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To: The Chair and Members of the Health and Wellbeing Board

County Hall
Topsham Road
Exeter
Devon
EX2 4QD

Date: 30 September 2020

Contact: Stephanie Lewis 01392 382486
Email: stephanie.lewis@devon.gov.uk

HEALTH AND WELLBEING BOARD

Thursday, 8th October, 2020

A meeting of the Health and Wellbeing Board is to be held on the above date at 2.15 pm to consider the following matters.

Phil Norrey
Chief Executive

A G E N D A

PART I - OPEN COMMITTEE

1 Apologies for Absence

2 Minutes (Pages 1 - 8)

Minutes of the meeting held on 16 July 2020, attached.

3 Items Requiring Urgent Attention

Items which in the opinion of the Chair should be considered at the meeting as matters of urgency.

PERFORMANCE AND THEME MONITORING

4 Devon Joint Health and Wellbeing Strategy: Priorities and Outcomes Monitoring (Pages 9 - 12)

Report of the Chief Officer for Communities, Public Health, Environment and Prosperity, which reviews progress against the overarching priorities identified in the Joint Health and Wellbeing Strategy for Devon 2020-2025.

The appendix is available at
https://www.devonhealthandwellbeing.org.uk/strategies/

BOARD BUSINESS - MATTERS FOR DECISION

5 Joint Commissioning in Devon, the Better Care Fund and Governance Arrangements (Pages 13 - 18)

Joint Report of the Associate Director of Commissioning (Care and Health) Devon County Council and NHS Devon CCG on the Better Care Fund (BCF), Quarter Return, Performance Report and Performance Summary on the BCF.

6 Adults Safeguarding Board Annual Report (Pages 19 - 72)

Report of the Chair of the Devon Safeguarding Adults Board (DSAB), attached.

7 Safer Devon Partnership Update

Presentation from the Communities & Strategy Officer.

8 Mental Health Prevention Concordat Action Plan (Pages 73 - 76)

Update Report of the Chief Officer for Communities, Public Health, Environment and Prosperity, attached.

9 Strategic Economic Assessment & Development Strategy

Presentation from the Head of Economy Enterprise & Skills.

10 Joint Health and Wellbeing Strategy Update (Pages 77 - 78)

Report of the Chief Officer for Communities, Public Health, Environment and Prosperity, attached.

11 Health Protection Committee Annual Report 2018-19 (Pages 79 - 126)

Report of the Chief Officer for Communities, Public Health, Environment and Prosperity, attached.

12 CCG Updates (Pages 127 - 130)

An update by the Chair of NHS Devon Clinical Commissioning Group, attached.

OTHER MATTERS

13 References from Committees

14 Scrutiny Work Programme

In order to prevent duplication, the Board will review the Council's Scrutiny Committee's Work Programmes. The latest round of Scrutiny Committees confirmed their work programmes and the plan can be accessed at; http://new.devon.gov.uk/democracy/committee-meetings/scrutiny-committees/scrutiny-work-programme/

15 Forward Plan (Pages 131 - 132)

To review and agree the Boards Forward Plan.

16 Briefing Papers, Updates & Matters for Information

17 Dates of Future Meetings

Please note that dates of future meetings and conferences will be included in the Devon County Council meetings calendar. All will take place virtually, unless otherwise stated.

Meetings
Thursday 8 Oct 2020 @ 2.15 pm
Thursday 21 Jan 2021 @ 2.15 pm
Thursday 8 Apr 2021 @ 2.15 pm
Thursday 15 Jul 2021 @ 2.15 pm
Thursday 28 Oct 2021 @ 2.15 pm
Thursday 13 Jan 2022 @ 2.15 pm
Thursday 7 Apr 2022 @ 2.15 pm

Annual Conference
Thursday 15 Jul 2021

Members are reminded that Part II Reports contain exempt information and should therefore be treated accordingly. They should not be disclosed or passed on to any other person(s). They need to be disposed of carefully and should be returned to the Democratic Services Officer at the conclusion of the meeting for disposal.

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Anyone wishing to film part or all of the proceedings may do so unless the press and public are excluded for that part of the meeting or there is good reason not to do so, as directed by the Chair. Filming must be done as unobtrusively as possible without additional lighting; focusing only on those actively participating in the meeting and having regard to the wishes of others present who may not wish to be filmed. Anyone wishing to film proceedings is asked to advise the Chair or the Democratic Services Officer in attendance.

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It is to be noted that Members of the Council must declare any interest they may have in any item to be considered at this meeting, prior to any discussion taking place on that item.

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Induction Loop available

HEALTH AND WELLBEING BOARD

16 July 2020

Present:-

Devon County Council

Councillors A Leadbetter (Chair), R Croad, J McInnes, B Parsons and C Whitton

Dr Virginia Pearson, Chief Officer for Communities, Public Health, Environment and Prosperity
Dr Paul Johnson, Devon Clinical Commissioning Group
Jeremy Mann, Environmental Health Officers Group
Diana Crump, Joint Engagement Forum
Phillip Mantay, Devon Partnership NHS Trust
Councillor Andrew MacGregor, Teignbridge District Council
Nick Pennell, Health Watch Devon
Kate Stephens – Head of Public Health Nursing (Substitute)
Shelly Machin – Torbay & South Devon NHS Trust (Substitute)
Keri Storey – Head of Adult Care Operations & Health (Substitute)

Apologies:-

Jennie Stephens, Chief Officer for Adult Care and Health

Jo Olsson, Chief Officer for Childrens Services

Adel Jones, Torbay and South Devon NHS Foundation Trust

* 156 Election of the Chair

RESOLVED that Councillor Leadbetter be elected Chair of the Board for the ensuing year.

* 157 Appointment of Vice Chair

RESOLVED that Dr P Johnson be elected Vice Chair of the Board for the ensuing year.

* 158 Welcome from the Chair

The Chair welcomed all Members to the meeting, including new Member Nick Pennell from Health Watch Devon.

* 159 One Minute's Silence

The Board observed a minute's reflection for those people who had lost their lives or had been affected by the Coronavirus.

* 160 Message of thanks from the Chair

The Chair and Board thanked all the frontline workers, NHS colleagues, healthcare workers and council staff for their continued efforts and hard work during the pandemic.

* 161 Minutes

RESOLVED that the minutes of the meeting held on 16 January 2020 be signed as a correct record.

*** 162 Items Requiring Urgent Attention**

There were no items requiring urgent attention.

*** 163 Responding to the COVID-19 Pandemic**

The Committee considered the Report of the Chief Officer for Communities, Public Health, Environment and Prosperity on an overview of the COVID-19 Pandemic and context for the impact on the Health and Care system and the responses.

The Report covered national preparation for pandemics through modelling, the impact of social distancing measures including data on the population and international comparisons, deaths in Devon and the future including identified risks and implications, financial, legal and equality considerations.

The Government recently asked Upper Tier and Unitary Local Authorities to establish COVID19 Health Protection Boards (chaired by their Directors of Public Health) and Local Outbreak Engagement Boards (Chaired by Leaders) to ensure outbreaks of COVID-19 could be managed at local level. The Local Outbreak Management Plan had now been published and Devon County Council had been selected as a 'Beacon Council' in the South West to develop and share best practice, one of eleven nationally.

The Board, in discussion, highlighted and asked questions on:

- People in Devon had generally been complying with social distancing and hygiene measures to manage the spread of infection;
- Low number of deaths in Devon – there had been a greater proportion of deaths in care homes, however Devon was still one of the lowest rates recorded in the country;
- A massive increase in demand on health protection services during April, pressures on NHS and social care colleagues and pressure on intensive care and hospitals;
- Good preparation and work by the wider community and colleagues to act quickly in managing infection rates;
- The current picture very positive – last week in Devon there was 11 positive cases, no deaths – 149 out of 150 local authorities for rate of Covid-19;
- More detailed analysis was being carried out by public health on the number of excess deaths in Devon;
- that social care and NHS staff had risen to challenge during the pandemic – but also the people of Devon who listened to advice around isolation and lockdown; and,
- End point of analysis – bring report back to future HWBB meeting to show figures and statistics.

It was **MOVED** by Councillor Leadbetter, **SECONDED** by Dr Johnson, and

RESOLVED that the Report be noted and a future item on the end point of analysis be added to the work programme.

*** 164 Priorities for Recovery**

The Board received a presentation from the Chief Officer for Communities, Public Health, Environment and Prosperity on the priorities for recovery, including: *(a copy of the presentation is attached to these minutes)*

Impact of Covid-19 in Devon

- health and care impact: 1,208 confirmed cases and 211 deaths; impact of lockdown on mental health, loneliness and general wellbeing;
- Confirmed cases and deaths per 100,000 population by each district area;

- UK health services impact: access to services, delivery of secondary care, hospital admissions, mental health services, adult social care, and early help services;
- UK Health Behaviours impact on drinking, smoking, physical activity and diet;
- Economic impact – number of people furloughed, increase in job seekers allowance, decline in spending, household debt, affecting certain communities more, educational attainment, job security, household income and work environment;
- Rates of unemployment – increase in claimant count rate above national average and small tourist towns most affected;
- UK social impact – loneliness and isolation, social cohesion increased, domestic violence and abuse, social disorder and safeguarding issues;
- Devon Environmental Impact – fall in road transport, drop in fuel consumption, drop in carbon emissions by 23%; and,
- The vast increase in use of cycling during lockdown.

Joint Health and Wellbeing Strategy - Vision and Priorities

- Is the JHWS still fit for purpose?
- Wider determinants of health and mental health – lack of employment and loneliness effects;
- Impact on young people, education and wider benefits of school, social interaction etc (priority 2c)
- Infectious diseases are very real and important – priority 4, talking about maximising/encouraging immunisation programmes and promoting benefits of vaccinations (flu/pneumonia and child vaccines) – **add – promoting public health interventions to prevent the spread of infectious disease**

Learning from Covid-19 response

- Healthwatch report – this would contribute to discussions on learnings from Covid-19 – NP will pass on to Members once produced;
- Physical health and weight a factor for Covid-19 – it was important to increase the levels of exercise amongst the population;
- Public services had pulled together through the pandemic and there had been more joined up and partnership working – it was important to ensure this continued beyond the pandemic;
- Clear national messaging required – there had been some confusion;
- Speed and efficiency of local authorities, communities and voluntary groups that came together and set up local community support, to help coordinate support for local residents;
- the national approach made action in localities difficult at times - further work was needed to look at care homes and vulnerable groups;
- at times there was a conflict in dynamics between the national directive and local work e.g. volunteering approach;
- how technology had been used throughout Covid-19 – including online virtual meetings; but also health, local government, police and voluntary work had continued during the pandemic through the virtual world – this must continue moving forward; and,
- Devon County Council had improved digital capabilities a lot in the last few years which had helped immensely moving through the pandemic.

Discussion points with Members included:

- a lack of consistency across GP and NHS delivery for non-essential things; a clear and consistent strategy across Devon was required;
- Cycling – this would likely tail off as people go back to work and don't have as much time to go out cycling;
- Impact of pandemic on voluntary and community sector as a whole?

- Impact on social prescribing programmes and how they have adapted and utilised opportunities to work very differently during Covid-19;
- Protective groups, impact on these groups?
- Stages of Covid-19 – burnout was mentioned, this is a real danger as so many people have pushed beyond their normal limits to put Devon in a positive position – with a potential resurgence in autumn/winter, how do we support those people that have already worked so hard to give them some recovery time to avoid burnout if there is a second wave?;
- Two positive trends around public participation and improving social cohesion, were these trends here to stay or will they likely revert to pre-pandemic levels; and,
- the hardcopy info sheets newspaper published by DCC and police updating households about coronavirus, also includes information on contacting their GPs and NHS should they have any illnesses.

It was **MOVED** by Councillor Leadbetter, **SECONDED** by Cllr Parsons, and

RESOLVED that the presentation be noted and 'promoting public health interventions to prevent the spread of infectious disease' be added to priority 4 of the Joint Health and Wellbeing Strategy.

*** 165 Local Outbreak Management Plan**

(Councillor Brazil attended remotely in accordance with Standing Order 25(2) and the Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020 and spoke to this item).

The Board considered the Report of the Director of Public Health (Chief Officer for Communities, Public Health, Environment and Prosperity) giving an update on the Local Outbreak Management Plan (LOMP) and the associated (non-statutory) governance arrangements.

The Board noted that on 22nd May 2020, Government announced new arrangements for Local Authorities to take a lead role in the management of COVID-19 as lockdown was released. This required Upper Tier Local Authority (County Councils and Unitary Authorities) to publish a Local Outbreak Management Plan by 30th June 2020.

As part of this process, upper tier Local Authorities had to establish COVID-19 Health Protection Boards, which were multi-agency strategic partnerships, non-statutory, working to detect, manage and contain outbreaks of COVID-19, working under the existing statutory duties of the Director of Public Health. This Board would be chaired by the Director of Public Health and its role was to oversee the Local Outbreak Management Plan and resource deployment via tactical and operational management, data and intelligence (with Joint Biosecurity Centre), leading the local Public Health response with Public Health England (and NHS Test and Trace) and assurance and reporting to other groups as required.

Councils were also required to establish Local Outbreak Engagement Boards which were also non-statutory and designed to provide political oversight of the local delivery of the Local Outbreak Management Plan and the local response as well as communicating and engaging with residents, businesses and communities. This Engagement Board would be chaired by the Leader of the Council.

It was noted that Local Outbreak Management Plans were dynamic and would be updated according to local need and any change in national requirements.

The Government had allocated £300 million to Upper Tier Local Authorities in the form of a ring-fenced Local Authority Test and Trace grant to support this work and the Council's allocation was £2,618,508.

It was **MOVED** by Councillor Leadbetter, **SECONDED** by Dr Johnson, and

RESOLVED that the Local Outbreak Management Plan and the associated (non-statutory) governance arrangements be noted.

*** 166 Devon Joint Health and Wellbeing Strategy: Priorities and Outcomes Monitoring**

The Board considered a Report from the Chief Officer for Communities, Public Health, Environment and Prosperity on the performance for the Board, which monitored the priorities identified in the Joint Health and Wellbeing Strategy for Devon 2020-25. The Report was themed around the four Joint Health and Wellbeing Strategy 2020-25 priorities and included breakdowns by South West benchmarking, local authority district and local authority comparator group.

These priority areas included:

- Create opportunities for all;
- Healthy, safe, strong and sustainable communities;
- Focus on mental health; and
- Maintain good health for all.

The following indicators below had all been updated since the last report: *(the presentation was attached to these minutes)*

- Adult excess weight – 60.7% across Devon
- Proportion of physically active adults – 74.8% across Devon
- Fruit and veg consumption – 63.4% across Devon

The outcomes report was also available on the Devon Health and Wellbeing website www.devonhealthandwellbeing.org.uk/jsna/health-and-wellbeing-outcomes-report

It was **MOVED** by Councillor Leadbetter, **SECONDED** by Dr Pearson, and

RESOLVED that the performance report be noted and accepted.

*** 167 Joint Commissioning in Devon, the Better Care Fund and Governance Arrangements**

The Board considered a joint Report from the Associate Director of Commissioning (Care and Health) and NHS Devon Clinical Commissioning Group (CCG) on the Better Care Fund (BCF), Quarter Return, Performance Report and Performance Summary. Regular Reports were provided on the progress of the Devon Better Care Fund Plan to enable monitoring by the Health and Wellbeing Board.

Performance and progress was reviewed monthly by the Joint Coordinating Commissioning Group through the high level metrics reports and progress overview.

It was **MOVED** by Councillor Leadbetter, **SECONDED** by Dr Johnson, and

RESOLVED that the Quarter 4 Better Care Fund return be approved by the Board and submitted to NHS England in accordance with its timescales.

168 Scrutiny Work Programme

The Board received a copy of Council's Scrutiny Committee work programme in order that it could review the items being considered and avoid any potential duplications.

*** 169 Forward Plan**

The Board considered the contents of the Forward Plan, as outlined below (which included the additional items agreed at the meeting).

Date	**Matter for Consideration**
Thursday 8 October 2020 @ 2.15pm	**Morning Session** Dementia Friends Training JSNA Tool Training session **Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund Adults Safeguarding annual report Gap in employment rate for those with mental health Strategic Approach to Housing Safer Devon Partnership update Homelessness Reduction Act Report - 12 month update Health Protection Committee Update Strategic Economic Assessment & Development Strategy (Presentation) Mental Health Prevention Concordat Action Plan - update CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Pape Updates & Matters for Information
Thursday 21 January 2021 @ 2.15pm	**Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund - frequency of reporting TBC JSNA / Strategy Refresh Children's Social Care Services OFSTED update (look at report) Population Health Management & and Integrated Care Management (Presentation CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Pape Updates & Matters for Information
Annual Reporting	Adults Safeguarding annual report (September / December) Joint Commissioning Strategies – Actions Plans (Annual Report – December) JSNA / Strategy Refresh – (June)
Other Issues	Equality & protected characteristics outcomes framework

RESOLVED that the Forward Plan be approved, including the items approved at the meeting.

*** 170 Dates of Future Meetings**

RESOLVED that future meetings and conferences of the Board will be held on:

Meetings
Thursday 8 Oct 2020 @ 2.15 pm
Thursday 21 Jan 2021 @ 2.15 pm
Thursday 8 Apr 2021 @ 2.15 pm

Please note that dates of future meetings and conferences will be included in the Devon County Council meetings calendar. All future meetings will take place virtually, unless otherwise stated.

