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HEALTH AND WELLBEING BOARD

Thursday 30 July 2020
10.00 am
Virtual Committee

Members:
Councillor Kate Taylor, Chair
Councillors Allen, Laing and Nicholson.

Statutory Co-opted Members: Strategic Director for People, Director of Children's Services, NHS Devon Clinical Commissioning Group, Director for Public Health and Healthwatch.
Non-statutory Members: Livewell SW, University Hospitals Plymouth NHS Trust and the Voluntary and Community Sector.

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

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Tracey Lee
Chief Executive

Health and Wellbeing Board

1. To note the Appointment of Chair and Vice-Chair

The Committee will be asked to note the appointment of the Chair for the municipal year 2020/21 and 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 - 6)**

To confirm the minutes of the meeting held on 12 March 2020.

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. COVID-19 Update from Board Members

8. Plymouth COVID-19 Local Outbreak Management Plan **(To Follow)**

9. 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 2018-2019 **(Pages 7 - 58)**

10. A Framework for COVID19 Inequalities **(To Follow)**

11. Work Programme **(Pages 59 - 60)**

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

Health and Wellbeing Board

Thursday 12 March 2020

PRESENT:

Councillor McDonald, in the Chair.
Dr Shelagh McCormick, Vice Chair.
Councillor Laing.

Apologies for absence: Councillors Mrs Bowyer and Kate Taylor, David Bearman (Devon Local Pharmaceutical Committee), Matt Bell (POP+), Ann James (University Hospitals Plymouth NHS Trust), Ch Supt Tamasine Matthews (Devon and Cornwall Police), Craig McArdle (Plymouth City Council) and Dr Adam Morris (Livewell SW).

Also in attendance: Professor Sube Banerjee (University of Plymouth), John Clark (Plymouth Community Homes), Ruth Harrell (Director of Public Health), Nick Pennell (Healthwatch), Imogen Potter (POP+), Gary Walbridge (Plymouth City Council), Alison Botham (Director of Children Services), Jean Kelly (Service Director for Children, Young People and Families), Siobhan Wallace (Head of Service Children, Young People and Families), Oliver Mackie and Shelly Shaw (NSPCC) and Amelia Boulter (Democratic Advisor).

The meeting started at 10.00 am and finished at 11.38 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.

29. **Declarations of Interest**

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

30. **Chairs urgent business**

Ruth Harrell (Director of Public Health) proposed an extension to the Health and Wellbeing Board membership to include a representative from the Wellbeing Hubs.

Agreed to invite a representative from the Wellbeing Hubs to be a member of the Health and Wellbeing Board.

31. **Minutes**

Agreed that the minutes of 9 January 2020 were confirmed.

An update was provided on the following minutes:

Minute 24 (2) - Dental Health Select Committee took place on 27 February 2020 and made a number of recommendations. The recommendations were endorsed by Cabinet on 10 March 2020.

Agreed that the Dental Health Select Committee recommendations to be circulated to the Health and Wellbeing Board.

32. **Questions from the public**

There were no questions from members of the public.

33. **Marmot Report Update**

Ruth Harrell (Director of Public Health) provided a verbal update on the Marmot Report 10 years on. It was highlighted that life expectancy for the most deprived groups of women in particular was dropping and that inequality was continuing to grow and this was outlined in the Director of Public Health's Annual Report. Also the reduction in funding and impact on health inequalities and that there was a clear correlation that funding cuts had impacted on the poorest in our society.

The Board noted the Marmot Report update.

(The order of the agenda was changed to facilitate good meeting management).

34. **COVID-19 Verbal Update**

Ruth Harrell (Director of Public Health) provided the Board with a verbal update on COVID-19. It was highlighted that the World Health Organisation have announced that COVID-19 now a pandemic with areas of Europe a particular concern. This was a new virus impacting the elderly and those with long term condition and was much worse than seasonal flu for these groups of people. This was a rapidly moving situation and were looking at national guidance which can be accessed on gov.uk and NHS.uk.

The Board noted the Covic-19 update.

(The order of the agenda was changed to facilitate good meeting management).

35. **Children and Young People's System**

Alison Botham (Director of Children Services) was present for this item and referred to the report in the agenda pack. It was highlighted that:

(a) they were in the process of agreeing the priorities for the coming year which included the new plan Bright Futures. They agree the priorities and ensure that they were right for children and young people in Plymouth;

(b) the Children and Young People Partnership which includes key stakeholders, from this partnership operates a number of steering groups:

- Children with special educational needs
- Maternity and early years
- Plymouth Education Board
- Safeguarding
- Early Help

(c) it was expected by the end of this month to have agreed the new Bright Futures and priorities and the Partnership itself would be refreshing the priorities going forward;

(d) most of the priorities would continue such as education and attainment; narrowing the disadvantaged gap and inclusion; early help and prevention; ensuring that the needs children with complex needs were met appropriately; children in care; sufficiency of appropriate placements and increasing capacity within the in-house fostering.

In response to questions raised, it was reported that within the Council and across the partnership it was an area of strength in how they involve children and young people such as the Junior and Senior Listen and Care Council for care leavers. The safeguarding partnership have young safeguarders and the recent joint targeted area inspection which took place at the end of last year and the inspectors commented very positively across the partnership on the way in which we do engage children and young people.

The Board noted the Children and Young People's system update and to add Bright Futures to the work programme.

36. **PAUSE Plymouth**

Jean Kelly (Service Director for Children, Young People and Families) was present for this item and referred to the report in the agenda pack. It was reported that:

(a) many local authorities experience recurrent care proceedings for one family where we are removing more than one child and wanted to find a solution and to support families to break the cycle;

(b) Pause a national programme that seeks to break the cycle. It was started in Hackney in 2013 and now live in 20 local authorities across the country. Plymouth went live in September 2019;

(c) they were using the trauma informed approach which fits with the approach that the city was taking;

(d) this work offers women an opportunity to pause and think about how they want the direction of their life to progress. Trevi House have been contracted to lead on this and work directly with the women;

(e) the first cohort or community as they liked to be called has 23 women and have had no women withdrawal from that programme which was significant because these women have struggled to trust professionals and practitioners and have a range of complex difficulties in their lives that make engaging with services difficult;

(f) they have not seen any or new care proceedings from this first cohort;

(g) the next phase was to commence with a further 25 women which would take the numbers up to 48 with the potential of additional funding for a further 24 or 25 women.

In response to questions raised, it was reported that they work very closely with the different co-ordinators across the country to ensure that the learning from all the projects was taken into account in Plymouth.

The Board noted the PAUSE Plymouth report.

37. **Together for Childhood**

Siobhan Wallace (Head of Service, Children, Young People and Families), Oliver Mackie and Shelly Shaw (NSPCC) were present for this item and referred to the report in the agenda. Following the video it was highlighted that:

(a) this project was started in Plymouth and was chosen as one of four pilot sites across the country to support the community to prevent harmful sexual behaviour and sexual offending;

(b) the project was about increasing confidence in preventing child sexual abuse particularly amongst professional groups and community leaders trying to increase the knowledge and evidence base about what works in terms of prevention;

(c) they undertook a survey within the community to understand what people know about preventing sexual abuse within the community as a baseline study;

(d) they were developing a multi-stranded evaluation approach embedded within the project and to look at what they can learn, the impact and how this project could be implemented within other communities;

(e) they wanted to create projects across the city but wanted to learn what works in one community first so to be absolutely sure about its efficacy before going further afield with the aim of create lasting change within a community;

(f) they have developed a training package based on early conversations with the different communities where there was still a lot of misconceptions around the prevention of sexual abuse. This training has

been delivered to 114 members of staff;

(g) the city was moving to become more trauma informed and the together for childhood was fundamental part of that. It was about creating the conditions for wanting to be more proactive around prevention work and so we're really seeing again multi-agency partners involved and currently have 159 different people as part of the Trauma Network;

(h) they were also delivering a programme called sharing the science so that staff have a common language when talking to families around brain development. Other programmes include the pants campaign and they have co-designed a healthy relationships campaign. They were also looking at peer to peer relationships and were working with 25 young people from Marine Academy;

(i) they have secured additional money to undertake work around harmful sexual behaviour over the next four years. This ambitious preventative programme was significant for the city in terms of preventative work and should be celebrated because it has given the city opportunities to intervene on a whole range of levels.

In response to questions raised, it was reported that:

(j) Ernesettle was the finally selected because of the strength of the community networks and they were a group of people who were already very concerned about the issues and wanted to work with us. The messaging was about positively addressing the issue of sexual abuse rather than saying that there was a problem within that community. This was about preventative work and using the strengths of the community;

(k) the Trauma Informed Network has actually been part of the building blocks to learning and have commissioning colleagues involved at a strategic level and operational level to share the learning. This also has to be business as usual and not about parachuting in and putting additional resources, it's about how do we as a system work together better to keep our children safe;

(l) it was very clear that a different community they wouldn't take the same approach which had worked well in Ernesettle. They would look at the differences and build on the learning to ensure the right outcomes.

The Board noted the Together for Childhood Update.

38. **Work Programme**

Board members were invited to forward items to populate the work programme. It was agreed to add the following items –

- Bright Futures
- PAUSE Plymouth Update
- PNSA

Health and Wellbeing Board

Date of meeting:	30 July 2020
Title of Report:	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 2018-2019
Lead Member:	Councillor Kate Taylor (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Ruth Harrell (Director of Public Health)
Author:	Julie Frier
Contact Email:	Julie.frier@plymouth.gov.uk
Your Reference:	
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

Local authorities, through their Director of Public Health, require assurance that appropriate arrangements are in place to protect the public's health. To this end the Health Protection Committee (HPC) is 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 to provide assurance to the local Health and Wellbeing Boards that adequate arrangements are in place for prevention, surveillance, planning and response to communicable disease and environmental hazards, to protect the public's health.

The HPC produces an annual report to the Health and Wellbeing Boards, which 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 2018 to 31 March 2019, 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 2018-19
- Actions taken to date against the programme of health protection work priorities established by the committee for the period 2018 to 2019
- Priorities for the work programme 2019-20

Recommendations and Reason

The Health and Wellbeing Board notes the contents of the report.

Alternative options considered and rejected

The report is for noting only

Relevance to the Corporate Plan and/or the Plymouth 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 caring priorities within the Corporate Plan, and particularly with regards to the Plymouth Plan aim to become a Healthy City.

Implications for the Medium Term Financial Plan and Resource Implications:

None.

Carbon Footprint (Environmental) Implications:

None.

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

** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

None

Appendices

**Add rows as required to box below*

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A								

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are <u>unpublished</u> works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	djn.19.20.256	Leg	MS.28.02.20	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Julie Frier											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 01/03/2020											
Cabinet Member approval: Cllr Kate Taylor Date approved: 04/03/2020											

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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

2018 - 2019

February 2020

PLYMOUTH CITY COUNCIL

TORBAY COUNCIL

CORNWALL COUNCIL

Council of the ISLES OF SCILLY

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1 Introduction

1.1 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 from 1 April 2018 to 31 March 2019, 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 antimicrobial resistance

1.3 The report sets out:

- Structures and arrangements in place to assure performance
- Performance and activity in all key areas during 2018-19
- Actions taken to date against health protection priorities identified by the committee for 2018-19
- Priorities for 2019-20

2 Assurance Arrangements

2.1 On 1 April 2013, most 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 including sexually transmitted infections;
- 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 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 local Health and Wellbeing Boards that adequate arrangements are in place for prevention, surveillance, planning and response to communicable disease and environmental hazards, to protect the public's health.

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

2.5 The follow groups sit alongside the Health Protection Committee and support mitigation of risks and achievement of local priorities:

- Devon Infection Prevention and Control Forum
- Cornwall Directors of Infection Control Group
- Devon, Cornwall and Somerset Health Care Associated Infection Network
- Devon Antimicrobial Stewardship Group
- Cornwall Antimicrobial Resistance Group

- Health Protection Advisory Group for wider Devon
- Locality Immunisation Groups for Devon, Plymouth, Torbay, Cornwall and the Isles of Scilly
- South West (South) Seasonal Influenza Strategic Group (and related flu network meetings)
- Devon Flu Planning and Oversight Group
- Cornwall System Flu Group
- Screening programme board meetings
- Plymouth Health Protection Locality Group
- Local Health Resilience Partnership and Group
- Devon, Cornwall and Isles of Scilly Local Resilience Forum
- Public Health England led Migrant and Refugee Health Network
- Public Health England led South West South TB Network
- South West Peninsula Hepatitis C Operational Delivery Network

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

2.7 Meetings of the Health Protection Committee are held quarterly.

2.8 A memorandum of understanding, which specifies the roles and responsibilities of the various agencies involved in Health Protection, is in place although this is currently being reviewed. A description of current organisational roles and responsibilities can be found in the subsequent sections. This may need to be reviewed for subsequent reports following agreement of the memorandum of understanding.

3 Prevention and Control of Infectious Diseases

Organisational Roles and Responsibilities

3.1 NHS England and NHS Improvement 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 and NHS Improvement 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 health protection, 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 NHS England and NHS Improvement.

3.3 The Clinical Commissioning Groups' 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 NHS Improvement and Public Health England, supported by the local Clinical

Commissioning Group. In addition, they must be assured that the local health protection system is robust enough to respond appropriately 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 containing epidemiological information on cases and outbreaks of communicable diseases of public health importance at local authority 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). Furthermore, Public Health England provides a daily list of all community outbreaks all year round.

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

Disease Outbreaks and Incidence 2018-19

Locality summaries

Devon

3.8 Public Health England recorded 145 situations across Devon in 2018-2019. Fifty-eight situations were declared in care homes, with 38 related to gastrointestinal illness, 18 as a result of flu-like illness including confirmed influenza, and one each as a result of scabies infestation and group A streptococcal infection. The most common settings for situations were schools and nurseries (total =66), including: gastrointestinal illness (37), scarlet fever (19), influenza-like illness (8), chickenpox (1) and whooping cough (1). Three situations were declared in higher education, two as a result of mumps cases and one following a case of meningococcal infection. Furthermore, three situations were declared in custodial institutions following gastrointestinal illness (2) and skin infections (1). In the wider community setting there were 15 further situations relating to infectious diseases (8) and chemical hazards (7) including a fire and carbon monoxide exposure.

Torbay

3.9 Forty-two situations were declared across Torbay between 2018-2019, the majority of which were in care homes (25) including gastrointestinal illness (17), influenza-like illness (7) and scabies (1). Fourteen situations were declared in schools and nurseries, mostly gastrointestinal illness (9) but also scarlet fever (3), conjunctivitis (1) and influenza-like illness (1). One situation was declared following reports of illness linked to a food outlet, but this was subsequently considered to be a result of norovirus and person-to-person spread. Public Health England were also involved in the management of influenza cases in a hospital setting and investigating cases of legionnaire's diseases with epidemiological links to the Torbay area.

