#healthyplym

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HEALTH AND WELLBEING BOARD

Thursday 7 March 2019
10.00 am
Warspite Room, Council House

Members:
Councillor Tuffin, Chair
Councillors Mrs Bowyer and McDonald.

Statutory Co-opted Members: Strategic Director for People, Director of Children's Services, NEW Devon Clinical Commissioning Group Representatives, Director for Public Health, Healthwatch Representative and NHS England.

Non-Statutory Co-opted Members: Representatives of Plymouth Community Homes, Plymouth Community Healthcare, Plymouth NHS Hospitals Trust, Devon Local Pharmaceutical Committee, University of Plymouth, Devon and Cornwall Police, Devon and Cornwall Police and Crime Commissioner and the Voluntary and Community Sector.

Members are invited to attend the above meeting to consider the items of business overleaf.

This meeting will be webcast and available on-line after the meeting. By entering the Council Chamber, councillors are consenting to being filmed during the meeting and to the use of the recording for the webcast.

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Tracey Lee
Chief Executive

Health and Wellbeing Board

1. Appointment of Vice Chair

The Committee will be asked to appoint a Vice Chair.

2. Apologies

To receive apologies for non-attendance by Health and Wellbeing Board Members.

3. Declarations of Interest

The Board will be asked to make any declarations of interest in respect of items on this agenda.

4. Chairs urgent business

To receive reports on business which, in the opinion of the Chair, should be brought forward for urgent consideration.

5. Minutes **(Pages 1 - 8)**

To confirm the minutes of the meeting held on 10 January 2019.

6. Questions from the public

To receive questions from the public in accordance with the Constitution.

Questions, of no longer than 50 words, can be submitted to the Democratic Support Unit, Plymouth City Council, Ballard House, Plymouth, PL1 3BJ, or email to democraticsupport@plymouth.gov.uk. Any questions must be received at least five clear working days before the date of the meeting.

7. Chairs Report - Verbal Update

8. Care Quality Commission Action Plan **(Pages 9 - 24)**

9. Integrated Commissioning Next Steps **(Pages 25 - 34)**

10. NHS Long Term Plan **(Pages 35 - 38)**

11. Tackling Physical inactivity in Plymouth - update **(Pages 39 - 42)**

12. Impacts of Poor Quality Housing on Health **(Pages 43 - 48)**

13. Loneliness Action Plan **(Pages 49 - 56)**

14. Health Protection Report for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council and Cornwall and the Isles of Scilly Councils 2017-2018 **(Pages 57 - 104)**

15. Work Programme **(Pages 105 - 106)**

The Board are invited to add items to the work programme.

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Health and Wellbeing Board

Thursday 10 January 2019

PRESENT:

Councillor Tuffin, in the Chair.
Councillor Mrs Bowyer, Vice Chair.
Councillor McDonald.

Carole Burgoyne MBE (Strategic Director for People), Ann James (University Hospital Plymouth NHS Trust), Dr Adam Morris (Livewell SW), Ruth Harrell (Director of Public Health), Professor Bridie Kent (University of Plymouth), Craig Downham (Devon and Cornwall Police), Sue Shaw (Plymouth Community Homes – substituting John Clark), Anna Coles (Strategic Commissioning Manager) and Justin Robbins (Healthwatch substituting for Nick Pennell).

Apologies for absence: David Bearman (Devon Local Pharmaceutical Committee), Alison Botham (Director of Children's Services), Craig McArdle (Director of Integrated Commissioning), Dr Shelagh McCormick (NEW Devon CCG), John Clark (Plymouth Community Homes) and Nick Pennell (Healthwatch).

Also in attendance: Sarah Ogilvie (Consultant in Public Health), Dan Preece (Advanced Public Health Practitioner), Gary Wallace (Public Health Specialist) and Amelia Boulter (Democratic Support Adviser).

The meeting started at 10.00 am and finished at 11.52 am.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

61. Appointment of Vice Chair

Agreed to appoint Councillor Mrs Bowyer as Vice-Chair for this meeting.

62. Declarations of Interest

There were no declarations of interest made in accordance with the code of conduct.

63. Chairs urgent business

There were no items of Chair's urgent business.

64. Minutes

Agreed that the minutes of 4 October 2018 were confirmed.

65. **Questions from the public**

There were no questions from members of the public.

66. **Chair's Report**

The Chair (Councillor Tuffin) presented his report to the Board and highlighted the following key points –

(a) attendance at the National Children and Adult Services Conference (NCASC) in November and the opportunity to share learning and innovation with other local authorities;

(b) that the CQC Local System Review, Beyond the Barriers report now published. They would monitor the report against the local system plan and once finalised by the CQC at a future Health and Wellbeing Board meeting;

(c) the recent LGA publication 'Shifting the Centre of Gravity' launched at the NCASC references the innovative work that had been delivered in the City;

(d) the Motor Neurone Disease (MND) Association would be facilitating a workshop with Members in February this follows an agreement to adopt the Charter across the city;

(e) NHS published the 'NHS 10 Year Plan' and the Chair invited Ann James (Chief Executive, University Hospital Plymouth NHS Trust) to provide an overview. It was highlighted that –

- the plan includes 9 domains of improving health and wellbeing outcomes;
- the work of this board aligns with the plan;
- Summary of the plan can be provided;
- Board to look at this at a future meeting.

67. **STP Update**

Carole Burgoyne MBE (Strategic Director for People) was present for this item and referred to the report contained within the agenda.

In response to questions raised, it was reported that -

(a) at an operational level locally they work very closely with the fire service but were unaware of the fire authority's involvement at an STP level. Carole Burgoyne and Ann James would feed this back to the STP Board;

(b) three health and wellbeing hubs had already opened with a further two opening over the next couple of months. It was reported that fantastic work and case studies were coming out from the hubs;

(b) there was a real appetite for the fire authority to work more closely with the police. This had resulted in a project which included a PSCO teaming up with a fire officer undertaking community visits to start addressing joint risks;

(d) the Chair reported that he had met with the Chairs of the Devon and Torbay Health and Wellbeing Boards to look at shared issues.

Agreed that the Health and Wellbeing Board to receive a report summarising the work of the Health and Wellbeing Hub's first 12 months including case studies.

68. **Aspiring Integrated Care System - Population Health Management**

Ruth Harrell (Director of Public Health) provided a verbal update to the Board, it was highlighted that -

(a) this was a programme led by NHS England around helping the STP in their preparations in becoming an integrated care system;

(b) there were three work streams; finance, governance and population health management and they were currently focussing on population health management;

(c) population health management aims to understand the health needs across different segments of the population. Their ambition was to look at the person as a whole and to align with the triple aims of improving the patient experience, improving health outcomes and ensuring that the system was cost effective;

(d) as part of the ambition was to look at the data flows across the city and across all partners focusing on health and wellbeing. This would allow us to understand and predict the needs at a patient level enabling us to intervene earlier. For example, identify people that were 'pre-frail' and putting interventions in place at a lower level before becoming acute.

In response to questions raised, it was reported that Public Health would be meeting with Plymouth Community Homes (PCH) to undertake collaborative work around identifying people that were 'pre-frail' as part of the population health management.

Agreed that the Health and Wellbeing Board at a future meeting receive a progress report on Population Health Management.

69. **Thrive Plymouth Update - People Connecting through Food**

Sarah Ogilvie (Consultant in Public Health) provided a verbal update. Due to technical difficulties a video clip was not shown but would be emailed to the Board. It was highlighted that -

(a) the theme for Thrive Year 5 was people connecting through food. They were working in partnership with Food Plymouth as the connecting platform for all things food related across the city;

(b) they were focussing on achieving the silver award for sustainable food cities. They currently have the bronze award and if successful Plymouth would be one of only four local authorities to achieve this;

(c) the award was designed to recognise and celebrate the success of places taking a joined up holistic approach to food and achieving significant positive change on a range of food issues;

(d) to achieve the award an action plan had been developed against 6 key areas and have asked partners to pledge their support –

- promoting healthy and sustainable food to the public;
- tackling food poverty, diet related ill health and access to affordable healthy food;
- building community food knowledge;
- promoting a vibrant and diverse sustainable food economy;
- transforming catering food procurement;
- reducing waste and illogical footprint of the food system.

(e) they would be hosting a number of events over the year and have developed a training package to enable partners to encourage and support local action within the community.

In response to questions raised, it was reported that –

(f) it had been challenging working with the large supermarkets, however Food Plymouth work closely with the food retailers particularly around sugar smart, promoting healthy options and calorie labelling. They were also looking to undertake a project working with takeaway outlets to reduce calorie content and portion sizes. Also lobbying larger organisations to take action against sugar and healthier options;

(g) they were fully evaluating the local impact of the sugar smart programme and Thrive Plymouth they would report on progress against Year 5 as part of the Director of Public Health's Annual report.

70. **Vaping and E-Cigarettes**

Dan Preece (Advanced Public Health Consultant) was present at the meeting and referred to the report in the agenda. A presentation was also provided, it was highlighted that –

(a) smoking was in decline both in England and Plymouth with an estimated 10,000 fewer smokers in Plymouth since 2011;

(b) of the remaining people that do smoker (around 39,000 people) still suffer from the devastating harm that tobacco causes and was the primary cause of ill health and health inequalities within the city;

(c) the annual costs of smoking in 2018 for Plymouth was £63 million;

(d) Plymouth's approach to tobacco –

- enforce regulations to disrupt illegal and under age sales;
- reduce starting through positive peer influence;
- support people to stop smoking;
- enable people to stop smoking;
- provide information.

(e) that the most effective way to quit smoking was to use expert behaviour support such as the Stop Smoking Service combined with nicotine replacement and/or using e-cigarettes;

(f) Public Health England's position on e-cigarettes was that they were 95% safer than tobacco. An e-cigarette doesn't contain any tobacco.

In response to questions raised, it was reported that -

(g) 5% harm would come from breathing in hot vapour and the ingredients used, however, the scale of harm was much lower than a cigarette. There were health benefits for a smoker switching from cigarettes to e-cigarettes;

(h) a response would be provided on the amount of people in Plymouth living with a significant smoking related illness which impacts on their quality of life and of that cohort what was the increased rate in unplanned admissions into acute services?

(i) e-cigarettes were the same as using a nicotine replacement patch and can be affective to help people quit smoking.

The Board were encouraged to look at their own workplace policies on smoke free and vaping. Guidance was available for organisations to help them develop their policies to encourage people to switch from tobacco to e-cigarettes.

It was agreed that the Health and Wellbeing Board adopt the following position on vaping and e-cigarettes –

1. We recognise that e-cigarettes have a key role in driving down rates of smoking in Plymouth.

2. Vaping with e-cigarettes is estimated to be 95% less harmful than smoking tobacco.

3. Consumers and the public deserve protection from potential harms of vaping and the use of e-cigarettes through restrictions on their sale and marketing to children and controls to ensure safety and quality.

4. Stopping smoking is the best thing a person who smokes can do for their health. Our advice to smokers is to consider switching from smoking tobacco to vaping with e-cigarettes.

5. Ongoing surveillance and research is crucial to detect long-term impacts on individuals and communities. If any new risks emerge, or guidance from Public Health England changes, we will revise our position on e-cigarettes. In the meantime, we have a vital responsibility to communicate the evidence that is emerging and currently that which is sufficiently robust to help guide us.

6. We need clear and consistent messages to the public. There is widespread public confusion about e-cigarettes and research shows people's perceptions have become less accurate. The evidence tells us e-cigarettes are less harmful than tobacco, but a growing number of people believe e-cigarettes are at least as harmful as tobacco, or say they don't know. This inaccurate view could be preventing smokers who have never tried e-cigarettes from quitting. We have a duty to provide clear messages to the public, based on the evidence. E-cigarettes carry a fraction of the risk of smoking and can help even some of the most addicted smokers to quit and smokers who switch to vaping reduce the risks to their health dramatically.

71. **Avoidable Deaths Approach**

Gary Wallace (Public Health Specialist) was present at the meeting and referred to the report in the agenda. A presentation was also provided, it was highlighted that –

(a) 29 services working together as a whole system approach around shared risk, learning and integrated care, common approach, dispersed leadership and transparency;

(b) there are two key structures and both groups generate learning –

- System Optimisation Group – strategic level
- Creative Solutions Forum – operational group

(c) our aim to reduce future deaths and focussing on alcohol and drug related deaths, suicide, domestic abuse leading to homicide, homicide by a person with mental health and death by fire;

(d) they want to develop the integrated approach at a strategic level and that the Health and Wellbeing Board becomes the strategic approach. At the operational level have proposed to convene an expert group to adopt methods that look at deaths within a systems context, backward looking, audit and review of the death and project those findings for future learning;

(e) they have developed a humane end of life pathways for marginal groups and have set up an designated area for homeless people to have a dignified death with support;

(f) the number of drug related deaths were at their highest and have identified bereavement training for staff exposed to their clients dying. Also providing better aftercare for relatives of suicides and drug overdoses.

In response to questions raised, it was reported that –

(g) they contact the Coroner to track where a person had died and if there was learning on the Coroner's files they would contact the relevant people within the hospital. Currently there was no systematic way of tracking this, an offer from the hospital was put forward to meet to discuss this;

(h) they were aware of the gaps in the system and were in talks with the NHS and Clinical Commissioning Group to expand and include working with the mental health providers and GP.

It was agreed that the Health and Wellbeing Board endorse the new approach because it will significantly improve understanding of the overlaps between avoidable deaths and thereby improve prevention across the system.

72. **Work Programme**

The Chair asked for feedback on a challenge set for the Board on people with learning disabilities finding employment. Carole Burgoyne MBE (Strategic Director for People) reported that Plymouth City Council (PCC) were currently operating a supportive internship in conjunction with the City College and have 7 people working in a variety of roles. Ann James (University Hospital Plymouth NHS Trust) also reported that have a very active programme and happy to link with PCC and Livewell SW and bring back a report to the Board.

The Board noted the work programme.

PLYMOUTH CITY COUNCIL

Subject:	Care Quality Commission Action Plan
Committee:	Health and Wellbeing Board
Date:	7 March 2019
Cabinet Member:	Councillor Tuffin (Cabinet Member for Health and Adult Social Care)
CMT Member:	Carole Burgoyne (Strategic Director for People)
Author:	Craig McArdle, Director for Integrated Commissioning
Contact details	Tel: 01752 307530 email: craig.mcardle@plymouth.gov.uk
Ref:	CQC
Key Decision:	No
Part:	I

Purpose of the report:

In 2017/18, at the request of the Secretaries of State for Health and Social Care and for Housing, Communities and Local Government, the Care Quality Commission (CQC) undertook a programme of 20 reviews of local authority areas to look at how well do older people move through the health and social care system, with a particular focus on the interfaces. This review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on older people aged over 65. It also focussed on the interfaces between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

The local system review of **Plymouth** was undertaken in December 2017 and was followed by a local summit and the development of a system action plan. The Action Plan was developed in partnership with the Social Care Institute for Excellence and with oversight from the Department of Health and was signed off by the Chair and Vice Chair of the Health & Wellbeing board.

CQC was subsequently asked in October 2018, to report on 9 of the first 12 local authority areas subject to review by conducting a monitoring exercise to establish how local systems have progressed since their review. On 10 October, Ian Trenholm, Chief Executive of the Care Quality Commission wrote to key partners in the Plymouth Health and Wellbeing System, informing us of their intention to review the progress made against the Action Plan following the System Review last December.

With the support and cooperation of the Health and Wellbeing system CQC concluded their required monitoring exercise of **Plymouth** and the attached supporting draft slide deck contains a summary of key areas of progress since the local system review. The finalised slide deck was shared with the Department of Health and Social Care.

Recommendations and Reasons for recommended action:

For information.

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Care Quality Commission

Local system reviews

Progress monitoring

Plymouth

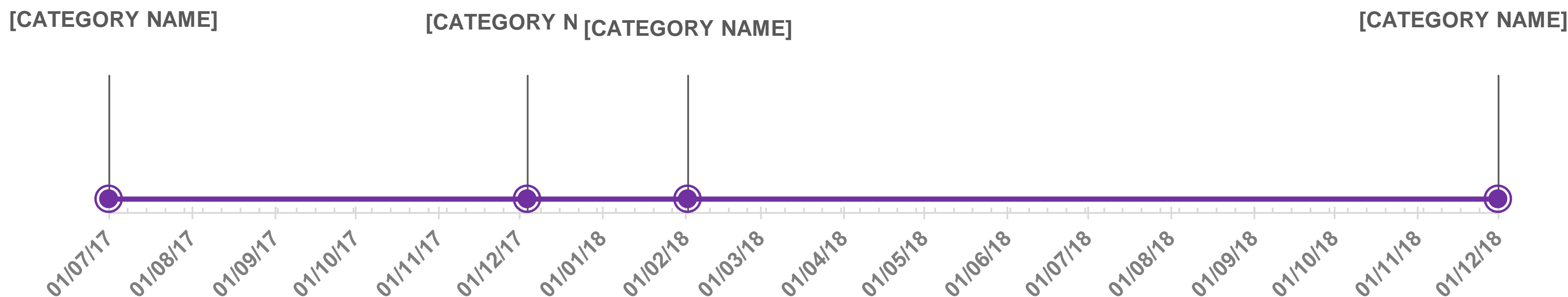
Introduction

Following CQC's programme of 20 local system reviews, we were asked by the Department of Health and Social Care and Ministry for Housing, Communities and Local Government to provide an update on progress in the first 12 areas that received a local system review.

Plymouth's local system review took place in December 2017 (report here) and the system produced an action plan in response to the findings. This progress update draws on:

- Plymouth's self-reported progress against their action plan (at 31.10.2018).
- Our trend analysis of performance against the England average for six indicators. With the exception of DToC, the data goes up to end 2017/18. DToC data goes up to July 2018.
- Telephone interviews with four system leaders involved in delivering and overseeing the action plan.

Timeline of activity



Overview progress against indicators

Indicator	Progress
A&E attendances (65+)	Remained below the England average and within control limits of its own average rate.
Emergency admissions (65+)	More in line with England average, where previously it was below England average. However, still within control limits of own average rate.
Emergency admissions from care homes (65+)	Increased a little during 2017/18 to be above England average, but still within the upper and lower control limits of own average.
Length of stay (65+)	Remained significantly above England average and in last quarter of 2017/18 increased to be significantly above its own average.
Delayed transfers of care	Often significantly higher the England average and spiked in February 2018 before falling in Q1 2018/19.
Emergency readmissions (65+)	Remained below the England average and fallen over 2017/18, although stayed within control limits of their own average.

Overview reported progress against action plan

Commissioning and market management	Plymouth developed and signed off its Health & Wellbeing System Strategic Commissioning Intentions (2018-2020) signalling the intention to integrate care. A proposal for a Neighbourhood Based Service Delivery Model is being finalised, before entering a period of co-design with the system and public, with the procurement of the Integrated Care Provider commencing after this activity. In the care home market, an Enhanced Health in Care Home programme was initiated with multi-disciplinary care home visits for the 10 highest admitters to Hospital. Medicines reviews across care homes have also been agreed. In domiciliary care, new fee structures have been agreed. New models of care are being developed including a pilot to maximise independence in home care and an 'independence at home' contract to provide reablement aligned to the discharge to assess pathway (Dec 2018). Integrated Market Oversight Group established to monitor demand across the system. Capacity in the home care market is better monitored through weekly calls. The VCSE contribution has been enhanced through engagement in urgent care pathway mapping, involvement in the roll out of health and wellbeing hubs, and embedded within this, the expansion of social prescribing in 2019. In primary care, the joint NHS commissioning of General Practice is in place with consultation around delegating primary care commissioning to a local level has initiated and plans to move to a 'delegated light' position. Several primary care programmes have been initiated to improve capacity, access, and support to care homes. The development of an Integrated Pharmacy Service has been put on hold.

Workforce	A local workforce strategy and implementation plan are being developed, with support from the LGA, to respond to the CQC recommendations and align to the STP plans. A group has been established, previous plans reviewed and priority areas established. A draft plan has been developed and circulated to stakeholders.

Overview reported progress against action plan

Admissions avoidance	The health and wellbeing hub programme has commenced with three hubs opening and a further six due to open in 2019/20. Contracts are being redesigned to be delivered from the hubs, pre-procurement work has been undertaken and providers are working closer together through colocation. GP practices have been supported to adopt the Electronic Frailty Index. The full roll out of risk stratification due March 2019 linking in with social prescribing and health and wellbeing hubs. The Acute Assessment Unit, Minor Injuries Unit and Acute Care at Home have been reviewed and plans in place to improve these services.

Hospital flow and discharge	Pathways out of hospital have been reviewed and refined including: hospital discharge processes simplified, ensuring an MDT approach to discharge. The Discharge to Assess pathways (home and care home) have been reviewed. The redesign of the long term care pathway has been completed. The implementation of these refined pathways is ongoing. The system wide leadership events have allowed each element which has been implanted to be shared, reviewed and refined at each of the meetings. Agreed measures of system metrics defined and measured to assist in patient flow. Work is ongoing and a command centre approach is being implemented to support the management of flow across the whole system.

Communication across partners	The single point of access has been shared with wider providers. The yellow card scheme has been rolled out and has won a national award.

Continuing healthcare	Following a review of performance and processes, revised framework and processes in place and recruitment of health assessors ongoing to reduce backlog.

Stakeholder reflections

Overall progress

Plymouth's progress against the action plan is reported into the Local Care Partnership, with oversight provided by the Health and Wellbeing Board and Overview and Scrutiny Committee.

Plymouth has made some good progress since their Local System Review in December 2017. They have agreed their strategic commissioning intentions for the system for the next two years which are signed up to by all system partners. The next step is to work with partners and people to coproduce a neighbourhood service model.

There was clear communication and buy in across the system to move away from bed based care. Independent social care and VCSE sector providers have been engaged in the design of these commissioning strategies.

Plymouth has rolled out three Health and Wellbeing Hubs, two in neighbourhoods and one city-wide, and are set to open two more in January 2019. External evaluation is embedded into the Hubs to monitor impact. The Hubs were in the planning stage during our review last year, and their introduction marks a shift in Plymouth's preventative approach by bringing together risk stratification, signposting and social prescribing to identify and meet peoples needs in the community.

Significant progress has been made in improving flow through. Our analysis up to March 2018 showed that Plymouth still had high rates of length of stay over seven days for people aged 65+. However the system supplied us with more recent validated data for quarters 2 and 3 during 2018 showing that Plymouth University Hospital Trust was performing better than the south west region as a whole for length of stay, as well the number of beds unavailable due to delayed transfers of care. The system has commissioned Healthwatch to evidence that the improved performance seen in the data is matched by an improved experience for people. The Chair of the Health and Wellbeing Board is encouraged by the progress, but is waiting until after winter to judge whether the improvements made can be sustained.

An integrated system-wide winter plan has been developed, incorporating learning from last year. This, combined with a better than ever understanding of capacity and demand, means that the system feel sufficiently prepared for winter.

Workforce is the single largest ongoing risk to the system. With support from the LGA they have succeeded in establishing a system-wide workforce group and have developed a plan that has been taken to the Local Care Partnership, linked to workforce planning at the STP. However workforce remains a challenge and an area of ongoing development.

Stakeholder reflections

Direction of travel

Plymouth’s health and social care system is built on a strong foundation of integrated working and relationships. There are joint funded posts providing accountability across organisations. Plymouth has the joint commissioning strategy in place, now it need to operationalise it.

Significant progress has been made in improving flow through hospital and reablement. They now need to embed these new pathways, and ensure that winter does not derail their improvement journey.

Health and Wellbeing Hubs and the forthcoming roll out of risk stratification is a significant opportunity to keep more people well in their community. Additional support for care homes has also been put in place for winter. it is important that enhanced support to care homes is embedded all year round as our analysis up to March 2018 shows an increase in hospital admission from care homes.

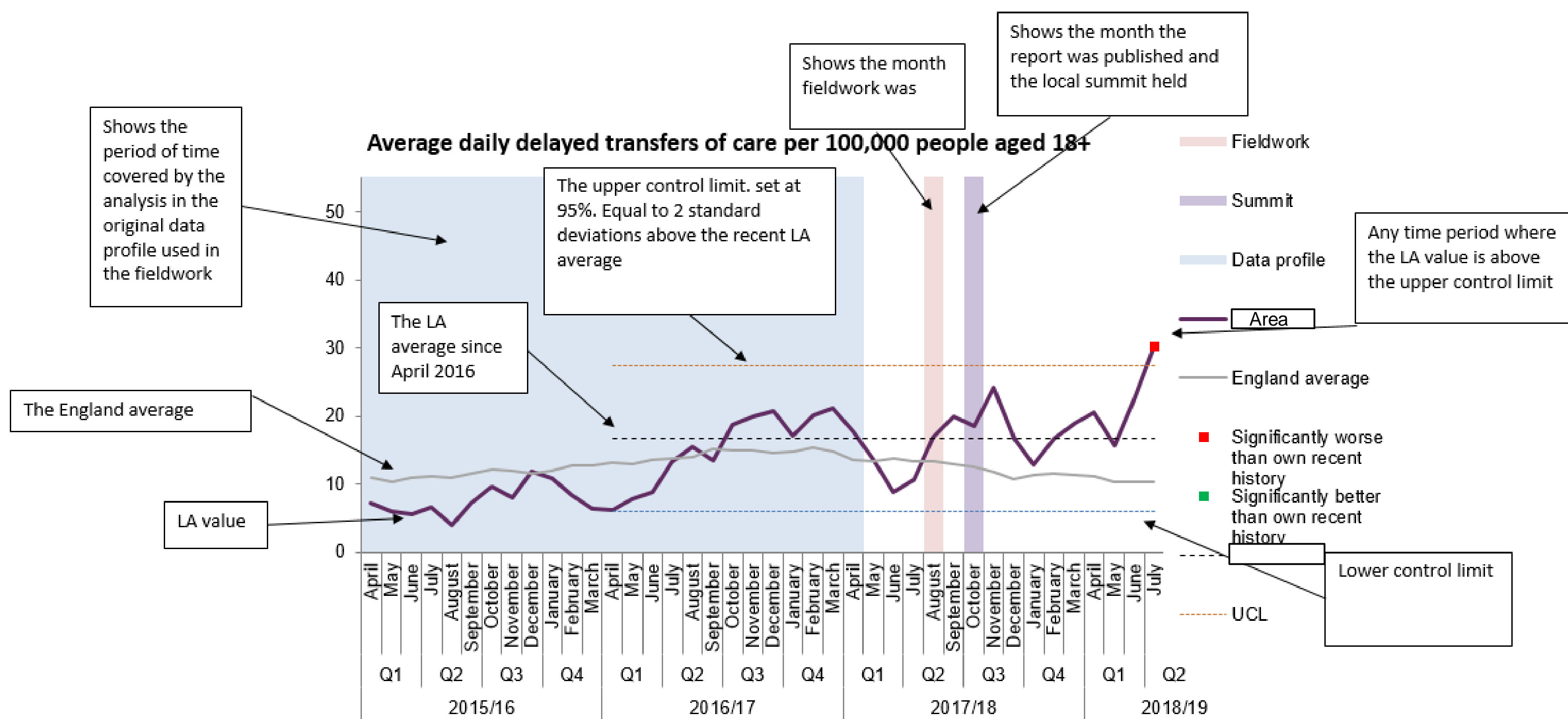
Plymouth has demonstrated a commitment to working with partners across the STP, for example in workforce planning. The Chair of the Health and Wellbeing Board has also met with his counterparts in Torbay and Devon to develop links across the local authorities.

Workforce, particularly the fragility of general practice, remains the biggest risk for the system.

Appendix: Trend analysis introduction

CareQuality Commission

The following slides present a trend analysis for six indicators. The **sample** diagram below shows how to interpret the graphs.