***DENOTES DELEGATED MATTER WITH POWER TO ACT**

The Meeting started at 2.00 pm and finished at 4.05 pm

NOTES:
1. Minutes should be read in association with any Reports or documents referred to therein, for a complete record.
2.The Minutes of the Board are published on the County Council's website at http://democracy.devon.gov.uk/ieListMeetings.aspx?CId=166&Year=0
3. *A recording of the webcast of this meeting will also available to view for up to six months from the date of the meeting, at http://www.devoncc.public-i.tv/core/portal/home*

Devon Health and Wellbeing Board
15th October 2020

Health and Wellbeing Outcomes Report

Report of the Chief Officer for Communities, Public Health, Environment and Prosperity

Recommendation: It is recommended that the Devon Health and Wellbeing Board note the updated Health and Wellbeing Outcomes Report.

1. Context

This paper and accompanying presentation introduces the updated outcomes report for the Devon Health and Wellbeing Board.

2. Summary of the Health and Wellbeing Outcomes Report, October 2020

2.1 The full Health and Wellbeing Outcomes Report for October 2020, along with this paper, is available on the Devon Health and Wellbeing website: www.devonhealthandwellbeing.org.uk/jsna/health-andwellbeing-outcomes-report. The report monitors the four Joint Health and Wellbeing Strategy 2020-25 priorities, and includes breakdowns by local authority, district and trends over time. These priorities areas include:

- **Create opportunities for all**
- **Healthy safe, strong and sustainable communities**
- **Focus on mental health**
- **Maintain good health for all**

Three indicators have been updated with new data and are as follows:

- **Fuel Poverty, 2018 -** The percentage of people classified as 'fuel poor' in Devon is 10.7% (down from 11.6% in 2017), placing Devon in the middle IMD quintile in England. Variation across the districts is minimal with all bar Teignbridge (9.6%) being significantly worse than the England average (9.4%).

- **Adult Smoking Prevalence, 2019 -** The percentage of adults in Devon who are currently smokers is 13.5% (up slightly from 13.4% in 2018), statistically similar to the England average of 13.9%. Variation across the districts is minimal with all districts being statistically similar to the England average.

- **Estimated Dementia Diagnosis Rate (65+), 2020 -** The estimated proportion of adults aged 65 and over with a dementia diagnosis in Devon is 59.7% (down slightly from 59.8% in 2019), significantly worse than the England average at 67.4%. Variation is minimal across the districts with all except, East Devon (65.3%), Exeter (70.8%) and West Devon (59.7%), being significantly worse than the England average.

Remaining outcome indicators demonstrate health and wellbeing inequalities across smaller areas which may not always be apparent when observing only the Devon figure.

Please refer to the Devon Health and Wellbeing Outcomes report for a full list of indicators.

3. Future developments to the Devon Health and Wellbeing Outcomes Report

3.1 The 'Explanatory' Headline resource was published online in December and has recently been revamped and updated in May. This can be used to compliment the outcomes report as it provides information at many different geographical levels.

3.2 The 'Exploratory' resource is still in development with delays caused due to the Coronavirus global pandemic. This tool will provide information on health and wellbeing across the life course focusing on geographic variation, trends, deprivation inequalities and correlations.

3.4 An easy read version of the Devon Health and Wellbeing Outcomes report is also in development, with delays caused due to the Coronavirus global pandemic.

4. Legal Considerations
There are no specific legal considerations identified at this stage.

5. Risk Management Considerations
Not applicable.

6. Options/Alternatives
Not applicable.

7. Public Health Impact
The Devon Health and Wellbeing Outcomes Report is an important element of the work of the board, drawing together priorities from the Joint Health and Wellbeing Strategy, and evidence from the Joint Strategic Needs Assessment. This report and the related documents have a strong emphasis on public health and other relevant health, social care and wellbeing outcomes. A number of the outcome indicators are also drawn from the Public Health Outcomes Framework. The report also includes a specific focus on health inequalities.

Dr Virginia Pearson CHIEF OFFICER FOR COMMUNITIES, PUBLIC HEALTH, ENVIRONMENT AND PROSPERITY DEVON COUNTY COUNCIL

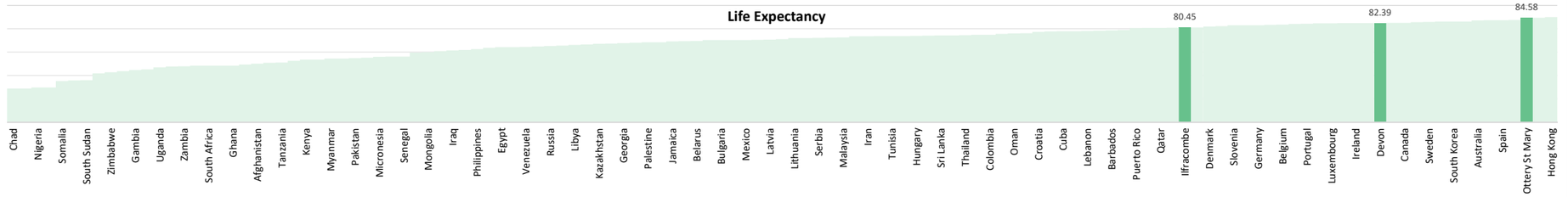
Electoral Divisions: All
Cabinet Member for Adult Social Care and Health Services: Councillor A Leadbetter and Cabinet Member for Community, Public Health, Transportation and Environmental Services: Councillor R Croad

Contact for enquiries: Simon Chant, Room No 155, County Hall, Topsham Road, Exeter. EX2 4QD Tel No: (01392) 386371

Background Papers
Nil

HEALTH AND WELLBEING OUTCOMES REPORT 2020-25

Vision - Health outcomes and health equality in Devon will be amongst the best in the world, and will be achieved by Devon's communities, businesses and organisations working in partnership



Priority and Indicator	Time Period	Devon	SW	Eng	Devon Trend	East Devon	Exeter	Mid Devon	North Devon	South Hams	Teignbridge	Torridge	West Devon	Deprivation MD <-------> LD	Value	Guide
1. Create opportunities for all																
GCSE Attainment (Free School Meals)	2018	18.2%	17.7%	21.7%	-	28.2%	21.1%	25.0%	17.9%	26.2%	17.5%	13.2%	16.7%		%	Higher is better
GCSE Attainment	2018	41.0%	43.2%	43.5%	-	48.0%	41.9%	45.3%	36.7%	45.2%	36.1%	28.0%	41.2%		%	Higher is better
Good Level of Development (Free School Meals)	2018/19	54.7%	53.0%	56.5%	⚑	58.1%	53.7%	55.7%	53.4%	59.5%	56.8%	49.0%	52.5%		%	Higher is better
Good Level of Development	2018/19	72.7%	72.0%	71.8%	⚑	73.5%	71.7%	70.3%	72.5%	77.7%	73.3%	68.8%	74.2%		%	Higher is better
% with NVQ4+ (aged 16-64)	2018	40.1%	38.7%	39.0%	⚑	35.8%	40.6%	40.3%	30.5%	45.7%	46.4%	33.6%	50.0%		%	Higher is better
% with no qualifications (NVQ) (aged 16-64)	2018	5.1%	5.3%	7.6%	⚑	6.5%	4.4%	5.4%	9.2%	2.4%	5.1%	-	5.5%		%	Lower is better
Child Poverty	2016	12.5%	14.0%	17.0%	⚑	11.2%	13.4%	11.6%	13.4%	10.5%	12.8%	16.0%	12.3%		%	Lower is better
Not in Education, Employment or Training	2019	6.3%	6.7%	6.0%	-	5.9%	8.5%	6.0%	6.8%	4.8%	6.0%	6.0%	5.7%		%	Lower is better
Gross Value Added - Per Head (Output)	2016	£ 20,843	£ 23,091	£ 27,108	⚑	£17,246	£ 31,446	£ 16,663	£ 20,929	£ 23,847	£ 18,583	£ 16,094	£ 17,371	-	£	Higher is better
2. Healthy, safe strong and sustainable communities																
Fuel Poverty*	2018	10.7%	10.3%	9.4%	⚑	9.7%	10.4%	11.0%	11.7%	10.8%	9.6%	12.6%	12.3%		%	Lower is better
Rough Sleeping	2018	1.5	1.9	2.0	-	0.8	3.2	0.9	2.9	1.8	1.2	0.9	0.0	-	Rate per 10,000	Lower is better
Dwellings with category one hazards	2014/15	15.4%	15.6%	10.4%	⚑	14.7%	9.4%	17.3%	17.7%	15.8%	13.4%	26.2%	13.8%	-	%	Lower is better
Private sector dwellings made free of hazards	2014/15	1.0%	1.0%	1.2%	⚑	1.1%	1.7%	1.1%	1.9%	0.4%	1.5%	0.1%	0.5%	-	%	Higher is better
People who use services who feel safe	2018/19	69.2%	70.0%	70.1%	⚑	78.7%	63.7%	68.5%	70.2%	66.7%	72.2%	60.8%	66.7%		%	Higher is better
Proportion of people with poor access to healthy assets	2017	26.5%	18.1%	21.1%	-	37.4%	-	30.7%	23.8%	38.4%	15.7%	44.6%	44.0%		%	Higher is better
Overall rate of crime	2018/19	57.1	67.1	67.3	⚑	44.0	84.0	45.0	60.0	41.0	52.0	43.0	40.0		Rate per 1,000	Lower is better
3. Focus on mental health																
Suicide Rate	2016-18	11.2	11.1	9.6	⚑	7.0	15.0	12.9	13.0	6.7	13.7	12.8	8.9		DASR per 100,000	Lower is better
Emergency Hospital Admissions for Intentional Self-Harm	2018/19	210.4	272.8	193.4	⚑	187.6	216.8	158.9	309.6	176.9	232.3	273.5	128.4		DASR per 100,000	Lower is better
Self-Reported Wellbeing (low happiness score %)	2018/19	5.7%	7.3%	7.8%	⚑	-	-	-	-	-	-	-	-	-	%	Lower is better
Social Contentedness	2018/19	44.7%	46.6%	45.9%	-	-	-	-	-	-	-	-	-	-	%	Lower is better
Access to psychological therapies	2017	17.5%	-	18.3%	-	16.8%	20.1%	16.1%	18.8%	13.3%	18.9%	17.3%	15.3%	-	%	Higher is better
4. Maintain good health for all																
Adults Excess Weight	2018/19	60.7%	61.3%	62.3%	⚑	55.7%	59.9%	67.9%	65.2%	61.6%	59.7%	62.7%	56.8%		%	Lower is better
Proportion of Physically Active Adults	2018/19	74.8%	71.8%	67.2%	⚑	78.8%	75.1%	73.9%	72.1%	75.2%	72.9%	71.5%	77.5%		%	Higher is better
Alcohol-Related Admissions	2018/19	547.0	680.0	664.0	-	461.0	590.0	479.0	703.0	459.0	593.0	654.0	456.0		DASR per 100,000	Lower is better
Alcohol-Specific Admissions in Under 18s	2016-19	46.1	44.1	31.6	-	45.8	37.5	30.0	63.2	54.4	62.2	26.8	50.1		Rate per 100,000	Lower is better
Fruit and Vegetable Consumption (5-a-day)	2018/19	63.4%	59.5%	54.6%	⚑	68.1%	61.4%	64.1%	61.3%	62.9%	62.3%	58.6%	68.0%		%	Higher is better
Mortality Rate from Preventable Causes	2016-18	159.9	167.2	180.8	⚑	136.8	193.1	154.8	183.6	137.4	157.5	175.4	157.6		DASR per 100,000	Lower is better
Cancer Diagnosed at Stage 1 or 2	2017	56.1%	53.3%	52.2%	⚑	58.5%	59.9%	56.0%	49.3%	57.4%	54.2%	57.1%	56.6%		%	Higher is better
Overall satisfaction of carers with social services	2018/19	38.3%	38.5%	38.6%	-	43.9%	47.1%	50.0%	32.4%	28.6%	36.0%	33.3%	30.0%		%	Higher is better
Feel Supported to Manage Own Condition	2019	84.2%	81.8%	78.4%	-	87.2%	83.5%	83.8%	83.6%	84.3%	82.7%	80.0%	88.4%	-	%	Higher is better
Re-ablement Services (Effectiveness)	2017/18	82.6%	80.2%	82.9%	⚑	77.5%	79.5%	79.5%	76.1%	97.8%	81.9%	87.1%	94.6%		%	Higher is better
Re-ablement Services (Coverage)	2017/18	1.8%	2.6%	2.9%	⚑	-	-	-	-	-	-	-	-	-	%	Higher is better
Injuries Due to Falls	2018/19	1785.0	2113.0	2198.0	⚑	1681.0	1862.0	1831.0	1866.0	1812.0	1900.0	1733.0	1550.0		DASR per 100,000	Lower is better
Adult Smoking Prevalence*	2019	13.5%	14.0%	13.9%	⚑	10.3%	11.4%	10.6%	16.5%	20.4%	11.8%	12.6%	20.6%		%	Lower is better
Estimated Dementia Diagnosis Rate (65+)*	2020	59.7%	61.8%	67.4%	⚑	65.3%	70.8%	52.1%	60.2%	41.6%	58.5%	59.2%	59.7%	-	%	Higher is better

Key Symbols

- `-` Data not available
- `#` Value missing due to small sample size
- `^` Change in methodology
- `^^` National method for calculating Confidence Intervals are being revised