Plymouth

3.10 A total of 56 situations were declared in 2018-2019 by Public Health England across Plymouth of which half (28) occurred in schools and nurseries including: gastrointestinal illness (14), scarlet fever (12) impetigo (1) and chickenpox (1). Twenty-one situations were declared in care homes, relating to gastrointestinal illness (15), scabies infestation (2) and influenza-like illness (4). One situation was declared in a college following two cases of meningococcal disease just over a month apart, and a further following cases of group A streptococcal

infection in a Plymouth hospital. In the community, situations were declared in response to infectious diseases (4 - including invasive group A streptococcal infection in the homeless community in Plymouth), a fire (1) and a ship's crew member with infectious disease.

Cornwall and the Isles of Scilly

3.11 Ninety-three situations were declared by Public health England across Cornwall and the Isles of Scilly in 2018-2019. Thirty-four situations in care homes included gastrointestinal illness (21), influenza-like illness (8), scabies (3), chickenpox (1) and exposure to tuberculosis (1). There were 35 situations in schools and nurseries including gastrointestinal illness (15), scarlet fever (9) and influenza-like illness (3), in addition to incidents relating to chickenpox, hand foot and mouth, conjunctivitis, environmental exposure, respiratory illness and infection control. Seven situations were declared in hospital settings, predominately following cases of tuberculosis and otherwise related to infection control. In the community there were situations relating to gastrointestinal illness (6), sexual health (1), environmental hazards (1) and other topics (5). Three gastrointestinal situations were recorded in hotels and one in a college.

Notable incidents

Devon

3.12 A multi-agency outbreak control team was formed in response to cases of group A streptococcal skin infections among prisoners at HMP Exeter; this increase was noted upon a local and national backdrop of increased infections - many of the same strain type among prison and homeless populations. Working closely with the prison estate, protocols for detection and infection control were established and at the time of writing this outbreak has settled considerably.

3.13 Consistent with the national picture, there was an increased number of notifications of mumps among students in Exeter; with 58 cases (24 confirmed; 3 later ruled out) reported as of June 2019. In response to the increase seen, the Public Health team at Devon County Council worked closely alongside Public Health England and university healthcare to develop a toolkit for universities including messaging and public health advice regarding measles, mumps and rubella immunisation.

Plymouth

3.14 Nil noted

Torbay

3.15 Public Health England investigated seven cases of legionnaire's disease over a six-month period of which three lived in, and four had visited, the Torbay area including from overseas. Strain-typing and further detailed information gathering did not suggest that the cases were linked to a common source.

3.16 Public Health England, both locally and with national experts, worked closely with Torbay Hospital following several cases of influenza linked to a unit in Torbay hospital. Strict infection control was put in place to control the outbreak in addition to the use of anti-viral prophylaxis.

Cornwall and isles of Scilly

3.17 As of March 2019 there were three cases of monkeypox in the UK. The first patient was staying at a naval base in Cornwall prior to transfer to the expert infectious disease unit at the Royal Free Hospital, London, and there is no UK link to the two cases that followed. This was the first time that this infection had been diagnosed in the UK. Monkeypox is a rare viral infection that does not spread easily between people. It is usually a mild self-limiting illness and most people recover within a few weeks. However, severe illness can occur in some individuals. The infection can be spread when someone is in close contact with an infected person;

however, there is a very low risk of transmission to the general population. As a precaution, Public Health England contacted those individuals who had been in close proximity to the patient to ensure that if they became unwell they could be treated quickly. This included a number of passengers who travelled on the same flight to the UK as the patient. Further details can be found on the Public Health England website: www.phe.gov.uk.

3.18 TB exposure in a care home – Public Health England worked with the Cornwall TB Service to warn and inform staff and residents. Staff and residents identified as potentially exposed were offered screening and uptake was good. There was no evidence of onward transmission. England has been classified as a low incidence country by the WHO since 2017 (defined as a rate of less than 10 per 100,000 population); however, further work is needed to improve the outcomes for those most at risk of TB, reduce in-country TB transmission and maintain the decline in TB incidence and numbers.

3.19 An outbreak of gastrointestinal illness in diners associated with consumption of potentially contaminated oysters was followed up by Cornwall Council, Public Health England and the Food Standards Agency (FSA). As oysters are traditionally eaten raw, people should be aware that eating them in this way carries a risk of food poisoning. The Food Standards Agency advises that older people, pregnant women, very young children and people who are unwell should avoid eating raw or lightly cooked shellfish to reduce their risk of getting food poisoning.

3.20 A peak in cases of gonorrhoea was reported by Cornwall Sexual Health Services and an epidemiological investigation undertaken but no clear cause identified in terms of risk factors. Numbers returned to expected levels and will continue to be monitored. Gonorrhoea is transmitted through unprotected vaginal, oral or anal intercourse or genital contact with an infected partner. An infected person may have no symptoms but still transmit the infection. Occasionally, gonorrhoea can cause serious complications such as pelvic inflammatory disease, ectopic pregnancy and infertility. It is the second most common bacterial sexually transmitted infection in the UK.

4 Immunisation and Screening

Organisational Roles/Responsibilities

4.1 NHS England and NHS Improvement is accountable for all national screening and immunisation programmes commissioned via the Section 7A arrangements. NHS England and NHS Improvement 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 and NHS Improvement remains the accountable commissioner. A list of all national screening programmes is included at **Appendix 3**.

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 protecting and improving the health of their local population under the leadership of the Director of Public Health, including supporting Public Health England in efforts to improve programme coverage and uptake.

Assurance Arrangements

4.4 Public Health England South West Screening and Immunisation Team provides quarterly reports to the Health Protection Committee for each of the national immunisation and screening programmes. Due to the nature of the programmes, the NHS England and NHS Improvement and Public Health England data capture and validation processes (except for the seasonal influenza vaccination programme), 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 and 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. For 2019/20, Devon, Plymouth, Torbay Cornwall and the Isles of Scilly will each have an immunisation locality group (Devon has not had one for the past two years). In addition, there is a separate South West (South) Seasonal Influenza Strategic Group. All the oversight groups have Terms of Reference and clear escalation routes to ensure accountability both within NHS England and NHS Improvement and Public Health England and into individual partner organisations.

SCREENING

Cervical screening

4.7 The national programme is in the process of moving to a Primary HPV model, where women's samples will first be tested for HPV infection and only those samples that are positive for high-risk HPV infection will go on to be tested for cytology. This is a very positive change as it will more effectively identify women at greatest risk of developing cancer, and at the same time return a higher proportion of women who are HPV negative (and at lower risk of cancer) back to routine screening intervals. However, the Primary HPV model means that there will be a significant reduction in the number of screening cytology samples inevitably leading to a reduction in the number of cytology laboratories needed across the country. In the South West, only one cytology laboratory will be needed, and this will be North Bristol NHS Foundation Trust.

4.8 During the past year, a significant number of laboratory staff left for other roles leading to big increases in the time it takes to process samples and get results to women (lab turnaround times). To address this, national and local mitigation plans were put in place to transfer work to alternative laboratories. In the South West, this was initially achieved through transfer of a proportion of Devon and Cornwall/IOS screening samples to North Bristol Trust and Royal Devon and Exeter Trust with good impact. This was followed by the decommissioning of the cervical cytology laboratory service at the Royal Cornwall Hospitals Trust in November 2018 with all Devon and Cornwall/IOS samples split between the two laboratories. To cope with the extra demand, both North Bristol Trust and Royal Devon and Exeter Trust labs made an early transfer to Primary HPV testing, securing benefits to local women ahead of the national roll-out.

4.9 After an extended period during 2018/19 when the turnaround times were falling short of the national standard (>98% of results sent to women within 14-days: Apr18 Cornwall/IOS samples 1.4%, Devon samples 69.2%), the service is now back on track with significant

improvement in sample turnaround times (Apr19: Cornwall/IOS 99.5%, Devon 96.8% and fully recovered in May19 99.5%).

4.10 Workforce issues are a challenge for all the cancer screening programmes. In the cervical screening programme, sample-taker training and assurance is a critical factor in maintaining the quality and safety of the screening programme. Several initiatives have been implemented during 2018/19 to support sample-takers:

- the Screening and Immunisation Team has undertaken assurance that all GP practices and sample-takers converting to HPV Primary screening have been informed of the changes to the programme;
- a new, national eLearning for Healthcare Cervical Screening module has been launched, offering a free to access nationally accredited online training programme for sample takers to complete as an alternative to attending a 3-yearly face-to-face half day update;
- NHS England and NHS Improvement South West has procured a new web-based live database of cervical sample takers. This is being managed by the South Central and West Commissioning Support Unit. The database allows for automated notification of sample takers approaching their update date and to more effectively manage the sign off for sample takers following training.

4.11 Coverage of the local cervical cancer screening programmes remains a concern. Rates remain above the national average, however, continue to fall mirroring the slow but consistent reduction in national rates over many years. All areas are below the national target of 80%.

Table 1: Cervical cancer screening coverage, 2016-2018

Indicator[1]	Lower threshold	Standard	Geography	2016	2017	2018
Cervical Cancer screening coverage	75	80	Devon	77.1	76.6	76.3
			Plymouth	74.5	73.6	73.1
			Torbay	74.8	73.9	73.0
			Cornwall	75.7	74.9	74.5
			Isles of Scilly	81.9	78.2	79.2
			England	72.7	72.0	71.4

4.12 The Integrated Public Health Commissioning Team (NHS England Public Health Commissioning and the PHE Screening and Immunisation Teams) had identified cervical screening coverage as one of its top priorities for 2018/19, working alongside the national campaigns led by Jo's Trust and the national Be Clear on Cancer campaign.

4.13 Developments for 2019/20 include:

- Continued local work to address the falling uptake, working closely with the Peninsula Cancer Alliance and Cancer Research UK, and supporting the workforce to embed Primary HPV screening into practice.
- Nationally, Primary HPV screening will be fully rolled out across the country, and work to design and implement the new national cervical screening IT system will continue led by NHS X, working with NHS Digital and Public Health England.
- The national team is also looking to test the feasibility of self-sampling through a study based in London.

[1] Data Source: LA Dashboard (data taken from Public Health Outcomes Framework (PHOF) http://www.phoutcomes.info/)

Breast screening

4.14 2018/19 was a challenging year for the breast screening programme. All breast screening services were affected by the national incident (May 2018) whereby some eligible women may not have been invited for their final screening appointment. Services were required to provide thousands of extra appointments in addition to maintaining the routine programme. All providers covering Devon, Cornwall/IOS worked extremely hard completing the catch-up in the nationally required timescales, with minimal impact on the routine programme. Learning from the incident has been implemented across the national programme with several additional quality improvement and assurance processes introduced with no concerns raised about local services.

4.15 Over the year, all providers have generally maintained performance however there have been in year fluctuations in several areas due to a mix of equipment and staffing issues, and pressures from symptomatic services. These issues are representative of pressures across the national programme and have been proactively managed to minimise any impact on women.

4.16 Workforce remains an area of concern with national and local shortages of key staff across the providers.

4.17 Coverage of breast screening remains stable though below the national target of 80%, mirroring the national trends. All areas are above the national average apart from Torbay, which has remained below the national average for the past three years.

Table 2: Breast cancer screening coverage, 2016-2018

Indicator[2]	Lower threshold[3]	Standard [4]	Geography	2016	2017	2018
Breast Cancer screening coverage	70	80	Devon	78.8	78.3	78.3
			Plymouth	79.3	79.0	78.2
			Torbay	74.7	74.1	74.4
			Cornwall	80.0	79.3	78.4
			Isles of Scilly	80.1	79.5	79.8
			England	75.5	75.4	74.9

4.18 All providers undertake a range of local activities prior to commencing screening in an area to engage with general practices and local groups to promote the programme to women.

4.19 Developments for 2019/20 include:

- a local rolling programme of health equity audit to support enhanced activities to target groups who are not currently taking up the offer of screening;
- work in conjunction with the South West Cancer Alliances will map and support the implementation of activities to reduce inequalities in uptake;
- nationally, several projects are underway to address low uptake in various community groups;
- a range of national, and local initiatives by the South West NHS England and NHS Improvement Integrated Public Health Commissioning Team supported by Health

[2] Data Source: LA Dashboard (data taken from Public Health Outcomes Framework (PHOF) http://www.phoutcomes.info/)

[3] Threshold based on 2017-18 Public Health Functions Agreement

[4] National Screening and Immunisation Programme Standard

Education England, to support providers to address workforce pressures, including the use of local CQUINS;

- the Plymouth and West Devon screening service is undertaking a pilot with the Avon service to read mammography films remotely - should this pilot be successful, it will help create film-reading capacity and enable faster processing of mammograms and results to women across the breast screening programme;

- introduction of the high-risk women guidance once IT changes are ready (due June 2020).

4.20 Following the national breast screening incident and a cervical incident soon after, the Secretary of State announced a review of the UK cancer screening programmes. This was later extended to adult screening programmes. The review was published in October 2019 and has made a series of recommendations regarding IT systems, better high-risk identification/screening, organisational and governance changes, and recommendations to improve uptake, including use of text reminders and extending access to clinic appointments.

Bowel screening

4.21 2018/19 has also been challenging for the bowel screening programme. Significant work has been done to plan for the implementation of the new screening test FIT120 that will replace the current Faecal Occult Blood (FOB) test during 2019. The rollout of Bowel Scope continues across the South West, however, work to meet planned trajectories has slowed in light of the introduction of FIT120 and pending a national announcement about the future of the programme.

4.22 The FIT120 is an important national development in the programme, with national pilots finding that the screening test is more acceptable and simpler to use requiring only one stool resulting in a 7% increase in uptake as well as a higher sensitivity, which is very positive. The anticipated increase in screen positivity and uptake will result in many more referrals into diagnostic colonoscopy services that are already under pressure. Ensuring sufficient colonoscopy capacity to cope with these expected increases in referrals, as well as management of the surveillance and symptomatic services (these are outside of the screening programmes), will result in significant challenges for providers during the coming year.

4.23 Workforce remains an area of concern with national and local shortages of key staff across the providers.

4.24 Coverage of the bowel cancer screening programme remains stable and above the national average.

Table 3: Bowel cancer screening coverage, 2016-2018

Indicator[5]	Lower threshold	Standard	Geography	2016	2017	2018
Bowel Cancer screening coverage	70	80	Devon	62.6	64.2	64.2
			Plymouth	61.6	61.1	61.6
			Torbay	61.4	61.8	61.1
			Cornwall	60.5	61.7	61.5
			Isles of Scilly	67.8	68.6	68.4
			England	57.9	58.8	59.0

4.25 It is expected that with the introduction of FIT120 during the early part of 2019, coverage rates for 2019 will have increased, hopefully in line with the 7% seen in the pilots. In addition, there are several national initiatives underway to improve uptake. These include all invitation letters

[5] Data Source: LA Dashboard (data taken from Public Health Outcomes Framework (PHOF) http://www.phoutcomes.info/)

now having a GP endorsement; all invitation letters are now large print and include a freephone helpline to access information in other formats, and leaflets are available on the GOV.UK website in HML format so that people can choose to increase font size if needed. The invitations also now include a sentence in the top 10 languages informing people of how they can access information and leaflets on the website about the programme in their language.