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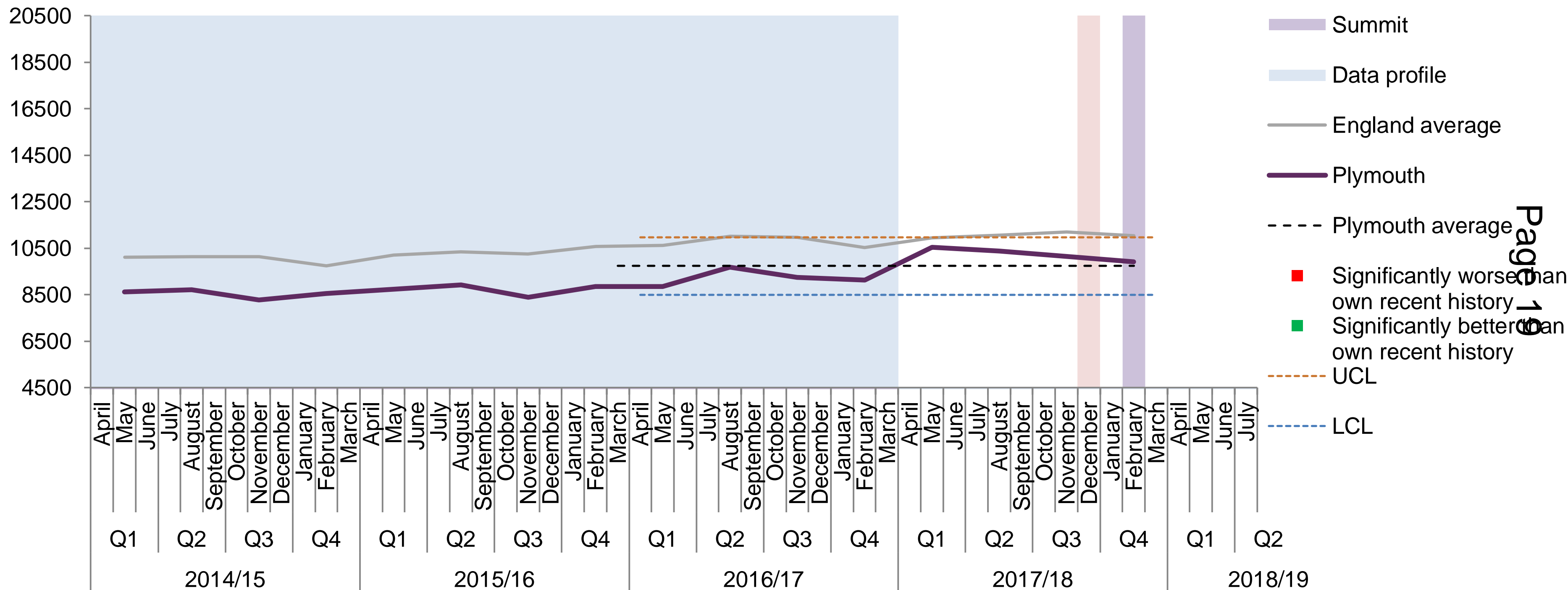
Appendix: A&E attendances

Care Quality Commission



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Since we produced the data profile for the original local system review Plymouth's rate of A&E attendances (65+) has remained below the England average. It has also remained within its control limits of its own average rate.

Appendix: Emergency admissions

Emergency admissions per 100,000 people aged 65+

10000
9000
8000
7000
6000
5000
4000
3000
2000

April May June July August September October November December January February March April May June July August September October November December January February March April May June July August September October November December January February March April May June July August September October November December January February March April May June July

Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2

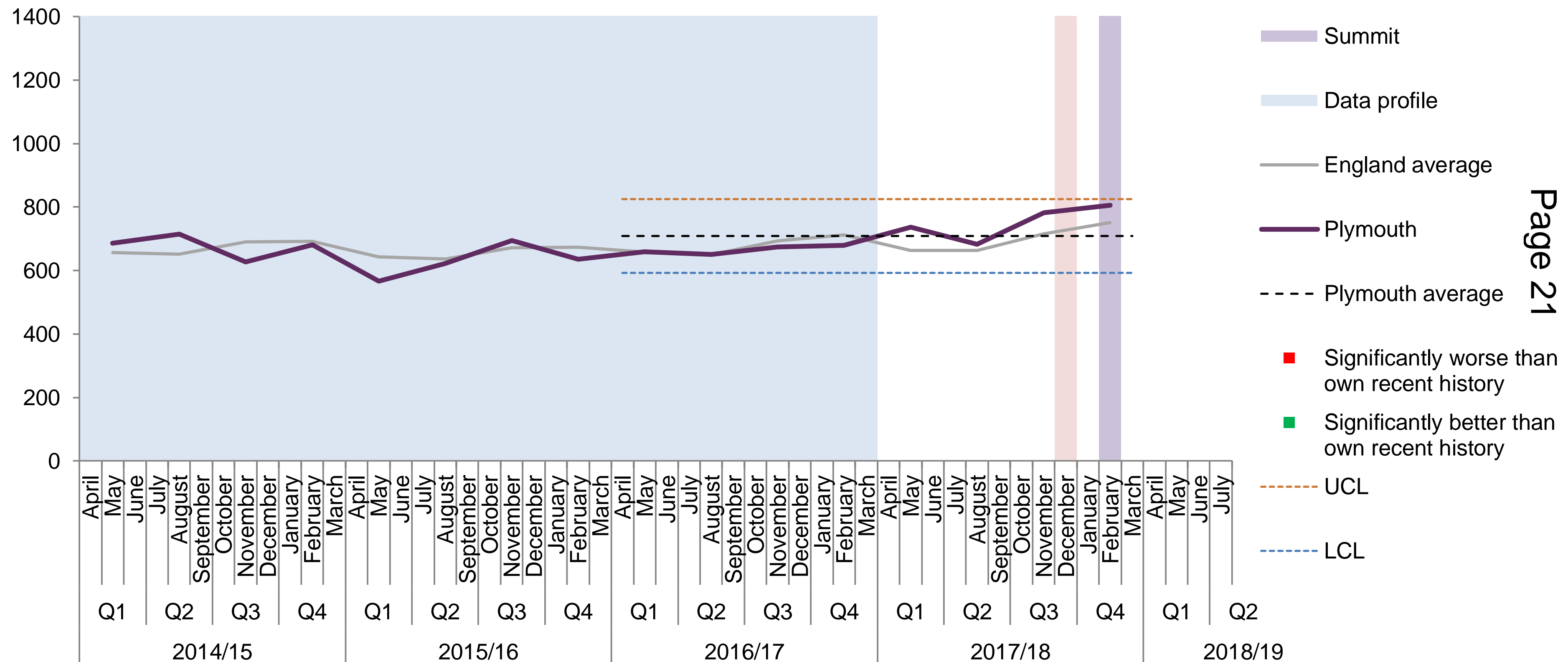
2014/15 2015/16 2016/17 2017/18 2018/19

Fieldwork
Summit
Data profile
England average
Plymouth
Plymouth average
Significantly worse than own recent history
Significantly better than own recent history
UCL
LCL

Since we produced the data profile for the original local system review Plymouth's rate of emergency admissions (65+) have stayed more in line with the England average, where in previous years it was below the England average. However performance was still within the control limits of Plymouth's own average rate.

Appendix: Emergency admissions from care homes

Care Quality Commission



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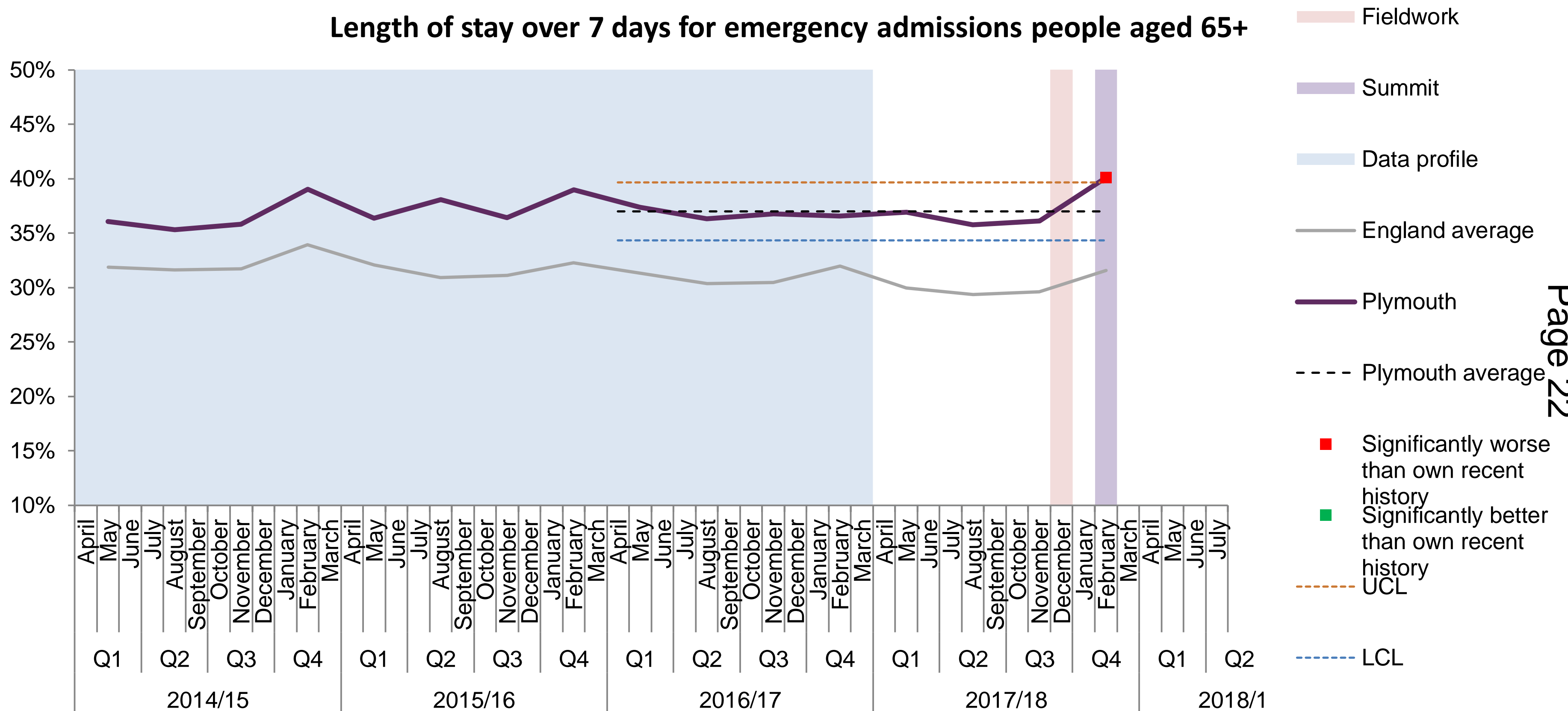
Since we produced the data profile for the original local system review Plymouth's rate of emergency admissions from care homes (65+) has increased a little during 2017/18 to be above the England average, however they remain within the upper and lower control limits of their own average.

Appendix: Lengths of stay over 7 days



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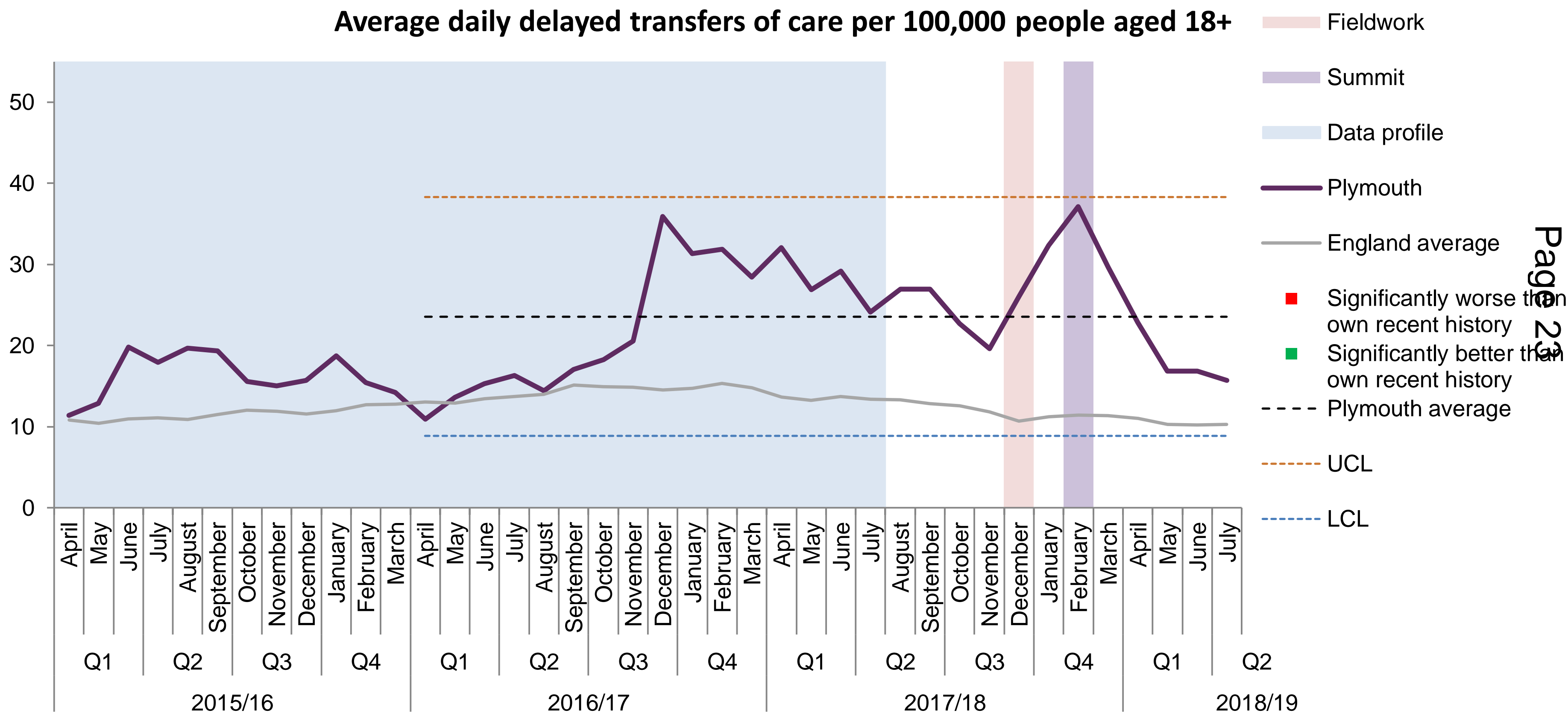
Since we produced the data profile for the original local system review Plymouth's performance for lengths of stay over 7 days (65+) has remained significantly above the England average and in the last quarter of 2017/18 increased to be significantly above its own average.

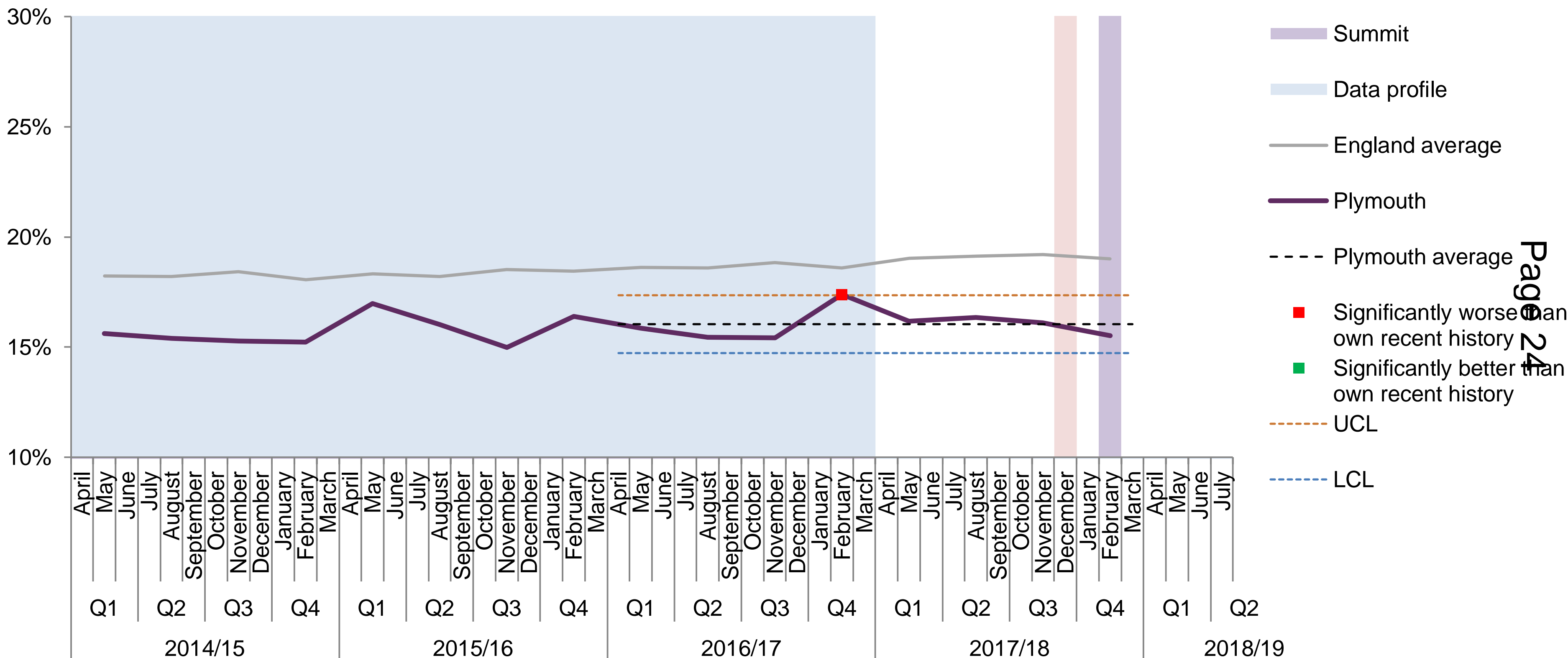
Appendix: Delayed transfers of care

CareQuality Commission



Since we produced the data profile for the original local system review Plymouth's DToC performance has remained above the England average (usually significantly so) and spiked in February 2018 before falling in Q1 2018/19.

Appendix: Emergency readmissions



Since we produced the data profile for the original local system review emergency readmissions (65+) in Plymouth have remained below the England average and have fallen over 2017/18 but stayed within upper and lower control limits of their own average.

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PLYMOUTH CITY COUNCIL

Subject:	Integrated Commissioning Next Steps
Committee:	Health and Wellbeing Board
Date:	7 March 2019
Cabinet Member:	Councillor Ian Tuffin
CMT Member:	Craig McArdle (Strategic Director for People)
Author:	Craig McArdle (Strategic Director for People)
Contact details	Tel: 01752 307530 email: craig.mcardle@plymouth.gov.uk
Ref:	CB/CMcA
Key Decision:	Yes
Part:	I

Purpose of the report:

The purpose of this report is to provide an update on the planned arrangements for how Devon, Plymouth and Torbay Local Authorities and the NHS Clinical Commissioning Groups will develop integrated commissioning through 2019/20.

Over the last 2 years Local Authorities and NHS organisations across Devon, Plymouth and Torbay have been working to develop more effective ways of delivering integrated health, care and well-being services whilst also making best use of public resources. Collaborative arrangements are continuing to develop between partner organisations, both commissioning organisations and providers of services, to improve population health and enable access to modern, safe and sustainable services. Effective collaboration between organisations will also enable progress toward working as a self-improving system with increased maturity and delegated regulatory functions.

Integrating how the local NHS and the Local Authorities undertake their respective commissioning responsibilities is seen as a key component of:

- supporting increased collaboration,
- enabling the delivery of integrated services,
- making the most effective use of available funding and
- developing the means of self-improvement as a system.

Plymouth has a long and established record of cooperation and collaboration with a formal commitment to integration being set down by the Plymouth Health and Wellbeing Board in 2013, based around Integrated Commissioning, Integrated Health and Care Services and an Integrated System of Health and Wellbeing.

Since then there has been some significant progress and notable achievements towards achieving this aim. NEW Devon CCG and Plymouth City Council (PCC) formed an integrated commissioning function in April 2015 as part of their single commissioning approach. An integrated fund is in place with risk and benefit sharing agreements. Integrated planning and governance arrangements between the two organisations are in place.

Commissioners, informed and supported by clinicians and public health experts, have collectively developed an integrated commissioning approach through the development of four Integrated Commissioning Strategies, which direct all commissioning activity and deliver the Healthy City element of the Plymouth and South West Devon Joint Local Plan. This means our commissioners work across health and social care system. They have been co-located to enable closer working and delivery for a number of years.

In April 2015, the commissioning budgets from the Western footprint of NEW Devon CCG were aligned with the People Directorate and Public Health budgets from the Local Authority to develop an integrated fund of £462m. This was facilitated through a Section 75 agreement and included housing, leisure, Public Health commissioned spend, children's services including education, and Adult Social Care spend. The fund is hosted by the CCG, with the fund manager being employed by the CCG and the deputy employed by PCC. Partners share financial risk through an innovative risk-share agreement that has received national recognition.

Also, in April 2015, the Local Authority transferred 173 Adult Social Care staff to Livewell Southwest (LWSW) to develop an integrated community health and care provider with a single point of access, locality-based services and improved discharge pathways from secondary care. Livewell now provides the majority of Adult Social Care services for and on behalf of the Local Authority.

The Local Authority has retained statutory responsibility for safeguarding and has a retained client function. The integrated service has achieved some notable outcomes including helping balance the Adult Social Care budget for three years in a row whilst at the same time achieving good outcome ratings:

- Above average satisfaction among people in receipt of long-term care (69% extremely or very satisfied);
- Of people who use services, 93% say that those services have made them feel safe and secure.

On 13 March 2018, Cabinet received a report on the Strategic Commissioning Intentions for the Plymouth Health and Wellbeing System 2018-20.

The purpose of this report was to provide a position statement on the shared ambition to develop Integrated Health and Wellbeing both within Plymouth and the wider Devon STP footprint. The report considered progress to date, key challenges, national context and future direction. It advised that a number of key documents would be brought forward to deliver on the next phase of our integration journey, these include:

- Plymouth System Strategic Commissioning Intentions
- Plymouth and Western Local Care Partnership Mandate
- Revised Sustainability and Transformation Plan
- Strategic Commissioner Options
- An Integrated Care System for Devon

Cabinet agreed to commence a period of stakeholder consultation on the Strategic Commissioning intentions.

On 10 July 2018, Cabinet received the outcome of the stakeholder consultation and approved the direction of Plymouth's Health and Wellbeing Strategic Commissioning Intentions 2018-20

This report provides an update on the next steps towards Integrated Commissioning across Devon which builds on the work already in place in Plymouth.

Corporate Plan:

The proposed next steps towards Integrated Commissioning align to the Plymouth City Council Corporate Plan by working with partners to meet the objectives of creating a Caring and Pioneering Plymouth. It also aligns to the Health and Wellbeing Board's vision of delivering Integrated Commissioning, Integrated Care and Support and an Integrated System of Health and Wellbeing.

This project will support the Corporate Vision through:

- Being **pioneering** in developing and delivering quality, innovative services with our citizens and partners that make a real difference to the health and well- being of the residents of Plymouth through challenging economic times.
- **Growing** Plymouth through learning and community development creating opportunities for vulnerable people to develop, making us and them stronger and more confident as a result.
- Putting citizens at the heart of their communities and work with our partners to help us **care for Plymouth**. We will achieve this together by supporting communities, help them develop existing and new enterprises, redesign existing services which will in turn create new jobs, raise aspirations, improve health and educational outcomes and make the city a place to live, to work and create a future for all.
- Raising aspirations, improving education, increasing economic growth and regeneration, people will have increased **confidence in Plymouth**. With citizens, visitors and investors identifying us as a "vibrant, confident, pioneering, place to live and work" with an outstanding quality of life.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land:

The approach to Integration in Plymouth is already in place with an Integrated Fund which is underpinned by a Section 75 Agreement between NEW Devon CCG and Plymouth City Council. The Integrated Fund is a cradle to grave fund, circa £480million covering wellbeing children and young persons, leisure, acute, adult social care and community health.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

The progress towards Integrated Commissioning continues to aim to reduce inequalities and through the implementation of Thrive Plymouth and the Well Being strategy and contributes to addressing Child Poverty and Community Safety issues across the city.

Equality and Diversity

Has an Equality Impact Assessment been undertaken? Not for this paper but EIA's are completed on individual areas of work within the Strategic Commissioning Intentions as and when required.

Recommendations and Reasons for recommended action:

Health and Wellbeing Board note the progress and support the Integrated Commissioning Next Steps for Health and Wellbeing as being in line with the original ambition set by Health and Wellbeing Board in 2013. Further updates will be provided to the Health and Wellbeing Board on progress.

Alternative options considered and rejected:

The Integration Commissioning Next Steps are not supported.
This has been rejected as delivering the Health and Wellbeing Board vision of Integrated Health and Wellbeing would not be achieved.

Published work / information:

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7
Integrated Health and Wellbeing Position Statement and Next Steps	X								
Strategic Commissioning Intentions for the Plymouth Health and Wellbeing System 2018-20	X								

Sign off:

Fin	**Djn.18.19.229**	Leg	lt/32148/2202	Mon Off		HR		Assets		IT		Strat Proc	
Originating SMT Member Craig McArdle Strategic Director for People													
Has the Cabinet Member(s) agreed the contents of the report? Yes													

Report Title: **Development of Integrated Commissioning**
Summary of the direction of travel for integrating commissioning between NHS Devon CCG, Devon, Plymouth and Torbay Local Authorities in 2019/20.

1. Background

Over the last 2 years Local Authorities and NHS organisations across Devon, Plymouth and Torbay have been working to develop more effective ways of delivering integrated health, care and well-being services whilst also making best use of public resources. Collaborative arrangements are continuing to develop between partner organisations, both commissioning organisations and providers of services, to improve population health and enable access to modern, safe and sustainable services. Effective collaboration between organisations will also enable progress towards working as a self-improving system with increased maturity and delegated regulatory functions.

Integrating how the local NHS and the Local Authorities undertake their respective commissioning responsibilities is seen as a key component of:

- supporting increased collaboration,
- enabling the delivery of integrated services,
- making the most effective use of available funding
- and developing the means of self-improvement as a system.

This paper describes the planned arrangements for how Devon, Plymouth and Torbay Local Authorities and the NHS Clinical Commissioning Groups will operate to integrate commissioning through 2019/20.

2. Process to Date

A number of related work streams have been taking place over recent months involving a wide range of staff from partner organisations. For example,

- Intelligence leads from public health, social care and NHS have developed a common outcomes framework and been planning how to share knowledge, analyse data and provide integrated intelligence to inform planning, prioritisation and decision making.
- Staff with a role in planning in either Local Authorities or NHS CCGs have reviewed the current planning processes and begun designing how these can be adapted to facilitate a more integrated approach.
- Commissioning staff, including Heads of Service, senior officers and executives, have undertaken work to design joint processes, teams and meeting structures and, through doing so, have also increased their understanding of different ways of working and started developing a shared culture.

The proposed arrangements developed through this collaborative process take into account of the current position of the organisations, acknowledge and retain clear accountability and are designed in such a way as to enable implementation

without significant re-organisation or disruption, whilst retaining the flexibility for further development.

3. Merger of the Devon CCGs

The merger of Northern, Eastern and Western Devon CCG and South Devon & Torbay CCG is an important step in the journey to create a single strategic commissioner for Devon as part of the CCG's ambition to better integrate health and care services to benefit our local communities. Together with delegated commissioning of primary care, the merger will enable the single NHS commissioner to work consistently and coherently with all local authorities across wider Devon as well as with local partners within each area.