Most deprived <---------> Least deprived

* Updated indicator

Significance compared to England figure

- Significantly worse
- Not significantly different
- Significantly better

Trend

- ⚑ Worsening trend
- ⚑ Static trend
- ⚑ Improving trend
- `-` Not enough data

Health and Wellbeing

Devon

Committed to promoting health equality

Indicator	Description	Detailed specification
1. Create Opportunities for All		
GCSE Attainment (Free School Meals)	Percentage of pupils achieving five or more GCSEs at grades 9 to 5 including English and Maths that are part of the Free School Meal 6 status.	Number of pupils at end of Key Stage 4 in schools maintained by the local education authority (includes special schools and pupil referral units) achieving five or more GCSEs at grades A* to C or equivalent, including English and maths GCSE as a percentage of all pupils at end of Key Stage 4.
GCSE Attainment	Percentage of overall pupils achieving five or more GCSEs at grades 9 to 5 including English and Maths.	Number of pupils at end of Key Stage 4 in schools maintained by the local education authority (includes special schools and pupil referral units) achieving five or more GCSEs at grades A* to C or equivalent, including English and maths GCSE as a percentage of all pupils at end of Key Stage 4.
Good Level of Development (Free School Meals)	The percentage of children with free school meal status achieving a good level of development at the end of reception	All children defined as having reached a good level of development at the end of the EYFS by local authority. Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy.
Good Level of Development	The percentage of children achieving a good level of development at the end of reception	All children defined as having reached a good level of development at the end of the EYFS by local authority. Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy.
% with NVQ4+ (aged 16-64)	Percentage of people aged 16-64 with and NVQ4+ qualification	The number of people with NVQ 4 equivalent and above, e.g. HND, Degree and Higher Degree level qualifications or equivalent divided by the total population age 16-64.
% with no qualifications (NVQ) (aged 16-64)	Percentage of people aged 16-64 with no qualifications (%)	The number of people with no formal qualifications divided by the total population aged 16-64.
Child Poverty	Percentage of children (aged 0 to 15) living in households dependent on benefits or tax credits.	Children living in families in receipt of Child Tax Credit (CTC) whose reported income is less than 60 per cent of the median income or are in receipt of income support (IS) or Income-Based Jobseeker's Allowance (JSA), as a proportion of the total number of children in the area.
Not in Education, Employment or Training	16-19 year olds not in education, employment or training (NEET) or whose activity is not known	The estimated number of 16-19 year olds not in education, employment or training or whose activity is not known. The England and South West figure represents the estimated proportion of 16-17 year olds not in education, employment or training or whose activity is not known.
Gross Value Added - Per Head (Output)	The value generated by any unit engaged in the production of goods and services.	A measure of the increase in the value of the economy due to the production of goods and services. It is measured at current basic prices, which includes the effect of inflation, excluding taxes (less subsidies) on products. GVA plus taxes (less subsidies) on products is equivalent to gross domestic product (GDP).
2. Healthy, Safe, Strong and Sustainable Communities		
Fuel Poverty	The percentage of households that experience fuel poverty based on the "Low income, high cost" methodology	Under the "Low Income, High Cost" measure, households are considered to be fuel poor where: 1.They have required fuel costs that are above average (the national median level) 2.Were they to spend that amount, they would be left with a residual income below the official fuel poverty line. The key elements in determining whether a household is fuel poor or not are income, fuel prices, and fuel consumption (which is dependent on the dwelling characteristics and the lifestyle of the household)
Rough Sleeping	The number of rough sleepers counted or estimated by the local authority as a rate per 1,000 households	These annual rough sleeping counts and estimates are carried out in October or November. Each local authority district either conducts a street count or provides an estimate. A count is a single night snapshot of the number of rough sleepers in a local authority area. Counts are independently verified by Homeless Link. An estimate is the number of people thought to be sleeping rough in a local authority area on any one night in a chosen week. Local authorities decide annually whether to provide a count or an estimate in light of their local circumstances. Counts and estimates may underestimate the true extent of rough sleeping.
Dwellings with category one hazards	Percentage of total dwellings with hazards rated as serious (category one) under the housing health and safety rating system (HHSRS)	The housing health and safety rating system (HHSRS) is a risk-based evaluation tool introduced under the Housing Act 2004, which identifies 29 hazards including damp, excess cold, excess heat, the presence of pollutants (including Asbestos), space, security, light, noise, hygiene, sanitation, water supply, and risk of accidental injury. Risks rated as category one pose a serious risk to health and safety. The numerator is the total number of dwellings identified as having category one hazards present (f6a). The denominator is the total number of dwellings from Live Table 100 (dwelling stocks by local authority).
Private sector dwellings made free of hazards	Percentage of private sector dwellings identified as having hazards rated as serious (category one) under the housing health and safety rating system (HHSRS) which were made free of these hazards in the previous financial year	The housing health and safety rating system (HHSRS) is a risk-based evaluation tool introduced under the Housing Act 2004, which identifies 29 hazards including damp, excess cold, excess heat, the presence of pollutants (including Asbestos), space, security, light, noise, hygiene, sanitation, water supply, and risk of accidental injury. Risks rated as category one pose a serious risk to health and safety. The numerator is the total number of private sector dwellings made free of category one hazards through local authority intervention. The denominator is the total number of private sector dwellings identified as having category one hazards present.
People who use services who feel safe	The measure is defined by determining the percentage of all those responding who choose the answer “I feel as safe as I want” from the Adult Social Care Survey.	This measures one component of the overarching ‘social care-related quality of life’ measure. It provides an overarching measure for this domain.
Proportion of people with poor access to healthy assets	Access to Healthy Assets & Hazards Index	Percentage of the population who live in LSOAs which score in the poorest performing 20% on the Access to Healthy Assets & Hazards (AHAH) index. The AHAH index is comprised of four domains: access to retail services (fast food outlets, gambling outlets, pubs/bars/nightclubs, off licences, tobacconists), access to health services (GP surgeries, A&E hospitals, pharmacies, dentists and leisure centres), the physical environment (access to green spaces, and three air pollutants: NO2 level, PM10 level, SO2 level) and air pollution (NO2 level, PM10 level, SO2 level).
Overall rate of crime	The rate of crimes, crude rate per 1,000	Numerator is the number of crime incidents recorded by the police. Denominator is the rounded mid-year population of the area. Rate is numerator divided by denominator multiplied by 1,000.
3. Focus on Mental Health		
Suicide Rate	Direct age-standardised mortality rate (DASR) from suicide and injury of undetermined intent per 100,000 population	Number of deaths from suicide and injury of undetermined intent (classified by underlying cause of death recorded as ICD10 codes X60-X84 (all ages), Y10-Y34 (ages 15+ only) registered in the respective calendar years, aggregated into quinary age bands, with corresponding mid-year population totals. Age specific rates are calculated and multiplied by the standard population for each age group and aggregated to give the age adjusted count of deaths for the area, and divided by the total standard population and multiplied by 100,000 to give the age standardised mortality rate for the area. New 2013 European Standard population used.
Emergency Hospital Admissions for Intentional Self-Harm	Direct Age Standardised Rate of finished admission episodes for self-harm per 100,000 population aged 10 to 24 years	Numerator is number of finished admission episodes in children aged between 10 and 24 years where the main recorded cause is between ‘X60’ and ‘X84’ (Intentional self-harm). Population for people aged 10 to 24, aggregated into quinary age bands. Age specific rates are calculated and multiplied by the standard population for each age group and aggregated to give the age adjusted count of deaths for the area, and divided by the total standard population and multiplied by 100,000 to give the age standardised mortality rate for the area. The 2013 revision to the European Standard Population has been used.
Self-Reported Wellbeing (low happiness score %)	Self-reported well-being - percentage of people with a low happiness score	The percentage of respondents who answered 0-4 to the question "Overall, how happy did you feel yesterday?"ONS are currently measuring individual/subjective well-being based on four questions included on the Integrated Household Survey. Responses are given on a scale of 0-10 (where 0 is “not at all happy” and 10 is “completely happy”)The first full year data from these questions was published by ONS in July 2012 and are being treated as experimental statistics. In the ONS report, the percentage of people scoring 0-6 and 7-10 have been calculated for this indicator.
Social Contentedness	Proportion of people who use services who reported that they had as much social contact as they would like.	The percentage of users responding "I have as much contact as I want with people I like" and carers choosing "I have as much contact as I want" to questions based on their social situation in the Adult Social Care Survey and Carers Survey. Currently just measuring social care users. Measures for users and carers will be presented separately
Access to psychological therapies	Access to IAPT services: people entering IAPT (in month) as % of those estimated to have anxiety/depression	The number of people entering IAPT services as a proportion of those estimated to have anxiety and/or depression.
4. Maintain good health for all		
Adults Excess Weight	Percentage of adults classified as overweight or obese.	Number of adults with a BMI classified as overweight (including obese), calculated from the adjusted height and weight variables. Adults are defined as overweight (including obese) if their body mass index (BMI) is greater than or equal to 25kg/m2. Denominator is number of adults ages 18+ with valid height and weight recorded.Height and weight is self-reported but is adjusted by age and sex using Health Survey for England data to adjust for differences between self-reports and actual BMI. Prevalences are weighted to be representative of the whole population at each level of geography and have been age-standardised.
Proportion of Physically Active Adults	Percentage of adults achieving at least 150 minutes of physical activity per week in accordance with UK CMO recommended guidelines on physical activity.	The number of respondents aged 19 and over, with valid responses to questions on physical activity, doing at least 150 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 16. This includes physical activity as a mode of transportation to work, as well as direct leisure activities.
Alcohol-Related Admissions (Narrow)	Direct age-standarised rate of hospital admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 population.	Admissions to hospital involving an alcohol-related primary diagnosis or an alcohol-related external cause. Admissions of children under 16 were only included if they had an alcohol-specific diagnosis i.e. where the attributable fraction = 1, meaning that the admission is treated as being wholly attributable to alcohol. For other conditions, estimates of the alcohol-attributable fraction were not available for children.
Alcohol-Specific Admissions in under 18s	Hospital admissions for alcohol-specific causes in persons aged under 18 per 100,000 population	Persons aged less than 18 years admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-specific condition for three financial years pooled. In addition, individuals admitted are only counted once per financial year. Denominator is ONS mid-year population estimates for 0-17 year olds. Three years are pooled. Rate is a crude rate per 100,000 population. See LAPE user guide for further details - http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf
Fruit and Vegetable Consumption (5-a-day)	Proportion of the population who, when surveyed, reported that they had eaten the recommended 5 portions of fruit and vegetables on a usual day.	Proportion of the population who, when surveyed, reported that they had eaten the recommended 5 portions of fruit and vegetables on the previous day. Respondents to the Active Lives Survey who answered both of the following questions were included: 1) How many portions of fruit did you eat yesterday? Please include all fruit, including fresh, frozen, dried or tinned fruit, stewed fruit or fruit juices and smoothies. Fruit juice only counts as one portion no matter how much you drink. 2) How many portions of vegetables did you eat yesterday? Please include fresh, frozen, raw or tinned vegetables, but do not include any potatoes you ate. Beans and pulses only count as one portion no matter how much of them you eat.
Mortality Rate from Preventable Causes	Direct age-standardised mortality rate from causes considered preventable per 100,000 population	Numerator is number of deaths that are considered preventable (classified by underlying cause of death recorded as ICD codes A15-A19, B17.1, B18.2, B20-B24, B90, C00-C16, C18-C22, C33-C34, C43, C45, C50, C53, E10-E14, F10-F16, F18-F19, G31.2, G62.1, I20-I26, I42.6, I71, I80.1-I80.3, I80.9, I82.9, J09-J11, J40-J44, K29.2, K70, K73-K74 (excl. K74.3-K74.5), K86.0, U50.9, V01-Y34, Y60-Y69, Y83-Y84) registered in the respective calendar years, aggregated into quinary age bands (0-4, 5-9,…, 80-84, 85+). The 2013 revision to the European Standard Population has been used for this measure.
Cancer Diagnosed at Stage 1 or 2	Proportion of cancers diagnosed at an early stage	New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed (specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin). This indicator is labelled as experimental statistics because of the variation in data quality: the indicator values primarily represent variation in completeness of staging information.
Overall satisfaction of carers with social services	The measure is defined by determining the percentage of all those responding who identify strong satisfaction, by choosing the answer “I am extremely satisfied” or the answer “I am very satisfied” from the Adult Social Care Survey.	This measures the satisfaction with services of carers of people using adult social care, which is directly linked to a positive experience of care and support. Analysis of user surveys suggests that reported satisfaction with services is a good predictor of the overall experience of services and quality.
Feel Supported to Manage Own Condition	Weighted percentage of people feeling supported to manage their condition.	Numerator: For people who answer yes to the Question 30 “Do you have a longstanding health condition”, the numerator is the total number of ‘Yes, definitely’ or ‘Yes, to some extent’ answers to GPPS Question 32: In the last 6 months, have you had enough support from local services or organisations to help you manage your long-term condition(s)? Please think about all services and organisations, not just health services • Yes, definitely • Yes, to some extent • No • I have not needed such support • Don’t know/can’t say. Responses weighted according to the following 0-100 scale: “No” = 0 “Yes, to some extent” = 50 “Yes, definitely” = 100.
Re-ablement Services (Effectiveness)	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.
Re-ablement Services (Coverage)	Proportion of older people (65 and over) offered reablement services following discharge from hospital.	The number of older people (65 and over) offered reablement services as a proportion of the total number of older people discharged from hospitals based on Hospital Episode Statitstics (HES)
Injuries Due to Falls	Emergency hospital admissions for falls injuries in persons aged 65 and over, directly age-sex standardised rate per 100,000.	Emergency admissions for falls injuries classified by primary diagnosis code (ICD10 code S00-T98) and external cause (ICD10 code W00-W19) and an emergency admission code. Age at admission 65 and over.Counted by first finished consultant episode (excluding regular and day attenders) in financial year in which episode ended, by local authority and region of residence from the HES data. Population based on Local Authority estimates of resident population produced by ONS. Analysis uses the quinary age bands 65-69, 70-74, 75-79, 80-84 and 85+, by sex. Calculated using the 2013 European Standard Population.
Adult Smoking Prevalence	Percentage of adults aged 18 and over who smoke	The number of persons aged 18+ who are self-reported smokers in the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response. Denominator is Total number of respondents (with valid recorded smoking status) aged 18+ in the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.
Estimated Dementia Diagnosis Rate (65+)	Number of persons recorded on a GP Dementia Disease Register as a % of those in the area estimated to have dementia (using age and sex based estimates)	Numerator is the number of people on a GP practice dementia disease register at the end of the given period and reported through the Quality and Outcomes Framework. Numbers predicted to have dementia in individual GP practice population in quinary age bands to age and sex specific dementia prevalence rates from the 2007 Dementia UK prevalence study. Rate divides the number on the GP register by the predicted number with dementia to give the percentage diagnosed. GP practice numerators and denominators are aggregated to areas based on location of practice.

Health and Wellbeing Board
8 October 2020

BETTER CARE FUND 2020/21 - UPDATE

Report of the Associate Director of Commissioning (Care and Health), Devon County Council and NHS Devon Clinical Commissioning Group.

Please note that the following recommendations are subject to consideration and determination by the Committee before taking effect

Recommendation:

1. That we continue 2019/20 arrangements for 2020/21 (as detailed in this report) pending receipt of national requirements.

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1. Background/Introduction

1.1 The Better Care Fund (BCF) is the only mandatory policy to facilitate integration between Health and Social Care, providing a framework for joint planning and commissioning. The BCF brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant and funding paid to local government for adult social care services. The Health and Wellbeing Board has oversight of the BCF and is accountable for its delivery.

1.2 Councils and CCGs are required to complete a BCF plan each year for endorsement by NHS England alongside the Section 75 agreement which details the agreement for how the fund will be utilised and operated between the Council and CCG.

1.3 Most of the pooled resources for the BCF come from existing activity within the health and social care system, with additional contributions from Local Authority or CCG budgets. There is a required CCG minimum contribution, uplifted each year. Additional funding from central government has been paid directly to Local Authorities, including the Winter Pressures Grant and Improved Better Care Fund, which are used for meeting adult social care needs, reducing pressures (including seasonal) on the NHS and ensuring that the social care provider market is supported.

1.4 The BCF has a framework of planning and local quarterly reports which are approved via the Health & Wellbeing Board. However, national requirements for 2020/21 have been delayed due to the COVID 19 pandemic.

2. Arrangements for 2020/21

2.1 The new national BCF Guidance for 2020-21 is still to be published, though it is expected that any requirements for a new plan will be light touch.
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2.2 In the absence of update guidance and formal planning processes, the Council and the CCG have agreed to continue with the arrangements defined in the previous (2019/20) agreement. The summary below highlights the plans for the BCF financial budget for 2020/21. There is a continuation of the schemes and services funded through the Better Care Fund for 2020/21 with some minor adjustments made which have been reported and approved via the Joint Co-ordinating Commissioning Group as part of the joint commissioning governance arrangements.

BCF Funding Sources (draft subject to ratification upon receipt of national guidance)

	2019/20	2020/21	Change	Comment
	£	£	£	
Winter Pressures Grant	3,575,532	0	(3,575,532)	Moved to BCF Grant
Capital	7,266,863	7,266,863	-	
NHS CCG	55,233,206	58,091,132	2,857,926	CCG 5.17% increase
Local Authority (including carry forwards)	11,204,027	5,894,376	(5,309,651)	Reduction in carry forward
BCF Grant	24,694,941	28,270,473	3,575,532	Winter Pressures
TOTALS	**101,974,569**	**99,522,844**	**(2,451,725)**	

Allocations

	2019/20	2020/21	Change	Comment
	£	£	£	
Winter Pressures	3,575,532	-	(3,575,532)	In iBCF for 2020/21
Capital	7,348,993	7,266,863	(82,130)	2018/19 carry forward
iBCF	30,956,314	29,280,090	(1,676,224)	Carry forwards plus winter pressures
Central	49,842,730	52,533,891	2,691,161	CCG increase less adjustment to Eastern
Northern locality	2,226,000	2,226,000	-	
Eastern locality	4,968,000	5,159,000	191,000	From Central
Western locality	1,274,000	1,274,000	-	
Southern locality	1,783,000	1,783,000	-	
TOTALS	**101,974,569**	**99,522,844**	**(2,451,725)**	

3. Performance in 2020/21

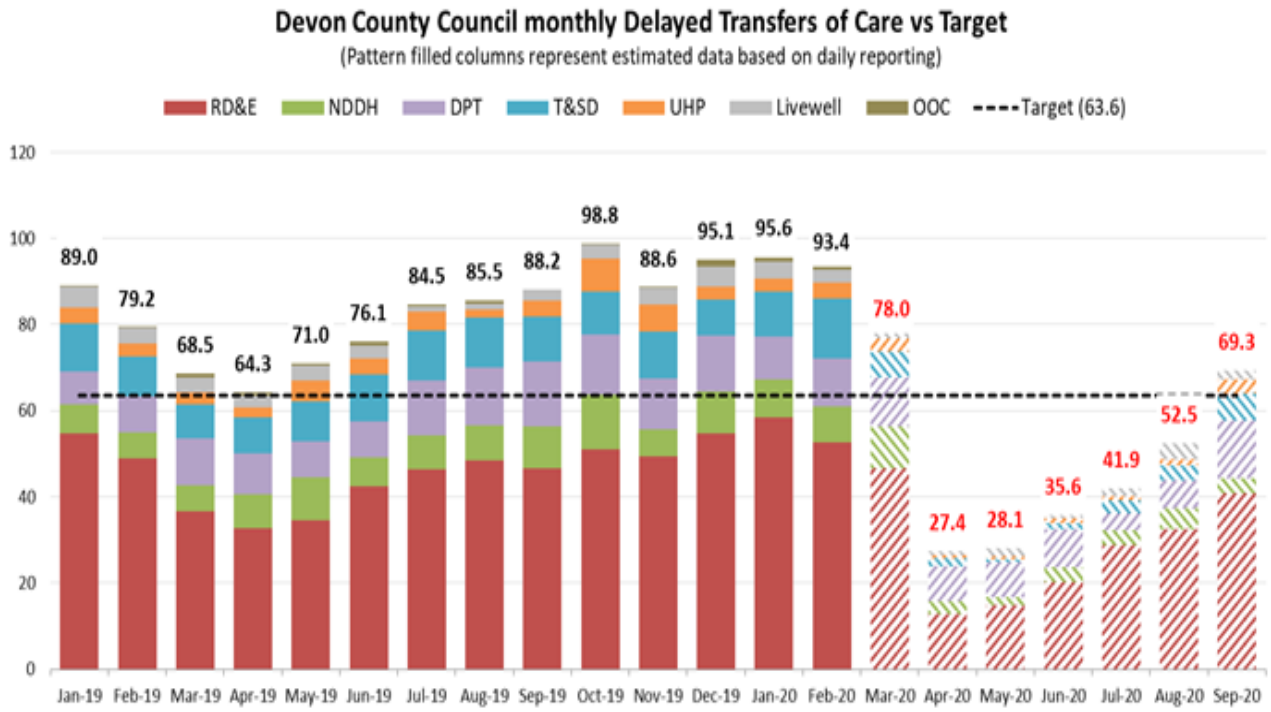
Quarterly returns are required to outline targets and plans for key metrics. A summary of performance and plans for these for quarter 1 (the latest complete quarter for which data are currently available) is included below:

3.1 Delayed Transfers of Care (DToC)

As a result of the pandemic, national reporting of DToC was put on hold from March 2020. Delays are monitored daily across all Devon's Acute trusts, with local A&E Delivery Boards taking ownership.