4.26 Work to increase uptake during the year was limited as focus has been on maintaining national quality given the challenging circumstance around FIT, bowel scope and workforce.

4.27 Developments for 2019/20 include:

- roll out of FIT120 screening;
- a range of initiatives by NHS England and NHS Improvement Integrated Public Health Commissioning Team supported by Health Education England, and the use of local CQUINS to support providers to address workforce pressures.

Antenatal and Newborn (ANNB) screening

4.28 There are 6 ANNB screening programmes in total and all are delivered as part of core maternity services by all maternity units. As a result, coverage of all ANNB screening programmes is extremely high (see **Appendix 3**: coverage of non-cancer screening programmes).

4.29 Coverage of the Newborn and Infant Physical Examination (NIPE) is a little lower than that of the other programmes. Historically, this screening programme was carried out by hospital paediatricians prior to discharge and by the GP after discharge. As a result, it was more challenging to ensure all babies were screened in a timely way. To address this, all providers have been moving to a midwife model and performance has improved. It is expected that all providers will achieve the national standard during 2019/20.

4.30 Despite the high coverage rates, some women do decline screening and there is a need to further explore this and ensure that women are enabled to make an informed choice.

4.31 Performance across the antenatal screening programmes during 2018/19 was excellent in all providers apart from key performance indicator ST2 (antenatal sickle cell and thalassaemia screening (SCT) – timeliness of test) where three providers have not achieved the acceptable standard. This is due, in the main, to the historic model of booking and the arrangements for women to access booking blood tests. Given that the Peninsula is a low-prevalence area for SCT, the timing of the bloods is aligned to the requirements of the first trimester foetal anomaly screening programme (FASP) rather than to the earlier blood testing requirements of the SCT programme. All providers have arrangements in place to ensure that women at high risk of SCT are able to be screened at the correct time. Quality improvement work has been ongoing throughout the year and part of external Quality Assurance reviews, and all three providers have plans to change the model and are expected to achieve the national standards early in 2019/20.

4.32 Consistent achievement of acceptable performance of the newborn bloodspot screening programme is more challenging. During 2018/19, providers have been delivering 2-year quality improvement plans to reduce the number of tests that have to be repeated. This has resulted in improvements to systems and processes, and to improvements in the quality of sample-taking, both contributing to a significant reduction in the number of avoidable repeat tests. Transport to the newborn laboratory from such a large geographical area also presents challenges and providers have been modifying arrangements to ensure samples arrive in the lab as fast as possible. Another challenging area is the follow-up of children up to 12 months old who move in the area without a screening result. Multiagency failsafe pathways are in place to ensure these children are offered testing if needed, however, the national standard to have a result in 21 days is not consistently met, for a multitude of reasons, and requires further investigation and action. The mobilisation process to send all results electronic transfer from the newborn lab to the Child Health information Service was completed in year.

4.33 Developments for 2019/20 include:

- an audit of women who decline antenatal screening, with recommendations to further enhance informed consent and improve access to screening;
- a South West wide review of the newborn bloodspot movers in failsafe pathway to identify any additional interventions that can be taken to improve performance;
- NIPT (non-invasive pre-natal testing) was due to be introduced into the first trimester foetal anomaly screening programme during 2018/19. The procurement process for this programme was delayed so this is now expected to be introduced during 2019/20.

Newborn hearing screening

4.34 There is almost universal uptake of the offer of screening, and coverage rates and performance in the newborn hearing screening programme remained excellent during 2018/19 (see **Appendix 3**).

4.35 Developments for 2019/20 include:

- The Peninsula is one of only a few areas of the country where the initial screening test is delivered by health visitors at the new birth visit, supported by the specialist screening team. Given the large geographical area, this model has served the area well since the start of the programme ensuring that the service is fully accessible to all families, thereby achieving the very high coverage. Interest has been expressed by providers about alternative models and these will be facilitated by the Screening and Immunisation Team during 2019/20.

Diabetic eye screening

4.36 During 2018/19, Diabetic Eye Screening services across the South West region were re-procured. There is now one provider for the whole of Devon (where previously there were 3 small services) and one provider for Cornwall (as previously). The mobilisation of both services was completed on time for the contract start date of 1st April 2019. Performance and uptake are being closely monitored to ensure a smooth transition of the service and the public.

Table 4: Diabetic eye screening coverage, 2016/17-2018/19

Standard	Acceptable Standard	Achievable Standard	Provider	2016/17	2017/18	2018/19
KPI 1: Diabetic Eye Screening Coverage	75%	85%	North and East Devon	87.5	88.8	86.5
			Plymouth	79.6	79.3	77.3
			Torbay	87.1	86.3	86.6
			Cornwall & IOS	78.8	76.7	75.2
			England	82.2	82.7	81.9
KPI 2: Percentage issued results within 3 weeks	70%	95%	North and East Devon	99.9	99.8	100.0
			Plymouth	96.9	97.6	98.2
			Torbay	95.2	90.9	93.0
			Cornwall & IOS	99.8	98.7	98.3
			England	96.5	94.3	97.5
KPI 3: Percentage urgent referrals seen within 6 weeks*	80%	-	North and East Devon	84.8	86.9	73.8
			Plymouth	77.4	33.3	33.3
			Torbay	89.2	84.4	84.8
			Cornwall & IOS	83.6	73.4	71.4
			England	75.4	76.0	77.7

* 2016/17 and 2017/18 within 4 weeks

4.37 All providers have met the acceptable standard for KPI 1 and KPI 2 in each of the last 3 years. For KPI3, there has been a significant drop in performance for the Plymouth service following the centralisation of the referral service for patients referred to Derriford Hospital. This issue has also impacted on Cornwall and North and East Devon screening services, though to a much lesser extent. The Integrated PHCT has led ongoing discussions with the key organisations to try to resolve this issue and feedback is that performance throughout 2019/20 has improved.

4.38 Developments for 2019/20 include:

- continued work with the new Devon provider to bring together the three 3 providers into a single service;
- work with the Cornwall provider to deliver their service improvement plan, and, to address the fall in uptake over the last 3 years;
- the anticipated change in national guidance and standards and IT software to enable increased screening intervals for people with low risk did not happen this year; it is now expected to commence during 2019/20.

Abdominal Aortic Aneurysm (AAA)

4.39 The three 3 AAA screening services in the Peninsula continued to perform well during 2018/19 with excellent performance and coverage. There are no significant challenges or risks in the programmes.

Table 5: Abdominal Aortic Aneurysm screening coverage, 2016-2018

Indicator[6]	Lower threshold	Standard	Geography	2016	2017	2018
Abdominal Aortic Aneurysm screening coverage	70%	80%	Devon	86.1	87.2	87.1
			Plymouth	83.1	85.1	81.9
			Torbay	80.2	85.3	86.8
			Cornwall	83.5	84.9	84.1
			Isles of Scilly	86.7	87.5	100
			England	79.9	80.9	80.8

Developments for 2019/20 include:

- For screen-detected cases, there is some variation in assessment to treatment protocols between the linked vascular treatment centres. The 3 AAA screening providers are working closely with their vascular service partners to ensure timely access to treatment. During 2019/20, there will be some reconfiguration within Peninsula vascular network, which it is hoped will address this issue.

[6] Data Source: LA Dashboard (data taken from Public Health Outcomes Framework (PHOF) http://www.phoutcomes.info/)

IMMUNISATION

Childhood immunisation

4.40 Childhood immunisation performance throughout 2018/19 is detailed in Appendix 2. The national target for coverage of childhood immunisation is 95%. Coverage of childhood immunisations continues to be high across the area, with a few exceptions. Of the 14 routine childhood vaccination indicators, the following was achieved:

- **Devon:** 3 indicators over 95%, 10 between 90 and 95% including 4 between 94 and 95%, 1 under 90% (pre-school booster)
- **Plymouth:** 7 indicators over 95%, 7 between 90 and 95% including 3 between 94 and 95%
- **Torbay:** 7 indicators over 95%, 7 between 90 and 95%
- **Cornwall:** 2 indictors over 95%, 9 between 90 and 95%, 3 under 90% (Rotavirus, pre-school booster and MMR2 at age 5)
- **MMR 1 at 2 years:** All areas over 90% (Plymouth increasing to 94.9%)
- **MMR 1 at 5 years:** All areas over 95% (herd immunity)
- **MMR 2 at 5 years:** All areas except Cornwall over 90%. Cornwall uptake has been below the other 3 areas for the last 3 years and has not had the slow but steady increase seen in the other areas. This year, coverage is several percentage points below the other areas at 86.4%. This may be partly explained by data issues and requires further investigation.

4.41 In 2018/19, there was another small downward trend in national coverage rates and there is to be a renewed focus on improving uptake rates with a national Vaccination Strategy and Value of Vaccines campaign, and a Measles and Rubella Elimination Strategy (MRES) being launched during 2019/20. The Screening and Immunisation Team will be working closely with partners to review the implications of the strategies and to develop action plans, which will be overseen by the Locality Immunisation Groups.

4.42 Improving MMR uptake continues to be a national and local priority, with several local initiatives undertaken during 2018/19. NHS England and the Screening and Immunisation Team set up an MMR Innovation Fund for primary care and there was good engagement from GP Practices with 85 practices delivering interventions and over 1,450 children vaccinated.

Table 6: Results of MMR innovation fund

	Number of GP Practices involved	Number of families contacted	Number of children vaccinated
Devon	45	1,423	788
Cornwall & IOS	30	1,380	681

4.43 In the last few years, Rotavirus coverage in Devon has been a concern. This was felt to be at least in part a data issue and audits with CHIS were undertaken. Rotavirus has a strict eligibility age cut-off so adequate access to clinic appointments and timeliness of vaccination is also key to ensuring high coverage. Coverage has improved for the second consecutive year in Devon, and all areas are now in line, or above the England average.

4.44 During the year, the Screening and Immunisation Team surveyed high performing GP Practices, developed a resource pack and shared good practice, and undertook targeted visits to GP practices with low uptake to provide a review of current practice and encourage quality improvement initiatives.

4.45 An audit of cold chain processes and incidents in GP Practices was also done whilst awaiting the update of the national vaccine incident guidance. More work is planned, in partnership with local NHS England and NHS Improvement and CCG Quality and Safety Groups, to share learning and embed improvements to working practice and strengthen the oversight and governance of primary care immunisation incidents.

4.46 2018/19 saw the start of the new CHIS contract across the South West region. The provider has a locality team for Devon and Cornwall/IOS. CHIS is a critical part of the childhood immunisation pathway and newborn screening pathway and NHS England and NHS Improvement is working closely with the new provider on several quality improvement projects, the streamlining and standardising of working practices underpinning the child immunisation pathway. It is hoped that over the next year or so, all information flows between CHIS and GP practices will become electronic, increasing efficiency and enhancing the accuracy of the CHIS database and coverage reporting.

4.47 Developments for 2019/20 include:

- review and re-launch of LIGs working closely with Local Authority Public Health Teams, as a vehicle for multiagency system working to address local barriers to access and attendance for immunisation;
- delivery of recommendations from the cold chain audit 2019/20 and developing joint reporting mechanisms into the Primary Care Quality and Sustainability Hubs and CCG Quality Groups;
- implementation of a MMR catch up for 10 and 11year olds in primary care;
- development of a multiagency, system-wide MRES action plan;
- development of a multiagency, system-wide vaccination action plan to include a communications strategy based on the Value of Vaccines campaign;
- working with the PHE Field Epidemiology Service to undertake a South West MMR needs assessment;
- facilitating the local arm of a national audit in to recording of MMR in general practice, to determine if MMR is systematically under-reported to CHIS;
- development of a South West CHIS childhood immunisation pathway to include tracking of ‘children not brought to clinic’;
- introduction of additional CHIS reporting looking at timeliness of vaccination in relation to due date and waiting lists, to enable better understanding of local issues and barriers to vaccination.

Targeted child immunisation (Hepatitis B for babies born to HepB positive mothers and newborn BCG)

4.48 During 2018/19, the Screening and Immunisation Team has been working to embed the South West best practice pathway, dried bloodspot scheme, and failsafe processes, working closely with the CHIS and GP practices. Learning from a run of incidents where the second immunisation at 4 weeks of age was missed, CHIS has been commissioned to undertake an additional step in the failsafe to ensure that the GP is aware and preparations to immunise at age 4 weeks are in place. The team has also delivered more training for primary care staff. Surveillance shows that the number of incidents has fallen and that the number of children completing the schedule has improved significantly and no babies have tested positive for HepB at 12 months. No data is presented in view of the small number of cases.

4.49 Developments for 2019/20 include:

The national Infectious Diseases in Pregnancy Screening Programme and Immunisation teams have been working on the development of an 'Enhanced hepatitis B screening and immunisation pathway' to support the delivery of care for pregnant women with hepatitis B and their babies in England. The quality improvement project is undertaking a comprehensive review of the whole hepatitis B screening pathway and the interface with the at-risk childhood vaccination programme with the aim of introducing an updated setting out a system-wide approach and clear roles and responsibilities. It is anticipated the new pathway will be implemented from April 2020.

School-aged immunisation

4.50 The HPV programme is delivered as a two-dose programme with both doses given in Year 8 or first dose given in Year 8 and second dose in Year 9. In the South West, all adolescent boosters are given in Year 9. In both programmes, the providers offer mop-up community clinics for young people who miss the school-based vaccination clinics. If children miss the mop-up clinics, they can access the vaccination in primary care. The school aged programme also includes flu vaccination (see Flu update below).

4.51 2018/19 saw the successful mobilisation of a new provider for the School Aged Immunisation programme in Devon. There were several challenges due to the complexities of delivering the programmes, the extension of the flu programme to include year 5, and the implementation of a new e-consent system. Additional clinics were delivered and the re-offering of vaccination within school settings aimed to minimise the impact on uptake. The Cornwall service was also re-procured, and the incumbent provider was successful thus providing continuity and enabling it to build on recent successes. An e-consent system was also introduced in Cornwall, starting with the primary flu programme.

4.52 Table 7 shows HPV uptake by Local Authority up to 31 August 2019. Table 8 shows adolescent booster uptake by Local Authority up to 31 August 2019. The adolescent booster data is part of the new national pilot data collection and is very provisional. Data quality is therefore not guaranteed and cannot be assumed to be fully accurate.