From 1 April 2019, NHS Devon CCG will become a new statutory organisation serving a patient population of nearly 1.2 million people with a budget of more than £1.8 billion. The CCG will comprise a membership of 131 GP practices across Devon, Plymouth and Torbay and will be chaired by a GP with member representation as a core part of its governing body. Through its membership and staff, NHS Devon CCG will work with local communities and partner organisations to improve people's health and make sure they are able to receive high quality, local services.

4. Integrated Commissioning Arrangements

In summary the arrangements will consist of:

1. An Integrated Commissioning Executive who will lead strategic planning, resource allocation and incentivising the system to make progress on joint priorities, development of joint funding arrangements between the NHS and each local authority to support integrated commissioning and review progress against planned outcomes, service quality and cost effectiveness.

2. Joint leadership of integrated commissioning teams with responsibility for commissioning health, care and well-being services for the local population of different communities in the geographical areas across Devon, Plymouth and Torbay as well as supporting commissioning programmes across wider Devon for services or care groups where this will be more effective and efficient.

The following section provides a brief outline of the executive and team function. A detailed description is provided on the accompanying power point slides.

4.1 Integrated Commissioning Executive – Function

The Integrated Commissioning Executive meeting will provide a mechanism for joint planning and shared decision making by the relevant responsible senior

officers who have the authority to act in accordance with the decision making framework of each partner organisation. It will be a meeting of executives rather than a joint committee of the statutory organisations or a new additional organisation. Each partner organisation will continue its own internal executive functions & meetings to manage the business of that organisation.

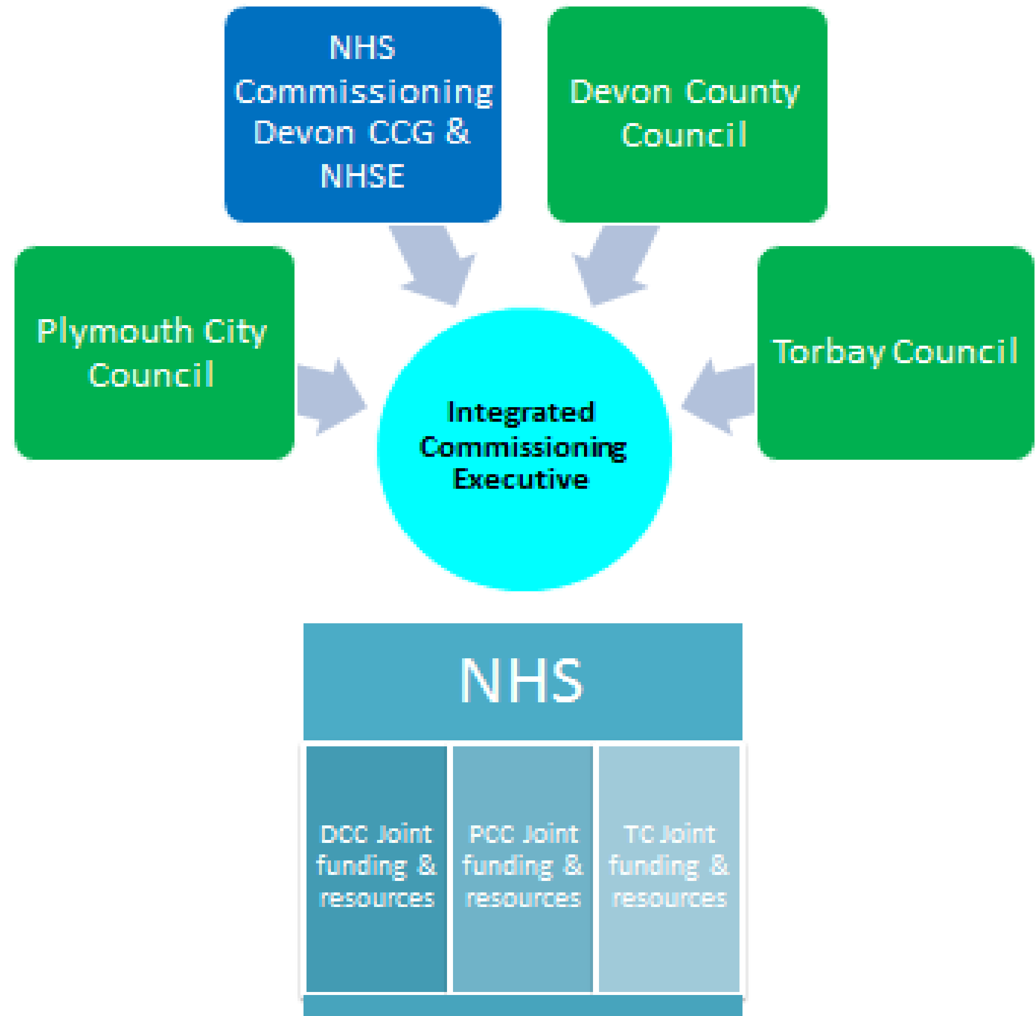

Diagram illustrating how executives / senior officers acting on behalf of the statutory organisations will operate through the integrated commissioning executive meeting.

The Integrated Commissioning Executive, through leadership of the commissioning process, will have a role in contributing to policy formulation or development of long term plans. However the responsibility for deciding and approving policies or long term plans rests with the appropriate bodies of respective organisations i.e. the Cabinets or Health & Well Being Boards of Local Authorities, CCG Governing Body and collectively through system governance mechanisms where statutory organisations are represented by leaders and chief

executives i.e. STP Collaborative Board. The integrated commissioning executive will agree joint strategies or actions to implement agreed policies or long term plans, prioritising and deploying resources in accordance with the decision making frameworks of individual organisations, and reviewing impact and progress.

Membership
The Integrated Commissioning Executive meeting will be a meeting of 'decision makers', with authority held by individual executives who will operate within the respective schemes of delegation and remain accountable through the governance mechanisms of their individual organisations.

Membership will comprise those senior officers with responsibility for commissioning services and managing resources on behalf of their organisations including those jointly deployed through pooled fund arrangements. Therefore it is proposed that the core membership will include:

- Devon CCG Accountable Officer
- Local Authority Directors from Devon, Plymouth and Torbay with DASS responsibility
- Devon CCG Director of Commissioning

Other relevant Devon CCG Executives, CCG clinical membership representative, Local Authority Officers and System Leadership roles will attend and inform decision making according to the agenda. In terms of the latter, it is proposed that an additional system role is created to provide dedicated leadership capacity for Population Health and Well Being with the role to be undertaken by a Director of Public Health on rotational basis in a part time capacity.

Directors of Children's Services will be invited to attend as needed to enable whole population planning and alignment of the priorities of local children and young people's plans with the wider Devon whole system plan or where improvement in service delivery requires action at executive level across services for adults and children.

4.2 Integrated Commissioning Team Function
The integrated commissioning teams will:

i. Develop local plans to support the system wide priorities in addressing the needs of the population and service delivery requirements that are specific to the local area.
ii. Work with partners, providers and the local population to design appropriate support and services that improve the experience of users and efficiency of service provision.
iii. Create the conditions to enable partners to deliver integrated care services for individuals and to support the development of healthy communities.

iv. Review the quality of service, progress on outcomes for the local population and financial productivity and performance.

The teams will include commissioning staff from both NHS Devon CCG and each Local Authority, managed through joint leadership arrangements. This will not require staff to transfer employment between partner organisations. The teams will manage the deployment of joint funds in accordance the agreements made at Executive level between the CCG and each local authority. It will commission services to promote well-being and prevention and deliver integrated health and care services including primary and secondary care, physical and mental health for the local population. The integrated teams will also identify when it is appropriate or likely to be more effective and efficient for staff to operate collectively with other teams and providers working across wider Devon.

5. Implementation and Review

The integrated commissioning arrangements as set out will commence in April 2019. The work programme 2019/20 will include aspects of both delivery and further development. Key tasks include:

- Delivery of the Operating plan for 2019/20 and supporting development of a Long Term Plan for wider Devon
- Agreeing a commissioning finance plan including allocation against priorities, resource distribution and incentives
- Delivery of commissioning plans, transformation schemes and reviewing the impact of these
- Creating the conditions to enable local partnership development inc. finance, performance, delivery of Integrated Care Model, local & system transformation
- Continue developing commissioning capabilities, including planning cycle, outcomes framework, intelligence, change capability
- Determine future approach with relevant providers to integrated or delegated Commissioning arrangements, e.g. commissioning individual care and support packages to service level commissioning and delivery.

The Integrated Commissioning Executive will review the effectiveness of the arrangements operating during 2019/20 and draw learning to inform how these should be further developed. In addition, adaptation of the planning processes will also take account of the ongoing work to develop a system governance framework that supports effective collaboration and democratic accountability including collaboration between the three Local Authority Health & Well Being Boards and Scrutiny Committees. The planned integrated commissioning arrangements are deliberately flexible, maintaining the agility to adapt and take opportunities for further development as required for future years.

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PLYMOUTH CITY COUNCIL

Subject: NHS Long Term Plan

Committee: Health and Wellbeing Board

Date: 7 March 2019

Ref:

Key Decision: No

Part: I

Purpose of the report:

On the 7 January the NHS long term plan was launched. The Plan set out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. It also expressed the action the NHS will take to –

- strengthen its contribution to prevention and health inequalities,
- improve care quality and outcomes,
- tackle current workforce pressures and support staff
- upgrade technology and digitally enabled care across the NHS.
- put the NHS back onto a sustainable financial path.

The purpose of this agenda item is to discuss and influence the local response to the NHS Long Term Plan.

Corporate Plan:

By reviewing the local response, the Health and Wellbeing Board will support the Corporate Plan Democratic, Co-operative values and Caring Plymouth Priorities.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land:

N/A

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

N/A

Equality and Diversity:

N/A

Recommendations and Reasons for recommended action:

That the Health and Wellbeing Board are recommended to approve the local plans in respect of the NHS Long Term Plan.

Alternative options considered and rejected:

None, the NHS Long Term Plan will have an impact upon the local health and social care system.

Published work / information:

https://www.longtermplan.nhs.uk/online-version/

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7
Long Term Plan – Summary	x								

Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Assets	N/A	IT	N/A	Strat Proc	N/A

NHS

The NHS Long Term Plan – a summary

Find out more: www.longtermplan.nhs.uk | Join the conversation: #NHSLongTermPlan

Health and care leaders have come together to develop a Long Term Plan to make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment.

Our plan has been drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts. And they have benefited from hearing a wide range of views, whether through the 200 events that have taken place, and or the 2,500 submissions we received from individuals and groups representing the opinions and interests of 3.5 million people.

This summary sets out the key things you can expect to see and hear about over the next few months and years, as local NHS organisations work with their partners to turn the ambitions in the plan into improvements in services in every part of England.

What the NHS Long Term Plan will deliver for patients

These are just some of the ways that we want to improve care for patients over the next ten years:

Making sure everyone gets the best start in life	• reducing stillbirths and mother and child deaths during birth by 50% • ensuring most women can benefit from continuity of carer through and beyond their pregnancy, targeted towards those who will benefit most • providing extra support for expectant mothers at risk of premature birth • expanding support for perinatal mental health conditions • taking further action on childhood obesity • increasing funding for children and young people's mental health • bringing down waiting times for autism assessments • providing the right care for children with a learning disability • delivering the best treatments available for children with cancer, including CAR-T and proton beam therapy.
Delivering world-class care for major health problems	• preventing 100,000 heart attacks, strokes and dementia cases • providing education and exercise programmes to tens of thousands more patients with heart problems, preventing up to 14,000 premature deaths • saving 55,000 more lives a year by diagnosing more cancers early • investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital • spending at least £2.3bn more a year on mental health care • helping 380,000 more people get therapy for depression and anxiety by 2023/24 • delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.
Supporting people to age well	• increasing funding for primary and community care by at least £4.5bn • bringing together different professionals to coordinate care better • helping more people to live independently at home for longer • developing more rapid community response teams to prevent unnecessary hospital spells, and speed up discharges home. • upgrading NHS staff support to people living in care homes. • improving the recognition of carers and support they receive • making further progress on care for people with dementia • giving more people more say about the care they receive and where they receive it, particularly towards the end of their lives.

How we will deliver the ambitions of the NHS Long Term Plan

To ensure that the NHS can achieve the ambitious improvements we want to see for patients over the next ten years, the NHS Long Term Plan also sets out how we think we can overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by:

1. **Doing things differently:** we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.
2. **Preventing illness and tackling health inequalities:** the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.
3. **Backing our workforce:** we will continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.
4. **Making better use of data and digital technology:** we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.
5. **Getting the most out of taxpayers' investment in the NHS:** we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly-used products for cheaper, and reduce spend on administration.

What happens next

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), which are groups of local NHS organisations working together with each other, local councils and other partners, now need to develop and implement their own strategies for the next five years.

These strategies will set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.

This means that over the next few months, whether you are NHS staff, a patient or a member of the public, you will have the opportunity to help shape what the NHS Long Term Plan means for your area, and how the services you use or work in need to change and improve.

To help with this, we will work with local Healthwatch groups to support NHS teams in ensuring that the views of patients and the public are heard, and Age UK will be leading work with other charities to provide extra opportunities to hear from people with specific needs or concerns.

Find out more

More information is available at www.longtermplan.nhs.uk, and your local NHS teams will soon be sharing details of what it may mean in your area, and how you can help shape their plans.

PLYMOUTH CITY COUNCIL

Subject:	Tackling Physical inactivity in Plymouth; update
Committee:	Health and Wellbeing Board
Date:	7 March 2019
Cabinet Member:	Councillor Ian Tuffin
CMT Member:	Ruth Harrell (Director of Public Health)
Author:	Ruth Harrell (Director of Public Health)
Contact details:	Ruth.harrell@plymouth.gov.uk
Ref:	
Key Decision:	No (report for noting only)
Part:	I

Purpose of the report:

This report provides an update to the Board on physical inactivity in Plymouth and the steps being taken to tackle this. The report will be supplemented by a verbal summary following a partnership Physical Activity Workshop being held on 27th February.

Corporate Plan:

Tackling physical inactivity is part of Thrive Plymouth, the city's plan for reducing inequalities and helping to ensure that 'an outstanding quality of life is enjoyed by everyone'

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land:
There are no additional resource implications for the council with regards to this report.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

None

Equality and Diversity:

Has an Equality Impact Assessment been undertaken? No but as the report details, a key element of our work is understanding and helping to overcome the barriers to physical activity identified in specific groups.

Recommendations and Reasons for recommended action:

The report is for noting only.

Alternative options considered and rejected:

The report is for noting only.

Published work / information:

Background papers: No linked background papers – content provided in attached report

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7

Sign off: Report for noting only – sign off not required

Fin		Leg		Mon Off		HR		Assets		IT		Strat Proc	
Originating SMT Member Ruth Harrell (Director of Public Health)													
Has the Cabinet Member(s) agreed the content of the report? Yes													

TACKLING PHYSICAL INACTIVITY UPDATE

ODPH

BACKGROUND

Physical inactivity is one of the lifestyle behaviours identified through Thrive Plymouth as a cause of ill health, poorer wellbeing, and inequalities in health.

Evidence tells us that unhealthy behaviours cluster in deprived communities because they are associated with underlying social determinants of health; this is why Thrive Plymouth considers all of these risk factors together rather than looking at one in isolation. This means that the drivers to support physical activity, and the barriers to being more active, are complex and require a whole-system approach.

Plymouth is well placed to undertake a 'whole system' approach to addressing physical inactivity, supported by a formally integrated health and social care system, a strong commitment from Plymouth City Council and a network of committed partners across the city. We are developing this approach with support from Sport England.

This brief paper is to update the Health and Wellbeing Board on our approach to physical activity and the work that we have been doing with Sport England.

WHY IS PHYSICAL INACTIVITY IMPORTANT?

Physical inactivity is linked to a range of undesirable physical and mental health outcomes including premature mortality, heart disease, stroke, type 2 diabetes, depression and some types of cancer (World Health Organization, 2017). Despite this, only 21% of boys and 16% of girls in England do the amount of physical activity required to fully support their development (Public Health England, 2014). Persuading those who are inactive to become more active is likely to have significant health benefits across every stage of a person's life:

- Keeping physically active can reduce the likelihood of premature mortality by 30% (British Heart Foundation, 2017).
- Persuading inactive people to be more active could prevent one in ten cases of stroke and heart disease in the UK (Public Health England, 2014)
- Physical activity can reduce the risk of vascular dementia and have a positive impact on non-vascular dementia (Public Health England, 2014)

The return on investment to promote physical activity at the population level is likely to be significant particularly when targeting adults most at risk of inactivity (Department of Health, 2012). For example, Cycling England estimated that a 20% increase in cycling by 2015 would save £107 million by reducing premature deaths, £52 million from lower NHS costs and £87 million due to fewer absences from work (see (Department of Health, 2012)). UK Active (UK Active, 2014) estimates that just a 1% reduction in the rates of inactivity each year for five years would save the UK around £1.2 billion.

Which groups are at risk of being inactive?

Physical inactivity rates are high; almost a quarter of the population of Plymouth are inactive. There are a number of groups of people who are at risk of being inactive and therefore producing inequalities in health and wellbeing. These include;

- Social deprivation – people living with low income are at high risk of being less physically active.
- Gender – men are more active than women at any age group

- Age – physical activity levels decline with age, even though there are considerable benefits to older people in become more active – even if they have not been active when younger.
- Disability – despite there being many activities suitable for people with disabilities, people with disabilities are far less likely to be active. This includes people with learning disabilities, who are half as likely to take part in physical activity.
- Ethnicity – BME groups tend to be less likely to be physically active
- Gender and sexual orientation – people who are lesbian, gay, bisexual and transgender are less likely to take part in activities within sports clubs

SPORT ENGLAND APPROACH

In May 2016, Sport England published their strategy 'Towards an Active Nation'. This set out a systems leadership approach to tackling physical inactivity, stating that;

We want everyone in England regardless of age, background or level of ability to feel able to engage in sport and physical activity. Some will be young, fit and talented, but most will not.

In particular, the strategy indicates that Sport England will be;

• Focusing more money and resources on tackling inactivity because this is where the gains for the individual and for society are greatest

• Investing more in children and young people from the age of five to build positive attitudes to sport and activity as the foundations of an active life

• Helping those who are active now to carry on, but at lower cost to the public purse over time. Sport England will work with those parts of the sector that serve the core market to help them identify ways in which they can become more sustainable and self-sufficient

It is very clear that the strategic aims of Plymouth and of Sport England are strongly aligned.

Joint working

We are pleased to welcome Jo Colin, a joint appointment between Sport England and Active Devon, who is working with us as part of Sport England's 'Extended Workforce Pilot'. Jo has a background in promoting physical activity using insights to understand the barriers and opportunities for specific groups of people.

At the time of writing, we are about to hold a Physical Activity Workshop with the remit below;

We have all been working hard to try and shift inactivity levels across the country but these efforts have not been successful in making the changes we all want to see, not because of lack of effort but this is a tough challenge. Sport England is changing their strategy, focussing on a systems leadership approach which is highly collaborative. This workshop will introduce this. It will help us to look at how we want to work together across Plymouth and develop clarity over what it is we want to achieve (for the population). We know a fair bit about our physical activity levels and we know something about barriers and behaviours; but we know our partners have a wealth of knowledge and INSIGHT into this. Can we pull this together to help us to create a more coherent picture over all? We also know that risky lifestyle behaviours tend to cluster together so we need to consider how this fits with the wider system and Thrive Plymouth.

A verbal update will be provided to the Board.

Plymouth City Council

Subject:	Impacts of Poor Quality Housing on Health
Committee:	Health and Well Being Board
Date:	7 March 2019
Cabinet Member:	Cllr Chris Penberthy & Cllr Ian Tuffin
CMT Member:	Ruth Harrell – Director of Public Health
Author:	Paul Elliott , Low Carbon City Officer Sarah Ogilvie, Consultant in Public Health
Contact details	Tel: 01752 307574 Email: Paul.elliott@plymouth.gov.uk
Ref:	Your ref.
Key Decision:	No
Part:	I

Purpose of the report:

The report aims to highlight the effects that poor quality housing has on health. It provides a review of the current state of housing stock in Plymouth across all tenures and how this leads to poor health outcomes for residents.

Corporate Plan

The report links into the Caring Plymouth strand, demonstrating how better co-ordination of existing housing and health services could lead to improved outcomes for residents. This also feeds into the pioneering strand of the corporate plan in the sense of joining up two previously unconnected service areas.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

Resource implications are minimal. The only resource needed for this is a small amount of existing officer time.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

Equality and Diversity

Has an Equality Impact Assessment been undertaken? No.

Recommendations and Reasons for recommended action:

1. Further acknowledge the importance of housing as a major determinant of health across all representations of the Health and Wellbeing Board

2. The establishment of an officer group of relevant stakeholders across the city to look at:
   - Scale and mapping of the challenge – building on our existing understanding of local hazards, risks and assets
   - Production of an action plan based on the Sustainable Transformation Partnership (STP) housing challenge paper
   - More innovative commissioning of services which includes preventative measures

Alternative options considered and rejected:
The alternative option would be to do nothing. This would be missing an opportunity to deliver better outcomes for residents.

Published work / information:

https://www.gov.uk/government/publications/improving-health-through-the-home/improving-health-through-the-home
Improving health through the home: a memorandum of understanding
https://www.nea.org.uk/research/under-one-roof/
https://www.bre.co.uk/filelibrary/pdf/87741-Cost-of-Poor-Housing-Briefing-Paper-v3.pdf

Background papers:
n/a

Sign off:

Fin		Leg	ALT/30508/25	Mon Off		HR		Assets		IT		Strat Proc	
Originating SMT Member – Paul Barnard													
Has the Cabinet Member(s) agreed the contents of the report? Cllr Penberthy -Yes , Awaiting a response from Cllr Tuffin													

THE IMPACTS OF POOR QUALITY HOUSING ON HEALTH AND WELLBEING

Report to the Plymouth Health and Wellbeing Board

1. Background

A meeting was called on 14 January 2019 by Cllr Penberthy and Cllr Tuffin to discuss the impacts of poor quality housing on health and wellbeing. The meeting included representation from integrated commissioning (PCC and NEW Devon CCG), Livewell SW, Plymouth Energy Community (PEC), and Plymouth City Council (PCC) including Public Health, Strategic Planning and Infrastructure, and Finance. It was agreed that a paper would be taken to the March Health and Wellbeing Board highlighting need in the city, work to date and recommendations to take this forward.

2. National context

There is a wealth of evidence available at a national level which clearly demonstrates the impact poor quality housing has on health and wellbeing. Recent guidance from Public Health England (https://www.gov.uk/government/publications/improving-health-through-the-home/improving-health-through-the-home) highlights that a safe, suitable and stable home environment is essential to health and wellbeing, across the life course. This guidance reaffirms housing as a key determinant of health and summarises the risks to health and wellbeing presented by the home or housing circumstances. The guidance highlights the risks to an individual's physical and mental health associated with living in:

- a cold, damp, or otherwise hazardous home (an **unsafe home**)
- a home that doesn't meet the household's needs due to risks such as being overcrowded or inaccessible to a disabled or older person (an **unsuitable home**)
- a home that does not provide a sense of safety and security including precarious living circumstances and/or homelessness (an **unstable home**)

The right home environment can, for example:

- enable people to live independently, safely and well in their own home for as long as they choose, thereby reducing demands on health care services and hospitals
- complete treatment and recover from substance misuse, tuberculosis or other ill-health
- move on successfully from homelessness or other traumatic life event
- access and sustain education, training and employment
- participate and contribute to society and their community

Good quality housing is also essential to delivering NHS England's Five Year Forward View and local plans for social care, including the Sustainable Transformation Partnerships (STPs), through preventing hospital admissions, enabling timely discharge from hospital and preventing readmissions, and delaying and reducing the need for primary and social care. Cold homes, for example, cost the NHS in England £850 million – equivalent to £1.36 billion per year (National Energy Action, Under One Roof Report, 2018). Overall poor housing represents a similar risk to the NHS as physical inactivity, smoking and alcohol (Building Research Establishment, The Cost of Poor Housing to the NHS, 2015).

Enabling the right home environment for health and wellbeing is complex and needs people, communities and organisations to come together. This has recently been recognised at a national level through sign up of nearly 30 organisations representing housing, homelessness, health and care professionals to Improving health through the home: a memorandum of understanding which is committed to improving health through the home.

3. Local context

Devon's Joint Strategic Needs Assessments, local area profiles and Health and Wellbeing Strategies highlight the importance of housing on health and wellbeing. Locally, we know that over 13,500 Plymouth households are defined as 'fuel poor'. Put simply this means that if those households were heated to the recommended level of warmth, the occupants' remaining income would see them fall below the poverty line. As a result many of these households face the unjust and impossible decision of either providing a warm home environment, or putting food on the table.

Last year, PCC received over 10,000 new referrals into its Adult Social Care service. Of these, at least 30% suffer from health conditions that can be exacerbated by living in cold/damp conditions, with another 19% being assessed as living in an unsafe or uninhabitable home.

A cross tenure analysis of our housing stock illustrates the high level of energy inefficient housing that exists in the city. The Government has a UK wide target for all homes to have an Energy Performance Certificate rating of C by 2035. Currently 78,000 homes (65%) in Plymouth do not meet this level, with 11,000 having a high risk of excess cold and no central heating.

In addition, the growth agenda for the city aims to build a further 26,000 homes over the next 15 years. These homes will be built to building regulations far higher than the existing housing stock, potentially leading to a widening of inequalities.

4. Work to date

Despite the challenges, the city has a strong history of providing assistance to householders through a variety of projects designed to improve living conditions. For example, the 'Healthy Homes' project delivered by PEC in 2016/17, showed improving housing conditions can lead to a 50% reduction in GP visits, as well as a 9 point increase in wellbeing scores. The well-being of residents was measured at the start of the process, and then measured again 6 months after PEC had delivered the intervention. This gave conclusive evidence of an improvement in Health and Well Being because of the improvement to the home. Currently PCC has external funding to install heating systems and insulation measures to eligible properties, though this funding is finite and will cease in March 2020. Most recently, the Well Being Hubs provide an opportunity for PEC to provide advice related to housing condition to those individuals who have been directed there by a health professional.

To support the Devon STP, a series of 'Challenge Papers' have been developed to influence delivery of prevention and early intervention across the wider system. Housing has been identified as one of the key health and wellbeing challenges we are facing. The challenge paper (Safe, Suitable and Stable Homes for Health) provides the basis of initial discussions with partners in order to collaborate on housing matters across Devon. It also provides a framework for the systematic approach to the identification assessment of risk factors and the potential positive and negative impacts on health. This paper concludes that partners across the system should agree priority areas for action across:

- **Safe and healthy homes**, e.g. warm homes, good repair, reduce risk of falls/unintentional injuries and good indoor air quality
- **Suitable homes**, e.g. adaptable homes, tenure mix, affordable homes, dementia friendly, suitable for individuals with a learning disability, delayed transfer issues
- **Stable homes**, e.g. homelessness, tenancy protection, financial resilience

- **Healthy communities and neighbourhoods**, e.g. climate adaptation, obesity, social isolation, lifetime neighbourhoods, role of the housing workforce in public health

5. Summary and recommendations

Improving health through the home is best achieved through co-ordinated efforts by all partners in the housing sector, with the health care system having a key role, both as a leader and an important partner in the identification and support of those at risk from poor homes and to maximise the protective features of homes and communities. The housing sector workforce can also play an important part outside of its direct impact on the standard of homes. Their workforce also has direct contact with those most vulnerable in our society (Making Every Contact Count).