DToC performance was greatly affected by COVID-19. Delayed transfers started to decrease in March due to the requirement to reduce bed occupancy levels to 50% as part of the pandemic response, dropping to a very low level in April and May. Since May delays have been steadily increasing as elective services recommence.

The chart below shows Devon County Council delays only and is based on daily data:



From the limited DToC data available, the majority of acute delays in Devon are caused by one of three issues (this reflects the national picture):

1. Care Packages in own home
2. Patients waiting for further non-acute NHS care
3. Patients awaiting residential care home placements

In response we continue to:

- increase capacity in the domiciliary and care home market
- build intermediate care capacity and skills
- extend community services and therapy and pharmacy hours to provide capacity at key weekends and escalation times.

This work ties together with recruitment and retention initiatives across Devon linked to the Proud to Care campaign and strong relationships with and investment in the voluntary and community sector and with carers.

The Covid-19 pathways to facilitate hospital discharge are reviewed daily. The implementation of these pathways and the discharge to assess model has meant that:

- All hospital discharges are now supported by a Covid health funding stream
- No social care assessments occur in hospital setting, except Mental Capacity Act & safeguarding assessments
- No Continuing Healthcare (CHC) assessments take place for the duration of the Covid funding pathway

3.2 Permanent Admissions to Residential and Nursing Care – Rate per 100,000 (age 65 and over)

We place fewer older people in residential/nursing care relative to population than comparator and national averages. However, we had seen an upward trend in permanent admissions to the end of March 2020.

From April, we saw increased pressure within the system as a result of Discharge to Assess pathways out of hospital, which increased numbers of placements. However, the number of permanent admissions has reduced which we think likely due to personal choice and available capacity due to outbreaks closing care homes to admissions.

Our ongoing aim is to ensure we have sufficient and robust alternatives to allow us to support people to remain living as independently as possible. This includes our integrated care model and a continuation of community based intermediate care solutions, such as Rapid Response, Social Care Reablement and regulated personal care. Alongside this we are continuing to focus on developing a range of alternatives including Extra Care Housing and Supported Living.

3.3 Percentage of People Still At Home 91 Days After Hospital Discharge Into Rehabilitation / Reablement Services

This target attempts to measure the effectiveness of rehabilitation and reablement services in keeping people out of hospital.

The provisional 2019-20 outturn for this indicator was 85.8%, which is an improvement on the 2018-19 position of 80.1%.

Due to the pandemic, performance has declined significantly to 71.8% at the end of Quarter 1 (June 2020) as a result of some staff self-isolating, some redeployed to support people to remain in their own homes, and a reduction in the take up of the service offer.

4.0 Winter Pressures
Each locality has been allocated winter pressures funding based on over 75's population, and an allocation has also been made for mental health.

Area of allocation (DCC footprint only)	Allocation £
North	600,000
East	1,462,500
West	337,500
South	600,000
Mental Health	575,532

The aim of the fund is to develop services that will support the health and care systems to manage winter demand, e.g. to avoid admission or support discharge. These schemes form part of the Devon Winter Plan, the spend and impact is monitored via the bi-monthly BCF reporting process and reported centrally via the BCF quarterly returns.

Tim Golby
Associate Director of Commissioning (Care and Health), DCC and NHS Devon CCG

Electoral Divisions: All

Cabinet Member for Adult Care and Health: Councillor Andrew Leadbetter

Chief Officer for Adult Care and Health: Jennie Stephens

LOCAL GOVERNMENT ACT 1972: LIST OF BACKGROUND PAPERS
Contact for Enquiries:
Rebecca Harty, Head of Integrated Care Model Northern and Eastern
Tel No: 01392 675344
Room: 2nd Floor, The Annexe, County Hall

BACKGROUND PAPER	DATE	FILE REFERENCE
Nil		

Devon Safeguarding Adults Partnership

Annual Report 2019/20

Contents:

1. Introduction from Independent Chair

I am proud to be introducing my fourth Annual Report as the Independent Chair of the Devon Safeguarding Adults Partnership (DSAP). This report, giving information on the work carried out in the year leading up to the end of March 2020, is brought to you as part of our duty under the Care Act 2014 which requires each Safeguarding Adults Board (SAB) to publish an annual report.

Our strategy during this year was simply described ensuring that all partners to the Board focussed on 4 key issues which are set out on Page 24. This work does not conclude and continues in the DSAP pursuit of assurance about good preventative services and improved understanding across communities, for individuals and within services.

We always intend our Annual Report to be clear and readable – there are set requirements for that which we must publish within it and you will see that we have included information on what the Board has delivered this year. This report sets out how the Board has:

- achieved its objectives, set out at the start of the year and how we implemented our strategy
- how each of our partners has implemented the strategy and worked to deliver effective safeguarding services
- the findings of 'Safeguarding Adults Reviews' – these are reviews which have been concluded between April 2019 and March 2020 and where an adult has died or where there have been serious issues and concerns; and where it was identified that there could be learning and improvements made by organisations to ensure that similar issues do not recur.

The Board and its partners must demonstrate how they ensure that people with care and support needs are protected from abuse and neglect. We do this by scrutiny of performance data and information and occasionally we focus on specific services. We usually receive a "personal safeguarding story' at each meeting with a focus on how services have been effective, but also in terms of whether we need to do more to 'make safeguarding personal'.

Whilst the period covered by the report only goes up to the end of March 2020, challenging times remain with the impact of Covid-19. These challenges have led organisations to restructure the way they organise their services, though it is impressive that despite these additional pressures, all partners to the Board have continued to work effectively together and to respond when being held to account by the SAB. Partners have shown continuous commitment to our key strategic areas and this will be reported within the next Annual Report.

Finally, I would like to thank everyone who has supported the work of the Partnership and its sub-groups. The effective work of the sub-groups reflected in this annual report is a massive commitment by those involved which contributes to continuously improving services. Importantly our engagement with people who use services through the Community Reference Group continues to evidence increasing awareness of safeguarding issues and supports the partnership to communicate better to raise safeguarding awareness amongst the wider public. All of this work would not be possible without the hard work and professionalism of the small team working in the DSAP office, to whom I am extremely grateful for their ensuring the smooth running of the partnership. Thus far, 2020 has been a particularly challenging time for citizens and communities and for those who work to deliver front-facing services

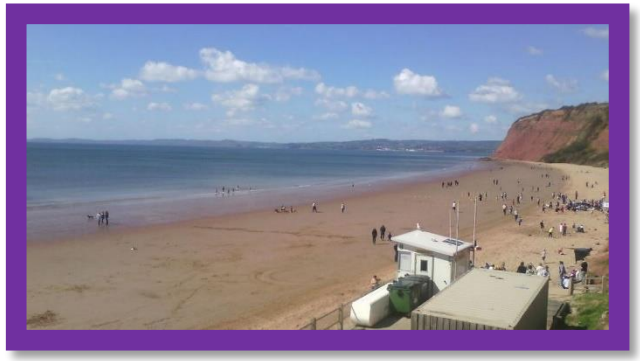
I hope that you find the annual report informative and helpful

2. Introduction to Devon

Devon is the third largest county in England, covering 2,534 square miles. It is also one of the most sparsely populated counties, its 1.9 million residents distributed between the city of Exeter, twenty or so coastal and market towns, and several hundred rural communities, some of which are isolated.

In Devon there is a higher proportion of older people than the national average due to a high migration into the county at retirement age, and a migration out of the county of younger adults. The county enjoys high levels of employment, but lower than average wages and productivity, and higher than average housing costs. There are areas of deprivation, but they are dispersed rather than concentrated.

There are eight district councils in the Devon County Council administrative area and two unitary authorities in Devon, Plymouth City Council and Torbay Council. From 1st April 2019 two Clinical Commissioning Groups (CCGs) merged to form NHS Devon Clinical Commissioning Group covering the geographic area of the Devon Sustainability and Transformation Partnership. Four Acute Hospital Trusts serve the area: Northern Devon Healthcare NHS Trust, Royal Devon and Exeter NHS Foundation Trust, South Devon Healthcare NHS Foundation Trust, and University Hospitals Plymouth NHS Trust. Mental health services and specialist learning disability services provided by the Devon Partnership NHS Trust on a county-wide basis. Police services are the responsibility of Devon and Cornwall Police.



3. What is Safeguarding Adults?

Safeguarding adults' means protecting an adult's right to live in safety, free from abuse and neglect. It is something that everyone needs to know about.

The legal framework for safeguarding adults work is set out by the Care Act 2014. Safeguarding involves:

- People and organisations working together
- Preventing abuse or neglect from happening in the first place
- Stopping abuse and neglect where it is taking place
- Protecting an adult in line with their views, wishes, feelings and beliefs
- Empowering adults to keep themselves safe in the future
- Everyone taking responsibility for reporting suspected abuse or neglect.

Who is an adult at risk?

An adult at risk of abuse or neglect is someone who has care and support needs and is unable to protect themselves from either the risk of, or the experience of, abuse or neglect. Their care and support needs may be due to their mental health, sensory or physical disability; age, frailty or illness; a learning disability or substance misuse.

A carer, for example a family member or friend, could be involved in a situation that may require a safeguarding response. A carer may witness or speak up about abuse or neglect; may experience intentional or unintentional harm from the adult they are trying to support, or from professionals and organisations with whom they are in contact; or may unintentionally or intentionally harm or neglect the adult they support on their own or with others.

The 6 Safeguarding Principles

The Care Act 2014 outlines the following principles that underpin all adult safeguarding:

Empowerment: people being supported and encouraged to make their own decisions and give informed consent

Prevention: It is better to act before harm occurs

Proportionality: the least intrusive response appropriate to the risk presented

Protection: support and representation for those in greatest need

Partnership: local solutions through services working with their communities- communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability: accountability and transparency in safeguarding practice

4. What do we mean by abuse?

- Abuse is an intentional or unintentional act that harms, hurts or exploits another individual/s. Abuse can take many forms, but no type of abuse is acceptable.
- Abuse can happen just once or many times; it can be done on purpose or by someone who may not realise they are doing it.
- It can happen anywhere including at home, in the community, in care homes or in day care centres or hospitals.

5. How to report abuse

Worried that an adult is at risk?

Report your concern

If you report a safeguarding concern you will be listened to, supported and involved in any decisions.

If you think that you, or someone you know, is being abused or neglected you can:

Call Care Direct on 0345 1551 007

OR

Email csc.caredirect@devon.gov.uk

(Monday-Friday 8am-8pm and Saturday 9am-1pm – outside of these hours or on bank holidays call 0845 6000 388 or email the address above)

Alternatively a safeguarding adult concern referral can be made to Care Direct using the referral form on the DSAP website: https://www.devonsafeguardingadultspartnership.org.uk/reporting-a-concern/

If it's an emergency, call 999

If it's a non-emergency, call 101

6. What happens when a Safeguarding Adults Concern is raised?

1. There are many reasons why a Concern might be raised. These reasons are explored with the referrer and the person at risk. Actions are taken to address the concerns.

2. Wherever possible, the adult will be contacted by the professional who has received the concern, to ask them about their situation and to find out what they would like to see done about it. Actions are then identified to achieve this wherever possible.

3. If no further action is needed as actions taken have addressed the concerns, the Safeguarding Adults Concern will be closed. If necessary, the Local Authority will decide to make further enquiries. The Safeguarding Adults Enquiry establishes the facts and works with the adult and those most close to them, to ensure both their safety and to resolve the issues putting the adult at risk.

7. Personal stories and good practice presented to the Board

Good Practice – Mr and Mrs Green (names changed to protect identity):

Mr and Mrs Green (pseudonym) are a middle-aged couple with two adult sons. In November 2019 Devon and Cornwall Police received a call from a neighbouring property reporting suspicious activity and potentially a break in progress at the home address of Mr and Mrs Green by a man.

Officers attended Mr and Mrs Green's property and met the man in question. He claimed to live at the address, which was later confirmed. He chose to climb out of the front window of the property and was detained by Police who were unaware that he had been spoken to. He continued to be abusive and threatening within sight and hearing of members of the public. He was subsequently arrested and taken to a local custody centre.

When the officers spoke to Mr Green he broke down in tears and disclosed that his son had been abusing him and his wife for several years. Mr Green disclosed that he had been subjected to a number of physical assaults, financial abuse, criminal damage and continuous verbal abuse. Much of this behaviour was accompanied with demands for money or demands for service (lifts etc). This contributed to a picture of coercive and controlling behaviour. Mr Green was able to show officers a log of incidents and CCTV from a camera he had installed in his house which showed the assaults. A highly detailed statement was taken from Mr Green with the emphasis on how his life had been affected by his son's behaviour. Mr Green also completed a risk assessment, which officers graded as high risk. Within this assessment, Mr Green disclosed that he had seen his GP as a result of how things were with his son, and he was now taking anti-depressants.

Mrs Green provided a comprehensive and detailed statement covering coercive and controlling behaviour from her son. He also repeatedly threatened to commit suicide or harm the dog. She was also assessed and was determined to be at high-risk. The son was further arrested in custody for coercive and controlling behaviour, assaults and theft. He was interviewed by officers, who were able to put overwhelming evidence to him in the form of CCTV and statements. He made a number of admissions and the officers took the case as a whole to the Crown Prosecution Service (CPS) for a charging decision. CPS decided to charge the son with coercive and controlling behaviour, the assaults, a theft and the S5 Public Order offence.

A Domestic Abuse Officer went to meet with Mr and Mrs Green at their home along with an Independent Domestic Abuse Advisor (IDVA). Arrangements were made to install an alarm within the property, to alert Police should their son turn up to the address. The son was given a Restraining Order for 5 years and was also given a 2-month prison sentence which was suspended for 18 months and a drug treatment and testing requirement. Significantly, these were the first criminal convictions he had been given. However, the following day he breached the Restraining Order by attending his parents address and was arrested again and charged with breaching the order. He was held in custody until 29th January 2020 when he was sentenced as follows:

- 3 weeks in prison, which he served on remand and a court surcharge of £122.00
- Breach of suspended sentence - total sentence 8 months imprisonment – suspended for 18 months – order extended by 3 months to 21 months. Drug rehabilitation requirement for 6 months. The restraining order was also extended to cover the whole of his parent's village.

On 7th January 2020, the case was discussed at a Multi-Agency Risk Assessment Conference (MARAC). It was confirmed the parents felt supported by the police and the IDVA.

Impact on Mr and Mrs Green

Mr and Mrs Green struggled to discuss the situation with each other, and Mrs Green continues to receive emotional support from the IDVA. Mr and Mrs Green have been away on two short breaks together since the order has been put in place feeling safe to leave their home. The older brother disclosed how difficult things had been for many years with his younger brother and he was always worried for Mr and Mrs Green when he was away at University. No further care or support needs have been identified and it is not known whether any other services have had any input with the family.

Previous police involvement.

Police had been called by Mr and Mrs Green numerous times since their son was 15. Numerous risk assessments were completed in 2016 and 2017 whilst the elder son was still a child, and these were passed to Children's Social Care. It was recorded that on one occasion he had told his family he would kill them one day. Children's services put some support in place and referrals were made to Children's Social Care exploitation teams and young people's addiction services. When he went missing, he would not engage in return home interviews. In 2017 a Problem-Solving Plan was implemented by police and for a short time he was engaged with Devon County Council's Youth Intervention Team.

What did we learn?

- Importance of an investigative mindset and culture of curiosity – across all agencies.
- Importance of detailed statements, especially victim personal statements re impact on convictions.
- Potential query re liaison with children's and adults' services – transition from childhood-adulthood – did any information exchange occur? Could police have referred directly to adult services or did police think this was done via risk assessment completion and referral?

Making Safeguarding Personal, which means finding out what those who have been abused wanted:

- The adult victims were listened to in detail and their thoughts/wishes considered at every step, as was their safeguarding.
- The safeguarding was done with the adult victims, not to them – e.g. consultation re bail conditions, alarm at their home etc.
- The outcome resulted in meaningful improvement in the lives of the victims and they felt less at risk of threat and harm.

Personal Story – John (name changed to protect identity):

Devon and Somerset Fire and Rescue Service received a referral from the ambulance service to carry out a Home Safety Visit as they had identified significant fire risks in John's (pseudonym) home.

The ambulance had attended John, who had experienced a fall within his property. They identified that John lived alone in an isolated location and that his property was very cluttered. There was evidence of alcohol use with vodka bottles lying around, although John denied that he was alcohol dependent. John was a heavy smoker and was suffering with poor mental-health.

The conditions within the property and the risks identified by the ambulance service are all significant fire risks which meant that John was at a higher risk of having a fire and it was therefore important that the fire service visited the property to carry out a Home Safety Visit.