Table 7: Local Authority uptake of HPV Dose 1 in Year 8 females (%) up to 31 August 2019

Indicator	Standard[1]	Geography	2016/17	2017/18	2018/19
HPV (%)	86.1	Devon	86.2	82.5	84.3
		Plymouth	85.1	86.6	83.6
		Torbay	85.0	86.2	86.2
		Cornwall & IoS	78.6	81.9	78.4
		Isles of Scilly*	80.0	87.5	100.0
		England	87.2	86.9	87.9

**IOS – very small numbers*

4.53 HPV uptake has been fluctuating over the last few years and this is thought to be due in part to some mobilisation problems with the new e-consent system and the continued commitment to deliver on the expanding childhood flu vaccine programme. NHS England is working very closely with both providers to ensure the necessary improvements are made for the 2019/20 academic year.

Table 8: Local Authority adolescent booster uptake in Year 10s (%)

Local Authority	2016/17 vaccinated up to 31/08/17	2017/18 vaccinated up to 31/08/18	2018/19 vaccinated up to 31/08/19
Devon	82.4	90.0	89.7
Plymouth	77.6	76.4	78.7
Torbay	75.9	77.9	76.7
Cornwall & IOS	80.3	76.9	76.8
England	82.0	82.9	86.0

4.54 Developments for 2019/20 include:

- the extension of the HPV vaccination programme to include year 8 boys from September 2019 (to be called the universal HPV programme) - given the good coverage already provided by the girls' programme with evidence of a partial herd immunity effect, there is to be no catch-up campaign for younger boys. PHE will be publishing gender neutral literature for providers, young people and parents/carers;

- the extension of the flu programme to year 6 in the 2019/20 flu season meaning every primary school aged child (including elective home educated) will be invited;

- self-consent is to be developed to be an additional tool to increase uptake.

Vaccines in pregnancy

4.55 Following the declaration of a national pertussis outbreak in April 2012, pertussis vaccine has been offered to pregnant women since 1 October 2012. This has had a positive impact and the pertussis activity in 2018 was the lowest since the onset of the outbreak.

4.56 Coverage of the pertussis programme is reported monthly based on data from participating GP practices and is felt not to be wholly representative and most likely an under-recording of the true coverage. This is due to less than 100% participation of GP practices in the data collection process (South West has historically been lower than national participation), and as

the delivery of pertussis vaccination has shifted toward maternity services over time (all maternity units in Devon and Cornwall now deliver pertussis and flu), less than 100% transfer of all the required information from maternity to GP practices and recording on the GP medical record, from where it is extracted. The expansion of delivery by maternity services is a benefit for women as it improves accessibility, however, ongoing work is needed to ensure effective and complete transfer and recording of all the info in primary care. This is a national as well as a local issue and long-term improvements in systems to transfer data between maternity and primary care systems are planned as part of the maternity digital transformation programme.

4.57 Table 9 shows the latest published reported coverage data by CCG, which is stable across the area, except for Cornwall (see below). Reported coverage is generally higher than national averages in Devon and lower in Torbay.

Table 9: Pertussis in pregnancy coverage by CCG

CCG	March 2019	March 2018	March 2017
NEW Devon	75.9	76.6	71.4
Torbay	67.8	67.9	69.0
Cornwall	52.6	47.0	70.4
SW South monthly	71.1		
SW monthly		71.6	
England monthly	70.2	70.8	72.6
South West (South) annual 2018/19	66.9		
South West (North) annual 2018/19	73.3		
England annual	2018/19 68.8	2017/18 71.8	

4.58 Monthly reported coverage in Cornwall has dramatically declined since 2017. This was in part due to an IT system issue affecting the data collection and extraction and was eventually resolved. An audit was undertaken by the Screening and Immunisation Team to investigate the decline which confirmed that the maternity provider was vaccinating a large number of women each month (on average 200 women for Pertussis and 180-200 for Flu), however, not all of this information was getting on to the GP record. The Screening and Immunisation Team has been working with all the local stakeholders to seek improvements in systems and processes.

4.59 There is an established seasonal variation in uptake of the vaccination almost certainly related to the impact of the flu season with increased opportunities to vaccinate and sign-post the pertussis vaccination.

4.60 A South West network meeting was held for the Vaccines in Pregnancy programme and was a very positive meeting. All providers are engaged in the programme and report that there is good acceptance by women of the vaccine. Providers are being supported to explore ways to better understand the reasons women decline vaccination, and how best to support women to make an informed choice about vaccination.

4.61 Developments for 2019/20 include:

- Continuing to work with maternity units and stakeholders to improve information flow and data recording.

Older persons immunisation

Shingles

4.62 The shingles vaccination programme started on 1st Sept 2013 offering routine vaccination to all 70-year olds, with catch-up each year for those turning 78. Individuals remain eligible until their 80th birthday. Due to the nature of the phased catch-up programme, understanding of the eligibility for the programme each year has been challenging and it is thought this may have had an impact of the uptake of the vaccination. 2019/20 is the final year of the catch-up programme and from 2020/21 everyone between 70 up to their 80th birthday will be eligible, making communications and promotion of the programme more straightforward. The definition of the national eligibility criteria was changed in April 2018, which affected the coverage data.

4.63 Up to August 2018, data on uptake of shingles vaccination was reported as a cumulative monthly uptake. Table 10 shows cumulative % uptake from Sept 2013 to August 2018. Uptake in the area is line with or higher than national rates:

Table 10: Shingles vaccination – cumulative % uptake from Sept 2013 to August 2018

CCG	Routine cohort aged 70	Catch-up cohort aged 78
NEW Devon	38.9	42.0
South Devon and Torbay	39.3	41.9
Kernow	33.6	35.6
England	34.6	34.8

(Source: ImmForm)

4.64 National reports have reviewed coverage from the previous routine cohorts, and this shows that for birth cohorts coverage continues to increase year on year through opportunistic vaccination, highlighting the importance of catch-up of eligible cohorts right up to their 80th birthday.

4.65 From September 2018, a new national quarterly collection was introduced to evaluate coverage of adults who had become eligible under the revised criteria in April 2018. This is based on uptake in those people becoming eligible in each quarter and is therefore not directly comparable to the previous cumulative data.

4.66 Table 11 shows the % uptake in 2018/19 for the routine and the catch-up groups.

Table 11: Shingles vaccination - % uptake in 2018/19 for the routine and the catch-up groups

Local Authority	Turning 70 during 2018/19	Turning 78 during 2018/19
Devon	33.1	32.9
Plymouth	29.0	30.2
Torbay	27.0	27.7
Cornwall	25.8	23.9
NHS England SW South	32.1	32.8
NHS England SW North	34.2	35.4
England	31.9	32.8

(Source: ImmForm)

4.67 The coverage in the South West was affected by an IT issue resulting in data from one of the GP IT suppliers in the area not extracting and submitting the data to the national collection. The reported data is therefore likely to under-estimate the true coverage.

Pneumococcal

4.68 Since 2005, all people aged 65 and over have been eligible for the routine PPV vaccination programme. GP practices are encouraged to offer this alongside flu vaccination during the flu season to support uptake. National surveillance shows that about 20% of people have already been immunised by the time they are 65 years due to other clinical risk factors. Only about 10-15% of people take up the offer of vaccination in their 65th year with the rest attending in subsequent years (proportion decreases with age as number of immunised increases).

4.69 Table 12 shows the cumulative % of people aged 65 and over who have been vaccinated up to 31 March 2019. Coverage is generally in line with national rates except for Cornwall, which is a little lower.

Table 12: Pneumococcal vaccination - cumulative % uptake for people aged 65 and over who have been vaccinated anytime up to 31 March 2019

Local Authority	2016/17	2017/18	2018/19
Devon	70.5	69.9	70.1
Plymouth	68.7	67.1	68.2
Torbay	67.7	68.8	69.2
Cornwall	66.7	66.2	64.3
Isles of Scilly	81.2	No data available	79.5
England	69.8	69.5	69.2

4.70 It is positive that coverage rates have been stable despite ongoing supply constraints of the vaccine during 2017 and 2018 (full supply was restored in April 2019), when practices were advised to prioritise individuals in high and moderate risk groups.

4.71 Developments for 2019/20 include:

- A focus on shingles in the South West is planned for 2020 with targeted practice visits anticipated for some of the lowest coverage practices in areas with the larger proportion of older people, including Cornwall and a resource pack being made available to all practices.

HPV-MSM immunisation

4.72 In 2018/19, following a national pilot, the HPV vaccination for men that have sex with men (MSM) programme was rolled out across all specialist sexual health services. The vaccine is offered opportunistically to MSM under 45 who are already attending clinics, with the recommended schedule being three doses. All eligible services in the South West are now providing HPV vaccination for MSM. A South West oversight group has been established, of which all providers of the service are engaged.

4.73 No coverage data is available yet but there will be national annual reports derived from GUMCAD data. The pilot had a 45% uptake for the first dose so it is hoped that population coverage will be of this order.

4.74 Work during 2019/20 will look to ensure that the programme is fully embedded.

Influenza immunisation

4.75 There were several significant challenges for the 2018/19 flu immunisation programme. Table 13 shows the final uptake rates (Feb 2019).

Table 13: Influenza immunisation uptake by local authority, 2017/18-2018/19

Indicator	Local Authority	2017/18	2018/19
Flu (aged 65+) (%)	Devon	72.9	72.5
	Plymouth	71.7	71.2
	Torbay	71.6	71.5
	Cornwall & IoS	66.3	70.3
	England	72.9	72.0
Flu (at risk individuals) (%)	Devon	50.0	49.2
	Plymouth	47.7	46.7
	Torbay	49.3	47.2
	Cornwall & IoS	48.8	46.0
	England	49.7	48.0
Flu (2-3 year olds) (%)	Devon	53.3	63.4
	Plymouth	44.7	53.3
	Torbay	45.0	56.3
	Cornwall & IoS	38.7	50.3
	England	44.0	44.9
Flu in pregnant women	Devon	51.2	52.4
	Plymouth	48.6	44.9
	Torbay	49.0	46.8
	Cornwall & IoS	41.9	32.6
	England	47.0	45.2

4.76 The South West Flu Review conference took place in March 2019. Key priorities for the 2019/20 flu season were agreed as improving uptake in the clinical at-risk groups, improving data transfer to practices, roll out of the school programme to include Year 6 and maintaining high uptake in the 2 - 3 year olds.

4.77 The only change to the national eligibility criteria for 2019/20 is the planned extension of the programme to school year 6 children, meaning that all primary school aged children in England will be offered the vaccine for the first time. There will also be a strong focus on continuing the increase in uptake amongst frontline healthcare workers as a major contributor to protecting staff health and wellbeing and the health of vulnerable patients. NHS England and NHS Improvement will also be continuing to support vaccination of social care and hospice workers and vaccination will be available through community pharmacy or general practice. This scheme is intended to complement, not replace, any established occupational health schemes that employers have in place to offer flu vaccination to their workforce.

5 Health Care Associated Infections

Organisational Roles and Responsibilities

5.1 NHS England and NHS Improvement 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 locality teams of NHS England and NHS Improvement 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 *Clostridioides 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 (NEW) Devon and South Devon & Torbay (SDT) Clinical Commissioning Groups (from April 2019, merged into NHS Devon Clinical Commissioning Group) deploy this role through the Nursing and Quality portfolio, with funding now available through the Prevention workstream for recruitment of a System Infection Prevention and Control Lead to lead this work. 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 NHS Improvement and Public Health England, supported by the Clinical Commissioning Group.

Health Care Associated Infection Forums

5.5 The Devon Infection Prevention & Control (IPC) Forum is a forum for all stakeholders 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 covers health and social care interventions in clinical, home and residential care environments, identifying risks, sharing best practice and collaborating in system-wide approaches. The group is co-ordinated by NHS Devon Clinical Commissioning Group and is 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 NHS England and NHS Improvement. The Group meets quarterly, with more frequent sub-groups as required.

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 most recent Devon IPC Forum was held in July 2019 and focused principally on operational detail regarding the implementation of the Devon Community Infection Management Service, as well as healthcare associated infection target setting for the coming year.

5.8 It is anticipated that the rates of C. *difficile* will be significantly impacted by new national definitions coming in, which will broaden the attribution of hospital-acquired cases to a certain subset of community-acquired cases.

5.9 Key areas for action in 2019-20 are:

- The creation and implementation of a Community Infection Management Service;
- Gram negative bacteraemia reduction;
- Continued monitoring of health care acquired infection by Clinical Commissioning Group area for C. *difficile* infection, MRSA, MSSA and Gram-negative infections;
- Outbreak monitoring to ensure timely patient transfers, system flow and resilience.

Healthcare Associated Infections Incidence 2018-19

5.10 Healthcare associated infection incidence is given for NEW Devon and South Devon and Torbay and Kernow CCGs in **Appendix 4**. Key points for Devon and Cornwall are:

MRSA

5.11 The national target for MRSA is zero cases. In 2018-19, multiple cases were identified within both NEW Devon CCG and SDT CCG. These cases were all investigated appropriately and were not found to be linked.

MSSA

5.12 Rates of reported MSSA were within target levels. In NEW Devon CCG, MSSA bacteraemia rates remained steady; in SDT CCG, a smaller population leads to more volatility in the figures but on average there is a similar picture. Individual providers across Devon are undertaking pieces of work to understand and modify their in-hospital MSSA rates.

C.difficile Infection

5.13 Devon, as a whole, matched the national C.difficile target. All cases have been investigated to an appropriate level, 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 across Devon remained steady during 2018/19, not achieving the national 10% reduction ambition. Reduction efforts are focused around urinary sources in the community setting, including catheter use, hydration, training, and improving communications between acute and community settings when patients are transferred. A community infection management service has now been funded through the STP Prevention workstream, and once implementation is completed this will improve infection control in the out of hospital setting.

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

6 Antimicrobial resistance

Data and trends

6.1 A monitoring report is included at **Appendix 5**. Key points are:

- There has been an increase in gram-negative bloodstream infections (e.g. 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 actions 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. This group has been renamed from The Devon Antimicrobial Stewardship Group to the Devon Antimicrobial Resistance Group (DARG) to ensure that its broader remit is clear.

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 DARG now has a membership that includes academia, public health, commissioning, general practice, secondary care and community pharmacy and has created links with both veterinary and dentistry AMR representatives. The group has a workplan that includes a focus on the AMR agenda across all healthcare settings. The group continues to support national and international antibiotic awareness campaigns and plans for 2019 World Antibiotic Awareness Week include a Devon AMR conference. The group contributes to local guideline development to support the reduction in inappropriate antimicrobial use.

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

Table 14: 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 NHS England and NHS Improvement 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 NHS England and NHS Improvement average.
This indicator does not take into account any antibiotics given through a non-oral route.

[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 relation to undertaking their local engagement, joint working, annual exercise programme, responding to incidents and undertaking learning as required.