The preliminary steps to achieve this is through a partnership and co-design approach as advocated in the National MoU and demonstrated by the approach taken by Nottingham. The Health and Wellbeing Board in Nottingham gave a clear mandate to officers to develop a Memorandum of Understanding (MoU) on this issue. This subsequently led to the Health and Housing Partnership group which has representatives from all MoU signatory's and co-ordinates action. The adoption of a local MoU in Plymouth could act as a vehicle to engage partners, ensure political leadership and establish a clear framework for Plymouth.

The Plymouth Health and Wellbeing Board is very well placed to own and co-ordinate action across these issues. Several other areas in England have adopted this approach, such as Cornwall, Gloucestershire, and Dorset, with great success. The Health and Wellbeing Board is therefore asked to endorse the following recommendations:

1. Further acknowledge the importance of housing as a major determinant of health across all representations of the Health and Wellbeing Board
2. The establishment of an officer group of relevant stakeholders across the city to look at:
    - Scale and mapping of the challenge – building on our existing understanding of local hazards, risks and assets.
    - Production of an action plan based on the STP housing challenge paper.
    - More innovative commissioning of services which includes preventative measures.

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PLYMOUTH CITY COUNCIL

Subject: Completed Pledge: Loneliness Action Plan

Committee: Health and Wellbeing Board

Date: 7 March 2019

Cabinet Member: Councillor Ian Tuffin

CMT Member: Craig McArdle (Strategic Director for People)

Author: Rachel Silcock (Strategic Commissioning Manager)

Contact details Tel: 01752 307176
email: rachel.silcock@plymouth.gov.uk

Ref:

Key Decision: No

Part: I

Purpose of the report:

The purpose of this report is to fulfil Council **Pledge 55**: Loneliness is a growing problem, and its effects were highlighted by the late Jo Cox MP. Far too many people in Plymouth face life in isolation without human contact. We will work with charities, social care providers and others to publish an action plan to ease loneliness.

Corporate Plan:

The 100 Pledges have informed development of the Corporate Plan and therefore the Pledges have been adopted by the Council as part of delivery of the Corporate Plan and its associated performance management framework.

This Loneliness action plan will support the Corporate Vision through:

- Being **pioneering** in adopting a whole systems approach to loneliness to make a real difference to the health and well-being of the residents of Plymouth through challenging times.
- Putting citizens at the heart of their communities and work with our partners to help us **care for Plymouth**. We will achieve this together by developing strong and resilient individuals and communities, destigmatising loneliness and providing opportunities for people to take part
- Raising aspirations, increasing wellbeing activity, developing strong and networked communities, people will have increased **confidence in Plymouth**. With citizens, visitors and investors identifying us as a "vibrant, confident, pioneering, place to live and work" with an outstanding quality of life.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land:

All resource implications have been considered and incorporated within the MTFS and Business Plans.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

Pledge completions complement the Council's existing policy framework with respect to the above.

Equality and Diversity

Has an Equality Impact Assessment been undertaken? Where potential equality and diversity implications are identified from the implementation of any new activities arising from the pledge completion, assessments will be undertaken in line with the Council's policies.

Recommendations and Reasons for recommended action:

Health and Wellbeing Board adopt the Loneliness Action Plan. Further updates will be provided to the Health & Wellbeing Board on progress.

Alternative options considered and rejected:

The Loneliness Action Plan is not adopted.

Published work / information:

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7
Council Pledges	X								

Sign off:

Fin	**Djn.**	Leg	It	Mon Off		HR		Assets		IT		Strat Proc	
Originating SMT Member Craig McArdle Strategic Director for People													
Has the Cabinet Member(s) agreed the contents of the report? Yes													

The Impact of Loneliness

In October 2018 the government published 'A connected society: A strategy for tackling loneliness – laying the foundations for change', in response to the Jo Cox Commission on Loneliness. The Government strategy defines loneliness as: "A subjective, unwelcome feeling of lack or loss of companionship. It happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want."

Loneliness is a feeling that most people will experience at some point in their lives. However, prolonged and extreme exposure to loneliness can seriously impact an individual's well-being, and their ability to function in society. Loneliness has been shown to be linked to poor physical and mental health, and poor personal wellbeing with potentially adverse effects on communities.

The health impact of loneliness can be:

- Higher rates of depression
- Higher rates of dementia
- Increased risk of high blood pressure
- Increased risk of mortality [30% higher than general population – similar to smoking and excess alcohol consumption]
- Increased risk of falls
- Increased use of health and care services
- Increased risk of needing long term care

The national strategy identifies that there are numerous life events that mean people can become lonely – for example, bullying, leaving care, becoming homeless, losing a job, becoming a parent, refugees and asylum seekers, discrimination, carers, victims of crime, ill-health, retirement, divorce and bereavement. The key is to ensure that we support social connectedness at these times for individuals and communities. The aim is to develop strong and connected communities

The Strategy outlines some areas for action for National and Local Government and partners:

- Support and connect with friends, neighbours and community groups, through volunteering and participation.
- Provide leadership and policy while encouraging network creation for sharing, learning and innovation.
- Help to build personal and community resilience, through skills, training and service delivery.
- Commission services and provide holistic health approaches through Health and Wellbeing Boards and provisioning community space and transport
- Provide increased support to employees, customers and the communities they serve.

These areas for action are the basis for the Loneliness Action Plan being launched by the Plymouth Health and Wellbeing Board.

Measuring Loneliness – Plymouth performance

Data collected as part of the national Adult Social Care Survey shows that Plymouth has a performance that is similar to the England average and to comparator Authorities in social connectedness / contentedness. The national Carers survey in 2018 shows an improved score from the previous survey (in which Plymouth was worse than the England average and comparator Authorities), but benchmarking data hasn't yet been received.

Recent local evidence was gathered through a resident postal survey conducted to capture an insight into residents' perceptions and feelings about the city, their community and their life. This was sent out early in 2018 with a closing date at the start of April. Overall 2,296 valid surveys were returned, giving a response rate of 28 per cent.

Overall, when looking at the average scores for the four national wellbeing indicators of: life satisfaction; feeling that what one does in life is worthwhile, happiness yesterday and anxiousness yesterday, Plymouth has seen an upturn when compared with the data collected in the 2014 Plymouth Wellbeing Survey, however still down in comparison to national data from 2017.

Significantly higher levels of dissatisfaction, and poorer wellbeing:

- Those in the younger age group: 16-24yrs
- Those 'limited a lot' through a disability/health problem
- Residents of certain wards (varies slightly - Southway, Honicknowle, Efford and Lipson, Drake)

There are some typical profiles in Plymouth of people who may be at risk of loneliness:

- Widowed older homeowners living alone with long term health conditions
- Unmarried middle-agers with long term health conditions
- Younger renters with little trust and sense of belonging to their area/neighbourhood

Consultation to develop the Plymouth Action Plan

The government and the Campaign to End Loneliness have carried out extensive national consultation.

In Plymouth, a conversation was held with partners and stakeholders at a Wellbeing System Design Group (SDG) in August 2018, using the evidence collected from the above survey and this has informed the creation of the action plan. A draft plan was then developed and consultation on the plan was held at a second Wellbeing SDG meeting in January 2019.

Recommendation to Health and Wellbeing Board

To adopt the attached action plan which contains proposals for ways in which the national strategy areas for action can be implemented locally.

Outcome	Actions	Progress to date	Who	COMMENTS/ADDITIONS
Awareness of loneliness is maximised and stigma eliminated; people are more connected	POP supports the development of thriving networks of neighbourhoods and the VCSE	Neighbourhood Network Launch, March 2nd 2019; POP Thursdays networking opportunities	POP	
	Promote Plymouth as a friendly place to be; Chatty Cafes - space for conversation	(i) Welcoming City programme in place, (ii) Moments Café joined Chatty Café movement	Chief Execs PCC	
	Use of open and green spaces to maximise community connectedness	Natural Infrastructure Team Active Neighbourhoods, Park events, Firework nights	PCC	
	Ensure there is a life course approach to tackling loneliness	Thrive 5 Ways to Wellbeing approach embedded: University of Plymouth SPACE on city centre campus; Childrens Centres & Wellbeing Hubs;	Public Health, PCC	
	Encourage intergenerational approaches	Elder Tree supporting younger people to befriend older people; commissioned care services provide peer support for vulnerable groups	Commissioning, PCC	
	Increase numbers of volunteers, e.g. with Elder Tree, Silverline, Timebanking	(i) Mayflower 400 - 200 older people to be signed up for Mayflower Makers volunteer training in 2019/20; (ii) One Plymouth Launched, all age volunteering	Chief Execs PCC	
A strong and resilient community	No health without mental health - commission strengths based and personalised support services	In place: Complex needs service, Headscount, mental health floating support, mental health recovery college; Warwick/Edinburgh Mental Wellbeing Scale (WEMWEBS) tool used to monitor reduction in loneliness	Commissioning, PCC	
	The Wellbeing Hubs to increase community engagement and involvement	3 hubs launched so far, priority is the vision for wellbeing of local people and community connectedness	Wellbeing Hubs	
	Skilling up staff to be able to promote resilience	(i) Emotional Wellbeing Service in schools; (ii) Public Health upskilling Funeral Directors to appropriately support and signpost bereaved; (iii) PCC Bereavement and Registration services being equipped to signpost	All Providers	
	Ensure there is good move on from secondary and community mental health services	(i) Commissioned low level support services in place, will be linked into Wellbeing Hubs; (ii) social prescribing service	Commissioning, PCC	

Outcome	Actions	Progress to date	Who	COMMENTS/ADDITIONS
	Developing a Compassionate Community around end of life/bereavement	St Lukes developing a Compassionate City - normalising the discussion around death;	St Lukes	
	Delivery of mental health and wellbeing training in businesses and communities e.g Understanding MH and Wellbeing, Connect 5	Delivery within Health Improvement Contract already taking place and expanded to include Connect 5; Mental Health First Aid training promoted across providers	Livewell Southwest	
Leadership through Thrive Plymouth using 5 Ways to Wellbeing, ensures that partners are fully aware of the causes and effects of loneliness and how to tackle it	Review and respond to trigger points for loneliness through the Wellbeing SDG and citywide events	(i) SDG Meetings 3 times a year; (ii) Compassionate City network launch	Commissioning & Public Health, PCC	
	Promote 5 Ways to Wellbeing through Wellbeing Hubs;	Thrive Year 4 = 5 Ways to Wellbeing; Hubs branding	Public Health, PCC	
	H&WB Board to sign up to Pledge to End Loneliness	To be signed March 2019	HWB Board	
	Identify leads in key institutions - 'champions' E.g. University, Large employers	Workplace wellbeing champions - good coverage already in place	Public Health, PCC	
Co-production supports strong and connected communities	Ensure services are making appropriate referrals/ using screening processes for loneliness	Hubs Wellbeing Service procurement will include KPIs on reducing loneliness	Commissioning, PCC	
	Wellbeing Hubs using community spaces to provide a focal point of activity in neighbourhoods	4 open by 31st March 2019, 5 more planned	Wellbeing Hubs	
	Where relevant, commissioned services have Spec to include reducing loneliness	Elder Tree Befriending Service for people over 50, Extra Care Social Inclusion, Sheltered Housing, Social Prescribing; new Wellbeing Service in development; new Family Hubs in development	Commissioning, PCC	
There is increased knowledge of services/ opportunities to reduce loneliness	Relaunch POD, including information on useful websites	Launch of new POD in April	Commissioning, PCC	
	Through the Universal and Targeted Hubs Network, keep neighbourhood activity maps	Social prescribing service and 3 existing hubs are all mapping services; POP also mapping; Information and Signposting training already rolling out, e.g. libraries, pharmacies etc	Wellbeing Hubs	

Outcome	Actions	Progress to date	Who	COMMENTS/ADDITIONS
	Employers signing pledge	Use of mental health toolkit for employers. Workplace wellbeing offer from Health Improvement Team to local businesses - due to launch in Feb	Public Health, PCC	

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PLYMOUTH CITY COUNCIL

Subject:	Health Protection Report for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council and Cornwall and the Isles of Scilly Councils 2017-2018
Committee:	Health and Wellbeing Board
Date:	7 March 2019
Cabinet Member:	Councillor Ian Tuffin
CMT Member:	Ruth Harrell (Director of Public Health)
Author:	Sarah Ogilvie (Consultant in Public Health, Plymouth City Council) on behalf of the Devon, Cornwall and Isles of Scilly Health Protection Committee
Contact details:	T +441752307334 sarah.ogilvie@plymouth.gov.uk
Ref:	PH HPC AR 17-18
Key Decision:	No (report for noting only)
Part:	I

Purpose of the report:

This report provides a summary of the assurance functions of the Devon, Cornwall and Isles of Scilly Health Protection Committee and reviews performance for the period 1 April 2017 to 31 March 2018, for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council and the Council of the Isles of Scilly.

The report considers the following domains of health protection:

- Communicable disease control and environmental hazards
- Immunisation and screening
- Health care associated infections and anti-microbial resistance

The report sets out:

- Structures and arrangements in place to assure performance
- Performance and activity in all key areas during 2017-18
- Actions taken to date against the programme of health protection work priorities established by the committee for the period 2017 to 2018
- Priorities for the work programme 2018-19

Corporate Plan:

The role of the Health Protection Committee, along with its annual assurance report, is to provide the structures and arrangements required to assure adequate performance against health protection priorities across communicable disease control and environmental hazards; immunisation and screening; health care associated infections and antimicrobial resistance. The function of the Committee and its assurance role helps to deliver against the priorities within the Corporate

Plan, particularly with regards to Caring Plymouth, and to our objectives for a healthy city outlined within the Plymouth Plan.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land:

By serving four Local Authorities, the Health Protection Committee allows health protection expertise from four public health teams to be pooled in order to share skill and maximise capacity. For external partners whose health protection functions serve a larger geographic footprint, this model reduces their need to attend multiple health protection meetings with similar terms of reference and considers system-wide risk more efficiently and effectively.

There are no additional resource implications for the council with regards to this annual assurance report.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

The Health Protection Committee is formally mandated by the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council and Cornwall Council and the Council of the Isles of Scilly. The aim of the Health Protection Committee is to provide assurance to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council and the Council of the Isles of Scilly that adequate arrangements are in place for prevention, surveillance, planning and response to communicable disease and environmental hazards, required to protect the public's health.

The Committee has a number of health protection groups supporting it to identify risks across the health protection system and agree mitigating activities for which the Committee provides control and oversight.

These include:

- Devon, Cornwall and Somerset Health Care Associated Infection Network
- Devon Antimicrobial Stewardship Group
- Cornwall Antimicrobial Resistance Group
- Health Protection Advisory Group for wider Devon
- Cornwall Directors of Infection Control Group
- Locality Immunisation Groups
- Local Health Resilience Partnership
- South West Seasonal Influenza Strategic Group

Terms of Reference for each of these groups are regularly reviewed to ensure they reflect the assurance arrangements overseen by the Health Protection Committee.

The Local Authority Lead Officers review surveillance and performance monitoring information in order to identify health protection risks and/or under performance prior to Health Protection Committee meetings. Officers are responsible for liaising with relevant partners to ensure that actions have been agreed to mitigate against a particular risk identified, or to improve performance. The outcomes of these discussions are formally reported to the Health Protection Committee for consideration and agreement.

Equality and Diversity:

Has an Equality Impact Assessment been undertaken? No

Recommendations and Reasons for recommended action:

The report is for noting only.

Alternative options considered and rejected:

The report is for noting only.

Published work / information:

Background papers: No linked background papers – content provided in attached report

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7

Sign off: Report for noting only – sign off not required

Fin		Leg		Mon Off		HR		Assets		IT		Strat Proc	
Originating SMT Member Ruth Harrell (Director of Public Health)													
Has the Cabinet Member(s) agreed the content of the report? Yes													

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Public Health Devon

Devon County Council

Health Protection Report for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council and Cornwall and the Isles of Scilly Councils

2017 - 2018

3rd December 2018

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1. Introduction

1.1 This report provides a summary of the assurance functions of the Devon and Cornwall Health Protection Committee and reviews performance for the period from 1 April 2017 to 31 March 2018, for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council and the Council of the Isles of Scilly.

1.2 The report considers the following domains of health protection:

- Communicable disease control and environmental hazards;
- Immunisation and screening;
- Health care associated infections and anti-microbial resistance.

1.3 The report sets out:

- Structures and arrangements in place to assure performance;
- Performance and activity in all key areas during 2017-18;
- Actions taken to date against the programme of health protection work priorities established by the committee for the period 2017 to 2018;
- Priorities for the work programme 2018/19.

2. Assurance Arrangements

2.1 On 1 April 2013, the majority of former NHS Public Health responsibilities transferred to upper tier and unitary local authorities including the statutory responsibilities of the Director of Public Health. Local authorities, through their Director of Public Health, require assurance that appropriate arrangements are in place to protect the public's health. The scope of health protection in this context includes:

- Prevention and control of infectious diseases;
- National immunisation and screening programmes;
- Health care associated infections;
- Emergency planning and response (including severe weather and environmental hazards).

2.2 The Health Protection Committee is formally mandated by the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council and Cornwall Council and the Council of the Isles of Scilly.

2.3 The aim of the Health Protection Committee is to provide assurance to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council and the Council of the Isles of Scilly that adequate arrangements are in place for prevention, surveillance, planning and response to communicable disease and environmental hazards, required to protect the public's health.

2.4 Terms of Reference for the Committee were agreed by Local Authority Directors of Public Health, their Health Protection Lead Officers, and representatives from Public Health England, NHS England Area Team and the Clinical Commissioning Groups.

2.5 By serving four Local Authorities, the Committee allows health protection expertise from four public health teams to be pooled in order to share skill and maximise capacity. For external partners whose health protection functions serve a larger geographic footprint, this model reduces their need to attend multiple health protection meetings with similar terms of reference and considers system-wide risk more efficiently and effectively.

2.6 The Committee has a number of health protection groups supporting it to identify risks across the health protection system and agree mitigating activities for which the Committee provides control and oversight. As illustrated in **Appendix 1**, these include:

- Devon, Cornwall and Somerset Health Care Associated Infection Network;
- Devon Antimicrobial Stewardship Group;
- Cornwall Antimicrobial Resistance Group;
- Health Protection Advisory Group for wider Devon;
- Cornwall Directors of Infection Control Group;
- Locality Immunisation Groups;
- Local Health Resilience Partnership;
- South West Seasonal Influenza Strategic Group.

2.7 Terms of Reference for each of these groups are regularly reviewed to ensure they reflect the assurance arrangements overseen by the Health Protection Committee.

2.8 The Local Authority Lead Officers review surveillance and performance monitoring information in order to identify health protection risks and/or under performance prior to Health Protection Committee meetings. Officers are responsible for liaising with relevant partners to ensure that actions have been agreed to mitigate against a particular risk identified, or to improve performance. The outcomes of these discussions are formally reported to the Health Protection Committee for consideration and agreement.

2.9 Meetings of the Committee 2017-18 were held quarterly.

2.10 A memorandum of understanding, which specifies the roles and responsibilities of the various agencies involved in Health Protection, is in place.

3. Prevention and Control of Infectious Diseases

Organisational Roles and Responsibilities

3.1 NHS England is responsible for managing and overseeing the NHS response to an incident, ensuring that relevant NHS resources are mobilised and commanding or directing NHS resources as necessary. Additionally, NHS England is responsible for ensuring that their contracted providers will deliver an appropriate clinical response to any incident that threatens the public's health. They also commission the national immunisation and screening programmes.

3.2 Public Health England, through its consultants in communicable disease control, will lead the epidemiological investigation and the specialist health protection response to public health outbreaks or incidents and has responsibility for declaring a health protection incident, major or otherwise. It also advises on screening and immunisation policy and programmes through NHSE.

3.3 The Clinical Commissioning Group's role is to ensure, through contractual arrangements with provider organisations, that healthcare resources are made available to respond to health protection incidents or outbreaks (including screening/diagnostic and treatment services) although financial arrangements have yet to be finalised.

3.4 The Local Authority, through the Director of Public Health or their designate, has overall responsibility for the strategic oversight of an incident or outbreak which has an impact on their population's health. They should ensure that an appropriate response is put in place by NHS England and Public Health England, supported by the Clinical Commissioning

Group. In addition, they must be assured that the local health protection system is robust enough to respond appropriately in order to protect the local population's health, and that risks have been identified, are mitigated against, and are adequately controlled.

Surveillance Arrangements

3.5 The Public Health England Centre provides a quarterly report for its catchment: Devon, Cornwall and the Isles of Scilly and Somerset. The report provides epidemiological information on cases and outbreaks of communicable diseases of public health importance. A quarterly report is also produced at council level.

3.6 Fortnightly bulletins are produced throughout the winter months, providing surveillance information on influenza and influenza-like illness and infectious intestinal disease activity, including norovirus. These bulletins report information for the Public Health England Centre geography (Devon, Cornwall and the Isles of Scilly, and Somerset).

3.7 The Health Protection Advisory Group, convened quarterly, provides a forum for hospital microbiologists, environmental health officers, consultants in public health and infection control nurses to share intelligence and any risks identified in local arrangements to manage communicable disease incidence.

Disease Outbreaks and Incidence 2017-18

Syphilis

3.8 In January 2018 it was noted by local Exeter sexual health services that they were seeing an increase in cases of early syphilis (primary, secondary, early latent); further investigation using bespoke data revealed that the number of cases seen per quarter had risen from on average of 2.4 from Q1 2013 to Q1 2017 to an average of 11 cases per quarter between January 2017 and March 2018 – with the caveat that this number may fall slightly following data cleaning prior to release of routine GUMCAD data. This increase in syphilis has been seen across the South West region generally and also nationally. Locally, using available data up until the end of 2017, there is some evidence of a less marked increase in Cornwall, and no increases seen in Torbay or Plymouth.

3.9 In response to this increase in syphilis, Public Health England is working closely with the local authorities, GUM clinics and sexual health charities to try and better understand what is driving this increase and planning interventions. Bespoke data has been collected and analysed from the clinics reporting a rise in cases and work is underway to ensure real-time reporting of new cases, thereby removing the six-month lag inherent in current routine sexual health data.

Invasive GAS in People Who Inject Drugs

3.10 An outbreak of Group A Streptococcus amongst the homeless and/or drug using community living in the Plymouth area was investigated and managed by Public Health England in collaboration with Plymouth City Council Public Health and Derriford Hospital Microbiology.

3.11 Eighteen cases have been identified as part of this outbreak with onset dates between June 2017 and March 2018; ten of the cases had invasive disease the remainder having non-invasive wounds. Information about Group A Streptococcus and infection control advice has been shared with front line staff (drugs and alcohol support workers, police, primary care, hostels) and the homeless community.

Other Outbreaks and Situations

Devon

3.12 In 2017/2018 there were 112 outbreaks reported in care homes; the majority were related to suspect viral gastroenteritis but, it is notable that there were 40 suspected outbreaks of influenza in care homes. Four outbreaks of scabies in care homes were reported. Fifty-four outbreaks were reported in schools or nurseries, including 33 related to suspected viral gastroenteritis; fifteen scarlet fever, three influenza and three chicken pox outbreaks were reported.

Torbay

3.13 In 2017/2018 there were 22 care homes outbreaks reported from Torbay, with eleven related to influenza, ten viral gastroenteritis and one scabies outbreak. Additionally, there were fifteen outbreaks in schools or nurseries; nine related to influenza, three scarlet fever, two chicken pox and one influenza.

Plymouth

3.14 Twenty-eight care home outbreaks were reported from Plymouth, of which only four related to influenza; twenty-two were as a result of suspected viral gastroenteritis and there were two scabies outbreaks. Eighteen outbreaks were reported in schools, predominately suspected viral gastroenteritis (nine) but also scarlet fever (four), chicken pox (three) and two outbreaks of suspected influenza. Cases of food poisoning over a two-week period were linked to a takeaway food establishment in Plymouth: Environmental Health worked closely with the manager to mitigate any further risk.

Cornwall

3.15 Forty-five outbreaks were reported in care homes from Cornwall, predominately related to suspected viral gastroenteritis (36) and influenza (8) in addition to a single scabies outbreak. There were 29 outbreaks reported from schools or nurseries, including 17 suspected viral gastroenteritis cases and 11 scarlet fever cases. Five cases of Campylobacter were linked to the sale of unpasteurised milk from a particular venue. An outbreak of suspected viral gastroenteritis in a Cornwall Hotel was noteworthy in that two other hotels across the South West from the same small chain were affected around the same time.

Summary of Cases Reported

3.16 This year was notable for a high number of cases of influenza across the South West, with levels of activity not seen since the pandemic of 2009/2010. In summary, there were 1,931 confirmed cases of influenza across Devon, Plymouth and Torbay in 2017/18 compared to 727 the previous year. The situation in Cornwall was similar, with 486 cases compared to 123 cases the previous year. No other consistent trends or notable increases were seen across the area of this report in 2017/18. For detailed case numbers please consult the quarterly surveillance reports produced by Public Health England.

4 Immunisation and Screening

Organisational Roles/Responsibilities

4.1 NHS England is accountable for all national screening and immunisation programmes commissioned via the Section 7A arrangements. NHS England is the lead commissioner for all immunisation and screening programmes except the six antenatal and newborn programmes that are part of the CCG Maternity Payment Pathway arrangements, though NHS England remains the accountable commissioner. A list of all national screening programmes is included at **Appendix 4**.

4.2 Public Health England is responsible for setting national screening and immunisation policy and standards through expert groups (the National Screening Committee and Joint Committee on Vaccination and Immunisation). At a local level, specialist public health staff in Screening and Immunisation Teams, employed by Public Health England, work alongside NHS England Public Health Commissioning colleagues to provide accountability for the commissioning of the programmes and system leadership.

4.3 Local Authorities, through the Director of Public Health, are responsible for seeking assurance that screening and immunisation services are operating safely whilst maximising coverage and uptake within their local populations. Public Health Teams are responsible for both protecting and improving the health of their local population under the leadership of the Director of Public Health, including supporting Public Health England in projects that seek to improve programme coverage and uptake.

Assurance Arrangements

4.4 Public Health England South West Screening and Immunisation Team provides quarterly reports to the Devon, Cornwall and Isles of Scilly Health Protection Committee for each of the national immunisation and screening programmes. Due to the nature of the programmes and the NHS England and Public Health England data capture and validation processes (with the exception of the seasonal influenza vaccination programme) means that real time published data are not available for all programmes and for some programme reports are up to two calendar quarters in arrears. The quarterly reports provide up-to-date commentary on current issues and risks and unpublished data, if this is necessary for assurance purposes. Reports are considered by lead Local Authority Consultants in Public Health and any risks identified are considered with Public Health England specialists to agree mitigating activities.

4.5 Serious incidents that occur in the delivery of programmes are reported to the Director of Public Health for the Local Authority and to the Health Protection Committee.

4.6 There are oversight groups (Programme Boards) for all screening programmes and these form part of the local assurance mechanisms to identify risks to delivery and to oversee continuous quality improvement. In addition, specific project groups are convened, as necessary, to oversee significant developments in the programmes and the introduction of new programmes. For all immunisation programmes, oversight and assurance is achieved through a multi-agency locality immunisation group - one for each local authority area. In addition, there is a separate Seasonal Influenza Immunisation Board for the South West. All the oversight groups have Terms of Reference and clear escalation routes to ensure accountability both within NHS England and Public Health England and into individual partner organisations.

Immunisation Performance 2017-18

4.7 Key highlights from immunisation performance include:

- Childhood immunisation performance throughout 2017-18 is detailed in **Appendix 3**. This data is taken from the national coverage statistics, which is accompanied by an interactive web-based data dashboard that allows users to visualise vaccine coverage data down to local authority level and has local and national trends for the years 2013-14 to 2017-18. The dashboard can be accessed via the link below: National COVER statistics 2017/18.