The Fire Service attempted to visit the property to carry out a visit. During this initial visit there was no answer and they were not sure whether x was in the property, and they therefore felt it was not appropriate to enter the property. A month later, a further Home Safety Visit was carried out by two fire service Home Safety Technicians, which on this occasion was successful, and the following concerns were identified:

Fire risks
Concerns were raised that John was living alone in rural isolated property which was extremely cluttered with beer cans, food containers, and general waste). John had poor mobility and was a heavy smoker. There was also evidence of alcohol use and John advised he slept a lot of the time. He was also presenting in a low mood. He had no phone contact as phone line cut off by sister.

Additional risks
John advised that he was receiving no post as it had been redirected to his sister's house and John also indicated that his sister had cut off phone line. John advised he felt isolated and lonely (Information disclosed by John indicated there was an acrimonious relationship with his sister and this was contributing to his isolation). John disclosed he was experiencing significant illness and hadn't been taking medication and advised "he had nothing to live for." He had been told by his GP that if he stopped taking medication, he would have 3 – 6 months to live. John appeared to be self-neglecting, there was mouldy food and John was using bottles to urinate in as he had no energy to move to bathroom.

In addition to providing general fire safety advice the Home Safety Technicians discussed in detail support services that might be available to him and as John had advised he had a military background the technicians provided him with details around SSAFA (Soldiers, Sailors, Airmen and Families Association) and The British Legion. However, John had no phone access or internet to initiate contact, and he felt that because of this he would not be able to access help. John advised that he would like to move home, nearer shops and amenities and would like help with finances and housekeeping.

The Home Safety Technicians were concerned for John's welfare and his disclosure of his illness and non-adherence to his medication. They advised John that they would be making a referral to the fire service's safeguarding team to try and instigate some support for him, which he consented to.

Technicians phoned the safeguarding team due to their concerns about John who then followed up with a written referral which was sent to the Care Direct Team in Devon County Council Adult Social Care, who responded to say that a colleague from Adult Social Care would visit John later in the day.

The fire service safeguarding received feedback from Adult Social Care that there had been previous attempt to visit John had been made by a social worker which had been unsuccessful. This lack of contact and the fire services subsequent referral into Adult Social Care prompted an enquiry.

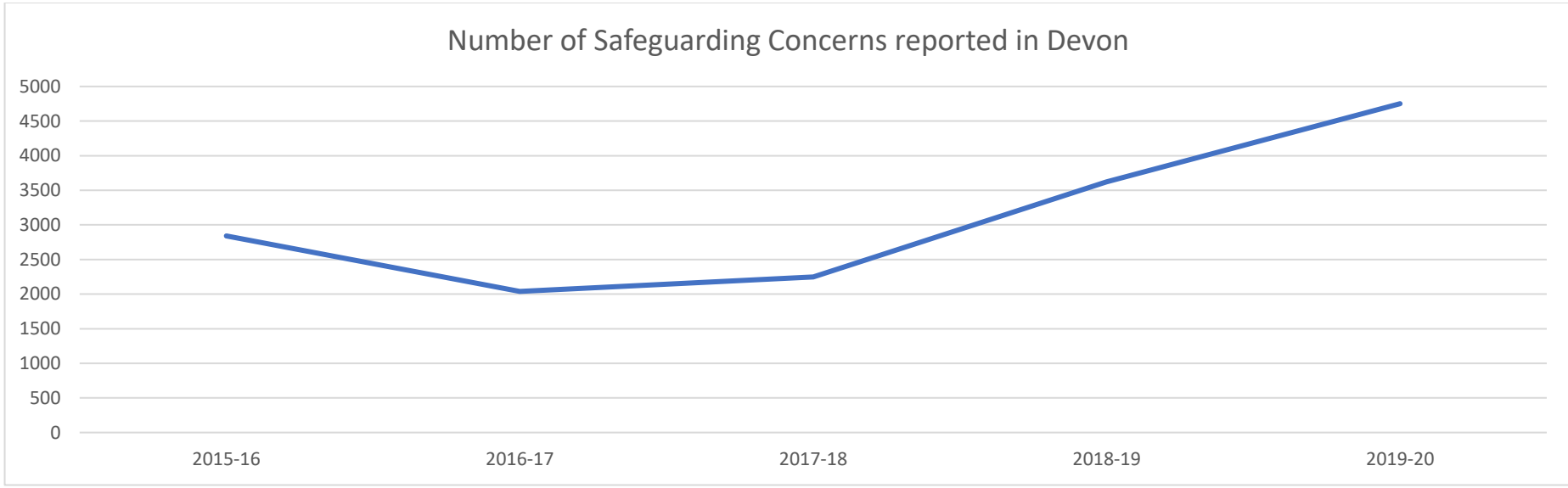
A plan of action was developed for John by Adult Social Care which involved trying to reconnect land line, engaging with SSAFA, contacting the council to discuss John's housing situation. John was also referred to mental health services to receive support.

John was re housed into supported accommodation which meant that he had support for his health and care needs.

Summary/conclusion

John was vulnerable and was experiencing significant self-neglect, poor physical and mental health issues and lived in accommodation that was presenting significant fire risks. John's situation was exacerbated by living in an isolated property and his acrimonious relationship with his sister. It appeared that agencies had tried to engage with him previously however his isolation and lack of phone contact and post meant it was difficult for contact to be made with him. The fire service's persistence in carrying out the second visit after the first visit was unsuccessful meant that the home safety technicians were able to engage with John and provide invaluable fire safety advice as well as providing information around other support agencies. The fire service's referral into Adult Social Care which highlighted the self-neglect that John was experiencing in addition to the fire risks prompted further action from adult social care who then developed a plan with John to start initiating further help and support.

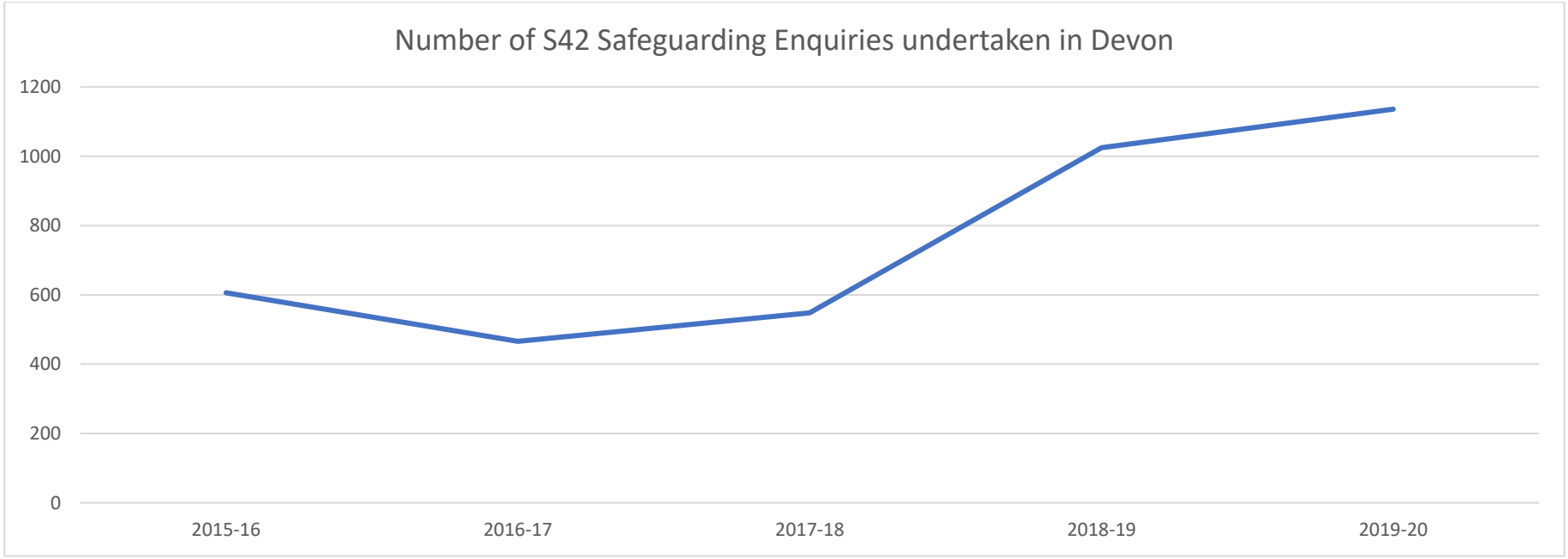
8. Safeguarding activity in Devon



Since the Care Act came into force in April 2015, the number of adult safeguarding concerns reported began to increase and then dipped in 2016-17 to 2017/18.

Devon Safeguarding Adults Board (DSAB) undertook a Deep Dive Audit to provide further analysis. It was identified that a proportion of safeguarding issues were being managed without reporting the incident formally to Devon County Council (DCC) as a safeguarding concern. This did not mean that the concerns were not being responded to, but the findings indicated that they were being directed to more appropriate pathways e.g. to receive an assessment of needs.

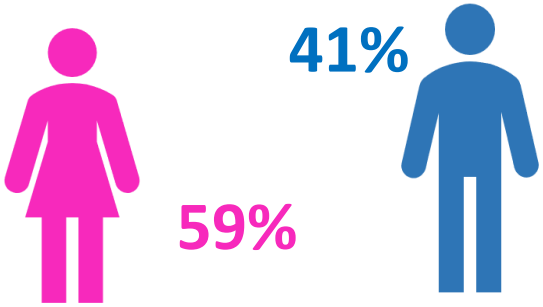
Since the 2018 Deep Dive Audit our trend changed. In 2019/20 the number of concerns reported has continued to significantly increase. Over the last 12 months Devon has seen a **31% increase** in Concerns raised bringing us closer to the Local Authority comparator group average in 2018-19. However, we still experienced a lower rate of concerns relative to the population in 2019-20 when compared to our comparator group Local Authorities and England rate in 2018-19 (2019-20 benchmarking not yet available).



Since the Care Act came into force, the number of section 42 safeguarding enquiries (concerns that meet the threshold for further investigation) decreased but significantly increased in 2018/19 and continued to increase during 2019/20.

However, we still experienced a lower rate of s42 enquiries relative to the population in 2019-20 when compared to the comparator group Local Authorities and England rate in 2018-19 (2019-20 benchmarking not yet available).

Devon County Council (DCC) understanding of increased numbers of concerns and enquiries.
DCC proactively worked with Community Health and Care Teams to ensure that safeguarding concerns were being appropriately raised; promoting the safeguarding process as a positive way of getting better outcomes for people at risk of harm. The upward trend indicates that this has had a positive impact.



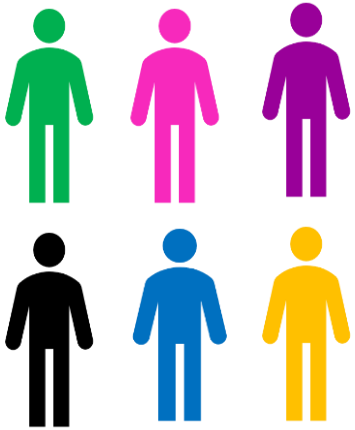
59% of individuals involved in safeguarding concerns in 2019-20 were female. This is consistent with previous years and the national trend. This is disproportionate to the overall, although not necessarily the elderly population in Devon, which the majority of our safeguarding activity relates to.

Approaches to safeguarding should be person-led and outcome-focused. In Devon, people were asked about their desired outcomes in 76% of safeguarding enquiries in 2019-20. This is an increase on the previous year.

47% of enquiries of abuse or neglect pursued in 2019-20 took place within the person's own home. This is consistent with previous years but a higher proportion than the national picture (45% in 2018-19).

A higher proportion of enquiries were recorded in care homes in 2019-20 than the previous year but remains significantly below the national picture in 2018-19.

The same level of enquiries were recorded in hospital settings in 2019-20 to the previous year and bringing us slightly under the national picture in 2018-19.

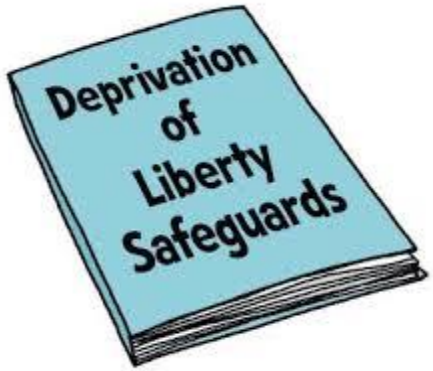


86% of individuals involved in safeguarding concerns in 2019-20 recorded their ethnicity as white. The proportion of people in Devon who describe themselves as white British increases with each age group and safeguarding data on ethnicity should therefore be considered in conjunction with data on age. This data shows that the majority of Safeguarding concerns in Devon relate to individual's aged 65+.

9. Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (2005).

The safeguards apply to people over the age of 18 who lack mental capacity to consent to their care and treatment arrangements in a hospital, or a residential / nursing care home setting.



Sometimes a person may need high levels of support and supervision to maintain their wellbeing. The level of care and support provided may amount to a deprivation of their liberty. The DoLS are designed to ensure that in those circumstances the person's human rights are protected. The person will have the right to representation, any authorisation should be monitored, a review can be requested at any time and the person has the right to appeal to the Court of Protection.

People can also be deprived of their liberty in other settings such as supported living or their own home. However, in these situations any deprivation of the persons liberty can only be approved by the Court of Protection and applications for authorisations will need to be made to the Court.

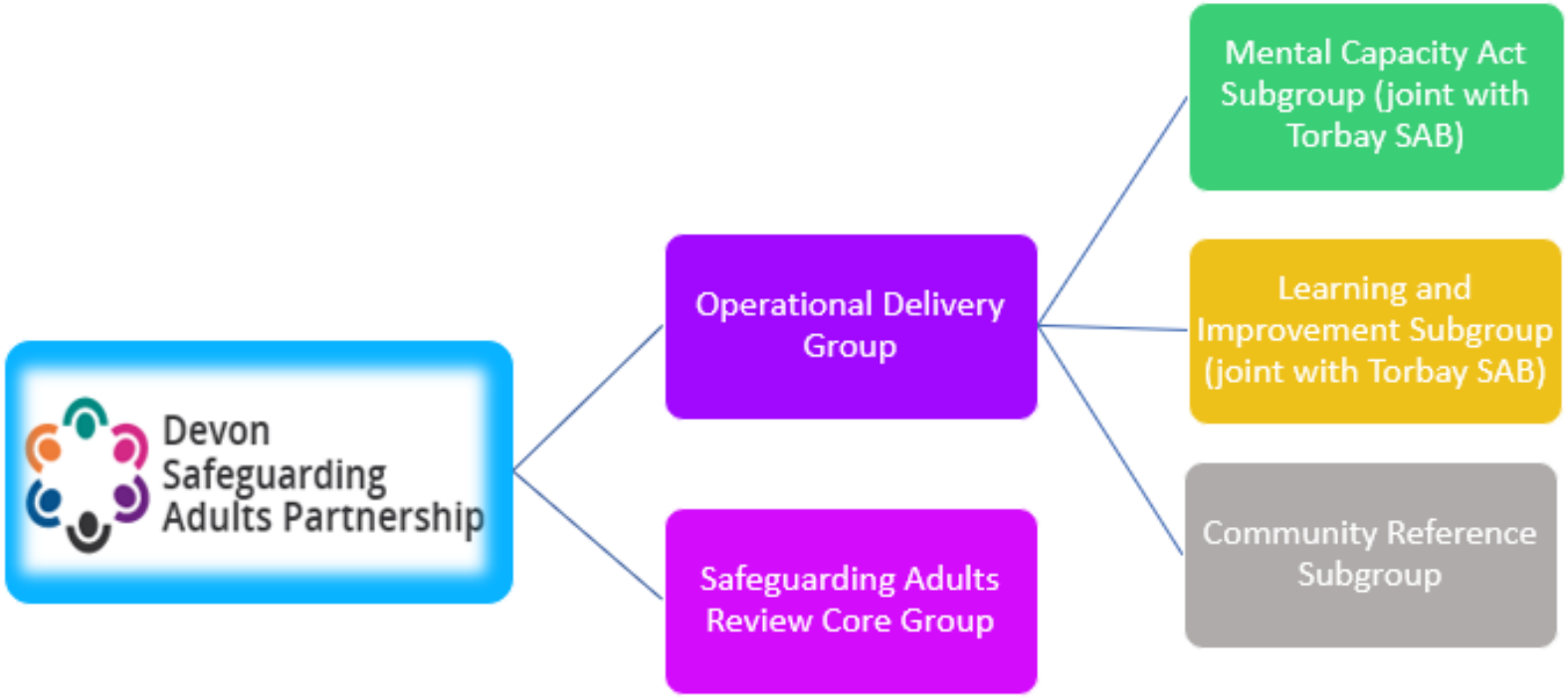
The DoLS scheme has been criticised for many things including being overly bureaucratic and costly. These criticisms have been exacerbated by the increase in demand for authorisations since the Supreme Court judgment of 2014 in the case now popularly known as 'Cheshire West', which effectively lowered the threshold for eligibility and significantly increased the volume of requests. The workload demands in relation to the DoLS remains a challenge, nationally and locally.

In March 2014, a House of Lords Select Committee published a detailed report concluding that the DoLS arrangements were "not fit for purpose" and recommended that they be replaced. The Mental Capacity (Amendment) Act 2019 received Royal Assent on 16 May 2019. The Deprivation of Liberty Safeguards legal framework was due to be replaced by the Liberty Protection Safeguards (LPS) on the 1st October 2020. Due to the impact of Coronavirus it is likely that LPS will be delayed. The Deprivation of Liberty Safeguards legal framework was due to be replaced by the Liberty Protection Safeguards (LPS) on 1 October 2020. Due to the impact of Coronavirus, the government recently announced that the LPS will now be coming into force in April 2022.