8 Work Programme Priorities 2018/19 - Progress Report

Establishment of comprehensive Community Infection Prevention and Control service across the system

8.1 Health Protection Committee members are routinely updated on community infection prevention and control and supported plans for a new Community Infection Management Service which will commence in 2020.

8.2 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 and NHS Improvement involvement.

Improving the Resilience of the Health Protection System

8.3 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.

8.4 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 Preparedness, Resilience and Response (EPRR) as well as Environmental Health.

Air Quality

8.5 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. Public Health England South-West Centre plan to consolidate their offer of support to Local Authority Directors of Public Health and their teams to take forward local priorities to reduce the adverse impact of poor air quality and air pollution on population health. This work will include the development and publication of guidance for preparing Joint Strategic Needs Assessment (JSNA) sections on air quality with reference to the available data and appropriate methodologies, scoping the additional support requirements of Local Authority Directors of Public Health and their teams in relation to air quality, including measures to address particulate air pollution and indoor air quality and establishing a South West Air Quality Network to share expertise, learning and resources.

Antimicrobial Resistance

8.6 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 now established and is widening its membership.

8.7 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.

8.8 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.

8.9 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.

Influenza Vaccination for Care Home and Domiciliary Staff and Special Schools

8.10 Local Authorities continue to work with PHE, Clinical Commissioning Groups and other partners to support the care sector in promoting staff flu vaccination to protect their residents. A winter readiness toolkit has been shared along with other communications including presentations at local care manager forums. Free vaccination for care staff was introduced nationally from October 2017; this was extended in 2018 and 2019.

Implementation of National MMR Initiative

8.11 A national UK Measles and Rubella Elimination Strategy has been developed in line with the World Health Organisation target to eliminate these diseases in Europe by 2020. Public Health England Screening and Immunisation Team have been working, through the locality immunisation groups, to develop robust multiagency action plans to further improve MMR uptake. This is having a beneficial effect on all childhood immunisation programmes. This continues to be a priority with the aim of achieving 95% coverage of the second dose by 5 years of age.

Emerging threats

8.12 The impact of climate change will increase. Across the South-West potential public health effects include increases in heat related deaths and morbidity, more frequent extreme events including heatwaves and flooding, increased burden of disease from air pollution and novel vector borne-diseases. These effects, added to significant socioeconomic change, have the potential to affect the physical and wellbeing of the local population.

9 Health Protection Committee Priorities 2019/20

9.1 The following priorities for the period 2019/20 have been agreed by all Health Protection Committee members and reflect areas for focused work in order to meet identified health protection needs for the populations of Devon, Cornwall and the Isles of Scilly.

9.2 **Integrating and strengthening the Health Protection system** – all members will continue to work collaboratively to build a resilient workforce and maximise opportunities to strengthen health protection within emerging integrated health and social care systems. This includes aligning local priorities to regional and national objectives including those outlined in Public Health England's Infectious Diseases Strategy 2020-2025. Included in this priority is the roll-out of the Single Case Plan to agree roles and responsibilities between local authorities and PHE in dealing with cases of infectious disease.

9.3 **Surveillance and intelligence –** the Health Protection Committee will continue to drive improvements to the local health protection system through improved and more timely intelligence and surveillance along with more effective performance monitoring mechanisms.

9.4 **Cancer and non-cancer screening programmes** - all members have agreed to work more closely with partners to drive improvements in screening uptake, to improve the quality of our screening programmes and to reduce inequalities.

9.5 **Immunisation locality groups** – all members will support the implementation or refresh of immunisation locality groups for Devon, Torbay, Plymouth, Cornwall and the Isles of Scilly. Groups will be led by the regional Screening and Immunisation team, supported by local authorities, and will work to improve immunisation uptake locally with focus on reducing variation between general practices and local communities.

9.6 **MMR vaccination programme** – all members will continue to support work to increase uptake of the MMR vaccination with the ambitious aim of achieving and then sustaining ≥95% coverage of the second dose of MMR by 5 years of age. The Committee will support delivery of the local response to the UK's Measles and Rubella Elimination Strategy 2019, led by the Public Health England Screening and Immunisation team, by working with locality immunisation groups to explore personalised approaches to invitations and extended access, catch-up campaigns in primary care, and strengthening surveillance and response where cases of measles occur.

9.7 **Pandemic flu** – the threat and potential impact of pandemic influenza is such that it remains the top risk on the UK Cabinet Office National Risk Register and continues to direct significant amounts of activity on a global basis. An ongoing priority for 2019/20 is to continue to support local planning arrangements for pandemic flu and to strengthen our response to major incidents and emergencies.

9.8 **Seasonal flu vaccination programme** – all members will continue efforts to ensure high uptake of flu vaccinations locally, particularly amongst at risk groups and frontline health and social care workers, and to support effective roll-out to the Year 6 primary school cohort. Efforts will be directed through regional and local flu groups and networks.

9.9 **Community Infection Prevention and Control** – all members will work to ensure that community infection prevention control is embedded and supported within emerging Integrated Care System structures to strengthen the local health protection system.

9.10 **Antimicrobial resistance** - all members will support action taken by both the Devon AMR Group and the Cornwall Antimicrobial Resistance Group (CARG) to tackle antimicrobial resistance.

9.11 **Complex lives** – all members will support work locally to address health protection challenges for people with complex lives, including local prison populations, people who inject drugs (PWID) and the homeless or vulnerably housed. This includes targeted work around bloodborne viruses, TB, Group A Streptococcus and Staph infections.

9.12 **Climate change** – all members to lead and support local action following declaration of a climate change emergency, including assurance that action is being taken to secure improvements to air quality where required.

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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
CDI	Clostridioides difficile infection
CHIS	Child Health Information Services
CQUIN	Commissioning for Quality and Innovation (incentivised payment system)
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)
NHSEI	NHS England and NHS Improvement
NIPE	Newborn Infant Physical Examination
NIPT	Non-invasive pre-natal testing
PHE	Public Health England
SDT	NHS South Devon and Torbay (Clinical Commissioning Group)
SW	South West
TB	Tuberculosis

12 Appendices

Appendix 1: Infectious Disease Incidence and Trends 2018-19
Appendix 2: Immunisation Performance 2018-2019
Appendix 3: Non-Cancer Screening Performance 2018-2019
Appendix 4: Healthcare Associated Infections (HCAI) 2018-19
Appendix 5: Antimicrobial Resistance: Trends and Developments

Appendix 1

Infectious Disease Incidence and Trends 2018-19

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 2018 to Week 13 2019)‡
Source: HPZone

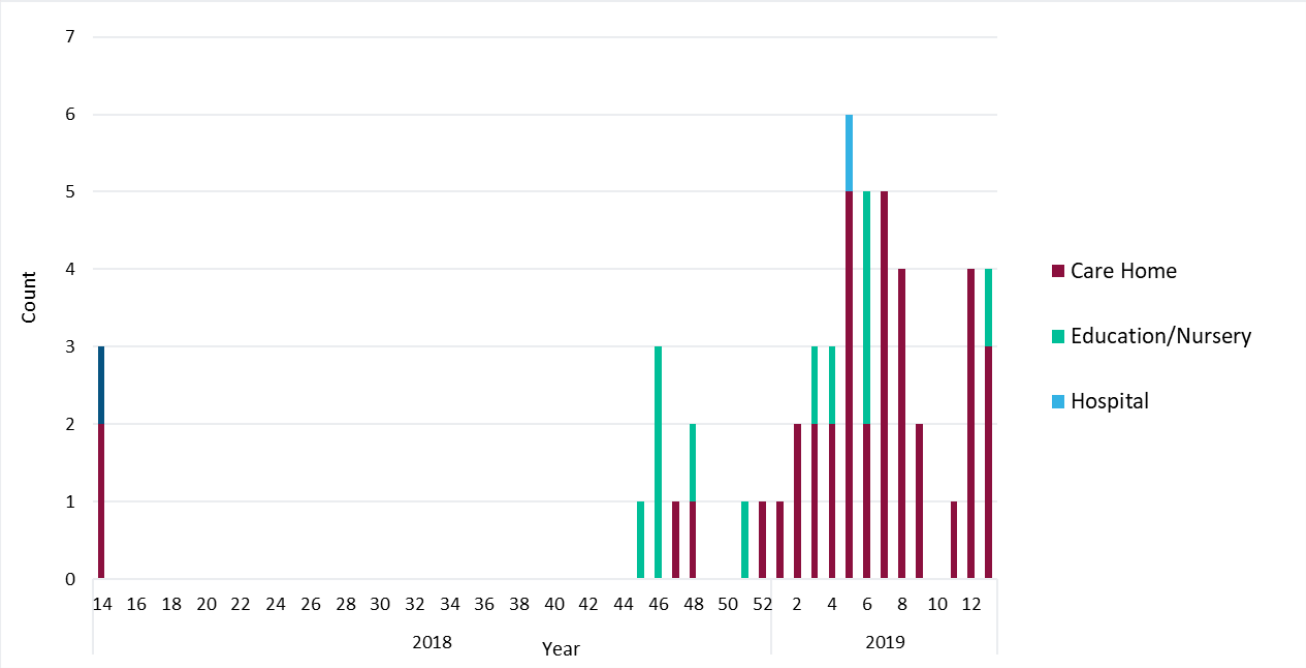


Table 1: All reports of influenza-like illness outbreaks/clusters (suspected or confirmed) by setting, Cornwall (including Isles of Scilly), Devon, Plymouth and local authorities, 2018/2019‡
Source: HPZone

Local Authority	Care Home	Education/Nursery	Hospital	Total
Cornwall (including Isles of Scilly)	9	3	0	12
Devon	18	8	0	26
Plymouth	4	0	0	4
Torbay	7	1	1	9

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

Gastrointestinal Infection

Figure 2: All reports of clusters/outbreaks of Infectious Intestinal Disease (suspected or laboratory confirmed), by setting, Cornwall (including Isles of Scilly), Devon, Plymouth and Torbay Local Authorities, Week 14 2018 to Week 13 2019‡
Source: HPZone and HNORS

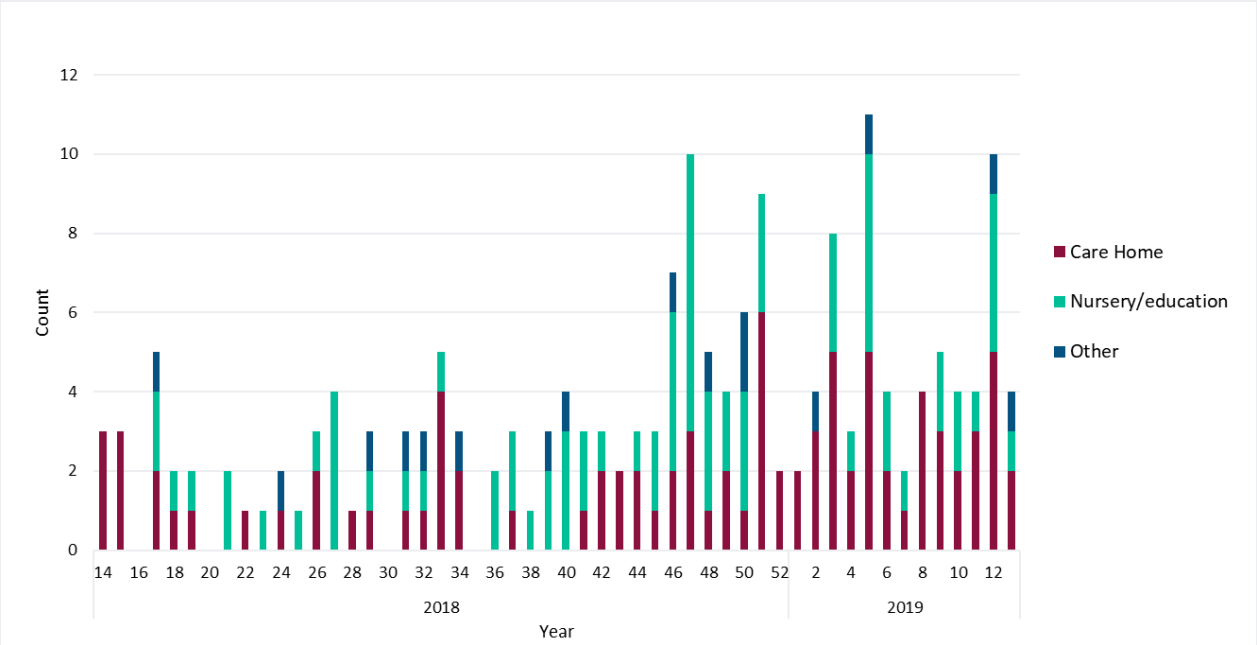


Table 2: All reports of clusters/outbreaks of Infectious Intestinal Disease (suspected or laboratory confirmed), by setting, Cornwall (including Isles of Scilly), Devon, Plymouth and Torbay Local Authorities, 2018/19‡
Source: HPZone and HNORS

Local Authority	Care Home	Education/Nursery	Other	Total
Cornwall (including Isles of Scilly)	23	15	6	44
Devon	35	37	9	81
Plymouth	15	15		30
Torbay	16	10	1	27

‡Outbreak/cluster data extracted based on date entered onto HPZone. They no longer report on IID outbreaks in a hospital setting

Data sources:

HPZone

HPZone 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. HPZone 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.

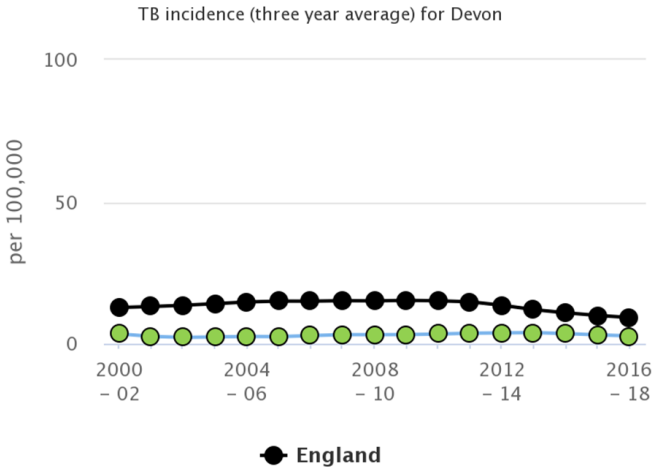
HNORS reports were extracted and analysed on date entered.