- The national target for coverage of childhood immunisation is 95%. Coverage of childhood immunisations continues to be high in Devon, Torbay, Plymouth, Cornwall and the Isles of Scilly. Of the 13 routine childhood vaccination programmes, the national target has been achieved for 12 programmes in Plymouth, eight programmes in Torbay, five programmes in Devon, and three programmes in Cornwall. All programmes in Plymouth and Cornwall also achieved over 90% coverage. Only two programmes in Devon (Rotavirus and pre-school booster) and one programme in Torbay (pre-school booster) achieved less than 90%.

- There is a year on year pattern of small fluctuations in coverage rates across vaccination programmes and geographical areas and this remains evident in the 2017/18 data. However, as coverage is variable, a continued focus on maintaining and improving coverage is needed to ensure that the local population is protected and does not become susceptible to outbreaks of vaccine preventable diseases.

- Improving MMR uptake is a national and local priority, with work continuing during 2017/18 in all areas, overseen by the multi-agency Locality Immunisation Groups. Herd immunity with coverage of 95% or above has been maintained for MMR1 at five years of age in all four local authority areas. For MMR2 at five years, all four areas have achieved over 90% with further increases in coverage in all areas except Devon.

- Rotavirus coverage in Devon has been significantly lower than the England average (82.7% vs 89.6% in 2016/17). This has been felt to be at least in part to data flow issues between GP practices and the Child Health Information Service. There has been a significant increase in coverage during 2017/18 with coverage now 88.1%. This remains below performance in the other three local authority areas and the England average. More detailed analysis is planned to understand if this is a data issue or an issue with system or parent factors.

- HPV (Human Papilloma Virus) coverage for 2017/18 has been submitted for national validation but is not yet published.

- The latest published data for Shingles is from January 2018 (cumulative monthly uptake from September 2013 to January 2018):

CCG	Routine cohort aged 70 (%)	Catch-up cohort aged 78(%)
England	34.6	34.8
Kernow	31.1	34.7
NEW Devon	36.1	37.0
South Devon and Torbay	37.3	37.0

- At a national level, there has been a decrease in uptake of about 5% compared to January 2017. This is considered to be mainly due to a data artefact resulting from the change in eligibility criteria for the vaccination programme in April 2017, whereby people turning 70 and 78 at any time in the financial year become eligible on 1st April. This means that some people have received the vaccine aged 69 and 77 therefore are not included in the uptake data. However, coverage among 69 and 77 year olds, which includes individuals eligible under the new eligibility criteria, has increased by 3.9% and 4.0% respectively. It is therefore likely that most of the decrease in coverage evaluated in January 2018 is a data artefact related to the change in eligibility criteria. Even after taking this into account, coverage has decreased compared to that achieved at the end of January 2017, however, the rate of decrease appears to be slower than in previous years. From September 2018, a new quarterly collection will evaluate coverage of adults who have become eligible under the revised criteria since April 2018 thus removing the data anomaly.

- Uptake of the influenza vaccination in 2017/18 increased in all population groups, except carers, where the uptake remained the same (see **Appendix 3**). In addition, there was a further increase in uptake of vaccination in frontline healthcare workers - almost certainly due to the national CQUIN.

Developments in National Immunisation Programmes During 2017-18

Childhood Immunisations

4.8 Although coverage in Devon, Torbay, Plymouth, Cornwall and the Isles of Scilly is very good, each locality immunisation group continues to focus on targeted work to reduce the inequalities that remain, building on the action plans following the South West Needs Assessment for 0 - 5 year old vaccinations, including the survey of GP practices that was undertaken last year. The Screening and Immunisation Team will be reviewing the arrangements of these groups to ensure they are working effectively going forward. Key to this is the partnership working with the Local Authority Public Health teams.

4.9 The main recommendations of the Needs Assessment for Devon, Torbay, Plymouth, Cornwall and the Isles of Scilly included a need to better understand some of the inequalities in the area, a focus on MMR by the age of 5, improving data flows between Child Health and GP practices, targeted support for practices with low uptake, and improving awareness in general practice of immunisation training. Work across all these areas has been progressing well. In addition, an MMR Innovation Fund has been set up to support practices to do specific work to improve the MMR uptake. The project will run over a year and will be evaluated in the near future. Learning will be shared via the locality immunisation groups and through primary care routes.

4.10 Nationally, measles continues to be a concern. During 2017/18, and more recently, there have been regular cases and a number of significant outbreaks in the Bristol and Gloucester area. In Devon, Cornwall and the Isles of Scilly, there have been several ad-hoc cases but no recent outbreaks. A multi-agency South West Strategic Oversight Group is in place and is co-ordinating the outbreak response. Despite the outbreaks, the main strategy to combat measles is to continue to improve coverage of the routine MMR vaccination programme and achieve herd immunity. This is a local priority for the Screening and Immunisation Team and interventions are being delivered jointly with key partners through the locality immunisation groups.

Targeted Immunisations – Hepatitis B and BCG

4.11 The pathway and failsafe process to follow up babies born to HepB+ mothers to try to ensure all infants complete the full schedule is now well established and working well. This pathway is an important part of the process to minimise the risk of the infant contracting the infection. The dried bloodspot scheme for HepB serology testing at 12 months, which was launched last year, has been successfully embedded into practice.

4.12 From 1st August 2017, universal Hepatitis B immunisation was introduced into the routine childhood immunisation programme. This was accomplished by the move to a hexavalent vaccine, combining a Hepatitis B vaccine with the other primary vaccines. The enhanced HepB vaccination programme continues for babies born to HepB+ mothers.

4.13 In 2015, stock of the only UK-licensed BCG vaccine was interrupted. In response, Public Health England issued advice on prioritisation of BCG vaccine stock for newborns and infants of recognised high-risk groups for tuberculosis, or to tuberculin negative children under 6 years of age. In 2016, PHE secured an interim supply of BCG vaccine and, more recently, a new UK-licenced BCG vaccine has been procured and will become available in the near future.

School-aged Immunisations

4.14 Developments during last year with the move to delivery of school-aged immunisations in Cornwall to a school setting, and the shift to Year 9 for the Td/IPV (teenage booster), alongside the routine MenACWY cohort in all areas, are now well embedded into practice and running well.

4.15 During 2017/18, NHS England undertook a procurement for school-aged immunisations for the whole of Devon. Virgin Healthcare is the new provider and the service has been successfully mobilised ready for the start of term in September 2018. A key focus of the procurement was for the service to be fully accessible to young people, to improve uptake, reduce inequalities, and to make use of technology such as e-consent and developments such as self-consent.

Child Health Information Services

4.16 During 2017/18, NHS England has completed a successful procurement of Child Health Information Services for the South West area. The new provider, Health Intelligence, will be prioritising the move to electronic data flow between GP practices and the Child Health Information System, and moving towards a greater role in failsafe and follow up of children who have incomplete vaccination schedules. It is hoped this will greatly improve the timeliness, accuracy and completeness of immunisation data and contribute to improvement in coverage rates.

Adult Immunisations

Pertussis and Flu Vaccination in Pregnancy

4.17 There has been good progress across Devon, Cornwall and the Isles of Scilly providers to establish vaccination of pregnant women within the maternity services. All providers have signed up and delivery is going well with levels of activity close to what was planned. More detailed work is needed to ensure reporting processes are fully embedded so that performance fully reflects activity.

4.18 Across Devon, Cornwall and the Isles of Scilly, up to 31 March 2018, 2,882 flu vaccinations were delivered to pregnant women by Trusts (compared to 5,393 by GP practices by the end of Jan 2018). Overall, uptake went up by 6% in Devon and 3% in Cornwall, however, it is not possible to conclude this is purely due to the maternity activity. Evaluation to date shows that most providers delivered as many flu vaccines between January and March 2018 as they did during November to December 2017, which suggests that the service is providing additional access to that provided in primary care during the later stages of the influenza vaccination programme.

4.19 Pertussis vaccination in pregnancy was introduced in England in 2012 as an outbreak response to a nationwide rise in pertussis infections and deaths in the very young. From September 2017, all Devon, Cornwall and the Isles of Scilly providers of antenatal care signed up to offer pertussis vaccination as part of antenatal care, meaning women do not have to make an additional appointment at their GP practice. Since its introduction, providers have delivered 3,457 pertussis vaccinations up to the end of March 2018.

4.20 The most recent national data, extracted from Sentinel practice GP systems across the South West, shows that overall uptake of pertussis across Devon, Cornwall and the Isles of Scilly, as at December 2017, has dipped a little to 71.8% from its highest level of 76.9% in January 2017. However, at a CCG level, uptake has continued to increase to its highest levels in NEW Devon CCG (80.7%) and in South Devon and Torbay CCG (81.3%), well above the England average (74.7%). Reported uptake in Kernow CCG was only 35.7%, however, this is due to an IT system data issue that is disproportionately affecting Cornwall, and there is no operational reason to believe that uptake in Kernow CCG is not following the national trend of a continuous increase. It is thought that the increase in coverage is due to the policy change resulting in immunisation being able to be given from 16 weeks gestation.

Shingles

4.21 During 2017/18, a Shingles work plan has been introduced to reduce variation in uptake across the wider South West area. The first phase of this work is to undertake a data validation exercise of CQRS claims and ImmForm records to confirm accuracy of the uptake rates, followed by targeted work with practices with low uptake. A Good Practice Guide has been published and learning shared from those practices with a good uptake. The Screening and Immunisation Team is also exploring a pilot to incentivise GP practices to send 70th birthday cards with invitation letter to all patients as they turn 70.

Influenza Immunisation

4.22 In 2017/18, the key changes in the South West seasonal flu programme were the successful continued expansion of the child flu programme to include:

- all children aged 2, 3 and 4, and to all children in school years 1, 2, 3 and 4
- inclusion of patients who are morbidly obese in the GP offer
- local roll-out across South West providers of the maternity service offer to pregnant women
- delivery of the programme to care home workers and social workers as an addition to access through their employer occupational health scheme
- continuation of the Advanced Community Pharmacy Seasonal Influenza Vaccination programme
- extension of the CQUIN for frontline health care workers for a second year.

4.23 Uptake rates of the vaccine increased in almost all groups and in all areas.

Key Issues for Immunisation Programmes in Plymouth, Devon, Cornwall and Isles of Scilly in 2018/19

4.24 Improving uptake and reducing inequalities of MMR will continue to be a top priority for all areas, working in partnership through the locality immunisation groups.

4.25 As a result of the introduction of the universal Hepatitis B vaccination, a national review of the programme for babies born to HepB+ mothers is to be undertaken during 2018/19. The aim of the review is to strengthen the enhanced programme for these mothers and babies and to develop a suite of guidance and resources that will support maternity units and primary care, in particular, to deliver the full programme to all babies.

4.26 In light of the anticipated supply of a new UK-licensed BCG vaccine, work will be undertaken with BCG vaccination providers to introduce the new vaccine and to support them to catch up eligible children who may have had delayed vaccination.

4.27 There is a need to work closely with the new school-aged immunisation providers in Devon and Cornwall, and the new SW CHIS provider to deliver the benefits identified during procurement. For school-aged immunisations, this focuses on increasing engagement of young people to develop a fully accessible service and making best use of technology, and for CHIS to implement in the first year fully electronic transfer of immunisation data between CHIS and GP practices, in particular, followed by other immunisation providers.

4.28 In July 2018, it was announced that the existing adolescent HPV vaccination programme for girls to prevent cervical cancer, will be extended to boys aged 12-13. The vaccine will not only protect men from HPV-related diseases, such as oral, throat and anal cancer, but will enhance the reduction of the overall number of cervical cancers in women, though herd immunity. Details about the timescales for implementation and operational guidance is awaited.

4.29 To continue to work to improve the uptake of the Shingles vaccination through work with GP practices and health promotion activities to raise awareness and increase demand from the public.

4.30 To continue to expand the Seasonal Influenza Vaccination programme by offering vaccination to all children aged 2 up to 9 years of age with a specific focus on pre-school children where uptake is not as high as in school-age children. Extension of the offer to care home workers and social workers for a second year, to include for the 2018/19 season, the offer to voluntary managed hospice sector to hospice workers. To deliver a gold standard vaccine offer of quadrivalent vaccine for those under 65 at risk groups and adjuvanted trivalent for those over 65 years, in addition to the quadrivalent vaccine for the children's programme.

4.31 Men who have sex with men (MSM) are a group at high risk of HPV infection and associated disease but receive very little indirect health benefit from the current HPV vaccination programme for girls, which was introduced to protect against cervical cancer. In November 2015, the Joint Committee on Vaccination and Immunisation (JCVI) advised that a targeted HPV vaccination programme should be established for MSM, aged up to and including the age of 45 years, who attend Level 3 Specialist Sexual Health Services (SSHS) and HIV clinics. This setting was chosen because it is by far the most accessed sexual health service by self-declaring MSM. MSM accessing SSHS services tend to be at greater risk of 'risky behaviour' and STI transmission. Following a successful pilot led by PHE, ministerial approval was given in February 2018 to roll out the programme nationally, with effect from April 2018, as part of the S7A agreement.

4.32 Active support from Local Authority colleagues and teams for the locality immunisation groups is important to ensure that work to increase the overall uptake of MMR and other immunisations, and to reduce local inequalities in uptake is being appropriately targeted, and that best use is being made of all available resources across the wider system to achieve the population coverage targets.

Screening Performance 2017-18

4.33 Screening coverage 2017-18 for the main cancer and non-cancer screening programmes is detailed in **Appendix 4**. Key points related to performance against national standards are:

- Performance in antenatal screening programmes continues to be excellent. The only area of persistent under-performance in two providers is the ST2 KPI that measures the timeliness of completion of screening for women at high risk of haemoglobinopathy. This is due to the low-prevalence model where first trimester screening blood tests are aligned to the foetal anomaly screening programme, with exceptions for high-risk women. This has always been accepted by the Screening Quality Assurance Service until recent QA visits, where recommendations for improvement have been made. Providers have been asked to review their delivery model to ensure the national standards are achieved.

- Performance of the newborn bloodspot screening programme has improved with a significant improvement in the avoidable repeat rate (KPI NB2). This has been achieved through a concerted effort by providers to improve a number of areas of practice and system processes, coupled with more robust Trust internal governance processes. This work has been supported by a local 2 year CQUIN.

- Completion of newborn bloodspot screening for some children up to a year old who move in to the area (KPI NB4) is proving a challenge. Systems are in place but it can be difficult to gather information for some children, particularly those who move in from abroad. In general, non-compliance is due to lack of data recorded on the CHIS rather than incomplete screening. The Screening and Immunisation Team will be working with providers and the CHIS team to investigate and identify any additional interventions that can be taken to improve performance.

- The roll-out of the NIPE SMART IT system has helped to increase the robustness of the failsafe processes ensuring all babies are identified and offered screening.

- Diabetic Eye Screening coverage has remained good in all programmes during 2017 and all providers are above the national acceptable target of 75%, with two above the achievable target of 85%.

- Cervical screening coverage remains below the national target of 80% in all areas and continues to decrease, however, rates remain above the national average.

- Breast screening coverage is just below the 80% target in all areas and significantly so in Torbay. All areas remain above the national average.

- Bowel screening coverage remains above the 60% target in all areas and is well above the national average. Devon coverage has increased by approximately 2% for the last two years.

- Performance in the abdominal aortic aneurysm (AAA) screening programme continues to be excellent. Coverage is stable and meets acceptable national standards.

Developments in National Screening Programmes During 2017-18

4.34 The key developments during 2017/18 included:

Antenatal and Newborn

4.35 Roll-out of the new KPIs for mid-trimester foetal anomaly scan has highlighted significant challenges due to pressures in obstetric ultrasound capacity. The enhanced monitoring has led to actions to improve service delivery and access for women. Work has also been undertaken with providers to enhance the tracking and failsafe of women to ensure that all women are offered a scan at the correct gestation and to follow-up women if they do not attend.

4.36 Extended working in the newborn lab to process bloodspot samples on Bank Holidays and Saturday mornings, has led to improved turnaround times and speedier results to parents.

4.37 Introduction of electronic transfer of newborn bloodspot results between the newborn lab and the CHIS service in Devon has led to more timely availability of results and a reduced risk of transcription errors due to manual data entry. It was not possible to roll-out to Cornwall during 2017/18 due to technical issues and this will be achieved as part of the mobilisation to the newly procured CHIS service.

4.38 A review of transport arrangements for newborn bloodspot samples leading to several improvements that have contributed to the improvement of NB2 KPI.

4.39 The introduction of the new IT system, NIPE SMaRT for the Newborn and Infant Physical Examination (NIPE) screening programme and the roll-out of new NIPE KPIs has led to significant improvements in the tracking and failsafe of screen-positive babies through screening, referral and attendance for assessment. Learning has been shared locally and nationally and has informed the development of a new national good practice guidance and led to improvements in provider screening policies and procedures.

4.40 Quality assurance visits for antenatal and newborn programmes have continued and all the Devon, Cornwall and Isles of Scilly programmes have been visited. All have had positive visits and show that programmes are delivering high quality and safe screening services that meet the majority of national standards. Work is underway in all providers to implement the QA recommendations.

Diabetic Eye Screening

4.41 Diabetic eye screening programmes continued to perform well across the area.

4.42 During 2017/18, NHS England South West commenced a large procurement for all South West Diabetic eye screening services. The new provider/s will be in place for 1st April 2019. A key focus of the procurement is the approach to locality working and access for patients to improve uptake and reduce inequalities.

4.43 The Screening and Immunisation Team has been working closely with the provider teams to facilitate a continued improvement in the accuracy and completeness of screening registers. These rely on information being shared and validated by both the GP practice and the provider screening team. Audits have been undertaken to assess accuracy and work to improve this has been undertaken where needed. During the last year, all providers are now moving towards implementation of GP2DRS, which enables details of registered patients eligible for screening to be automatically extracted from practice systems. This should improve the timeliness and accuracy of the identification of the eligible cohort as long as GP practices continue to ensure accurate coding of diabetes in patient records.

Cervical Screening

4.44 2017/18 has been a challenging year for the national cervical screening programme. South West providers have continued to perform well across most of the KPIs and standards, however, more recently there has been a marked deterioration in the cytology lab turnaround time. This is a consequence of the transition to primary HPV testing, which is being implemented to achieve further improvements in the screening programme and greater benefits to women. Primary HPV testing will mean a reduction in the demand for cytology laboratory services long-term and staffing levels are reducing, impacting on the ability of labs to maintain throughput within the two-week target. National and local mitigation plans are in place to sustain the current service ahead of the full implementation of primary HPV testing.

4.45 Reducing coverage has been a major concern over several years, with local rates mirroring the slow but consistent reduction in national rates. The Screening and Immunisation Team had identified cervical screening coverage as a top priority for 2017/18 planning a range of activities, working alongside Jo's Trust and other local Screening and Immunisation Teams to share learning. In view of the intense pressure on local screening labs and services resulting from the national programme changes, the focus was shifted in-year to work with GP practices on improving systems and processes, and to deliver training for practice reception staff.

4.46 Sample-taker training and its effective oversight is a critical factor in the quality and safety of the screening programme. The Screening and Immunisation Team has reviewed and updated the training policy and created a single South West sample-taker database to ensure that all sample-takers are registered, have a unique ID code to track samples, and are alerted to when they need to update.

Breast Screening

4.47 Breast screening services in Devon, Cornwall and the Isles of Scilly continue to meet the majority of the national minimum standards. A particular challenge in some areas includes maintaining consistent performance against the standard for time between screening and assessment. The West Devon service has seen a significant improvement in performance and quality since last year. There has been significant and continued pressure on the programmes due to a combination of demand from the symptomatic service and capacity pressures within screening teams due to shortages of key staff (radiographers, radiologists, and specialist breast care nurses). This is a national problem that is starting to affect many programmes across the country.

4.48 Last year, the increasing number of GP practice mergers and closures was having a negative impact on round length. When women have to re-register with a new practice their screening invitation date may be affected. This affects the women and the service has to find capacity for unplanned appointments. This can create pressure on the service temporarily affecting performance against targets and this is a national issue. Local action by NHS England South West to improve communication of practice changes has enabled the screening units to plan ahead for these fluctuations, thus minimising the disruption to women and the screening service.

Bowel Screening

4.49 Roll-out of bowel scope screening remains a significant challenge across Devon, Cornwall and Isles of Scilly providers due to a range of issues, including for Cornwall, the closure of the Bodmin Treatment Centre. Staffing issues continue, particularly for endoscopists and radiographers, thus sustaining the pressure on both screening and symptomatic endoscopy services. However, performance against national standards is mostly being maintained.

4.50 Following national consultation, a decision has been taken to introduce FIT120 as a screening test in to the bowel screening programme, to replace the current faecal occult blood test (see 4.59 below). In light of this decision, national work is underway to review and consult on the long-term implications for the bowel scope programme. At present, roll-out is continuing in all Devon, Cornwall and Isles of Scilly providers to the agreed trajectories.

Key Issues for Screening Programmes 2018/19 Onwards

Antenatal and Newborn

4.51 Providers who are not yet achieving ST2 KPI have been recommended, through QA visits, to review their services and make changes to ensure compliance with this KPI and the associated service standards. The Screening and Immunisation Team will be monitoring progress via the screening programme boards.

4.52 The Screening and Immunisation Team will undertake a specific piece of work with the maternity providers and Health Intelligence (CHIS provider) to investigate the low NB4 KPI (movers-in newborn bloodspot) to identify any additional interventions that can be taken to improve performance.

4.53 NIPT (non-invasive pre-natal testing) is to be introduced into the first trimester foetal anomaly screening programme. Women who screen positive in first trimester combined testing will be offered NIPT instead of invasive testing. A national implementation team is in place and the exact timeline is awaited. A large reduction in the number of invasive diagnostic tests (amniocentesis and CVS) is expected and this is likely to have an impact on foetal medicine services.

Diabetic Eye Screening

4.54 Contract award for the newly procured services will take place in Autumn 2018, and the Screening and Immunisation Team will be supporting the Public Health Commissioning Team and the new providers to mobilise the new services.

4.55 The current programme invites all eligible patients for annual screening. During 2018/19, screening intervals will be extended and those patients whose screening history identifies them to be at lower risk of retinopathy will be invited every two years. Other patients will continue to be invited every year.

Cervical Screening

4.56 Work is well underway to implement primary HPV testing. The aim of this change is to more effectively identify women at greatest risk of developing cancer (those who are positive for high risk HPV infection) and, at the same time, return a high proportion of women who are HPV negative (and at lower risk of cancer) back to routine screening intervals. A national procurement of a small number of new primary HPV screening labs is underway and this is being accompanied by a new national cervical screening IT system. Women’s experience of the cervical screening test will be the same.

4.57 A national decision is awaited about a possible change to screening intervals (currently three or five years depending on age) following the introduction of primary HPV testing. It is unlikely that this will be during 2018/19.

4.58 Work is being undertaken to procure a new sample-taker database with increased functionality to support the sample takers and the programme. This is progressing well during the year and will be in place by the end of the 2018/19 financial year.

Bowel Screening

4.59 Following national consultation, a decision has been taken to introduce FIT120 as a screening test into the bowel screening programme to replace the current faecal occult blood test. Current planning is for FIT120 to go live from December 2018, or April 2019 at the latest, with a phased roll-out. Detailed operational guidance and funding agreements are awaited. National survey data in 2017 indicated that many providers, including those in the South West, would have difficulty rolling out FIT due to the expected increase in the number of colonoscopies. The Public Health Commissioning Team and the Screening & Immunisation Team are working closely with providers to support local planning.

5 Health Care Associated Infections

Organisational Roles and Responsibilities

5.1 NHS England sets out and monitors the NHS Outcomes Framework which includes Domain Five (safety): treating and caring for people in a safe environment and protecting them from avoidable harm. The Area Teams of NHS England hold local Clinical Commissioning Groups to account for performance against indicators under this domain, which includes incidence of healthcare associated methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia and incidence of *Clostridium difficile* infection (CDI).

5.2 Public Health England, through its consultants in communicable disease control, leads the epidemiological investigation and the specialist health protection response to wider community non-hospital outbreaks, and is responsible for declaring a health protection incident.

5.3 The Clinical Commissioning Group's role is to ensure, through contractual arrangements with provider organisations, that health care associated infection standard operating procedures are in all provider contracts and are monitored regularly. Northern Eastern & Western Devon and South Devon & Torbay Clinical Commissioning Groups deploy this role through the Nursing and Quality portfolio. NHS Kernow Clinical Commissioning Group employs a nurse consultant for health care associated infections. This is an assurance and advisory role. In addition, Clinical Commissioning Groups must be assured that the Infection Prevention and Control Teams covering the hospital and NHS community healthcare provided services sector are robust enough to respond appropriately to protect the local population's health, and that risks of health care associated infection have been identified, are mitigated against, and are adequately controlled.

5.4 The Local Authority, through the Director of Public Health or their designate, has overall responsibility for the strategic oversight of a health care associated infection incident affecting their population's health. They should ensure that an appropriate response is put in place by NHS England and Public Health England, supported by the Clinical Commissioning Group.

Health Care Associated Infection Forums

5.5 The Devon Health Care Associated Infection Programme Group was a sub-group of the Health Protection Committee during 2014-17, working towards the elimination of avoidable health care associated infections (HCAI) for the population of Devon, including the Unitary Authorities of Plymouth and Torbay. The group covered health and social care interventions in clinical, home and residential care environments, through the identification of risks, the planning of risk mitigation actions, and the sharing of best practice in the field. The group was co-ordinated by NEW Devon Clinical Commissioning Group and was a cross-agency forum involving Acute and Community NHS Trusts, Ambulance and Out of Hours Doctors, Local Authority Public Health, Public Health England, Medicines Optimisation and the NHS England Area Team.

5.6 In Cornwall there is a Directors of Infection Control Group with multi-agency attendance working on a similar agenda, also reporting into the Health Protection Committee. There is cross-attendance between the Devon and Cornwall groups.

5.7 The final Devon Health Care Associated Infection Programme Group meeting was held in July 2017, when E. coli reduction strategies were discussed and the lack of a community infection management service highlighted as a risk.

5.8 The Devon Health Care Associated Infection Programme Group became the Devon, Cornwall and Somerset Health Care Associated Infection Network at the beginning of 2017/18.

5.9 Key areas for action in 2018-19 are:

- Community infection prevention, management and control;
- Gram negative bacteraemia reduction;
- Continued monitoring of health care acquired infection by Clinical Commissioning Group area for C.difficile infection, MRSA, MSSA and E.coli;
- Outbreak monitoring to ensure timely patient transfers, system flow and resilience.

Healthcare Associated Infections Incidence 2017-18

5.10 Healthcare associated infection incidence is given for NEW Devon and South Devon and Torbay and Kernow CCGs in **Appendix 5**. Key points for Devon and Cornwall are:

MRSA

5.11 The national target for MRSA is no cases. In 2017-18, five cases of MRSA were reported in NEW Devon; three in South Devon & Torbay, and five in Cornwall. All cases were investigated, and processes reviewed. As of April 2018, the requirements for MRSA post-infection reviews (PIR) have changed. There is no longer a national requirement for a PIR to be completed although local reviews are still expected. This change has been communicated to all providers.

MSSA

5.12 Rates of reported MSSA were within target levels. Reported community-acquired MSSA bacteraemia rates in South Devon & Torbay increased in the final quarter of the year, and full root cause analysis is now being undertaken on all cases for a three-month period. MSSA rates have also increased in Cornwall and line care has been targeted for improvement in the acute setting with further work needed to understand the drivers for this.

C.difficile Infection

5.13 Devon, as a whole, matched the national C.difficile target, however, there was considerable local variation. North, West and South Devon providers breached the national target. All cases were investigated, and the CCGs are assured that the number of avoidable cases remains low. Cornwall exceeded the target by 24 cases with only seven avoidable cases identified in the hospital onset cohort.