10. Introduction to the Partnership and its subgroups

The Devon Safeguarding Adults Partnership is a statutory board set up in accordance with Section 44 of the Care Act 2014.

Its main objective is to assure itself that local safeguarding arrangements and partners act to help and protect adults at risk and those most vulnerable, in its area. To help the Partnership achieve this objective, there a number of focused subgroups.



11. The work of the Safeguarding Adults Partnership subgroups

Safeguarding Adults Review Core Group (SARCG)

Safeguarding Adults Boards are required to consider commissioning Safeguarding Adults Reviews (SARs) by the Care Act when:

- An adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- An adult is still alive but has experienced serious neglect or abuse and there is concern that partner agencies could have worked more effectively to protect the adult.

The purpose of a SAR is to identify whether there are any lessons to be learnt from a person's experience about the way in which organisations work together to safeguard adults at risk. A SAR process should promote effective learning and improvement action to prevent future deaths or serious harm occurring. The main objectives of a SAR are:

- To review the effectiveness of procedures,
- To inform and improve local inter-agency practice,
- To improve practice by acting on learning, and,
- To highlight good practice.

The purpose of having a SAR is not to reinvestigate or to apportion blame. It is an opportunity to derive learning for all agencies involved and to make changes to practices in the future.

In Devon, the Board delegates the work of SARs to the Safeguarding Adult Review Core Group (SARCG) which organises and delivers them ensuring that they are presented to the Board for final agreement, discussion, dissemination of key learning and review amongst all partner organisations. The SARCG is made up of key individuals from a variety of partner agencies in Devon.

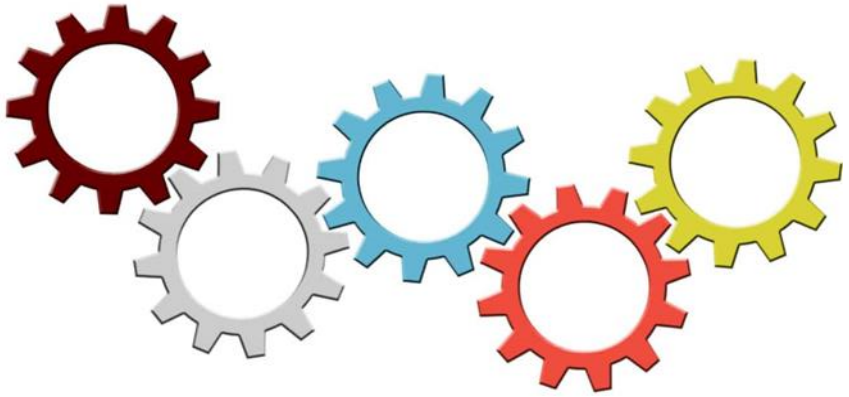
In 2019/20, 5 SAR's were completed, which aim to improve the quality of lives of people with care and support needs in Devon. Details of the reviews published in 2019/2020 are set out later in this report.

Operational Delivery Group (ODG)

The Operational Delivery Group (ODG) is responsible for delivering the objectives set out in the DSAP Business Plan. The ODG considers multi-agency processes across Devon to ensure that there is effective communication and working practices in place that contribute to protecting members of the public from potential abuse.

The ODG works closely with the other sub-groups and will ensure that any potential duplication is minimised.

The ODG is the engine room of the Board and drives forward actions by working together with system wide partners. The DSAP subgroups report directly to the ODG thus ensuring close communication and effective collaboration is in place.



Over the last year the ODG has focused on:

- Developing a tool to capture feedback from people who have lived experience of safeguarding.
- Developing an escalation protocol for use in 'live situations' where there are disagreements regarding the course of action or decision making.
- Developing an adult People Position of Trust Protocol to provide a framework and process for responding to allegations and concerns against people working with adults with care and support needs.
- Developing an Adult Safeguarding Public Awareness Campaign.
- Undertaking a data analysis examining seven insights offered from quantitative and qualitative information in the National Safeguarding Adult Collection and Service User Survey for 2018/19 to identify potential areas for further improvement Safeguarding Practice in Devon.

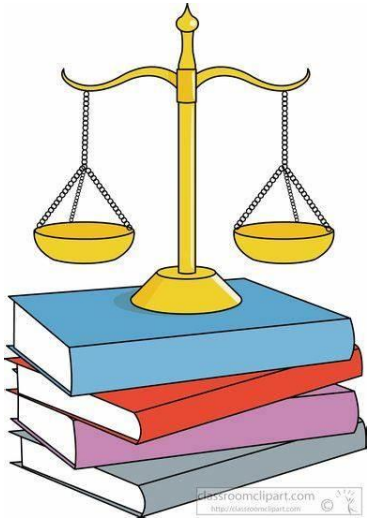
The Mental Capacity Act (MCA) Subgroup

The Mental Capacity Act (2005) is a legal framework designed to empower and protect the rights of people who may lack the mental capacity to make some of their own decisions.

Over the last year the MCA Subgroup, (a joint sub-group with Torbay Safeguarding Adults Board), started to explore the impact on partner organisation s of the transfer from the Deprivation of Liberty Safeguards legal framework to The Liberty Protection Safeguards. In addition, the subgroup commenced work on issues relating to restriction, restraint and seclusion in practice.

All of the above focuses on increasing legal literacy across front line staff groups to protect the wellbeing and rights of people living in Devon and Torbay.

This work was naturally all paused as a result of the Covid-19 pandemic and will be resumed as soon as possible.



Learning and Improvement (L&I) Subgroup

The joint Devon and Torbay Learning and Improvement Subgroup has continued to focus on five work streams:

- Multi-Agency Case Audit
- Training and Competency framework review
- DSAB commissioned training
- Embedding Learning into Practice
- The interface between Domestic Abuse and Sexual Violence with Safeguarding Adults.

The majority of work streams are set out within the strategic business plan of the Devon Safeguarding Adult Boards.

Multi-Agency Case Audits findings are discussed within the Learning and Improvement Subgroup and the learning from the case audits have resulted in some specific work for the Devon Safeguarding Adults Partnership, including an escalation protocol for professional disagreements, development of a Risk Assessment tool and Devon and Cornwall police are currently reviewing the Information Sharing Agreement.

The Joint Safeguarding Adults Training Strategy 2019/2020 has been approved with its implementation a core focus for 2020/2021.

Community Reference Group (CRG) Subgroup

The Community Reference Group includes people recruited from local Voluntary, Community and Social Enterprise (VCSE) and people with lived experience of safeguarding investigations across the DSAP area.

The CRG has grown from strength to strength undertaking co-production, consultation and engagement work. Methods to gather intelligence has included focus groups, on-line and telephone surveys. We are now providing new ways for people who have been through Safeguarding processes to input directly into the CRG work. The CRG continues to provide feedback on key priorities for future work, raised awareness of safeguarding and provided two-way communication channels with representatives within and across the VCSE.

12. What have we done in the last year?

The Devon Safeguarding Adults Partnership's Strategic Plan for 2019/2020 focuses on four key priorities. These priorities have guided our focus through the last year and helped to shape our practice.

Our 2019/20 priorities were:

1. Finding the right solution at the right time for the most at-risk people.

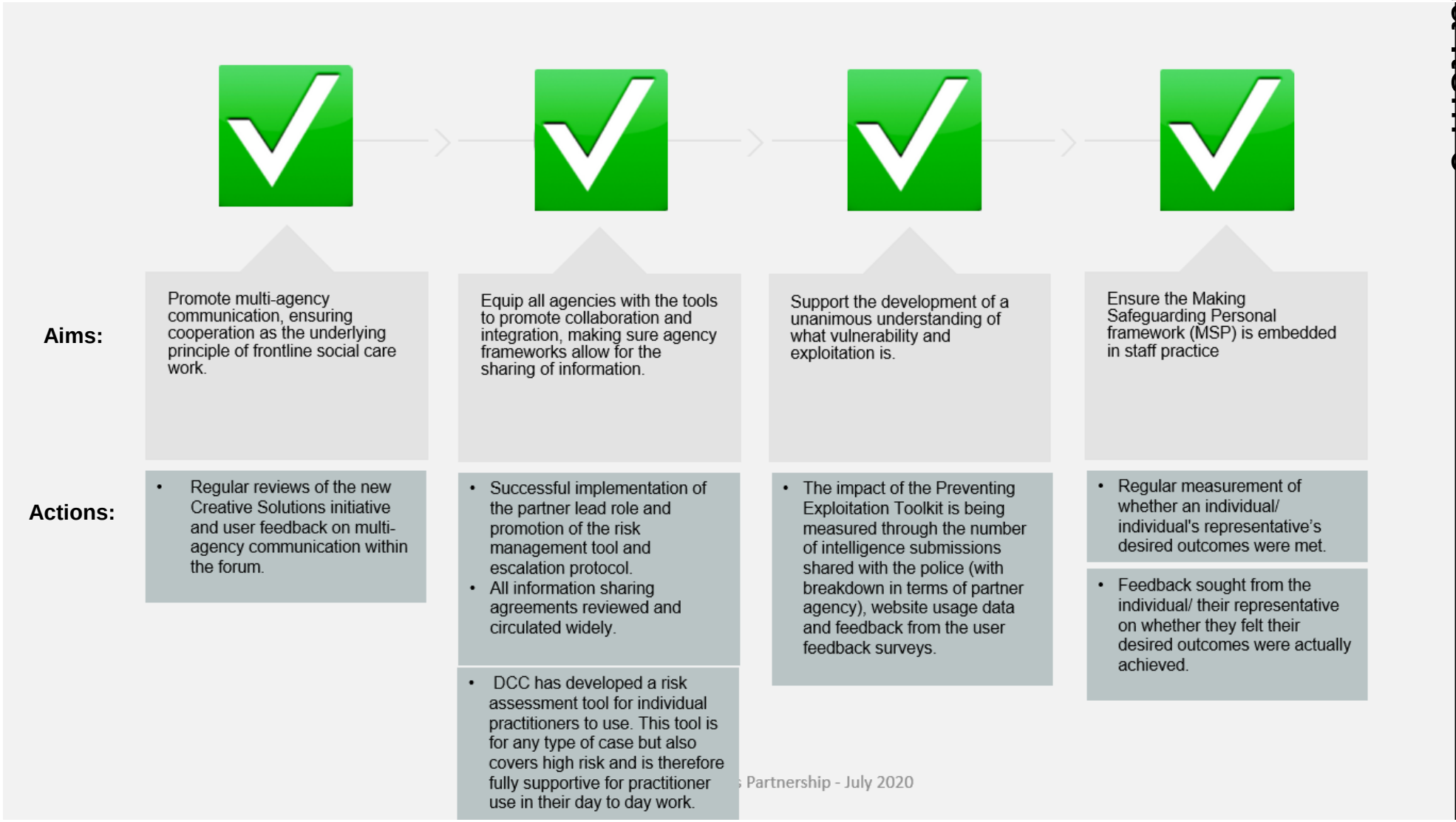
2. Increasing the public awareness of Safeguarding

3. Improving the experience of children transitioning (moving) to adult services, working together to ensure they remain safe.

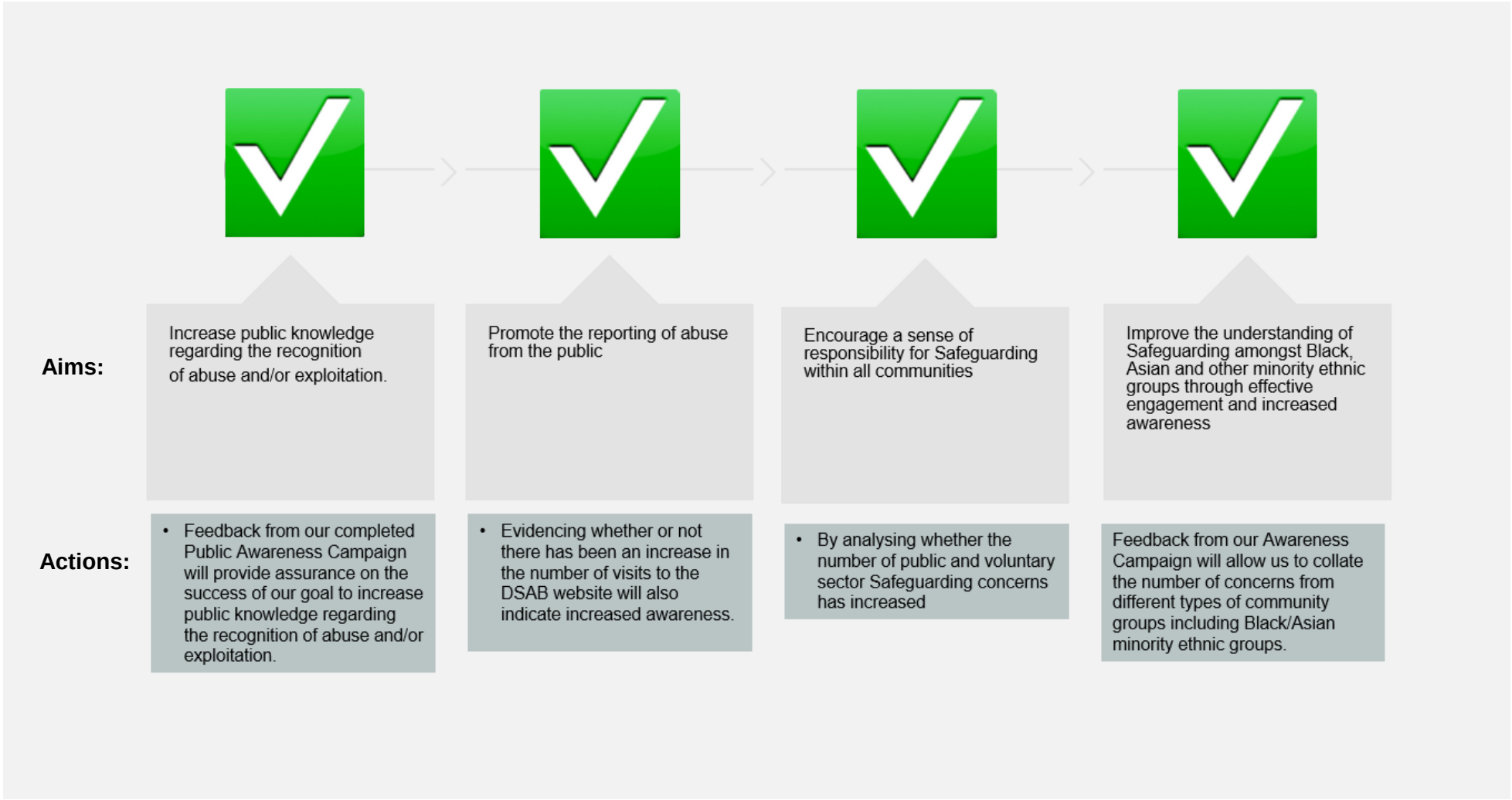
4. Increasing our staff understanding of the law in relation to Safeguarding Adults.

How have we addressed these?

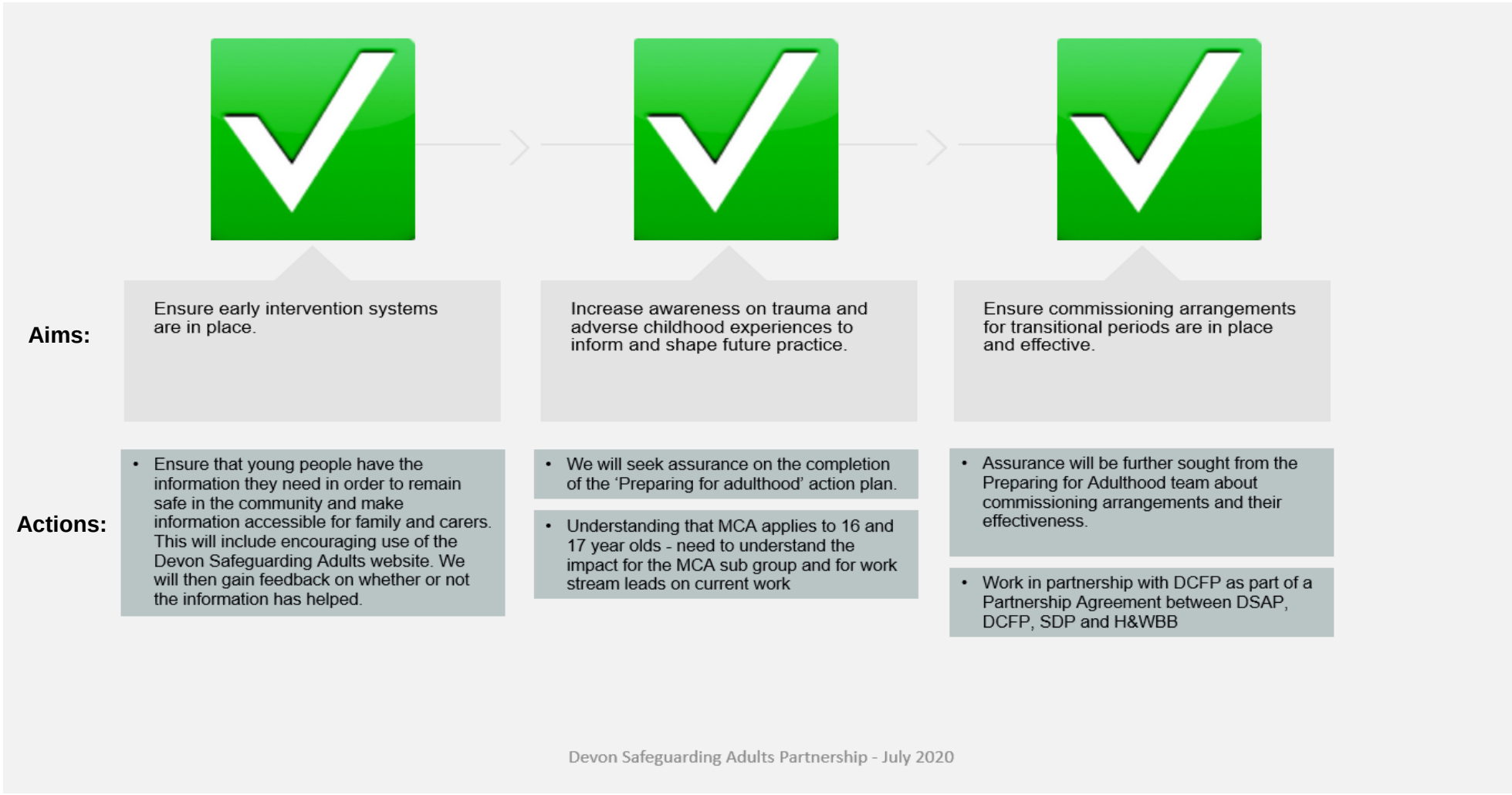
Priority 1- Finding the right solution at the right time for the most at-risk people.