Meningococcal Disease

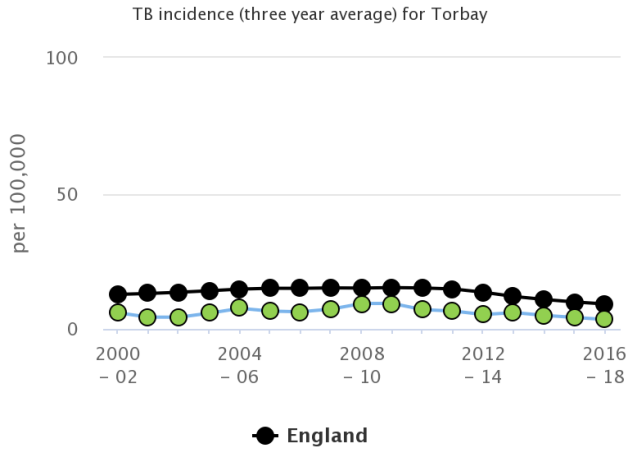
In 2018-2019 there were nine confirmed or likely cases of meningococcal disease in Cornwall, 15 in Devon, five in Plymouth and less than five in Torbay. These figures are consistent with data from the previous three years.

Tuberculosis

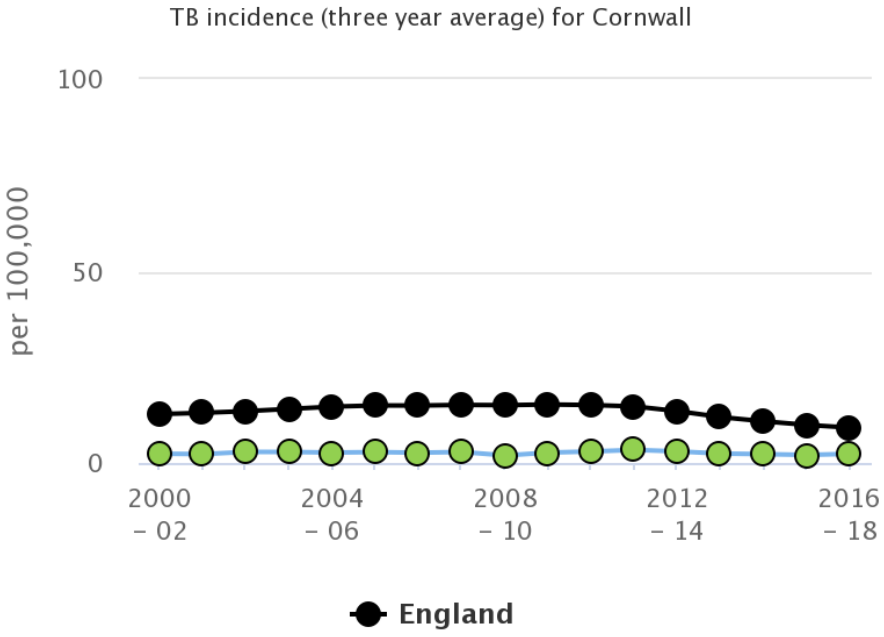
Figure 3: TB Incidence (three-year average)
Source: PHE Fingertips



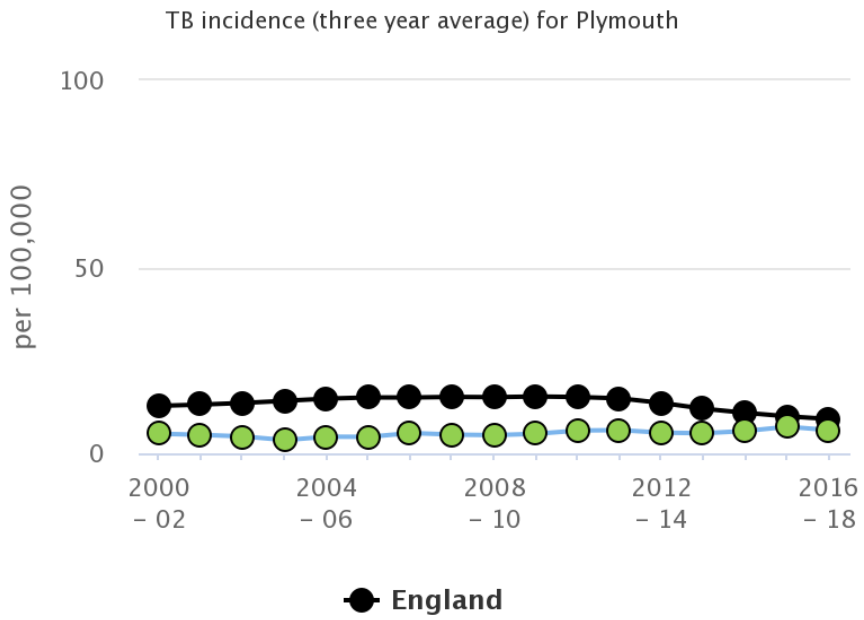
The three-year average incidence of TB in Devon was 2.7/100,000 population per year for 2016-18 compared to 3.1 for 2015-2017.



The three-year average incidence of TB in Torbay was 3.5/100,000 population per year for 2016-18 compared to 4.2 for 2015-2017.



The three-year average incidence of TB in Cornwall was 2.4/100,000 population per year for 2016-18 compared to 2.1 for 2015-2017.



The three-year average incidence of TB in Plymouth was 6.2/100,000 population per year for 2016-18 compared to 7.1 for 2015-2017.

Appendix 2

Immunisation Performance 2018-2019

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

Cohort	Indicator	Standard	Geography	2016/17	2017/18	2018/19
12 months	Dtap / IPV / Hib	95	Devon	92.6	94.3	94.6
			Plymouth	96.9	96.1	95.8
			Torbay	96.3	95.1	95.5
			Cornwall & IoS	93.9	93.9	93.1
			England	93.4	93.1	92.1
	PCV	95	Devon	93.1	94.6	94.9
			Plymouth	96.9	96.2	95.9
			Torbay	96.4	95.7	95.5
			Cornwall & IoS	94.0	93.9	93.4
			England	93.5	93.3	92.8
	Rotavirus	95	Devon	82.7	88.1	91.1
			Plymouth	93.2	93.2	93.0
			Torbay	86.4	91.2	93.5
			Cornwall & IoS	91.9	92.1	89.8
			England	89.6	90.1	89.7
	MenB	95	Devon	NA	93.9	94.4
			Plymouth	NA	96.0	95.8
			Torbay	MA	95.5	95.1
			Cornwall & IoS	NA	93.6	93.1
			England	NA	92.5	92.0
24 months	Dtap / IPV / Hib	95	Devon	95.3	95.7	95.9
			Plymouth	97.6	97.7	96.7
			Torbay	98.0	97.0	95.8
			Cornwall & IoS	96.1	95.5	94.9
			England	95.1	95.1	94.2
	Hib / MenC booster	95	Devon	92.4	91.9	93.2
			Plymouth	94.5	95.7	94.7
			Torbay	94.8	94.6	93.3
			Cornwall & IoS	92.6	91.4	91.7
			England	91.5	91.2	90.4
	PCV booster	95	Devon	92.7	92.2	93.4
			Plymouth	94.5	95.9	94.4
			Torbay	95.1	94.8	93.0
			Cornwall & IoS	93.0	91.7	91.9
			England	91.5	91.0	90.2
	MMR one dose	95	Devon	93.4	92.7	93.5
			Plymouth	95.3	95.7	94.9
			Torbay	95.2	95.4	93.3
			Cornwall & IoS	93.0	91.4	91.5
			England	91.6	91.2	90.3

Cohort	Indicator	Standard	Geography	2016/17	2017/18	2018/19
5 years	MMR one dose	95	Devon	95.7	95.2	95.6
			Plymouth	97.4	97.9	97.5
			Torbay	97.8	97.2	97.0
			Cornwall & IoS	96.1	95.9	95.1
			England	95.0	94.9	94.5
	Hib / Men C booster	95	Devon	94.8	94.1	94.8
			Plymouth	95.3	96.5	96.2
			Torbay	96.9	95.5	96.3
			Cornwall & IoS	95.1	94.6	93.9
			England	92.6	92.4	92.2
	MMR two doses	95	Devon	91.3	90.3	91.6
			Plymouth	91.4	94.1	93.9
			Torbay	92.1	93.9	93.3
			Cornwall & IoS	90.9	91.1	89.0
			England	87.6	87.2	86.4

Data source: Cover annual data https://www.gov.uk/government/publications/cover-of-vaccination-evaluated-rapidly-cover-programme-annual-data

Interactive dashboard: http://bit.ly/child_vacc_stats_annual

Appendix 3

Non-Cancer Screening Performance – Percentage Coverage

Indicator	Acceptable	Achievable	Geography	Provider/CCG (varies by indicator)	2017/18	2018/19
Infectious diseases in pregnancy HIV coverage	>=90	>=95	Devon	Royal Devon and Exeter NHS F Trust	99.8	99.8
				Northern Devon Healthcare NHS Trust	99.7	99.7
			Plymouth	Plymouth Hospitals NHS Trust	99.8	99.8
			Torbay	Torbay and South Devon NHS F Trust	99.0	99.7
			Cornwall	Royal Cornwall Hospitals NHS Trust	99.7	99.6
			England		99.6	99.7
Sickle cell and Thalassaemia coverage	>=95	>=99	Devon	Royal Devon and Exeter NHS F Trust	99.8	99.7
				Northern Devon Healthcare NHS Trust	99.6	99.8
			Plymouth	Plymouth Hospitals NHS Trust	99.8	99.8
			Torbay	Torbay and South Devon NHS F Trust	99.0	99.8
			Cornwall	Royal Cornwall Hospitals NHS Trust	99.7	99.6
			England		99.5	99.7
Newborn blood spot coverage (born in area)	>=95	>=99.9	Devon	NHS North, East, West Devon	94.8	96.7
			Torbay	NHS South Devon and Torbay	94.6	95.2
			Cornwall	NHS Kernow	94.6	97.2
			England		96.7	97.8
Newborn hearing coverage	>=95	>=99.5	Devon	North Devon and Exeter	98.9	98.8
			Torbay	Torbay and Teignbridge	99.0	99.1
			Plymouth	Plymouth	99.0	99.3
			Cornwall	Cornwall and Isles of Scilly	99.6	99.6
			England		98.5	98.8

Indicator	Acceptable	Achievable	Geography	Provider/CCG (varies by indicator)	2017/18	2018/19
Newborn & infant physical examination coverage	>=95	>=99.5	Devon	Royal Devon and Exeter NHS F Trust	99.0	99.3
				Northern Devon Healthcare NHS Trust	98.8	99.3
			Plymouth	Plymouth Hospitals NHS Trust	97.4	97.6
			Torbay	Torbay and South Devon NHS F Trust	96.8	97.7
			Cornwall	Royal Cornwall Hospitals NHS Trust	91.1	94.5
			England		95.4	96.4
Diabetic eye screening coverage	>=70	>=80	Devon	North and East Devon	88.8	86.5
			Plymouth	Plymouth	79.3	77.3
			Torbay	South Devon	86.3	86.6
			Cornwall	Cornwall	76.7	75.2
			England		82.7	82.6
Abdominal Aortic Aneurysm coverage	>=67.5	>=75	Devon	South Devon	86.8	86.8
				Somerset and North Devon	87.4	86.8
			Peninsula	Cornwall and Devon	84.0	85.9
			England		80.5	81.3

Appendix 4

Healthcare Associated Infections (HCAI) 2018-19

Healthcare Associated Infections Report for Northern, Eastern and Western Devon Clinical Commissioning Group, South Devon and Torbay Clinical Commissioning Group (the Devon CCGs), and Kernow Clinical Commissioning Group 2018-19. Note that from April 2019 the Devon CCGs have combined to form NHS Devon CCG.

Extracted and amended from June 2019 Health Protection Committee joint report.

Methicillin Resistant Staphylococcus Aureus (MRSA)

NHS Devon CCG

1.1 There have been several cases of MRSA in Plymouth over the past twelve months. These have been reviewed and found not to be linked, although learning has been identified for the Trust. The raw numbers stated are not representative of the true number affected as one patient had multiple episodes in one hospital stay.

1.2 The local review process is continuing to provide assurance from both acute provider and community investigations.

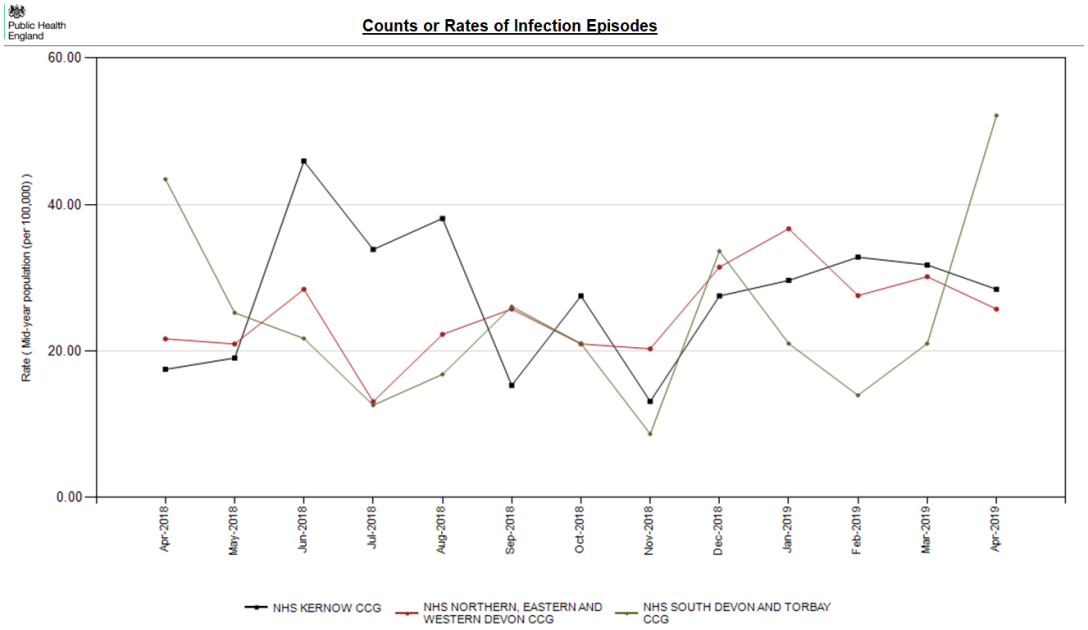
1.3 There have been no cases in Plymouth since December 2018, and only one case across the rest of Devon.

NHS Kernow CCG

1.4 There have been three cases of MRSABSI since April 2018 in Cornwall patients. One case was associated with injecting drug use and the second and third cases occurred in the same patient. A chronic skin condition combined with a suspected deep-seated focus were noted.