E.coli Bacteraemia

5.14 E.coli bacteraemia rates, chiefly community acquired, increased during 2017-18 across Devon. Reduction efforts are focused around urinary sources, including catheter use, hydration, training, and improving communications between acute and community settings when patients are transferred. A community infection management service business case is being drafted, and this is a key aspect of the reduction strategy in Devon.

5.15 In Cornwall, hospital cases have reduced but community onset cases continue to increase. Reduction work streams focus on urinary and hepatobiliary sources and antimicrobial stewardship.

6 Antimicrobial resistance

Data and Trends

6.1 A monitoring report is included at **Appendix 6**. Key points are:

- There has been an increase in gram-negative bloodstream infections (eg E.coli and Klebsiella), both nationally and locally, with a related increase in antibiotic resistance. Resistant E.coli particularly affects older people and infants.
- The Secretary of State for Health has announced an ambition to reduce gram-negative bloodstream infections by 50% by 2021. Surveillance of these organisms changed from April 2017 to include Klebsiella and Pseudomonas.
- Carbapenamase producing organisms, resistant to certain anti-microbials, remain relatively uncommon but are continuing to increase year on year, including within the Peninsula. Public Health England has confirmed with hospitals within the region that they are confident in following procedures for dealing with cases identified.

System-wide Action to Address Antimicrobial Resistance

6.2 A successful antimicrobial resistance steering group has been in place in Cornwall for several years and now there is a similar group covering the whole of Devon (The Devon Antimicrobial Stewardship Group).

6.3 Outputs from the Cornwall Antimicrobial Resistance Group include the launch of the Antimicrobial Resistance (AMR) section of the Kernow CCG webpage; the availability of primary care antibiotic guidelines in mobile phone application format, and the appointment of two Drug and Bug nurse educators who delivered Infection Prevention and Control, Antimicrobial Stewardship and Antimicrobial Resistance education to 88% of nursing homes in Cornwall. The nurses also delivered education around infection control and urinary tract infection management based on the “To Dip or Not to Dip” project, initiated by Bath and North East Somerset CCG. Eden One Health Conference in May 2017 brought together a diverse group of practitioners from different sectors in Cornwall, including vets and podiatrists, for a one-day session on AMR from a One Health perspective. The day showcased a variety of AMR-related subjects and was highly evaluated by delegates. The lectures from the event are available on YouTube and have been shared widely with stakeholders.

6.4 The Devon Antimicrobial Stewardship Group has widened its membership to include academia and dentistry and is exploring links to animal health. The group is working on the development of a comprehensive action plan to ensure effective co-ordination of a Devon-wide approach to addressing antimicrobial resistance. This includes actions to reduce inappropriate antimicrobial demand and use, and actions to prevent and limit the spread of infections across Devon. As part of this the group is supporting the development of a business case for a Devon-wide community infection prevention and control service. The group is supporting World Antibiotic Awareness Week and European Antibiotic Awareness Day 2018. Discussions are also taking place as to whether community IPC is dealt with within AMS or via another pan Devon group with a community IPC focus.

6.5 The following table summarises the most up-to-date prescribing indicator data for Devon and Cornwall (Data Source = AMR Fingertips).

Table 1: Summary of Prescribing Indicator Data for Devon and Cornwall from December 2017, AMR Fingertips

Indicator	England	South West	Kernow CCG	NEW Devon CCG	**South Devon and Torbay** CCG	**Comment**
Twelve month rolling total number of prescribed antibiotic items per STAR-PU by Clinical Commissioning Group (CCG) within England[1]	1.03	1.00	1.02	1.01	1.04	No confidence intervals available
Twelve month rolling percentage of prescribed antibiotic items from cephalosporin, quinolone and co-amoxiclav class (%)[2]	8.82	8.70	9.90	10.21	10.36	No confidence intervals available

Explanatory text
Total number of prescribed antibiotic items per STAR-PU
Numerator: Total number of antibiotic items prescribed in practices located within the area ie in a primary care setting.
The number of items is a measure of how often a prescriber has decided to write a prescription. It is often used to look at prescriber behaviour as every prescription is an opportunity to change treatment. The item is a reasonable measure of the number of courses of treatment.
Denominator: STAR-PU are weighted units to allow comparisons adjusting for the age and sex of patients' distribution of each practice.
STAR-PU removes confounding effects of age and sex in the comparison of prescribing between different geographical areas.
In this specific indicator, a higher value is associated with increased prescribing, with all CCG areas being greater than the South West average, with SDT and Torbay being greater than the NHSE average.
This indicator does not take into account any antibiotics given through a non-oral route.
Percentage of prescribed antibiotic items from cephalosporin, quinolone and co-amoxiclav class (%)
The percentage of broad-spectrum items prescribed in primary care settings accounted for by the following antimicrobials; cephalosporin, fluoroquinolone and co-amoxiclav as a percentage of all antibacterial agents, as defined by the British National Formulary (BNF).
This is a target to reduce the usage of broad-spectrum antibiotics. The respective proportions of broad-spectrum prescribing within specific geographical areas and percentage change over time can be seen.
In this specific indicator, a higher value is associated with increased levels of prescribing, with all CCG areas being greater than the South West and NHS E average.
In this specific indicator, a higher value is associated with increased prescribing, with all CCG areas being greater than the South West average, with SDT and Torbay being greater than the NHSE average.
This indicator does not take into account any antibiotics given through a non-oral route.

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[1] In order to fully appreciate antimicrobial prescribing, it is necessary to take into consideration demographic characteristics of the population as it may influence levels of prescribing. For that reason, STAR-PU data is adjusted for both age and sex.

STAR-PU is an indirectly standardised ratio that removes confounding effects of age and sex in the comparison of prescribing between different geographical areas. This method allows for more accurate comparison of prescribing. In this specific indicator, a higher value is associated with increased prescribing.

[2] This indicator specifically shows the rolling twelve-month percentage of broad-spectrum items that are being prescribed. It is a target to reduce the proportion of broad-spectrum antibiotics consumed. Using this indicator, individuals will be able to see the respective proportion of broad-spectrum prescribing within specific geographical areas, and also monitor the trend of the proportion over time.

7 Emergency Planning and Exercises

7.1 All Councils continue to engage with the Local Resilience Forum and the Local Health Resilience Partnership in undertaking their local engagement, joint working, annual exercise programme, responding to incidents and undertaking learning as required.

7.2 All Councils contributed to the Health Protection Audit, which was completed in September 2017.

8 Work Programme Priorities 2017/18 - Progress Report

8.1 **Infection Prevention and Control**

- Health Protection Committee members are routinely updated on community infection prevention and control and have been kept apprised of, and have supported, plans for a Community Infection Management Service.

- The enhanced surveillance of E.coli bacteraemias, driven by the national reduction expectation and the CCG quality premium, has proven to be challenging in 2017/18. Actions are in place for 2018/19 to improve this aspect of E.coli reduction, including regional collaboration and NHS England involvement.

8.2 **Improving the Resilience of the Health Protection System**

- A full review has been completed with results shared with the Health Protection Committee. This work continues to be taken forward with full engagement of all Local Authorities and Health partners. A full regional exercise was held in October to validate the new radiation monitoring unit guidance before a final plan can be implemented.

- A system wide approach to health protection training for speciality registrars in public health was introduced in 2017 in the South West, including emergency planning and response. This process ensures that registrars understand the wider system of health protection, which includes civil and public protection delivered by the Local Authority, including the wider system of Emergency Planning, Resilience and Response (EPRR) as well as Environmental Health.

8.3 **Air Quality**

- In 2017/2018, Public Health England, in collaboration with Local Authority colleagues across the South West, planned an air quality conference which was held on 13th June 2018.

8.4 **Antimicrobial Resistance**

- The Cornwall Antimicrobial Resistance Group (CARG) is well established and is seen as a beacon in AMR partnership working and the One Health approach. The Devon AMR Group is newer but getting established and widening its membership. At present, it is supporting the development of a business case for a community infection control service for Devon.

- The Devon baseline assessment of NICE guideline 63 was presented to the National Performance Advisory Group by the Devon AMR Group, and a Devon-wide action plan has been developed following this.

- The E.coli bacteraemia reduction work is progressing, with each individual provider creating and implementing an E.coli reduction action plan. NEW Devon CCG and South Devon & Torbay CCG are involved in work streams emerging from this, including the Community Infection Management Service business case.

- A pilot for implementing a tool to promote antimicrobial stewardship and self-care advice in community pharmacies was planned within Devon and Cornwall led by Public Health England South West. This project is now finished, the data has been collected and data analysis is underway.

8.5 Influenza Vaccination for Care Home and Domiciliary Staff and Special Schools

- Local Authorities worked with PHE and other partners to support the care sector in promoting staff flu vaccination to protect their residents. A Winter toolkit and a flu bulletin were produced, and guidance was shared and discussed at local care manager forums across the Peninsula. Free vaccination for care staff was introduced nationally from October 2017; this was extended in 2018.

8.6 Implementation of National MMR Initiative

- A national UK Measles and Rubella elimination strategy is being developed in line with the World Health Organisation target to eliminate these diseases in Europe by 2020. Public Health England Screening and Immunisation Team will be working, through the locality immunisation groups, to develop robust multiagency action plans to further improve MMR uptake. It is anticipated that this will have a beneficial effect on all childhood immunisation programmes.

9 Work Programme Priorities 2018/2019

- MMR vaccination programme – this continues to be a priority with the aim of achieving 95% coverage of the second dose by 5 years of age.

- Flu vaccination programme – ensuring uptake of vaccination rates are achieved and that there is a smooth roll-out of the additional cohorts, with a particular focus on frontline health and care workers to support winter preparedness and the extension to the childhood programme.

- The establishment of a comprehensive Community Infection Prevention and Control Service across the system.

- Assurance that actions are in place following the National Health Protection Audit.

- Air Quality – ensure programmes to improve air quality are in place and continue to secure improvements to air quality.

- Antimicrobial resistance.

- Emerging threats.

10 Authors

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In association with members of the Health Protection Committee.

11 Glossary

AMR	Anti-microbial resistance
BCG	Tuberculosis (Bacillus Calmette-Guerin) vaccination
CCG	Clinical Commissioning Group
C.diff	Clostridium difficile
CHIS	Child Health Information Services
CVS	Chorionic villus sampling (antenatal screening)
E.coli	Escherichia Coli
HPV	Human papillomavirus testing (for risk of developing cervical cancer)
MMR	Measles, Mumps and Rubella (immunisation)
MRSA	Methicillin resistant Staphylococcus aureus
MSSA	Methicillin sensitive Staphylococcus aureus
NEW Devon	Northern, Eastern and Western Devon (Clinical Commissioning Group)
NIPE	Newborn Infant Physical Examination
NIPT	Non-invasive pre-natal testing
PHE	Public Health England
NHSE	NHS England
CQUIN	Commissioning for Quality and Innovation (incentivised payment system)
TB	Tuberculosis

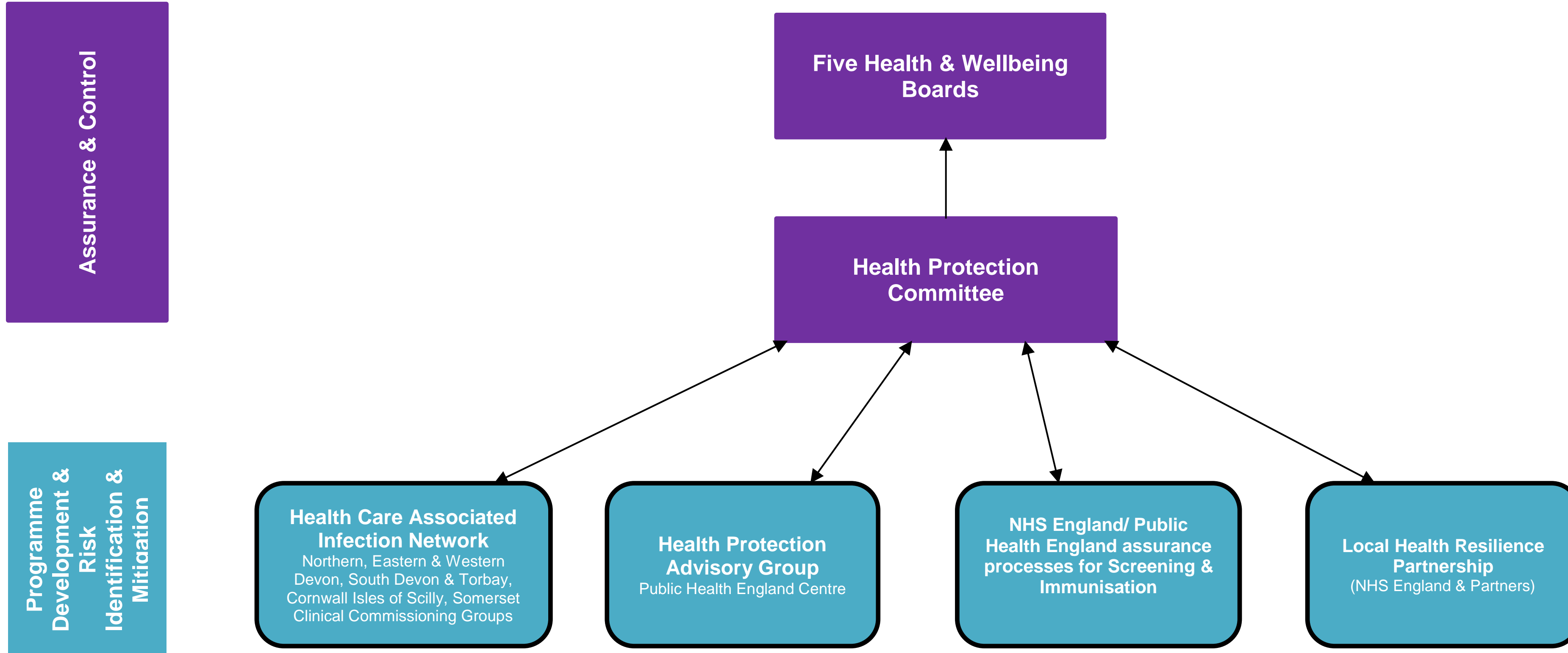
12 Appendices

Appendix 1: Health Protection Committee Reporting Arrangements
Appendix 2: Infectious Disease Incidence and Trends 2017-18
Appendix 3: Immunisation Performance 2017-2018
Appendix 4: Screening Performance 2017-2018
Appendix 5: Healthcare Associated Infections (HCAI) 2017-18
Appendix 6: Antimicrobial Resistance: Trends and Developments

Appendix 1

Health Protection Committee Reporting Arrangements

Reporting to the Devon, Plymouth, Torbay, Cornwall and Council of the Isles of Scilly Health & Wellbeing Boards and relationship to existing Health Protection Partnership Forums



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Appendix 2

Infectious Disease Incidence and Trends 2017-18

Influenza

Figure 1: All reports of influenza-like illness outbreaks/clusters (suspected or confirmed) by setting, Cornwall (including Isles of Scilly), Devon, Plymouth and Torbay local authorities, Week 14 2017 to Week 13 2018)
Source: HP Zone

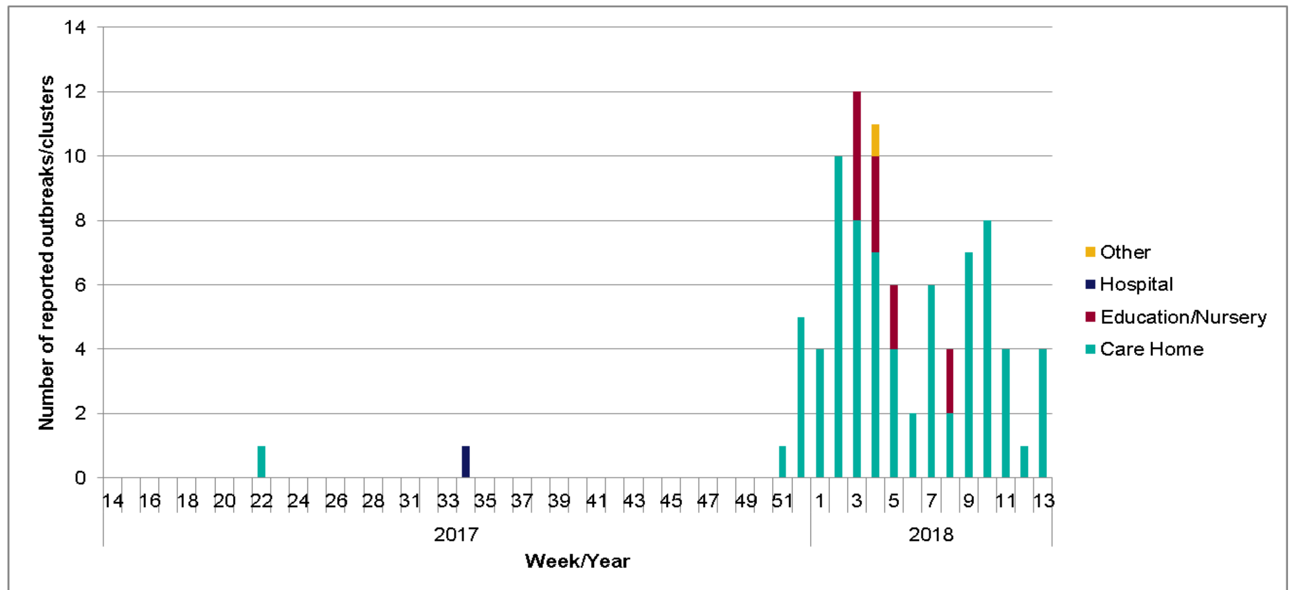


Table 1: All reports of influenza-like illness outbreaks/clusters (suspected or confirmed) by setting, Cornwall (including Isles of Scilly), Devon, Plymouth and local authorities, 2017/2018
Source: HP Zone

Local Authority	Care Home	Education/Nursery	Hospital	Other	Total
Cornwall (including Isles of Scilly)	9	1	0	0	10
Devon	45	6	0	0	51
Plymouth	4	2	1	0	7
Torbay	16	2	0	1	19

‡ Outbreak/cluster data extracted based on date entered onto HP Zone.

Gastrointestinal Infection

Figure 2: All reports of clusters/outbreaks of gastrointestinal infection (suspected or laboratory confirmed), by setting, including food poisoning outbreaks, Cornwall (including Isles of Scilly), Devon, Plymouth and Torbay Local Authorities, Week 14 2017 to Week 13 2018.
Source: HP Zone and HNORS

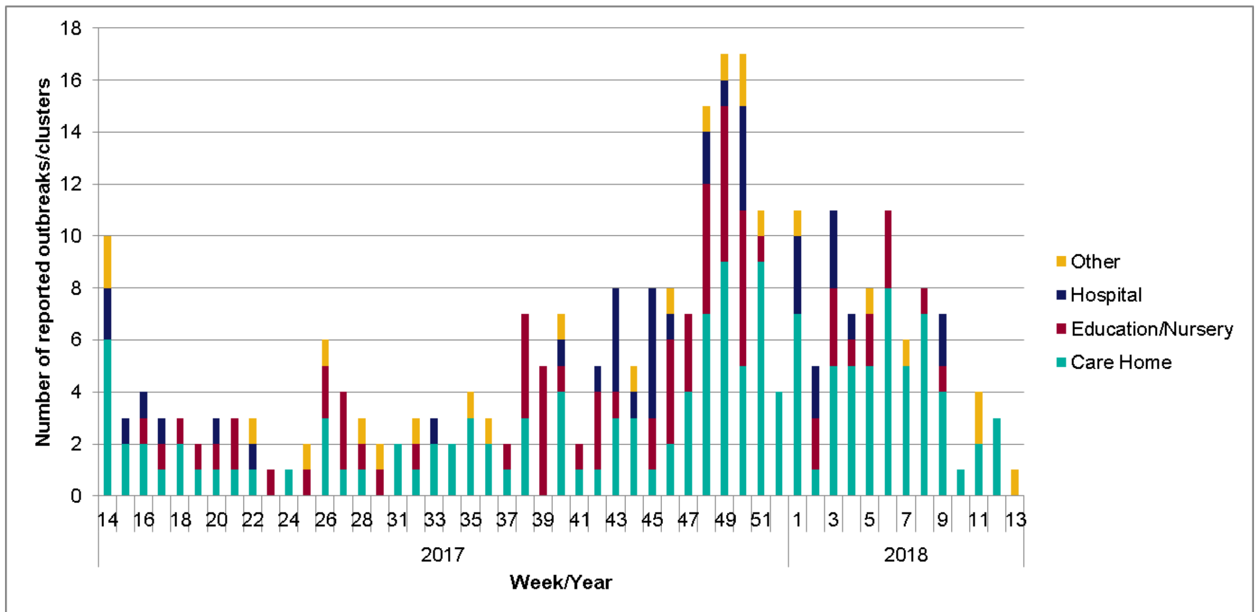


Table 2: All reports of clusters/outbreaks of gastrointestinal infection (suspected or laboratory confirmed), by setting, including food poisoning outbreaks, Cornwall (including Isles of Scilly), Devon, Plymouth and Torbay Local Authorities, Week 14 2017 to Week 13 2018.
Source: HP Zone and HNORS

Local Authority	Care Home	Education/Nursery	Hospital	Other	Total
Cornwall (including Isles of Scilly)	40	19	9	9	77
Devon	73	33	30	12	148
Plymouth	22	11	0	1	34
Torbay	10	10	0	2	22

‡ Outbreak/cluster data extracted based on date entered onto HP Zone.

Data sources:

HP Zone

HP Zone is a case management system that captures data on suspected or laboratory confirmed outbreaks within the community that have been reported to the Public Health England Centres (PHECs).

It is believed that reporting of outbreaks is not uniform or consistent and it is likely that only a small portion of outbreaks have samples collected for microbiological confirmation. As such these should be interpreted with caution as it is likely to underestimate the level of community activity. HP Zone reports were extracted and analysed on date entered.

Hospital Norovirus Outbreak Reporting Scheme (HNORS)

The Hospital Norovirus Outbreak Reporting Scheme (HNORS) is a voluntary web-based surveillance system introduced to help the NHS share information norovirus outbreaks in Trusts. Please note the system is voluntary and may underestimate the number of hospital norovirus outbreaks.

HNORS reports were extracted and analysed on date entered.

Meningococcal Disease

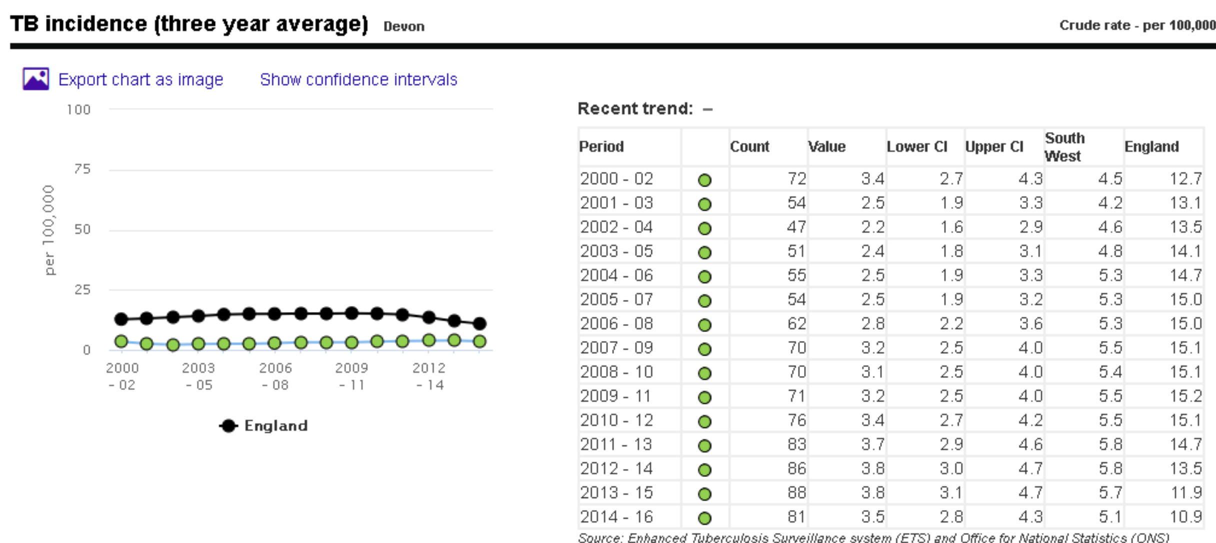
In 2017-2018, there were eight cases of probable or confirmed meningococcal disease in Devon; 13 in Cornwall; fewer than five in Torbay, and nine in Plymouth. These figures are largely consistent with those from 2016-2017.

Scarlet Fever

In 2017-2018, 189 suspected or confirmed cases of scarlet fever were reported across Devon (previous year 185); 155 from Cornwall (127); 42 from Torbay (48) and 73 from Plymouth (89). Forty-eight cases of confirmed invasive group A streptococcal disease were reported from Plymouth (47 in previous year); 34 from Cornwall (23); four from Torbay (11) and 25 from Plymouth (25). Given the severity of this infection, these figures represent a significant burden of disease.