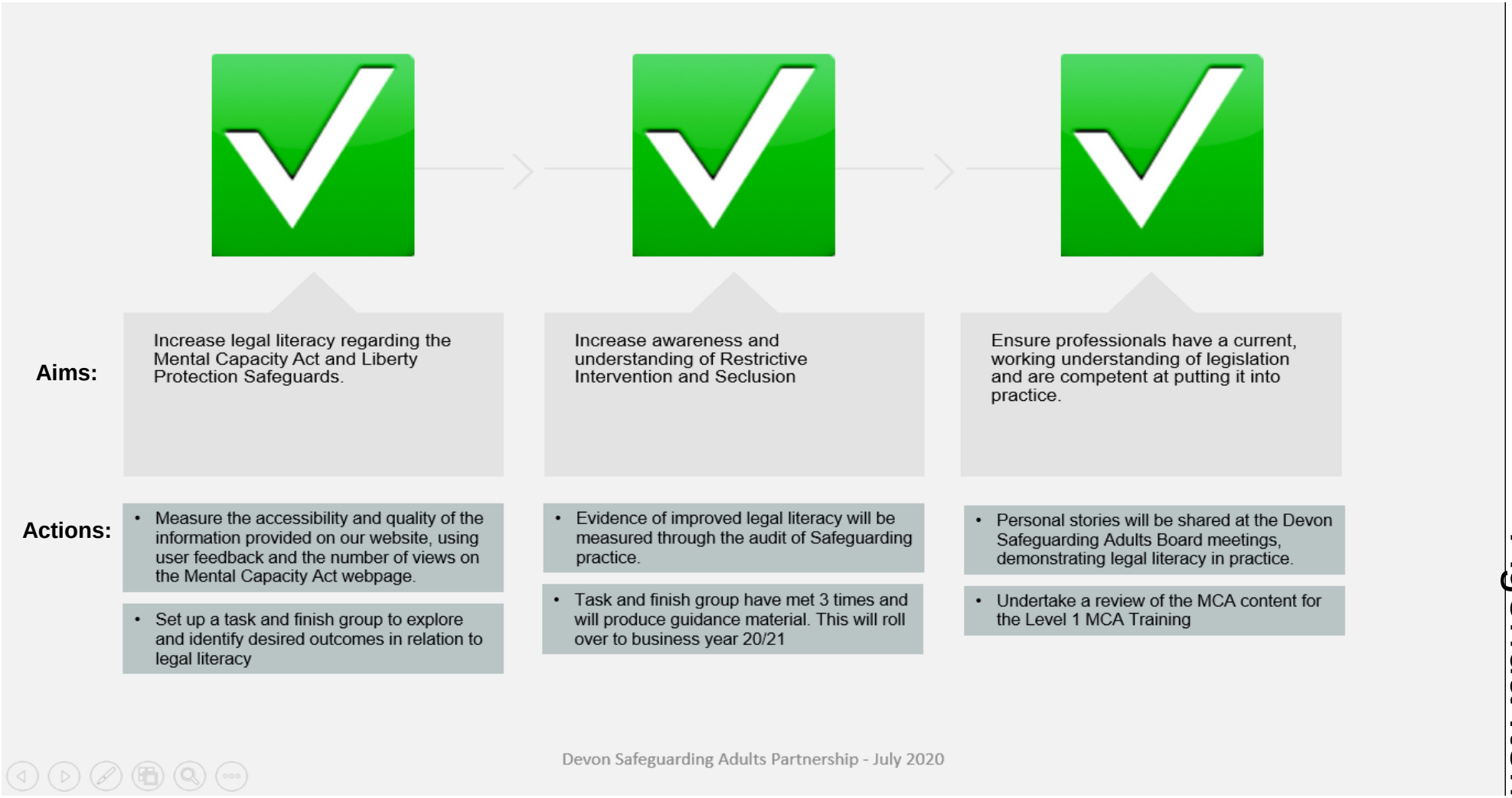
Priority 2- Increasing the public awareness of Safeguarding



Priority 3 - Improving the experience of children transitioning (moving) to adult services, working together to ensure they remain safe.



Priority 4 - Increasing our staff understanding of the law in relation to Safeguarding Adults.



13. Learning Events

Here are some examples of learning activity that partners of the DSAP undertook in 2019/20.

Northern Devon Healthcare NHS Trust (NDHT):

- In–Trac Safeguarding Supervisors Training (internal but with invitation to social care colleagues).
- Monthly face to face Level 3 Safeguarding Adults and MCA training (External and Internal agencies).
- Domestic Abuse '16 days of Action' multiple communications on website and internet.
- Domestic Abuse Level 3 provided by Pathfinder trainers (Internal).
- Domestic Abuse Level 3 specific to Maternity, Emergency Department and Sexual Health (Internal).
- Safeguarding Newsletters biannually sent to all Trust staff.
- Tailored training to wards and teams e.g. dental team and pain team, hospital wards, departments, community teams, endoscopy.
- Presentations at Big Gov.
- Teaching Medical staff.

Devon Partnership Trust (DPT):

- In–Trac Safeguarding Supervisors Training (internal but with invitation to social care colleagues).
- Monthly face to face Level 3 Safeguarding Adults training (External and Internal agencies)
- Monthly face-to-face Level 3 MCA & DoLS training. DASH training.
- Level 4 SA undertaking and leading individual s42(2) enquiries - delivered to over 120 clinicians.
- Supported clinicians to access and complete CRAFT training
- Tailored training to specific groups - e.g. professional boundaries/ legal literacy / assessing capacity in relation to sexual wellbeing
- Quarterly Safeguarding Bulletin includes learning from enquiries/safeguarding reviews
- Presentations to Medical Advisory Committee
- Bespoke training for Trust Board Members
- E-learning is available covering a range of modules

Devon County Council (DCC)

- Level 1 E-Learning Awareness of Safeguarding Adults for in house provider service and care management staff
- Level 1 E-Learning Awareness of MCA for in house provider and care management staff
- Monthly face to face 2-day MCA training for care management staff
- Twice Monthly face to face Level 2 Responding to Safeguarding Concerns for all care management staff
- Twice Monthly access to Level 2 Responding to Safeguarding Concerns for in house provider services (accessed through the partnership board)
- Twice Monthly access to Level 2 MCA training for in house provider services (accessed through the partnership board)
- Monthly face to face Level 3 Participating in Safeguarding Enquiries for qualified OT and SW
- 3 Courses of Level 4 (Part A) Leading Adult Safeguarding Enquiries; Individual (accessed through the Partnership)
- 2 Course of Level 4 (Part B) Leading Adult Safeguarding Enquiries: Whole Service (accessed through the Partnership)
- 8 x half day Us Too Domestic Abuse & Women with Learning Disabilities/Autism training
- 1 Course on Drug and Alcohol Training as scoping exercise more planned in next financial year
- Delivery of bespoke additional training and development session for Newly Qualified Social Workers for each cohort running two a year
- Part 1 Understanding Domestic Abuse – provided by the Devon Children's & Families Partnership
- Part 2 Responding to Domestic Abuse provided by the Devon Children's & Families Partnership
- Part 3 Challenging Domestic Abuse provided by the Devon Children's & Families Partnership
- Multi-Agency Safeguarding & Child Protection (Group 2 Core) E-Learning provided by the Devon Children's & Families Partnership
- Embedding of prevent training strategy in existing training and working towards e-learning package for level 1.
- DCC Self-Neglect workshop held with representation from across all CHSCTs within Devon to discuss and develop an action plan on how DCC can improve their responses to self-neglect issues.

Royal Devon and Exeter NHS Foundation Trust (RD&E)

- Safeguarding newsletters monthly to all staff, emailed, on Trust intranet, staff meetings, Comm Cells and disseminated also via the governance meetings
- In-house training in safeguarding adults, Prevent and domestic abuse, and induction for all staff. Training was face to face for induction but is now given via eLearning with Lanyard cards given out on practical steps for making referrals and contact for advice.
- Social media and intranet awareness raising = 16 Days of Domestic Abuse and Safeguarding Weeks.
- Bespoke training in MCA and Domestic Abuse where requested or when needed.
- Domestic Abuse eLearning being reviewed using Pathfinder Toolkit.
- DA training given to line managers, following changes to HR documents – staff now asked routinely about DA on exit interviews, return to work after sickness and in appraisal.
- Presentations to Governance Committee
- "Was not Brought" video shared widely through the governance structure
- Formal training resources sent out and informal training of staff on the wards and in community following contact on phone/email/face to face.
- Regular communication with staff on intranet and "Must reads", with regular updates online during Covid pandemic and telephone support for staff 7 days per week during pandemic March – May 2020.
- Trust has been shortlisted for HSJ Patient Safety Award for "Multi-systems approach to domestic abuse".
- RD&E Head of Safeguarding led on safeguarding processes for Nightingale Hospital in liaison with Trusts across the region offering support and training during this process

NHS Devon Clinical Commissioning Group (CCG):

- The CCG held a Primary Care Safeguarding Conference in November 2019 and a Domestic Violence Conference in March 2020
- A variety of safeguarding updates covering safeguarding adults, domestic violence and abuse, exploitation and modern slavery and learning from SARS are included in the GP and staff newsletters.
- Two Executive level Safeguarding Adult training sessions have been delivered to the Governing Body
- A training needs analysis of safeguarding adults has been updated, along with a review of the Level 2 safeguarding training that incorporates adults, children and children in care.
- CCG safeguarding adult team have attended a variety of training sessions including L4 DSAB training and Clinical Leadership in Safeguarding
- The safeguarding adult team attends TSAB Safeguarding Adult Forums, for example Operation Emotion - The Prisoner of Silence regarding a local project to support men who have experienced historical abuse.
- CCG staff receive a Safeguarding letter in induction for level 1 & eLearning is mandatory for those staff requiring Level 2.
- Level 3 SGA training is offered via external providers training and NHSE Level 3 SGA blended training via NHS Futures.
- Staff are also offered training appropriate to their job role to level 4 via the Local Authority, with an access to an inhouse package subject to frequency of local authority training.

University Hospitals Plymouth MHS Trust (UHPNHST):

- MCA training is offered via on-line and specific face to face training to international nurses, clinical apprentices, ED and ICU staff.
- Prior to COVID we had trained over a 1,000 staff in DoLS and MCA directly, this has been on hold due to COVID and will be re-introduced in September 2020.
- Tailored training for MCA, DoLS and Safeguarding Adults is available as required to wards and departments
- Level 3 Safeguarding Adult training plans are in place, launch has been delayed due to COVID and is expected to be fully operational in September 2020
- Safeguarding Newsletters are available to all Trust staff and frequent updates made available via Trust newsletters, this included COVID related safeguarding issues and information regarding Domestic Abuse

14. Strategic Priorities and Partners' Key Achievements 2019/2020

Each year DSAP sets out key priorities that it will focus on in the next year to make sure that adults at risk of harm and/or are vulnerable are safeguarded to reduce the risk of harm. These priorities are constructed collectively by the board members.

For 2019/20, these priorities were:

1. **Finding the right solution at the right time for the most at-risk people**
2. **Increasing the public awareness of Safeguarding**
3. **Improving the experience of children transitioning (moving) to adult services, working together to ensure they remain safe**
4. **Increasing our staff understanding of the law in relation to Safeguarding Adults.**

National Probation Service (NPS

Priority 1:

- Safeguarding supervision is held in relation to service users with complex needs. In areas where there is a 'Complex Lives Team', referrals are made in to provide a holistic response. Probation have also made use of the Creative Solutions panels and also had multi-agency meetings to discuss services users who are vulnerable.

Priority 2:

- The NPS does not have a specific role in increasing the public awareness of Safeguarding but has promoted safeguarding awareness amongst their staff and amongst those who use their services.

Priority 3:

- We have now embedded probation officers in the Youth Offending Team (YOT) who oversee the transitions between children's services to adult services. This aids the transfer of pertinent information and risk assessments and supports the transitioning young person appropriately. The Probation Officer spends 2 or 3 sessions working with the young person to help them understand the differences between the services and takes them to the adult service for a tour and 3-way meetings with their Probation Officer.
- Quarterly transitions meetings are held with managers and practitioners from the NPS and the YOT to discuss up and coming transitions.

Priority 4:

- Staff have statutory training in adult safeguarding which is completed at required intervals. This covers the required understanding of the law at Alerter level.

Devon and Cornwall Police (DCP)

Priority 1:

- Better utilisation of the Vulnerability Screening Tool (ViST) to identify vulnerable people in the community. Supervisors within the Central Safeguarding Team quality assure the ViST's to seek improvements and identify training needs.
- Creative Solutions Forum which looks at innovative ways to deal with complex issues facing vulnerable adults. Cases are discussed and interventions made as required.
- Problem Solving Plans held within vulnerable adult enquiries are progressed by specialist problem solvers whose role has been specifically designed to resolve complex issues involving vulnerability.

Priority 2:

- DCP has promoted all literature and campaigns provided to us from the partnership. This is also reinforced with updates on legislation through ongoing training processes. DCP provides information on Adults at Risk through the external website, this includes a section on types of domestic abuse, self-neglect, Prevention, Fraud and County Lines for example.
- Our Serious Case Review team contribute to Safeguarding Adult Reviews to gain learning and prevent further instances occurring.

Priority 3:

- DCP works with children's services to design and embed the Adolescent Safety Framework, launched on 01/11/19, providing enhanced identification of children at risk, utilising relevant interventions should these children become known to adult services.
- Anyone within partner agencies can use the Partnership Information Sharing Portal on the DCP website to share information about a child, vulnerable adult or any other information that will enable police to protect a vulnerable individual.
- Staff within the Public Protection Unit attend Child Safeguarding Partnership meetings in addition to Adult Safeguarding meetings.

Priority 4:

- Police new recruits now receive a more detailed programme around vulnerable adults and recognising their vulnerabilities and risk factors (including self-neglect). The ViST training has been delivered to all operational police staff.
- Training is currently being developed for Detectives within the Public Protection Unit (PPU) who deal with Adults at Risk. A working group has been established to develop a training package that will be delivered to PPU and eventually all front-line Detectives.
- Work is ongoing to develop an Adults at Risk training package to be delivered to all frontline staff in Autumn 2020

HMP Exeter

Priority 1:

- This Safeguarding Strategy is used to support the reduction or removal of identified risks and equip professionals with the knowledge to protect the residents in our care, visitors and families at risk. Local policy advocates swift and personalised safeguarding responses, ensuring full involvement of those at risk/ their representatives during the process.
- Services to those individuals who may have Safeguarding needs or require additional support is managed through the Safer Custody department. A weekly Safety Intervention Meeting takes places to manage those at risk of harm to themselves or others.

Priority 2:

- Where a Safeguarding concern has been reported about the safety of an adult at risk, any member of staff may make a referral. This encourages 'a whole prison' approach to improving our service delivery.
- Information is visibly displayed around the Prison and our comprehensive safeguarding policy is shared with all staff. Anyone recognised as being vulnerable and who may need assessment for social care will be subject of a referral through to Devon County Council Adult Social Care. Safer Custody staff will offer guidance as well as ensuring that the referral is passed to the most appropriate person for an assessment.
- Safeguarding is everyone's business and the Prison operates zero tolerance of abuse and/or exploitation of any prisoner, particularly adults at risk. The Prison has robust safeguarding arrangements, integral to its 'duty of care' to ensure that 'prisoners, particularly adults at risk, are provided with a safe and secure environment which protects them from harm and neglect.'

Priority 3:

- N/A – HMP Exeter does not have any men under the age of 18 years old within our care.