Methicillin Sensitive Staphylococcus Aureus (MSSA)

NHS Devon CCG



(The above graph is courtesy of Public Health England)

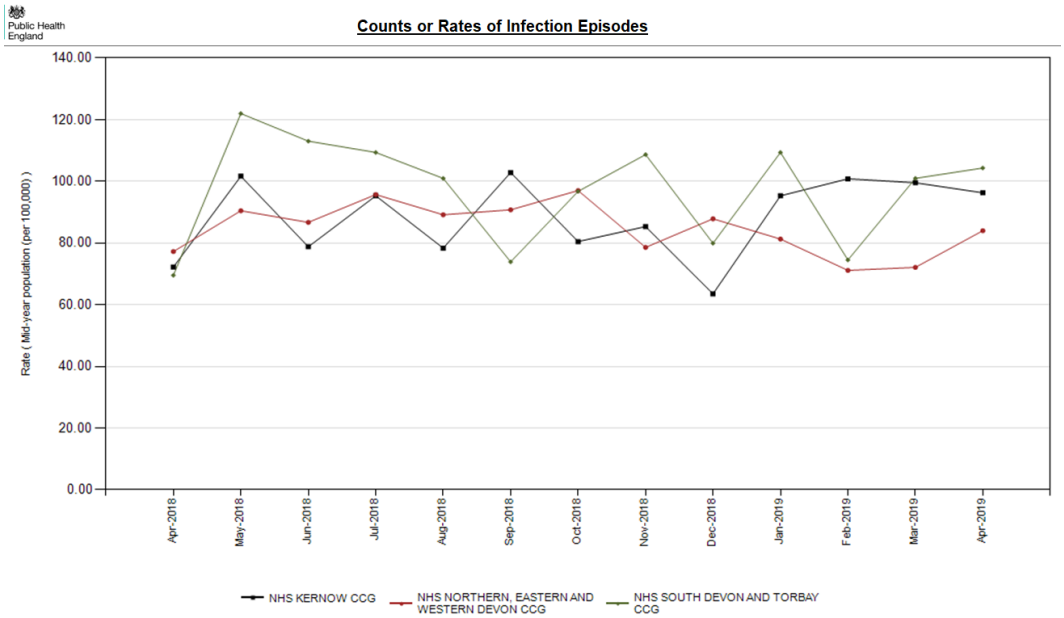
1.5 In NHS Devon CCG, MSSA bacteraemia rates remain stable with minor variation. SDTCCG has a smaller population so the rate is more volatile. Individual providers across Devon are undertaking pieces of work to understand and modify their in-hospital MSSA rates.

NHS Kernow CCG

1.6 There has been relatively little variation in the CCG rate of MSSA since December 2018.

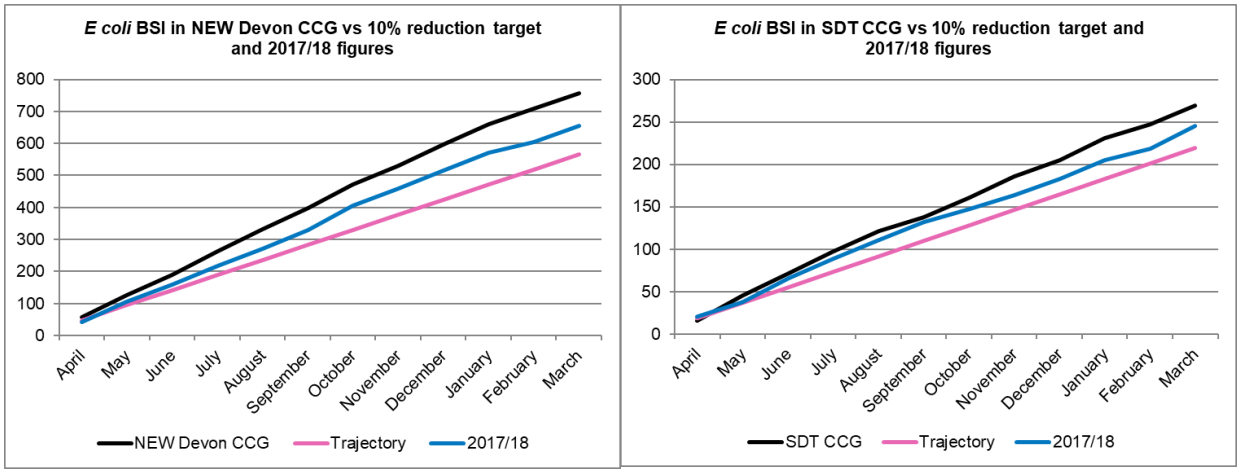
E.coli bacteraemia

NHS Devon CCG



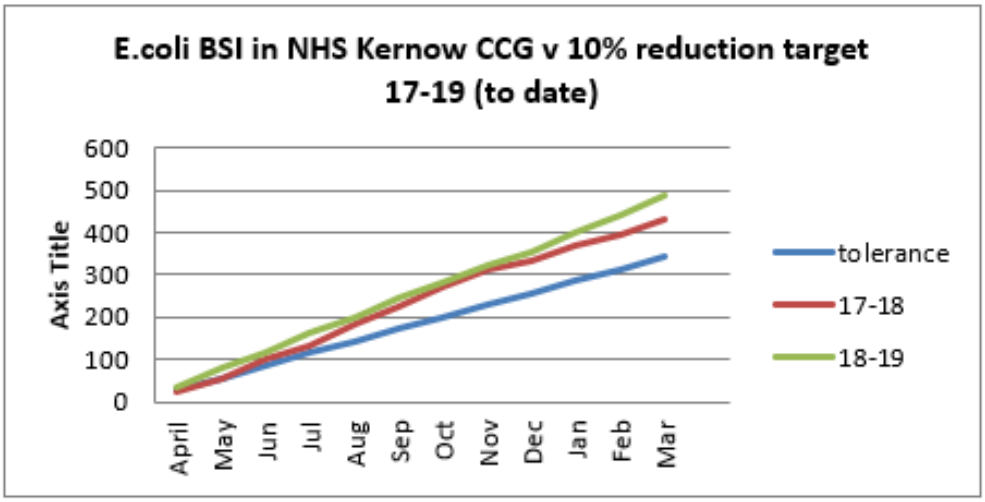
(The above graph courtesy of Public Health England)

1.7 E.coli bacteraemia rates across both Devon CCGs broadly track the averages provided by Public Health England (PHE) for England and the South West.



1.8 These graphs show that both Devon CCGs were unable to achieve a 10% reduction by year end. This is reflective of the national picture. The graph below shows a similar picture in Cornwall (which includes all April 2018 - March 2019 data). In April 2019, there were 44 cases which are 54% above the trajectory.

1.9 In Cornwall, the rate of E.coli bacteraemia remains lower than the South West rate and just above the England rate. A distinct summer peak was not seen.



Updates against the pan-Devon E coli reduction work plan

1.10 Community Infection Management Service (CIMS): The business case for the CIMS has been endorsed by the Clinical Cabinet, with a final financial confirmation awaited in the 2019/20 financial plan. The CCG finance plan for 2019/20 is awaiting approval by NHS England and NHS Improvement and this has not yet occurred, so implementation has been delayed.

1.11 There is a lack of clarity on national targets for *E coli* as no guidance has been released. Devon is likely to ask for year-on-year equity as opposed to an unrealistic reduction target.

1.12 Funding has been obtained for a range of web-based educational resources for use across the health and care system. The clinical team at Livewell Southwest is providing infection control

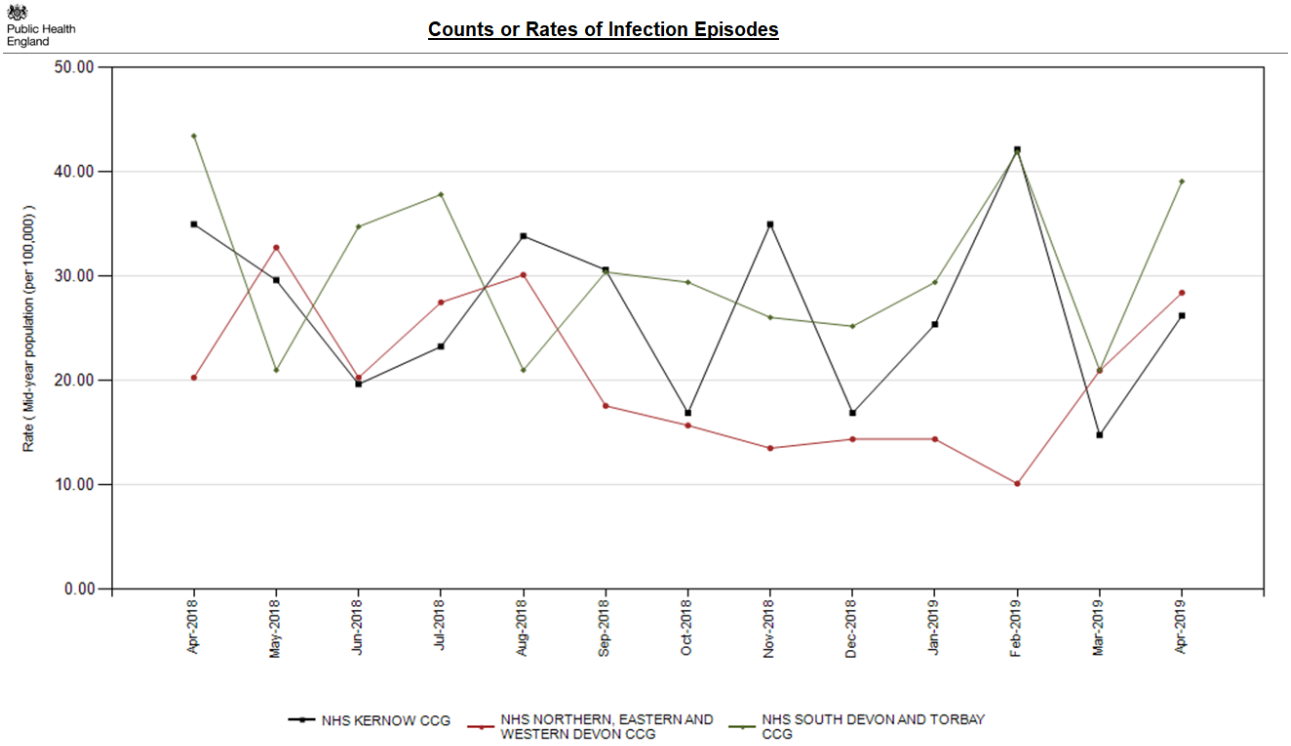
expertise; the videos will be available from March and will be distributed via hospital discharge teams, practice nursing teams and care home QAIT teams.

NHS Kernow CCG

1.13 Action plans are project based and the focus remains on hydration, UTI prevention and catheter avoidance, care and removal as well as optimising the hepato-biliary patient pathway.

C.difficile infection

NHS Devon CCG



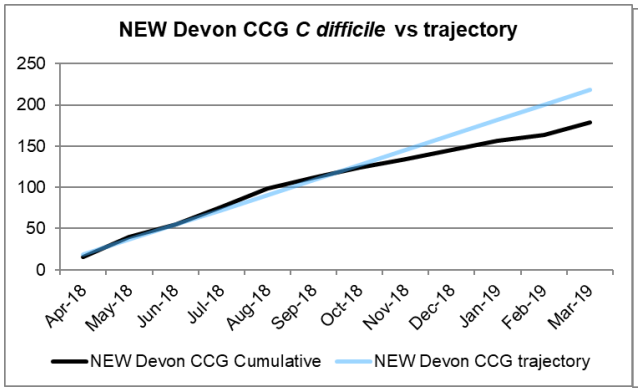
(The above graph courtesy of Public Health England)

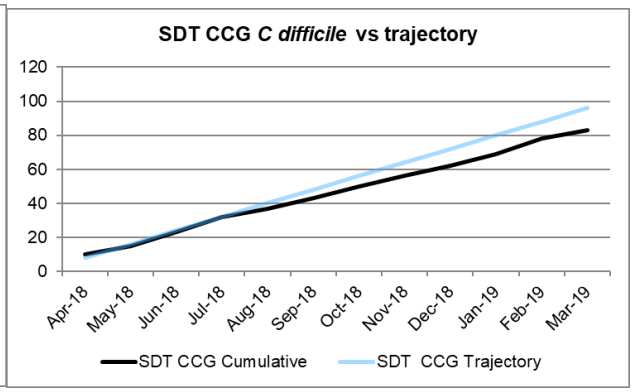
1.14 The graph above shows all cases of *C difficile* within the joint Devon CCGs and NHS Kernow CCG. The community acquired cases, which make-up the larger proportion of the population cases, historically have not been scrutinised for avoidability like those in acute and community hospitals.

1.15 Scrutiny of community cases has now increased, with the inclusion of cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

1.16 This change has resulted in variable numbers of additional cases for acute trusts, and this variability has not been explained by the national team. The CCG is engaging with the national team to seek clarification.

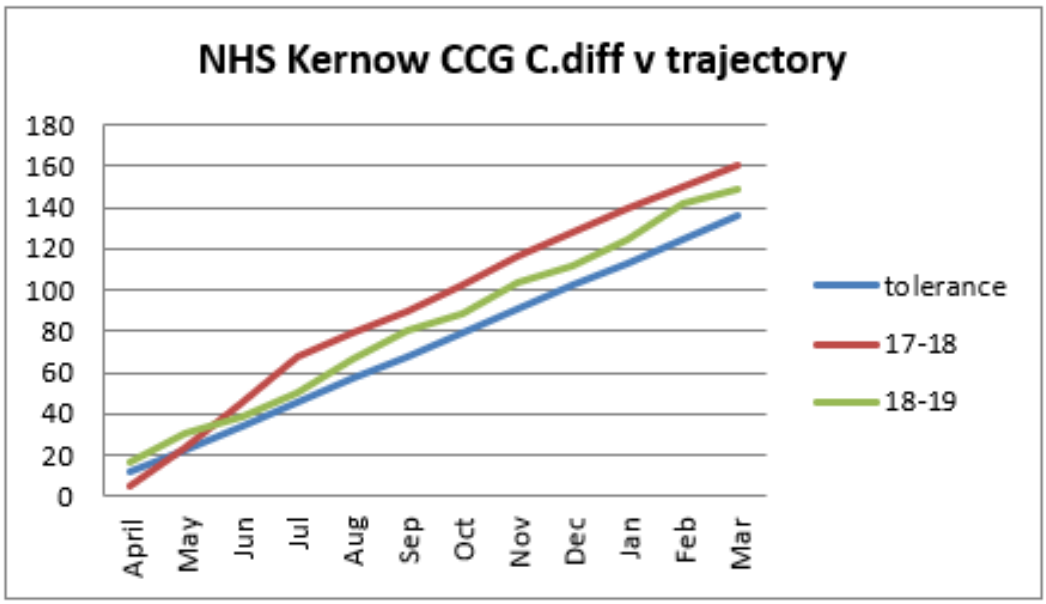
1.17 The case numbers for NEW Devon CCG and SDT CCG both ended the year under the nationally set trajectory.





NHS Kernow CCG

1.18 The graph below shows incidence above the trajectory which includes April 2018 - March 2019 data. In April 2019 there were a total of 12 cases of C.diff which is in line with the current trajectory.