Tuberculosis

Figure 3: TB Incidence (three-year average)
Source: PHE Fingertips[1]

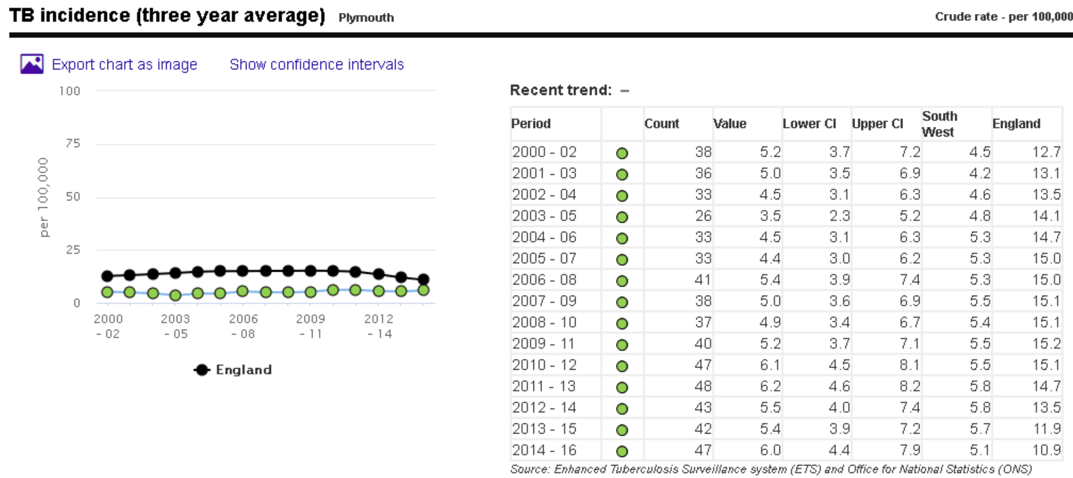


Period		Count	Value	Lower CI	Upper CI	South West	England
2000 - 02		72	3.4	2.7	4.3	4.5	12.7
2001 - 03		54	2.5	1.9	3.3	4.2	13.1
2002 - 04		47	2.2	1.6	2.9	4.6	13.5
2003 - 05		51	2.4	1.8	3.1	4.8	14.1
2004 - 06		55	2.5	1.9	3.3	5.3	14.7
2005 - 07		54	2.5	1.9	3.2	5.3	15.0
2006 - 08		62	2.8	2.2	3.6	5.3	15.0
2007 - 09		70	3.2	2.5	4.0	5.5	15.1
2008 - 10		70	3.1	2.5	4.0	5.4	15.1
2009 - 11		71	3.2	2.5	4.0	5.5	15.2
2010 - 12		76	3.4	2.7	4.2	5.5	15.1
2011 - 13		83	3.7	2.9	4.6	5.8	14.7
2012 - 14		86	3.8	3.0	4.7	5.8	13.5
2013 - 15		88	3.8	3.1	4.7	5.7	11.9
2014 - 16		81	3.5	2.8	4.3	5.1	10.9

Source: Enhanced Tuberculosis Surveillance system (ETS) and Office for National Statistics (ONS)

[1] https://fingertips.phe.org.uk/search/tb#page/4/gid/1/pat/6/par/E12000009/ati/102/are/E06000027

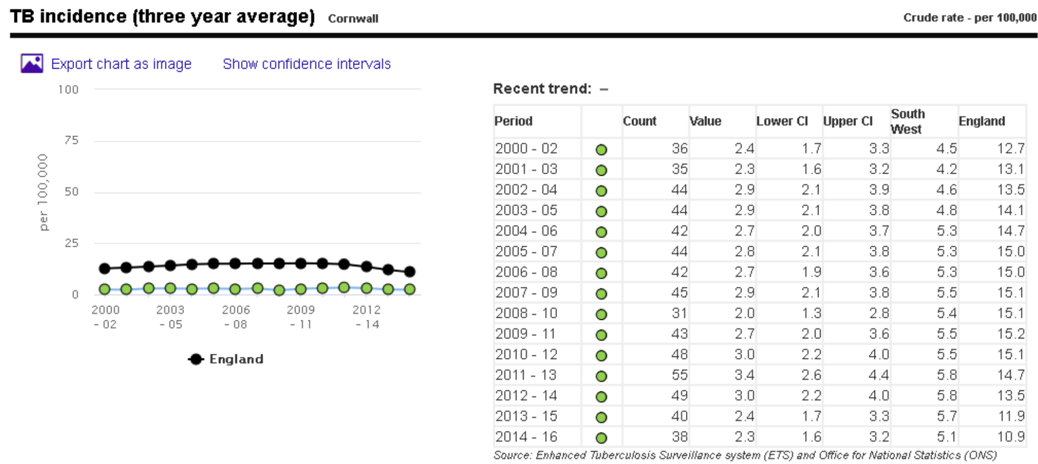
Figure 4: TB Incidence (three-year average)
Source: PHE Fingertips[2]



Period		Count	Value	Lower CI	Upper CI	South West	England
2000 - 02	●	38	5.2	3.7	7.2	4.5	12.7
2001 - 03	●	36	5.0	3.5	6.9	4.2	13.1
2002 - 04	●	33	4.5	3.1	6.3	4.6	13.5
2003 - 05	●	26	3.5	2.3	5.2	4.8	14.1
2004 - 06	●	33	4.5	3.1	6.3	5.3	14.7
2005 - 07	●	33	4.4	3.0	6.2	5.3	15.0
2006 - 08	●	41	5.4	3.9	7.4	5.3	15.0
2007 - 09	●	38	5.0	3.6	6.9	5.5	15.1
2008 - 10	●	37	4.9	3.4	6.7	5.4	15.1
2009 - 11	●	40	5.2	3.7	7.1	5.5	15.2
2010 - 12	●	47	6.1	4.5	8.1	5.5	15.1
2011 - 13	●	48	6.2	4.6	8.2	5.8	14.7
2012 - 14	●	43	5.5	4.0	7.4	5.8	13.5
2013 - 15	●	42	5.4	3.9	7.2	5.7	11.9
2014 - 16	●	47	6.0	4.4	7.9	5.1	10.9

Source: Enhanced Tuberculosis Surveillance system (ETS) and Office for National Statistics (ONS)

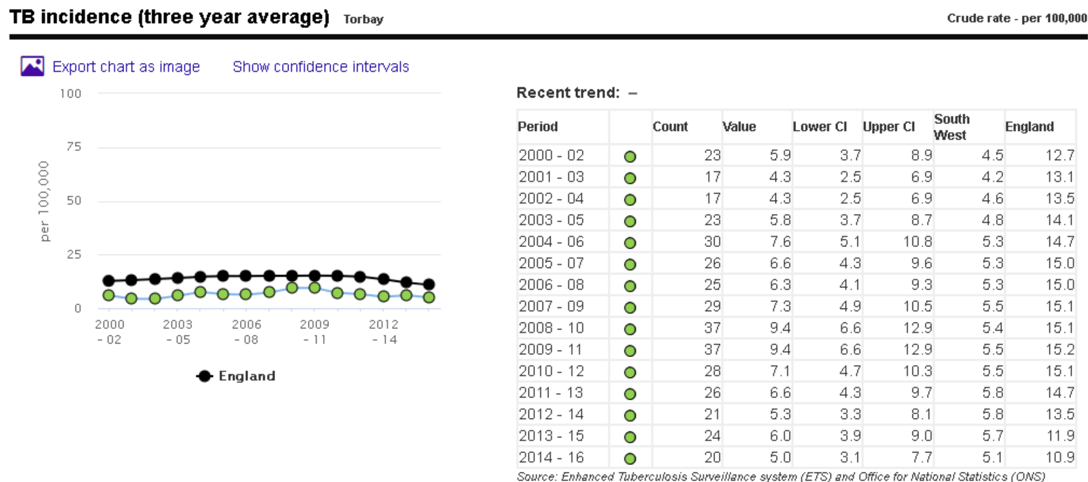
Figure 5: TB Incidence (three year average)
Source: PHE Fingertips[3]



Period		Count	Value	Lower CI	Upper CI	South West	England
2000 - 02	●	36	2.4	1.7	3.3	4.5	12.7
2001 - 03	●	35	2.3	1.6	3.2	4.2	13.1
2002 - 04	●	44	2.9	2.1	3.9	4.6	13.5
2003 - 05	●	44	2.9	2.1	3.8	4.8	14.1
2004 - 06	●	42	2.7	2.0	3.7	5.3	14.7
2005 - 07	●	44	2.8	2.1	3.8	5.3	15.0
2006 - 08	●	42	2.7	1.9	3.6	5.3	15.0
2007 - 09	●	45	2.9	2.1	3.8	5.5	15.1
2008 - 10	●	31	2.0	1.3	2.8	5.4	15.1
2009 - 11	●	43	2.7	2.0	3.6	5.5	15.2
2010 - 12	●	48	3.0	2.2	4.0	5.5	15.1
2011 - 13	●	55	3.4	2.6	4.4	5.8	14.7
2012 - 14	●	49	3.0	2.2	4.0	5.8	13.5
2013 - 15	●	40	2.4	1.7	3.3	5.7	11.9
2014 - 16	●	38	2.3	1.6	3.2	5.1	10.9

Source: Enhanced Tuberculosis Surveillance system (ETS) and Office for National Statistics (ONS)

Figure 6. TB Incidence (three year average)
Source: PHE Fingertips[4]



Period		Count	Value	Lower CI	Upper CI	South West	England
2000 - 02	●	23	5.9	3.7	8.9	4.5	12.7
2001 - 03	●	17	4.3	2.5	6.9	4.2	13.1
2002 - 04	●	17	4.3	2.5	6.9	4.6	13.5
2003 - 05	●	23	5.8	3.7	8.7	4.8	14.1
2004 - 06	●	30	7.6	5.1	10.8	5.3	14.7
2005 - 07	●	26	6.6	4.3	9.6	5.3	15.0
2006 - 08	●	25	6.3	4.1	9.3	5.3	15.0
2007 - 09	●	29	7.3	4.9	10.5	5.5	15.1
2008 - 10	●	37	9.4	6.6	12.9	5.4	15.1
2009 - 11	●	37	9.4	6.6	12.9	5.5	15.2
2010 - 12	●	28	7.1	4.7	10.3	5.5	15.1
2011 - 13	●	26	6.6	4.3	9.7	5.8	14.7
2012 - 14	●	21	5.3	3.3	8.1	5.8	13.5
2013 - 15	●	24	6.0	3.9	9.0	5.7	11.9
2014 - 16	●	20	5.0	3.1	7.7	5.1	10.9

Source: Enhanced Tuberculosis Surveillance system (ETS) and Office for National Statistics (ONS)

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[2] https://fingertips.phe.org.uk/search/tb#page/4/gid/1/pat/6/par/E12000009/ati/102/are/E06000027
[3] https://fingertips.phe.org.uk/search/tb#page/4/gid/1/pat/6/par/E12000009/ati/102/are/E06000027
[4] https://fingertips.phe.org.uk/search/tb#page/4/gid/1/pat/6/par/E12000009/ati/102/are/E06000027

Appendix 3

Immunisation Performance 2017-2018

Annual Childhood Immunisations by Local Authority Showing Percentage Coverage for Latest Three Years

Cohort	Indicator	Standard [1]	Geography	2015/16	2016/17	2017/18
12 months	3.03iii - Population vaccination coverage - Dtap / IPV / Hib	95	Devon	92.0	92.6	94.3
			Plymouth	95.5	96.9	96.1
			Torbay	95.5	96.3	95.1
			Cornwall & IoS	94.5	93.9	93.9
			England	93.6	93.4	93.1
	3.03iv - Population vaccination coverage - MenC	95	Devon	95.2		
			Plymouth	97.3		
			Torbay	97.4		
			Cornwall & IoS	96.3		
			England	-		
	3.03v - Population vaccination coverage - PCV	95	Devon	92.4	93.1	94.6
			Plymouth	95.4	96.9	96.2
			Torbay	95.9	96.4	95.7
			Cornwall & IoS	94.7	94.0	93.9
			England	93.5	93.5	93.3
	Population vaccination coverage - MenB	95	Devon			93.9
			Plymouth			96.0
			Torbay			95.5
			Cornwall & IoS			93.6
			England			92.5
24 months	3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	95	Devon	96.2	95.3	95.7
			Plymouth	97.7	97.6	97.7
			Torbay	97.5	98.0	97.0
			Cornwall & IoS	95.8	96.1	95.5
			England	95.2	95.1	95.1
	3.03vi - Population vaccination coverage - Hib / MenC booster	95	Devon	91.8	92.4	91.9
			Plymouth	95.1	94.5	95.7
			Torbay	94.9	94.8	94.6
			Cornwall & IoS	92.6	92.6	91.4
			England	91.6	91.5	91.2
	3.03vii - Population vaccination coverage - PCV booster	95	Devon	91.9	92.7	92.2
			Plymouth	94.9	94.5	95.9
			Torbay	94.7	95.1	94.8
			Cornwall & IoS	93.2	93.0	91.7
			England	91.5	91.5	91.0

Cohort	Indicator	Standard [1]	Geography	2015/16	2016/17	2017/18
	3.03viii - Population vaccination coverage - MMR for one dose	95	Devon	92.5	93.4	92.7
			Plymouth	95.4	95.3	95.7
			Torbay	95.2	95.2	95.4
			Cornwall & IoS	92.5	93.0	91.4
			England	91.9	91.6	91.2
5 years	3.03ix - Population vaccination coverage - MMR for one dose	95	Devon	95.5	95.7	95.2
			Plymouth	96.6	97.4	97.9
			Torbay	96.8	97.8	97.2
			Cornwall & IoS	96.2	96.1	95.9
			England	94.8	95.0	94.9
	3.03vi - Population vaccination coverage - Hib / Men C booster	95	Devon	94.9	94.8	94.1
			Plymouth	94.8	95.3	96.5
			Torbay	96.1	96.9	95.5
			Cornwall & IoS	95.1	95.1	94.6
			England	92.6	92.6	92.4
	3.03x - Population vaccination coverage - MMR for two doses	95	Devon	91.5	91.3	90.3
			Plymouth	90.4	91.4	94.1
			Torbay	92.1	92.1	93.9
			Cornwall & IoS	91.6	90.9	95.6
			England	88.2	87.6	92.4

1 National Screening and immunisation Programme standard. Where this is blank, no standard has been set.

Where coverage is blank, no programme was in place or data is not yet available.

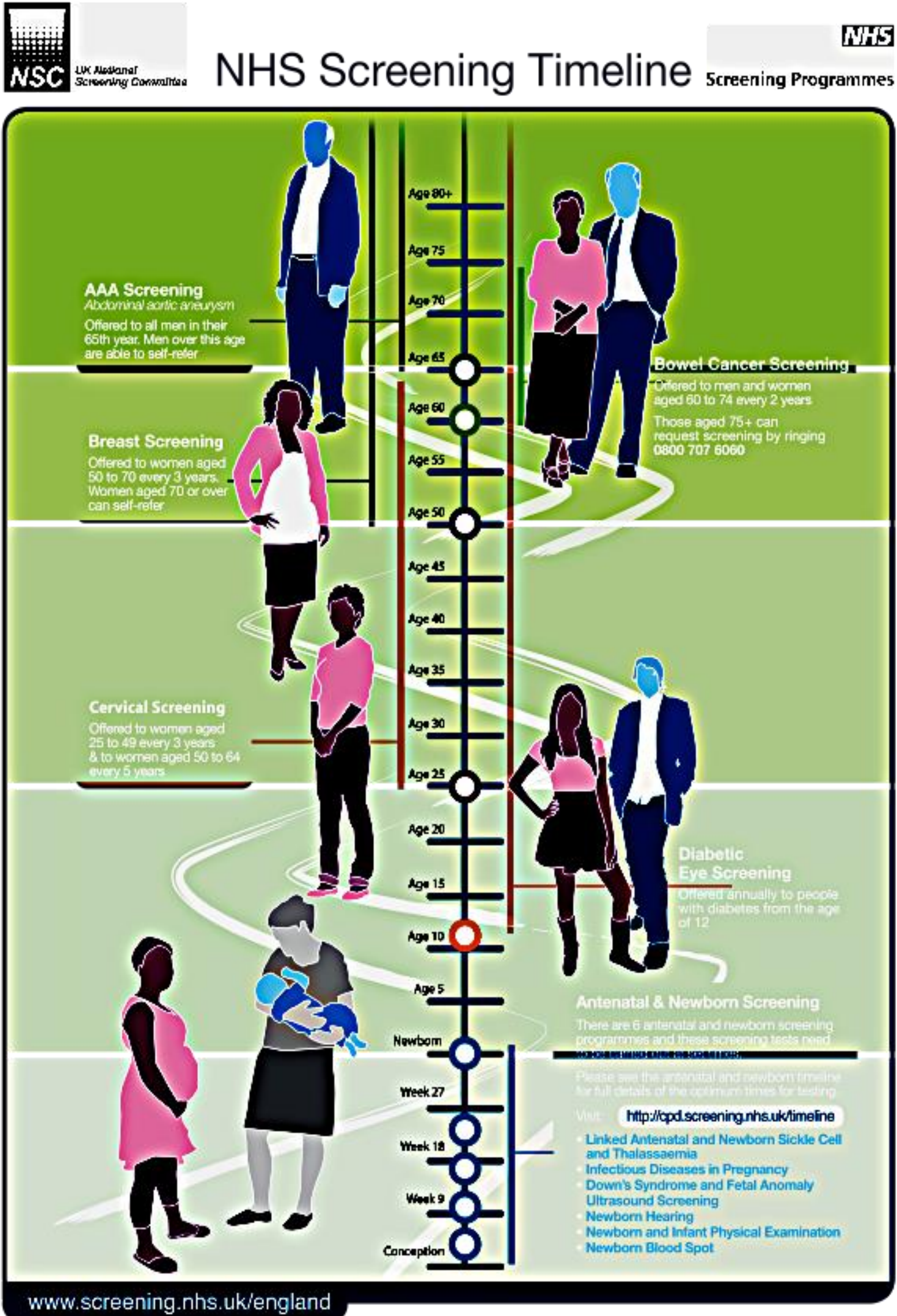
Annual adolescent, adult and influenza immunisations by local authority showing percentage coverage for latest three years

Indicator	Standard[1]	Geography	2015/16	2016/17	2017/18
3.03xii - Population vaccination coverage - HPV (%)	86.1	Devon	86.9	86.2	Not yet published
		Plymouth	89.4	85.1	Not yet published
		Torbay	83.1	85.0	Not yet published
		Cornwall & IoS	79.5	78.6	Not yet published
		England	87.0	87.2	Not yet published
3.03xiii - Population vaccination coverage – PPV (aged 65+) (%)	68.9	Devon	70.2	70.5	69.9
		Plymouth	68.7	68.7	67.1
		Torbay	67.5	67.7	68.8
		Cornwall	67.0	66.7	66.2
		England	70.1	69.8	69.5
3.03xiv - Population vaccination coverage - Flu (aged 65+) (%)	75	Devon	69.8	69.8	72.4
		Plymouth	71.5	70.3	71.5
		Torbay	66.4	66.4	71.2
		Cornwall & IoS	69.4	68.4	71.1
		England	71	70.5	72.6
3.03xv - Population vaccination coverage - Flu (at risk individuals) (%)	75	Devon	42	46.2	49.1
		Plymouth	44.9	46.0	47.5
		Torbay	40.6	45.8	48.6
		Cornwall & IoS	45.6	44.4	47.0
		England	45.1	48.6	48.9
3.03xviii - Population vaccination coverage - Flu (2-4 years old up to 2016/17, 2017/18 2-3 year olds) (%)		Devon	41.3	44.3	51.2
		Plymouth	33.6	37.2	44.0
		Torbay	34.8	38.4	44.3
		Cornwall & IoS	33.8	34.2	38.2
		England	34.4	38.1	43.5
3.03xvii - Population vaccination coverage - Shingles vaccination coverage (70 years old) (%)		Devon	60.3	52.3	Not yet published
		Plymouth	54.3	51.8	Not yet published
		Torbay	52.6	42.4	Not yet published
		Cornwall & IoS	53.8	40.1	Not yet published
		England	54.9	48.3	Not yet published

Source: National vaccination coverage statistics, Public Health England (GOV.UK) [1] National Screening and Immunisation Programme standard

Appendix 4

National Screening Programmes - Summary



Appendix 4

Screening Performance

Cancer Screening (Breast, Cervical, Bowel) – Showing Percentage Coverage for Latest Three Years

Indicator	Lower threshold [1]	Standard [2]	Geography	2015	2016	2017
Breast Cancer screening coverage	70	80	Devon	79.1	78.8	78.3
			Plymouth	79.1	79.3	79.0
			Torbay	76.7	74.7	74.1
			Cornwall	80.3	80.0	79.3
			England	75.4	75.5	75.4
Cervical Cancer screening coverage	75	80	Devon	77.7	77.1	76.6
			Plymouth	75.5	74.5	73.6
			Torbay	75.9	74.8	73.9
			Cornwall	76.4	75.7	74.9
			England	73.5	72.7	72.0
Bowel Cancer screening coverage	55	60	Devon	60.5	62.6	64.2
			Plymouth	61.3	61.6	61.1
			Torbay	62.0	61.4	61.8
			Cornwall	58.3	60.5	61.7
			England	57.1	57.9	58.8

[1] Threshold based on 2017-18 Public Health Functions Agreement
[2] National Screening and Immunisation Programme Standard

Non Cancer Screening – Showing Percentage Coverage for Latest Three Years at Quarter 4

Indicator	Acceptable[1]	Achievable[2]	Geography	Trust/Service	2015/16 Q4	2016/17 Q4	2017/18 Q4
				Quarterly figure			
Infectious diseases in pregnancy - HIV coverage	>=90	>=95	Devon	Royal Devon and Exeter NHS Foundation Trust	99.1	100.0	99.7
				Northern Devon Healthcare NHS Trust	99.8	99.5	98.9
			Plymouth	Plymouth Hospitals NHS Trust	99.6	99.7	99.9
			Torbay	South Devon Foundation Trust	-	-	-
				Torbay and South Devon NHS Foundation Trust	97.2	99.2	99.1
			Cornwall	Royal Cornwall Hospitals NHS Trust	99.7	99.9	99.9
			England				
Sickle cell and Thalassaemia coverage	>=95	>=99	Devon	Royal Devon and Exeter NHS Foundation Trust	99.5	100.0	99.7
				Northern Devon Healthcare NHS Trust	99.8	99.5	98.9
			Plymouth	Plymouth Hospitals NHS Trust	99.8	99.7	99.9
			Torbay	South Devon Foundation Trust	-	-	-
				Torbay and South Devon NHS Foundation Trust	97.7	99.2	98.1
			Cornwall	Royal Cornwall Hospitals NHS Trust	99.7	99.9	100.0
			England				
Newborn blood spot coverage	>=95	>=99.9	Devon	NHS North, East, West Devon (CCG at birth)	90.7	97.6	92.6
			Plymouth	NHS North, East, West Devon	90.7	97.6	92.6
			Torbay	NHS South Devon and Torbay	86.0	94.1	99.1
			Cornwall	NHS Kernow	86.9	92.3	93.2
			England				
Newborn hearing coverage	>=95	>=99.5	Devon	North Devon	98.6	98.5	98.9
				Torbay and Teignbridge	98.7	99.4	99.1
			Plymouth	Plymouth	99.5	99.2	98.9
			Torbay	Torbay and Teignbridge	98.7	99.4	99.1
			Cornwall	Cornwall and Isles of Scilly	99.9	99.7	99.6
			England				

Indicator	Acceptable[1]	Achievable[2]	Geography	Trust/Service	2015/16 Q4	2016/17 Q4	2017/18 Q4
Newborn & infant physical examination coverage	>=95	>=99.5	Devon	Royal Devon and Exeter NHS Foundation Trust	98.5	98.6	98.9
				Northern Devon Healthcare NHS Trust	97.9	99.1	98.6
			Plymouth	Plymouth Hospitals NHS Trust	97.6	96.2	96.6
			Torbay	South Devon Foundation Trust	97.3	97.0	98.4
				Torbay and South Devon NHS Foundation Trust	86.0	94.1	98.4
			Cornwall	Royal Cornwall Hospitals NHS Trust	-	-	90.8
			England				
* Diabetic eye screening uptake	>=70	>=80	Devon	North and East Devon Diabetic Eye Screening Programme	82.6	87.5	88.8
				South Devon NHS Diabetic Eye Screening Programme	87.7	87.1	86.3
			Plymouth	Plymouth Diabetic Eye Screening Programme	80.1	79.6	79.3
			Torbay	South Devon NHS Diabetic Eye Screening Programme	87.7	87.1	86.3
			Cornwall	Cornwall Diabetic Eye Screening Programme	81.5	78.8	76.7
			England				
* Abdominal Aortic Aneurysm Completeness of offer	>=67.5	>=75	Devon	South Devon AAA Screening Cohort	99.9	99.9	84.3
				Somerset and North Devon AAA Screening Cohort	99.8	100.0	99.7
			Plymouth	Peninsula AAA Screening Cohort	99.7	99.9	87.4
			Torbay	South Devon AAA Screening Cohort	99.9	99.9	84.3
			Cornwall	Peninsula AAA Screening Cohort	99.7	99.9	87.4
			England				

* All figures are for coverage except provider figures for diabetic eye screening which represent uptake
* AAA 2015/16 Represented 'completeness of offer'; AAA 2017/18 changed to Coverage of annual surveillance screen
Where data field is blank, no programme was in place or data is not available.

Appendix 5

Healthcare Associated Infections (HCAI) 2017-18

Healthcare Associated Infections Report for Northern, Eastern and Western Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group (the Devon CCGs), 2017-18.

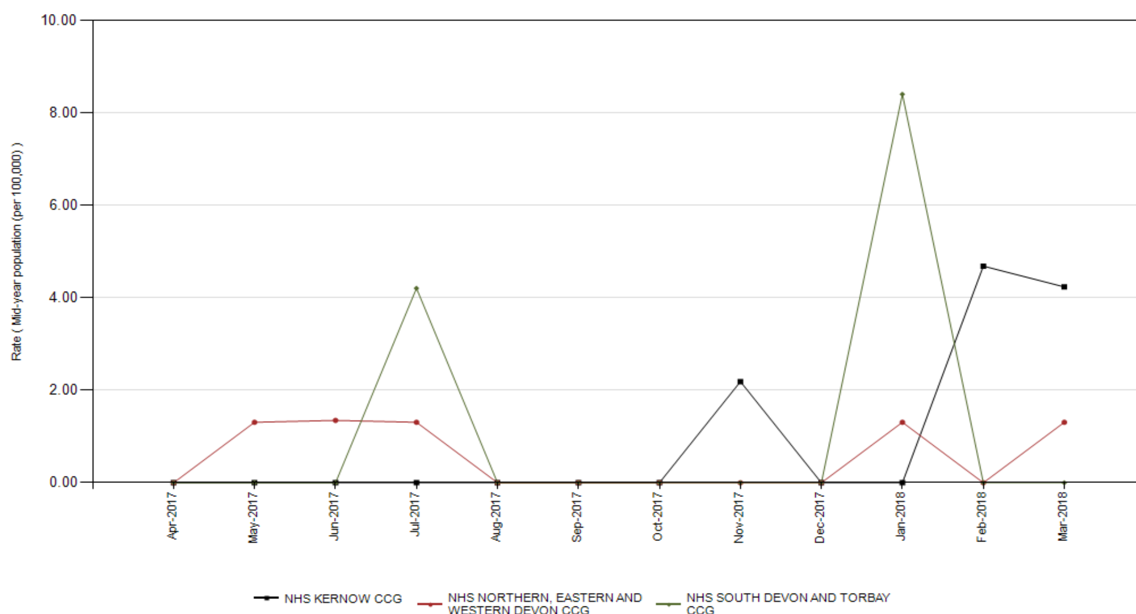
Extracted and amended from May 2018 Joint Quality Committee report with additions for Cornwall.

1. Executive Summary

This report provides information and updates against the following Infection Prevention and Control areas:

- Healthcare Associated Infections (HCAI)
- Gram negative Bloodstream Infection Reduction (GNBSI)

2. Healthcare Associated Infections - Methicillin Resistant *Staphylococcus Aureus* (MRSA)

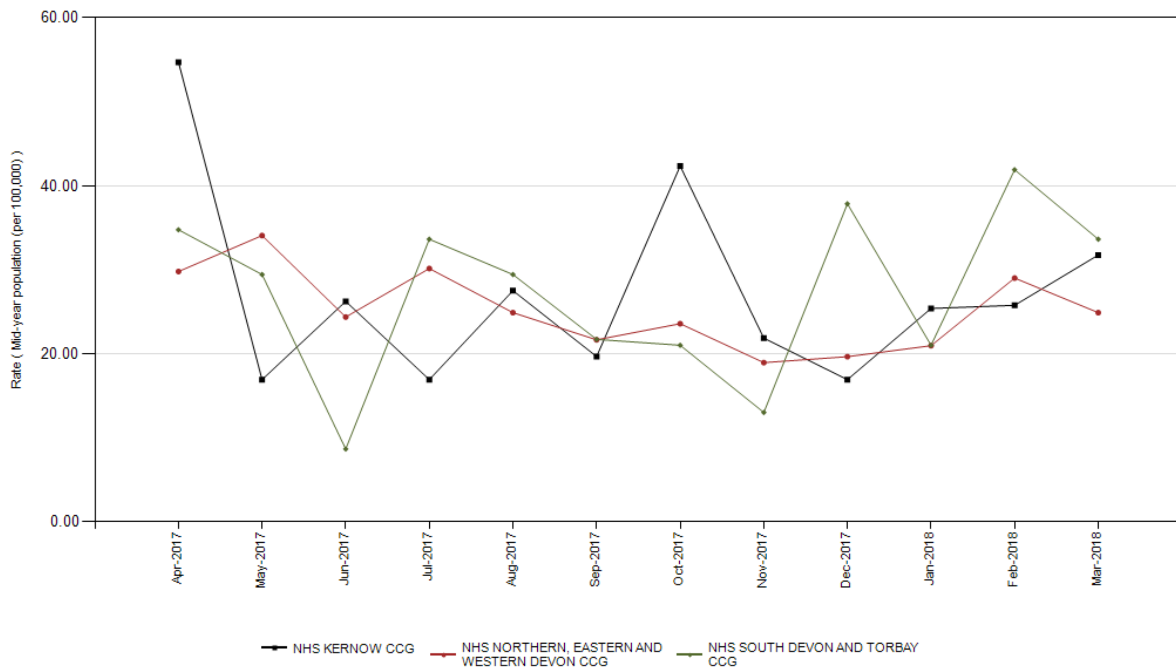


The above graph courtesy of Public Health England.

