ended at Roundhay Park. The organisers ‘Human Race’ had arranged for medical cover from the British Red Cross to cover the participants along the route.

For both races the Emergency Planning Officer for Health Protection was based within the local bronze command in order to manage any ‘on the day’ issues. The lessons learned for health and social care will be fed into the Council’s Debrief report and the recommendations noted for future events. For both events regular planning updates and assurance was presented to the Leeds Health Protection Board.

3.9 Screening

3.9.1 NHS England West Yorkshire Screening and Immunisation Service is responsible for the commissioning of screening programmes nationally under the Public Health Functions Agreement (Section 7A).

3.9.2 Progress on performance is considered at the Health Protection Board for the following screening programmes cervical, breast, bowel, AAA (Abdominal Aortic

Aneurysm), diabetic retinopathy, new born blood spot, ante-natal infectious diseases, Down's syndrome, Thalassemia, sickle cell, new born hearing.

For the purpose of this report three areas of concern are highlighted – cervical, breast, cancer screening.

3.9.3 Women attending for cervical screening in Leeds is declining and this reflects the position across England. Against the uptake target of 80%, Leeds has slipped from just under 80% to around 75%. Breast cancer screening uptake too has fallen although each CCG is still just above the minimum standard of 70%. Again, this mirrors the national position where screening uptake has fallen for the third year running.

NHS England has established a Leeds plan to improve coverage. There is a particular focus on addressing inequalities in terms of access of defined at risk groups (more needed)

3.9.4 The Bowel Screening programme meets the National Service specification target of 52%. However, there is an aspirational national target of 60%. In 2014/15 though, the priority for the Health Protection Board has been to extend the ages covered by the programme. Previous operational difficulties were overcome by commissioners and providers so that the programme age was extended in January 2015.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 This report has been developed in collaboration with the members of the Health Protection Board including NHS England, Public Health England, LTHT, Leeds Community Health Care, Leeds and York Partnerships Trust, Leeds City Council, Leeds CCGs. All organisations consult and engage with the affected population groups.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 While there are no direct Equality/Diversity/Cohesion or integration implications of this paper, all organisations concerned are actively involved in work in this area, and the raising of the standard of quality care in the city contributes directly to access and equality issues.

4.3 Resources and value for money

4.3.1 There are no direct resources/value for money implications arising from this paper.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no legal or access to information implications of this report. It is not subject to call in.

5 Risk Management

5.1 A robust evidence base is vitally important in ensuring our collective approach to tackling health and wellbeing inequalities. We aim to ensure that we continually strengthen our approach to understanding the health protection risks in Leeds; this process is managed through the Health Protection Board.

6 Conclusions

6.1 This paper provides the Health and Wellbeing Board with the first annual report of the progress of the Health Protection Board since it was established in June 2014.

6.2 The Health Protection Board has identified emerging health protection priorities for Leeds and has developed an annual work plan and comprehensive dashboard endorsed by members of the Board.

6.3 The Health Protection Board has been assured to date that robust arrangements are in place to protect the health of communities. The Board gains assurance that these arrangements meet local health needs across Leeds through the development of robust assurance frameworks, including a health protection indicators report, associated reporting systems, strengthened governance arrangements and the formation of the Leeds Health & Social Care Resilience Group.

7 Recommendations

7.1 The Health and Wellbeing Board is asked to:

a) Endorse the Health Protection Board's Annual report.

b) Note the key priorities identified in the Health Protection Board Annual report.

c) Consider how the board can contribute and/or support the Health Protection Board.

d) Consider the priorities of the Health Protection Board in their planning for the refresh of the Joint Health and Wellbeing Strategy.

8 Background documents[1]

8.1 Appendix 1 Health Protection Indicators report.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.