1.19 Case investigations have used the national template this year without an improved outcome. Joint, acute and community investigation of cases is being encouraged. Community onset healthcare associated cases are part of the reduction ambition in 2019-20.

Appendix 5

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

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]

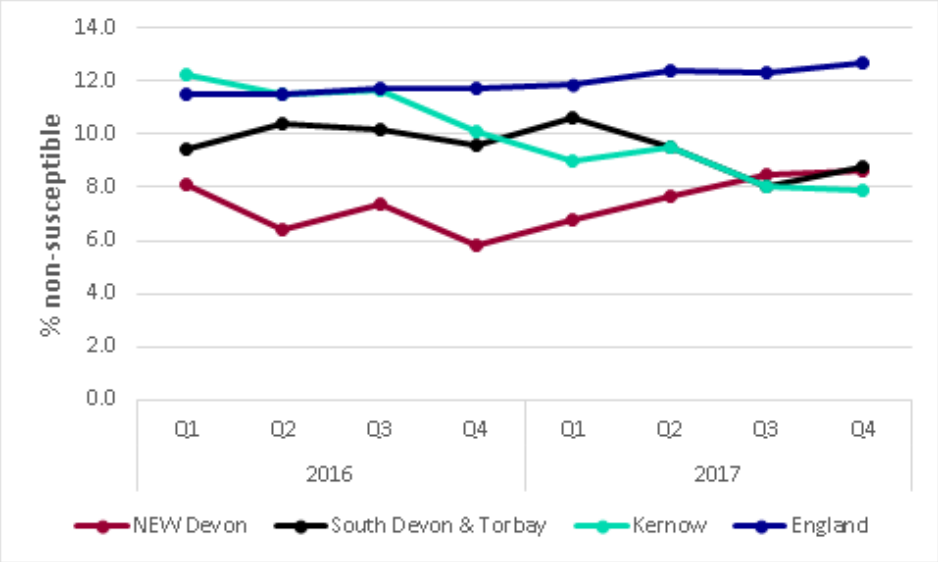


Figure 3: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to gentamicin, by quarter
Source: PHE AMR local indicators[1]

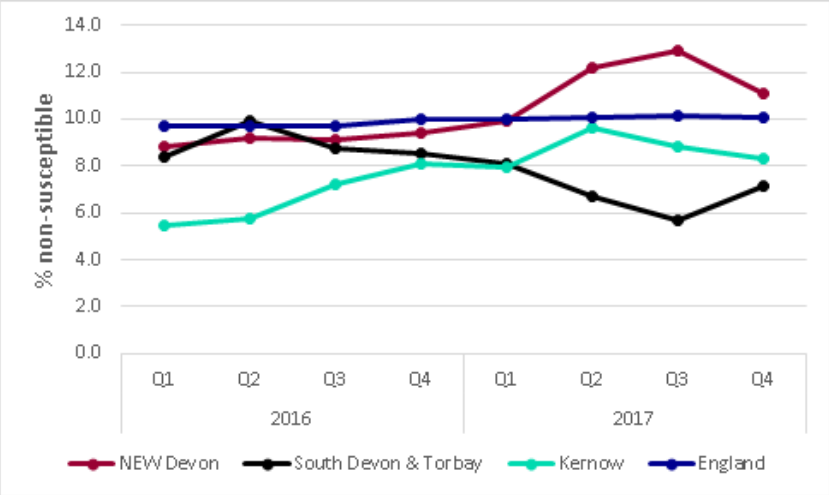


Figure 4: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to piperacillin/tazobactam, by quarter
Source: PHE AMR local indicators[1]

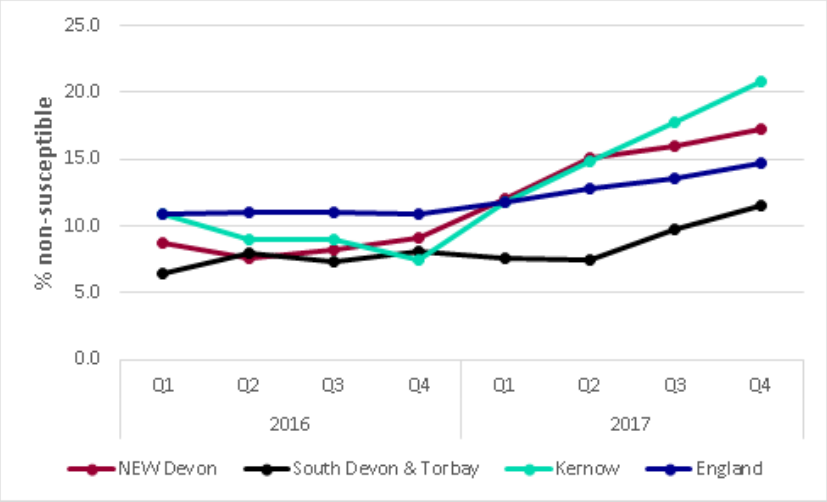
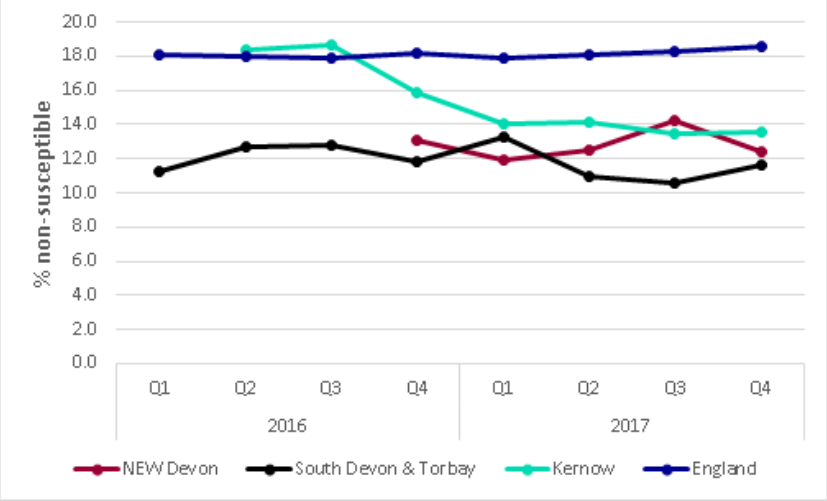


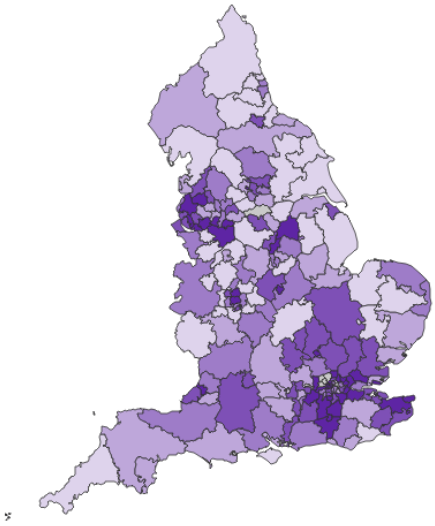
Figure 5: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to ciprofloxacin, by quarter*
Source: PHE AMR local indicators[1]



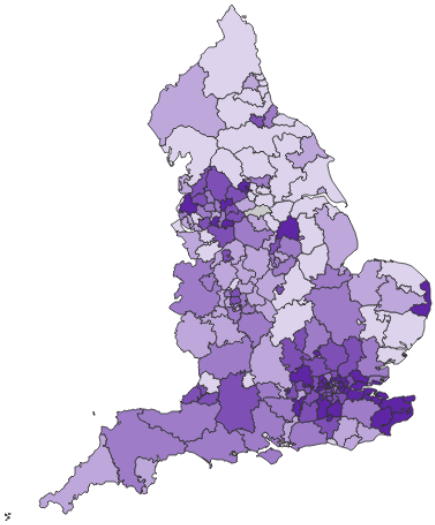
*Where less than 70% specimens have been tested for a particular CCG the results have been suppressed for data quality reasons.

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]

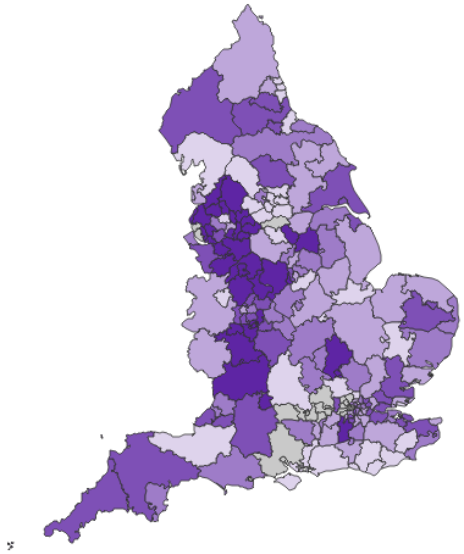
A



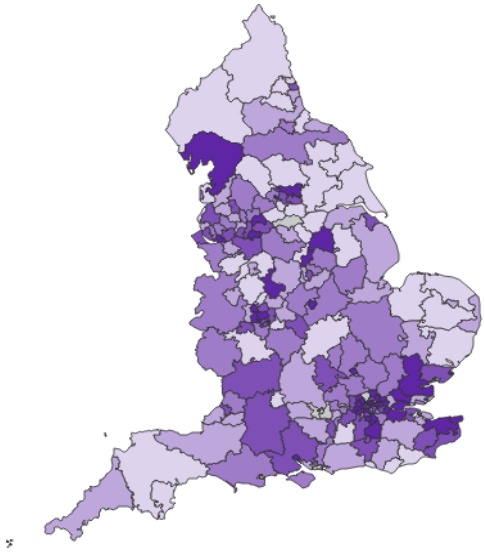
B



C



D



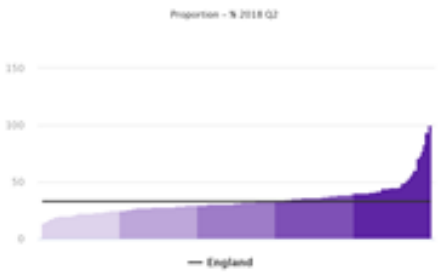
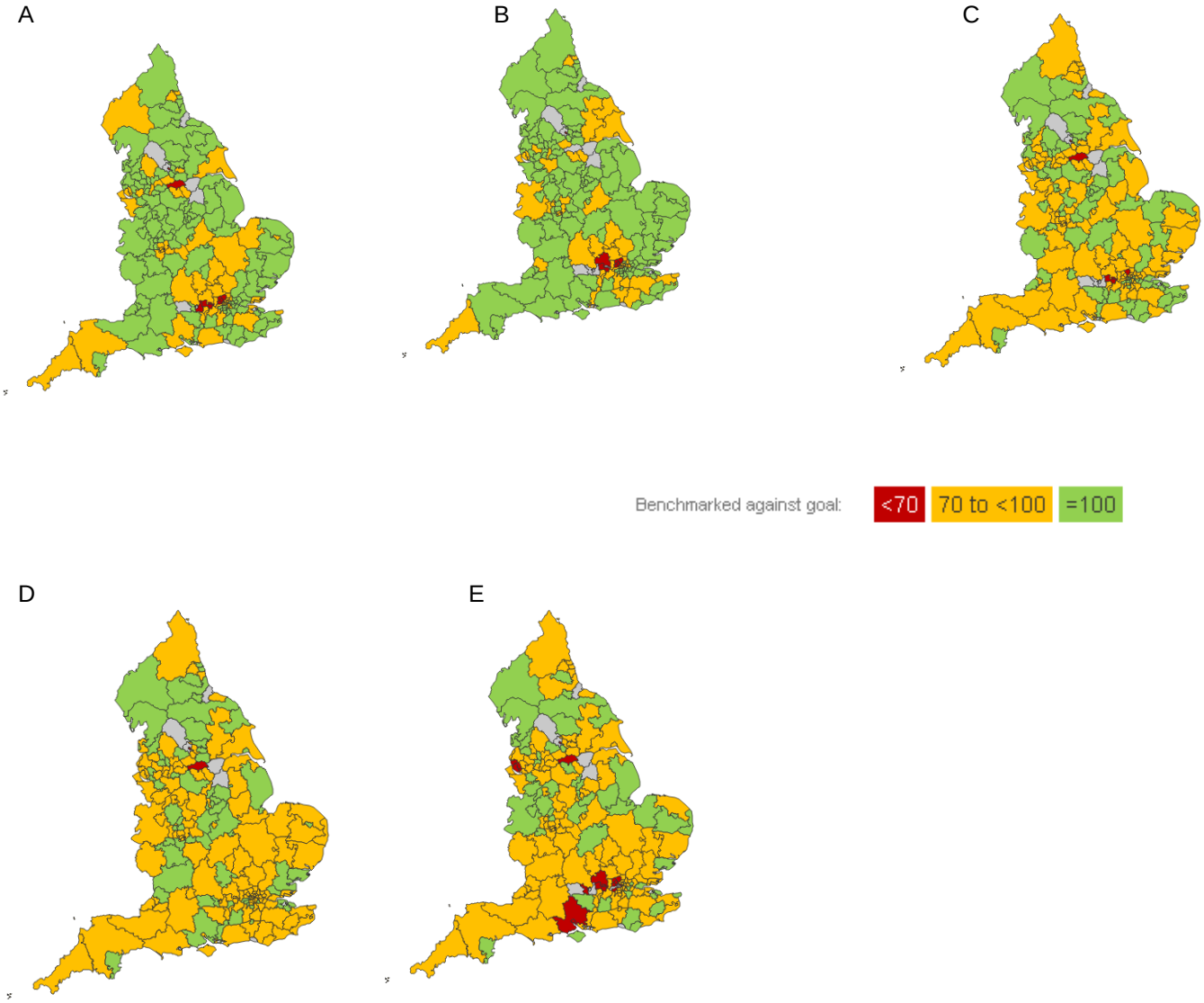


Figure 7: Proportion of *E.coli* from blood tested for susceptiblity to: A (a carbapenem), B (a 3rd generation cephalosporin), C (ciprofloxacin), D (gentamicin), E (piperacillin/tazobactam). Data presented by CCG for quarter four 2017
Source: PHE AMR local indicators[1]



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 2020 - 2021

Date of meeting	Agenda item	Responsible
30 July 2020	COVID-19 Update from Board Members	All Board Members
	Plymouth COVID-19 Local Outbreak Management Plan	Ruth Harrell
	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 2018-2019	Julie Frier
	A Framework for COVID19 Inequalities	Ruth Harrell
8 October 2020		
7 January 2021		
4 March 2021		
Items to be scheduled	Impacts of Poor Housing on Health Progress update	Ruth Harrell
	Substance Misuse and Impacts on the City	
	SEND Access	Judith Harwood
	Barnado's Care Journey Partnership	Jean Kelly, Nick Cook (Barnado's)
	Working Together Update	Judith Harwood

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