As of April 2018, the requirements for MRSA post-infection reviews (PIR) have changed. There is no longer a national requirement for a PIR to be completed, although local reviews are still expected. This change has been communicated to all NHS providers.

In Cornwall, rates remain low and the post infection review process continues despite the relaxed requirements.

3 Healthcare Associated Infections - Methicillin Sensitive *Staphylococcus Aureus* (MSSA)

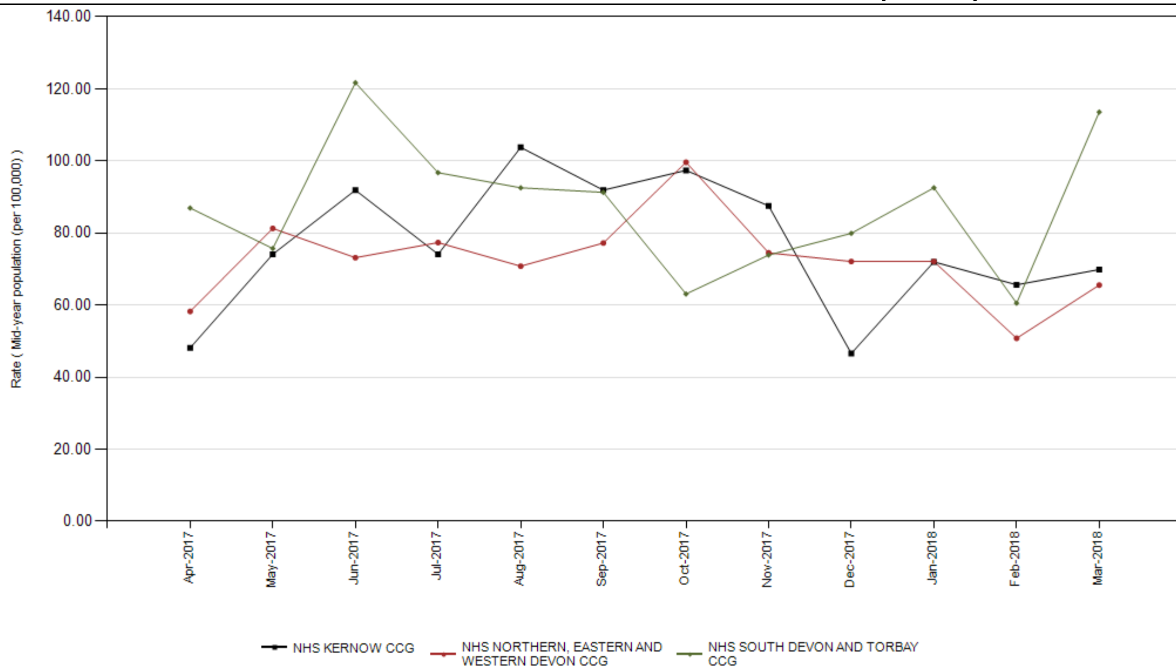


The above graph courtesy of Public Health England.

In NEWD CCG, MSSA bacteraemia rates remain steady.
SDTCCG has a smaller population so the rate is more volatile - the increases seen on this graph are down to one or two patients per month and so conclusions cannot be drawn at this time. However, in discussion with the NHS provider, thematic reviews will be undertaken of all MSSA cases identified across acute and community settings for a period of three months.

In Cornwall some work has in the acute setting has focussed on line care.

4 Healthcare Associated Infections - *Escherichia Coli (E coli)*



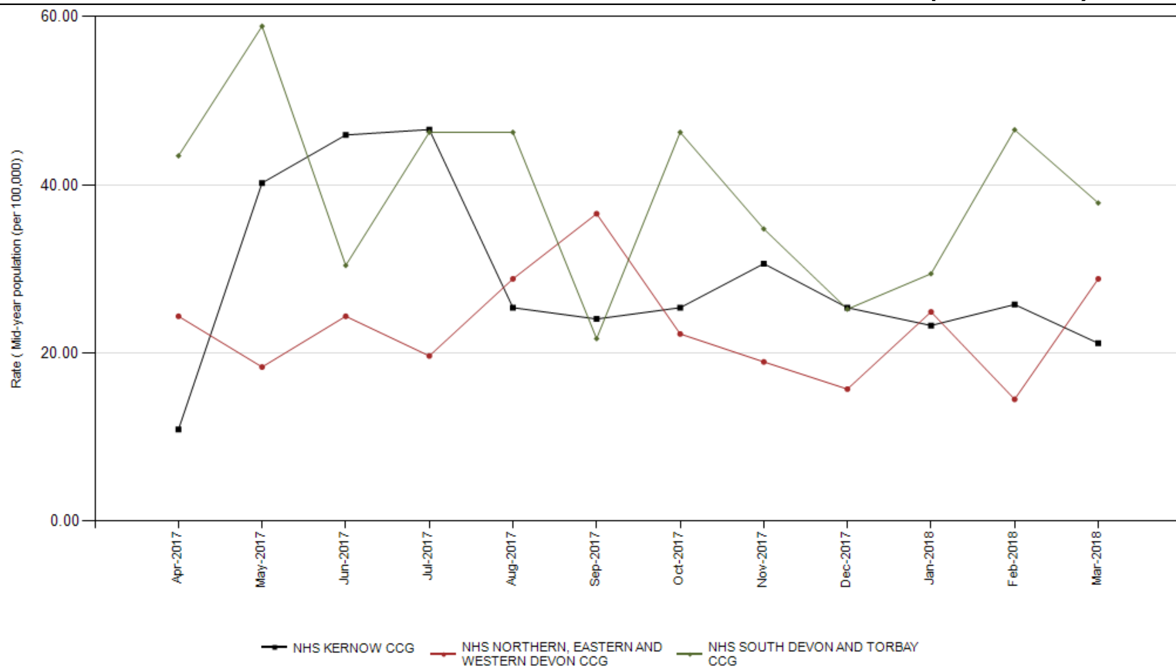
The above graph courtesy of Public Health England.

E.coli bacteraemia across both CCGs, as shown in the graph above, broadly track the averages provided by Public Health England (PHE) for England and the South West.

The Quality Premium for 2017-18 includes a 10% E.coli bacteraemia reduction. This work is being taken forward jointly by NEW Devon CCG and South Devon & Torbay CCG, and is being reported quarterly to the Quality Committees in Common. This target has not been achieved this year. The target for 2018/19 has not yet been released but is likely to include a further 10% reduction.

In Cornwall, rates continue to rise. Joint work programmes focus on urinary sources.
Clear reduction strategies are not emerging.

5 Healthcare Associated Infections - *Clostridium difficile (C difficile)*



The above graph courtesy of Public Health England.

The graph above shows all cases of *C difficile* within NEWDCCG. The community acquired cases, which make-up the larger proportion of the population cases, are not scrutinised for avoidability like those in acute and community hospitals.

The case numbers for NEWD CCG (208) are below the nationally set trajectory (219).
The case numbers for SDT CCG (109) are above the nationally set trajectory (96).

The nationally mandated targets for acute providers have all been reduced by one case for 2018/19.

In Cornwall, the majority of hospital onset cases occur despite good care.

Appendix 6

Antimicrobial Resistance: Trends and Developments

Table 1: *E.coli* bacteraemia rates per 100,000 population, by CCG and England, 2013/14 to 2017/18
Source: HCAI Data Capture System

Source: HCAI Data Capture System

Financial Year	North, East and West (NEW) Devon CCG	South Devon and Torbay CCG	Kernow CCG	England
2013/14	57.2	78.2	55.9	63.7
2014/15	66.9	77.2	53.7	65.9
2015/16	68.4	80.1	61.4	69.8
2016/17	69.6	87.6	71.0	74.1
2017/18	72.9	87.5	77.0	74.3

Figure 1: Rates of *E. coli* bacteraemia resistant to third-generation cephalosporins or ciprofloxacin in patients of different age groups. Data derived from voluntary reports to SGSS; 85% of isolates were subject to susceptibility tests
Source: ESPAUR Report 2017

Please see ESPAUR Report 2017 for figures:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/656611/ESPAUR_report_2017.pdf

Figure 2: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to 3rd generation cephalosporins, by quarter
Source: PHE AMR local indicators[1]

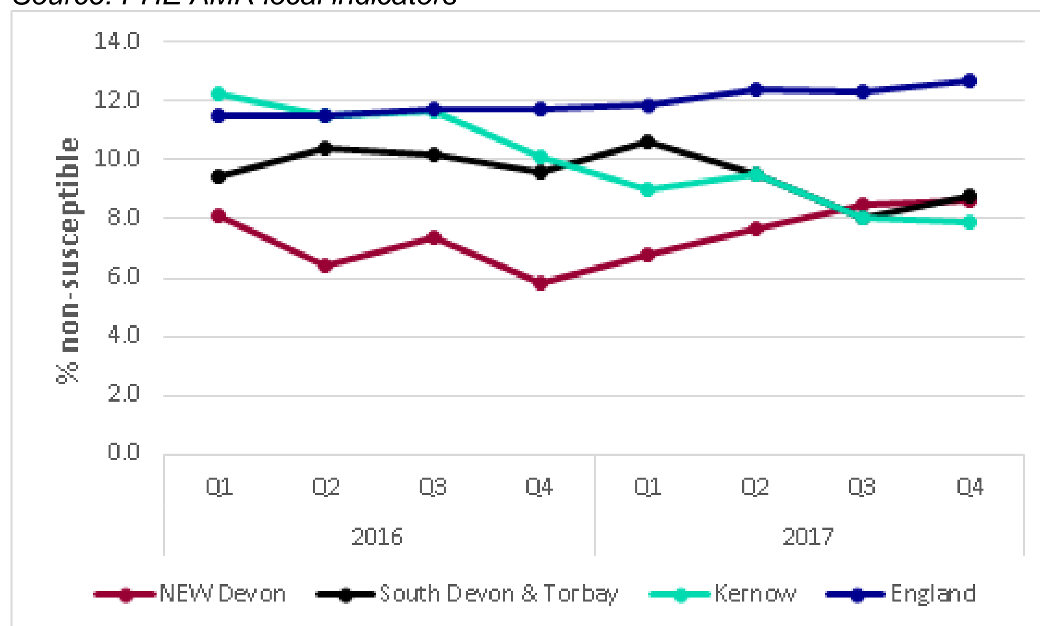


Figure 3: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to gentamicin, by quarter
Source: PHE AMR local indicators[1]

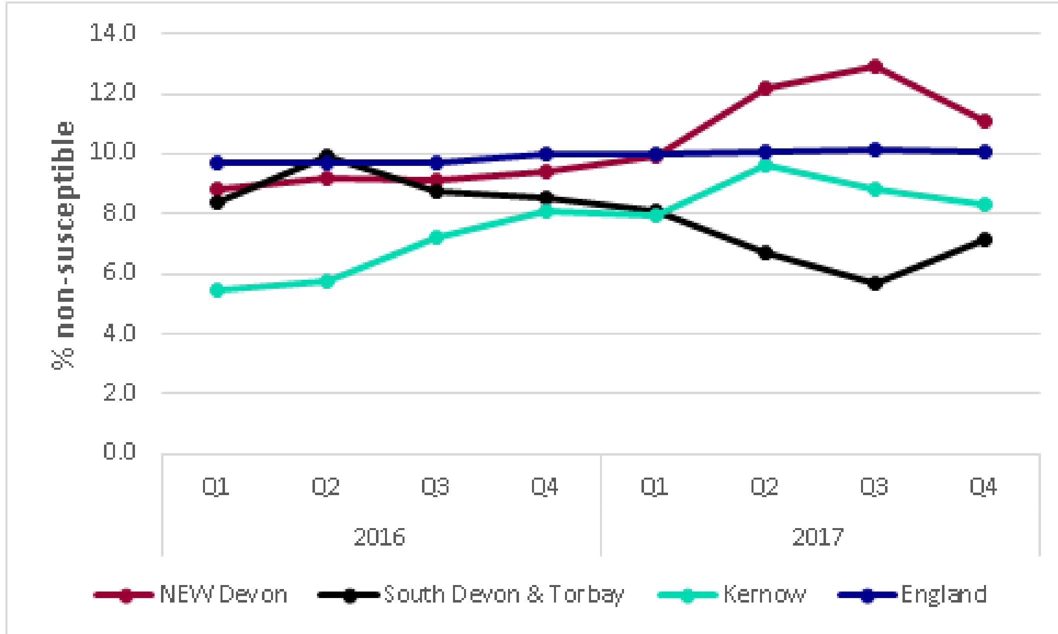


Figure 4: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to piperacillin/tazobactam, by quarter
Source: PHE AMR local indicators[1]

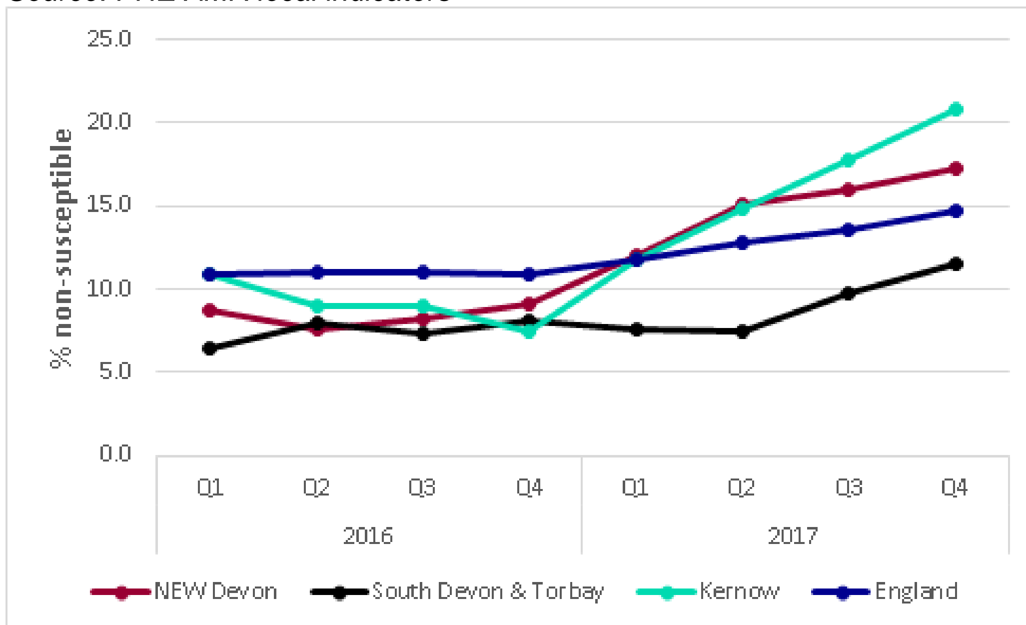
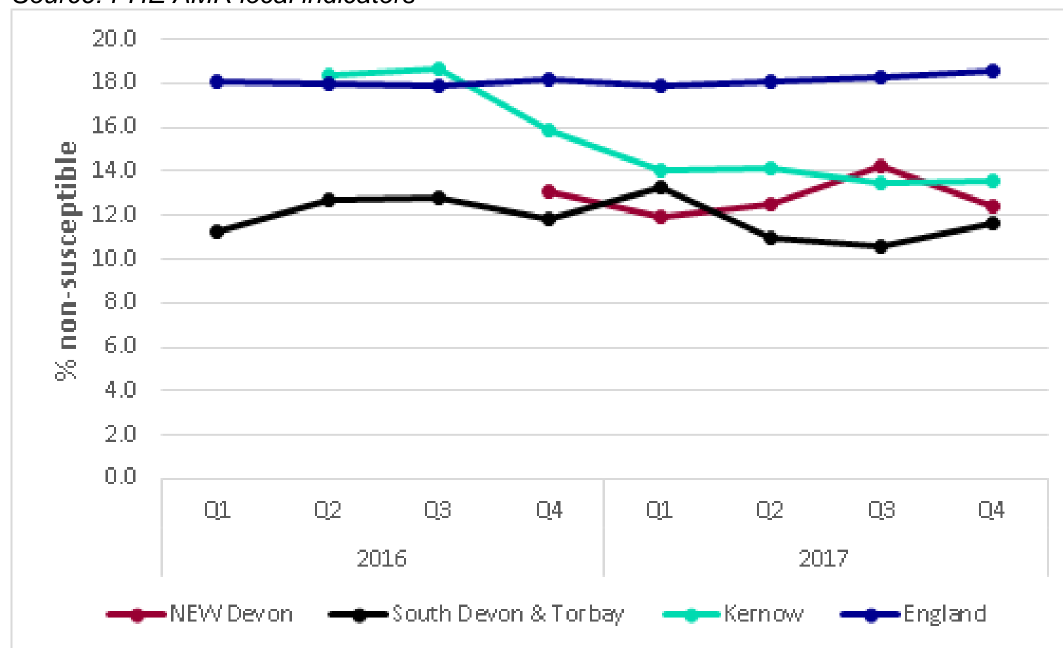


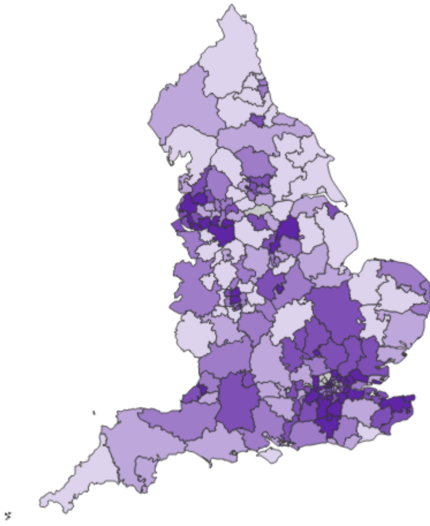
Figure 5: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to ciprofloxacin, by quarter*
Source: PHE AMR local indicators[1]



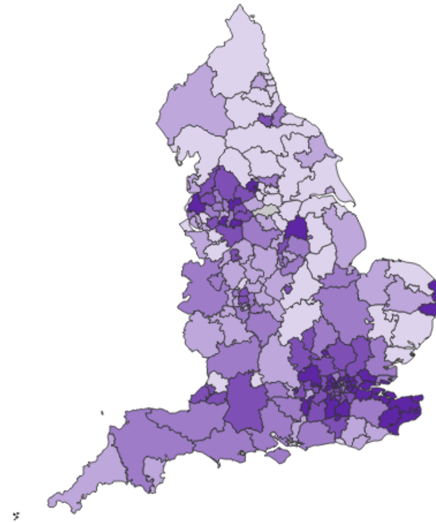
*Where less than 70% specimens have been tested for a particular CCG the results have been suppressed for data quality reasons.

Figure 6: Rolling quarterly average proportion of E. coli from blood non-susceptible to: A (a 3rd generation cephalosporin), B (gentamicin), C (piperacillin/tazobactam), D (ciprofloxacin). Data presented by CCG for quarter four 2017. The colour coding for the level of resistance is presented in quintiles.
Source: PHE AMR local indicators[1]

A



B



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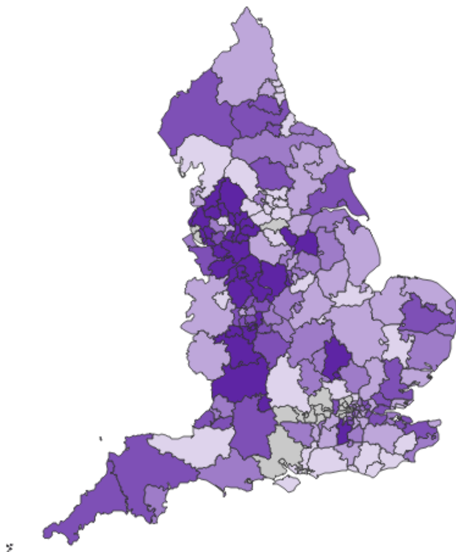

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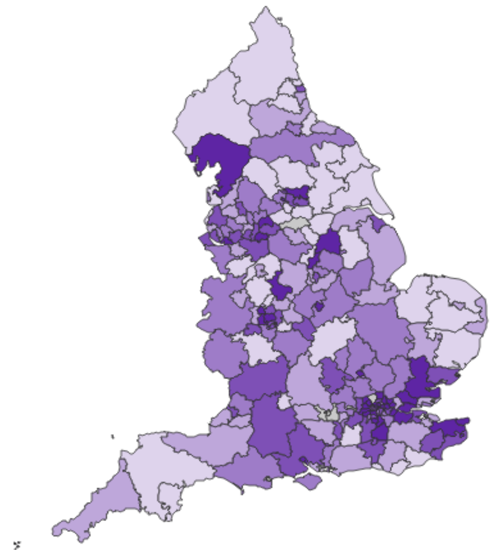


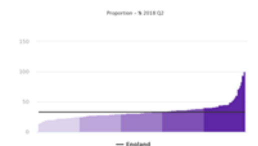
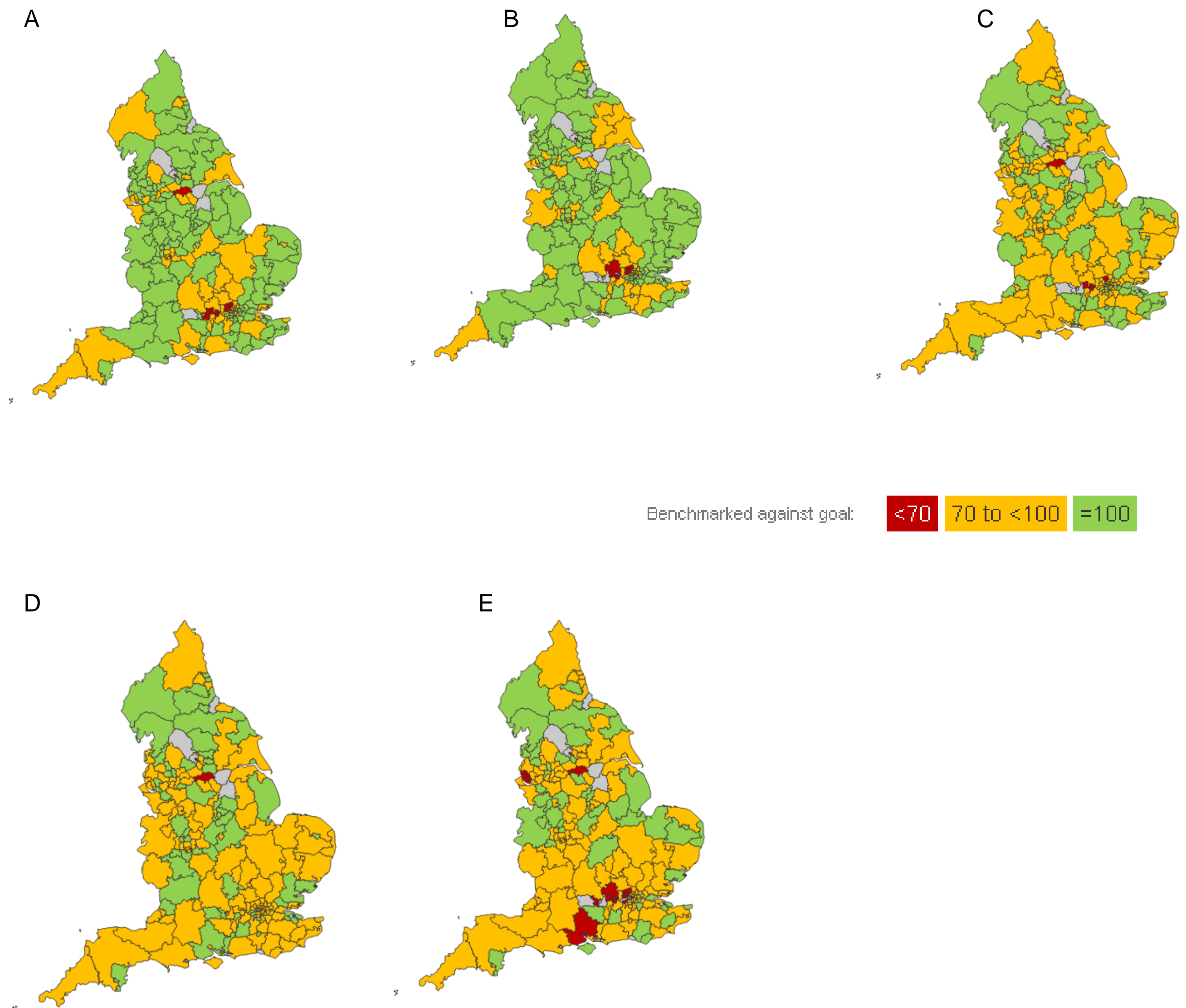


Figure 7: Proportion of *E.coli* from blood tested for susceptiblity to: A (a carbapenem), B (a 3rd generation cephalosporin), C (ciprofloxacin), D (gentamicin), E (piperacillin/tazobactam). Data presented by CCG for quarter four 2017
Source: PHE AMR local indicators[1]



Carbapenemase producing organisms
In 2017/18 there were 12 episodes referred from hospitals within Devon, Torbay, Cornwall and Plymouth local authorities that were confirmed as CPOs by AMRHAI, an increase from 2016/17, in which 11 episodes were confirmed CPOs.

References
1. Public Health England. AMR Local Indicators https://fingertips.phe.org.uk/profile/amr-local-indicators

HEALTH AND WELLBEING BOARD

Work Programme 2018 - 2019

Date of meeting	Agenda item	Responsible
12 July 2018	CQC Action Plan	Craig McArdle (Director for Integrated Commissioning)
	Commissioning intentions	Craig McArdle (Director for Integrated Commissioning)
4 October 2018	CQC Action Plan	Craig McArdle (Director for Integrated Commissioning)
	Suicide Prevention	Sarah Lees (Consultant in Public Health)
	Prevention Concordat For Better Mental Health	Sarah Lees (Consultant in Public Health)
	DPH Annual Report	Ruth Harrell (Director for Public Health)
	STP Year 2 Update	
	The Joint Health and Social Care Refreshed LD Strategy for Devon	
	Integrated Care System Strategy	Carole Burgoyne (Strategic Director for People)
	Loneliness and Social Isolation	
10 January 2019	Aspiring Integrated Care System	Ruth Harrell (Director for Public Health)
	Update on Year 5 – People Connecting Through Food	Sarah Ogilvie (Consultant in Public Health)
	Tackling Smoking	Dan Preece (Advanced Public Health Practitioner)
	Avoidable Deaths	Gary Wallace (Public Health Specialist)
7 March 2019	Impacts of Poor Quality Housing on Health	Ruth Harrell (Director for Public Health)
	Physical Inactivity	Ruth Harrell (Director for Public Health)
	Loneliness Action Plan	Anna Coles/Ruth Harrell
	CQC Local system review progress monitoring	Anna Coles/Ruth Harrell
	DCIOS HPC Annual Assurance Report	Sarah Ogilvie
	Integrated Commissioning	Anna Coles/Craig McArdle
	NHS Long Term Plan	Sonja Manton
Items to be scheduled	Integrated sexual health	Laura Juett

Date of meeting	Agenda item	Responsible
	Dementia in Devon	Craig McArdle (Director for Integrated Commissioning)
	Update from Safer Plymouth	Matt Garrett
	Sexual Violence	Laura Griffiths
	Trauma informed approach/network	Julie Frier/Gary Wallace
	ICM – alternatives to seeing your GP	Nicola Jones