Priority 4:

- HMPPS have adopted the use of an electronic based learning aids to advise all staff of their responsibilities surrounding safeguarding issues within the custodial environment.
- All staff are briefed on the Care Act 2014 which underpins our local operating procedure, during initial induction.
- Throughout 20/21 HMP Exeter will increase staff's understanding of the law in relation to Safeguarding Adults through the use of staff briefings and information sharing, to improve awareness and knowledge for all.

Devon County Council (DCC) Adult Social Care

Priority 1:

- DCC has developed a risk assessment tool for practitioners to use to support in assessing and responding to risk. The DSAP People in Position of Trust (PiPoT) protocol provides a process for dealing with people in position of trust referrals.
- DCC is engaged in the creative solutions: doing what matters forum and steering group.
- DCC has strengthened its training offer to ensure complex case studies are explored, enabling practitioners to reflect and consider creative responses to high risk, complex safeguarding work.

Priority 2:

- DCC is regularly attending the provider engagement network to share learning regarding safeguarding adult work and to update regarding any policy or practice changes. Providers can feedback their experience of safeguarding and explore any areas which remain confusing i.e. when is a concern a concern (part of the national ADASS work).
- DCC is aware of the upcoming DSAP public awareness campaign (due to go live in February 2020 delayed due to COVID) and will proactively support this. DCC continue to proactively explain and support members of public about safeguarding during contacts.
- DCC have reviewed our outcome letters to support better understanding regarding both the outcome and actions taken.

Priority 3:

- DCC is working in partnership with Children's Services regarding the development of the adolescents at risk framework and have a team supporting those who are preparing for adulthood.
- DCC provides e-learning training on child protection and think family training is embedded within safeguarding training.
- DCC is working in collaboration with Devon Children and Families Partnership to make Domestic Violence training available to staff.

Priority 4:

- Staff are trained in alignment with the Intercollegiate document at level 2 for all staff and level 3 for qualified staff, this training covers the law in relation to safeguarding. DCC staff receive Mental Capacity Act Training. MCA is also covered within our safeguarding training offer, ensuring that staff understand how the MCA relates to their statutory duties around safeguarding.
  The Local Authority is additionally scoping out the availability of legal literacy training.

NHS
Devon
Clinical Commissioning Group

Devon Clinical Commissioning Group (CCG)

Priority 1:

- The increased capacity of the safeguarding adults' team has enabled the team to meet regularly with health providers to support them. The team has worked with providers to complete the performance audit tool, which is then incorporated into the multi-agency case audit report. The CCG safeguarding team has increased the profile of safeguarding within the CCG's quality assurance processes. This has included closer working relations with the Patient Safety Leads with the outcome of timely responses to concerns regarding quality of care.

Priority 2:

- The CCG safeguarding team supports the Devon Safeguarding Adults Partnership (DSAP) in developing public campaigns. We forward safeguarding communications, public awareness campaigns and information from DSAP, NHS England & Improvement, Community Safety Partnership and other partners for dissemination.
- The safeguarding page of the CCG website links to the DSAP website. The communications sent to CCG staff are tailored, as most staff are non-clinical, with the aim of achieving wider awareness.

Priority 3:

- The CCG safeguarding adult team and children's team work closely to ensure awareness and monitor issues affecting both adults and children. The team works closely with CCG commissioners to ensure that a seamless transition from child to adult services continues to be developed. Additionally, the safeguarding adult team, including the Mental Capacity Act Lead, works closely with the Complex Care Team supporting those young people who are transitioning from children to adult services.

Priority 4:

- The CCG safeguarding adult team, including the Mental Capacity Act Lead works closely with CCG commissioners to ensure both CCG and NHS providers have appropriate measures in place to support staff with understanding their legal requirements.
- Following identification of a development need for CCG commissioners, in relation to both leading and participating in Safeguarding Enquiries (Section 42.2 Care Act), the CCG safeguarding adult team has developed a bespoke Level 4 "Leading an enquiry" training package which will be rolled out in 2020 -2021

Royal Devon and Exeter NHS Foundation Trust

RD&E Hospital

Priority 1:

- A video for staff entitled “Was not brought” was developed to highlight that people may not be attending clinics due to the inability to get there, as opposed to an unwillingness to attend. The video helps staff think about the broader needs of the patients.
- Collaborative working with the ward staff and community staff, facilitated at times by the safeguarding team helps find the right solution at the right time. Integration of services in many departments have produced robust methods of making sure people susceptible to particular risks are cared for holistically.
- Domestic Violence awareness has increased with new forms being used prompting staff to ask patients and for staff to address with colleagues at appraisal and on return to work after a period of leave.

Priority 2:

- RD&E has had posters and leaflets in prominent places including in different languages, particularly to highlight human trafficking, modern slavery and ‘County Lines’. Domestic Violence information stickers are on all toilet doors (for patients, staff and visitors)
- A safeguarding adult leaflet has been developed to give people going through the safeguarding process, and their families, more information. It also gives people permission to ask questions and feel a part of the process

Priority 3:

- We work as an integrated safeguarding team, although there are subgroups for adults and children. The Trust has a dedicated Paediatric Liaison and Transition Nurse who has met with the chairs of the adults and children safeguarding groups.
- A Transition group was set up in the Trust to allow for the smooth transition of children through teen and adult services. For young adults with multiple complex needs there are key physicians who continue to be the named physician for the young person, liaising with social services and specialist services. A newsletter used this theme to inform staff about who to talk to for help with transition

Priority 4:

- COVID-19 halted the role out of face to face teaching and updates, but the safeguarding newsletters continued electronically
- During the COVID 19 crisis, the updates in the law regarding DoLS were actively communicated to staff. The law surrounding Liberty Protection Safeguards was also reinforced amongst staff with e-mailed bulletins and messages on the intranet.
- The themes for the Safeguarding Newsletters over this year have been: Mate crime, Female Genital Mutilation, Domestic Violence, Transition to adulthood, Financial exploitation, Sexual assault, Encouraging curiosity, Radicalism, extremism and terrorism, Modern slavery, Looking after people on the sex offender register respectfully, Increased risk of abuse in isolation during lockdown

Devon Partnership NHS Trust (DPT)

Priority 1:

- We monitor our compliance with undertaking routine enquiries about whether our patients have previously or are currently experiencing abuse. This question is actively explored in 70% of adult's initial assessments. The enquiry may not be appropriate for all our patients – for example where patients are acutely unwell or lack the mental capacity to respond.
- Any concern where a clinician has identified a safeguarding risk is triaged and reviewed within one working day.
- Our Executive Complex Case Forum has met regularly throughout the year to support clinicians to find resolutions where an individual patient's needs are complex. During Covid-19 this has been replaced by a daily meeting of a Clinical Advisory Group

Priority 2:

- During 2019-2020 we have produced posters and leaflets explaining what safeguarding adults is, a leaflet on safeguarding enquiries, guidance on domestic abuse. Information and self-help guides are also hosted on our public facing website including signposting to resources in relation to domestic abuse.
- Our sexual safety policy has been updated in response to recent changes in case law and information on sexual safety is shared with patients on both our wards and in the community. We are working with some of our patients to design leaflets on sexual safety

Priority 3:

- We have clinicians who ensure a smooth transition for any young person moving from children to adult mental health services and have implemented a Child and Adolescent Mental Health Service (CAMHS) to Adult Mental Health Service (AMHS) transition protocol. Young people with complex needs who are transitioning from child to adult services have been discussed in the Devon Partnership Trust Executive Complex Case forum.
- During Covid-Lockdown we have contributed to the system-wide Vulnerable Children meetings, maintained our contributions to MASH (multi-agency safeguarding hub) meetings and Early Help meetings. 'Think family' guidance is provided to all our clinicians.

Priority 4:

- All our registered clinical staff complete Level 3 training in accordance with the Intercollegiate Guidance on Safeguarding Adults. We commissioned In-Trac to provided bespoke training on Safeguarding Supervision. Extensive training is available to staff with training compliance reported through our internal Safeguarding Committee on the Mental Health Act, Mental Capacity Act, Multi-Agency Risk Assessment Committees (MARAC) and Multi Agency Public Protection Arrangements (MAPPA). This includes L4 training on Safeguarding Adults on 'Undertaking and Leading individual Safeguarding Adults Enquiries'. This has been bespoke training - delivered to over 80 clinicians working in our Learning Disability Services and 40 clinicians working in our Secure Services.

Public Health Devon

Public Health Devon

Priority 1:

- Public Health commissions the Domestic & Sexual Violence Advice (DSVA) service and substance misuse and lifestyle service and ensure design and delivery support the most at-risk people. An example includes work during the recent Pandemic to ensure substance misuse and stop smoking support was available and accessible to improve health and allow rough sleepers and vulnerably housed individuals to remain in accommodation. Increased funding was allocated for DVSA to allow a timely response to need. The CCG has funded development work on multiple complex needs funded through prevention to seek innovative solutions to support some of the most at-risk people, learning from best practice including increased capacity to support DVSA.

Priority 2:

- This is achieved through the requirements of our commissioned and provided services and the awareness of our staff.

Priority 3:

- Public Health are partners on the Children, Young People & Families Executive (CYPFE) and are accountable for the Public Health Nursing Service and Y-Smart (under 18s Drug and Alcohol service) and ensure transition arrangements are in place when designing and delivering public health services.

Priority 4:

- All staff complete annual mandatory training which includes the agreed safeguarding adult's video and children level 1

University Hospitals Plymouth NHS Trust

University Hospitals Plymouth NHS Trust (UHPNHST)

Priority 1:

- A dedicated Staff net provides up-to-date, alternative learning through a variety of mediums and is accessible to all e.g. video links, national and regional published serious adult review reports as well as specialist subject guidance and resource.
- Quarterly *Champion* meetings, where Wards and Departments have a representative, allows for expert presentations and case reflection. We manage and raise referrals to the local authority(s) for those identified as adults-at-risk and for those who meet the concern threshold; Devon adult referrals average 12% of total referrals made.
- The Trust works closely with the Complex Discharge Team; this ensures the principle of *making safeguarding personal* is met.

Priority 2:

- Public display that *Safeguarding Everyone* is core Trust business is available in the main concourse of Derriford Hospital.
- A dedicated display board with take-away leaflets is available and regularly updated to raise awareness. There is extensive publicity and information sharing at management staff meetings and through on-line publicity internally.
- Internal qualitative data directs focus on bespoke awareness raising and training to service delivery teams

Priority 3:

- Work within clinical teams continues to improve transition from children to adult services for those under our care.
- UHPNT's safeguarding team is a "Think Family" integrated adults and children's Safeguarding service where contact and coordination is hard for same such young adults- both reactive and proactive.
- Policy is that any concern(s) raised during the transition process where concerns that the young adults needs will not be fully met e.g. the family are unable to provide the level of support required on hospital discharge, social care must be involved early.

Priority 4:

- Appointment of our Trust Mental Capacity Advocate (MCA) and Mental Health Act Clinical Lead to support the work of the wider safeguarding team has further enhanced staff understanding of the law in relation to Safeguarding Adults
- Safeguarding training is delivered in line with the intercollegiate document and includes vital safeguarding and MCA information as required. Training compliance for level 1 and 2 remain over 90% and work is established to implement a robust Level 3 offer. Enhanced training is currently offered to areas of increased need and on request. In addition, we have delivered enhanced training in 2019 to over a thousand staff in the Trust to raise awareness and understanding MCA, DoLS and Safeguarding.

Torbay and South Devon NHS Foundation Trust (TSDFT)

Priority 1:

- The Trust has attended and contributed to local arrangements including the Regional Health network, joint Mental Capacity Act and Learning Improvement Sub-Groups, Devon Safeguarding Adult Partnership Operational Group, Anti-Slavery and Prevent Partnership Boards. In 2019, The Trust hosted three partnership safeguarding forums to promote trauma informed practice.
- Our Forum in October 2019 was facilitated by Operation Emotion based in Plymouth. The charity supports adult male survivors of sexual abuse. The forum included the screening of an awareness film 'The Prison of Silence' followed by a panel discussion.

Priority 2:

- Our Safeguarding public information page provides a range of information to patients and our local communities. This includes how to report safeguarding concerns, a public information film 'if you see something say something' and a range of posters and other information on local safeguarding arrangements. We also actively seek feedback from patients that have attended hospital sites in order to inform and improve our knowledge of patient experiences.

Priority 3:

- The Trust has a joint integrated safeguarding adult and inclusion group which allows for a joint consideration and focus on safeguarding adult and safeguarding children agendas. Our paediatric clinics allow for joint working between paediatric and adult clinicians and allow access for clinical supervision if needed.
- Our commitment to transition working can be evidenced in our work with Action for Children and the Children's Society as the new Torbay 0-19 Partnership. This will be the first of its kind in the region and possibly the UK and aims to combine develop and deliver services both universally and targeted for the Torbay children, young people and their families/carers.

Priority 4:

- Safeguarding training is mandatory for all staff within the Trust. Training content includes a focus on Human Rights, Care Act and other specific legal frameworks relevant to safeguarding agendas. A range of other training is available to all staff on themes such as modern slavery. During 2019 we distributed a high number of modern slavery Royal College of Nursing information 'wheels' to frontline teams, so they had relevant information at hand to respond to a modern slavery concern.
- The Trust has made a recent decision to make Mental Capacity Act (2005) training mandatory for all staff and we are currently planning to implement this. Each member of staff will have an identified level of training to complete.

Northern Devon Healthcare NHS Trust

Northern Devon Healthcare NHS Trust (NDHT)

Priority 1:

- The most recent Care Quality Commission (CQC) inspection in 2019 identified: “The safeguarding team has shown outstanding innovation, multi-disciplinary working and external engagement with other stakeholders”. We have developed multi-agency local networks to support people neglecting themselves. An example of this is a person who had multiple health needs which were impacting on her sight. She was noted to have missed appointments and this was escalated to the safeguarding team. A co-ordinated approach was led by NDHT team with various different agencies. The person was supported emotionally and physically to attend her appointments and given some support at home, with an ongoing support plan

Priority 2:

- NDHT attends and supports the work of the DSAP at Board and Sub-Groups and actively engages in work to increase public awareness of safeguarding. We have been a contributor to and active member of the ‘Pathfinder Domestic and Sexual Violence’ research project. Our work to raise the profile of domestic and sexual violence support within the community and health settings remains paramount. During the COVID pandemic the Safeguarding teams and Health Independent Domestic Violence Advisor met with and provided support to the ‘swab centres’ to support practice. They asked, “Do you feel safe at home?” to all people and were able to direct them to or provide immediate safety advice if disclosures were made.

Priority 3:

- The Integrated Safeguarding Team provide leadership support and guidance to staff across NDHT, allowing for oversight of children that are moving from paediatric to adult care services. All disciplines supporting young people have access to advice and support from the integrated team. An example: A young person regularly attended the hospital to access urgent care, in-patient and sexual health services because of the injuries sustained when they harmed themselves. A joint response was co-ordinated by the specialist sexual health nurse with DPT, adult hospital services and adult social care to support this person and ensure consistent care.

Priority 4:

- The Integrated safeguarding team provides specific advice, support and feedback to staff which encourages learning and understanding through, for example, responding to incident reports and reviewing safeguarding. We have increased and improved our training provision for Staff at all levels and provide blended learning opportunities. We have invested in the training and development of Safeguarding Supervisors across the Trust- Link Practitioner Groups are held each quarter.

Dorset, Devon and Cornwall Community Rehabilitation Company (CRC)

Priority 1:

- The CRC works closely with partners and local communities as well as the service user themselves, to manage the risk service users present to themselves and others. All service users have an initial risk assessment and sentence plan which is then reviewed every 12 weeks. The CRC participate in local professional forums to discuss, plan and manage those at most risk.
- The CRC has taken on board the lessons learnt from previous Safeguarding Adult Reviews and national inspections to ensure it improves on the quality of its assessments and management of cases.

Priority 2:

- The CRC has not participated in any public awareness events over the last year due to the re-organisation of the business following the demise of the previous service provider 'Working Links'.

Priority 3:

- The CRC works closely with National Probation Service (NPS) colleagues and the youth offending service to ensure smooth transition between our organisations. There is a set protocol for the hand over and management of children to our adult service. This includes 3-way meetings with the organisations and the child involved and multi-agency planning forums. For those sentenced to unpaid work, the CRC has trained some of its supervisors to work with young people under 18yrs and we have sourced individual placements to cater for the needs of children coming into our service. The CRC and the youth service in some areas have a service level agreement in place to provide Unpaid Work Requirement (UPW) for the Youth offending team which ensures that the individuals are worked safely in the community.

Priority 4:

- All staff within the CRC, including managers and senior managers, have mandatory training which includes Safeguarding Adults. This has been completed every year and is updated by our learning and development team to ensure it remains relevant to current research and activity. All existing staff and managers within Devon are now trained and all new recruits will be trained by August 2020.

Devon District Councils

This has been produced jointly by Devon District Councils. Not all activities mentioned have been undertaken by all Councils but are examples of the safeguarding adults work that has been delivered throughout the year.

Priority 1:

- There are Safeguarding processes and policies in place in each Council with referral mechanisms to partner agencies and have central points of contact in councils to monitor numbers and quality of referrals
- We ensure attendance at a range of different Forums including: Early Help, Multi Agency Risk Assessment Conference (MARAC), Domestic Homicide Reviews (DHRs), Creative Solutions and High Flow. We share the learning from Safeguarding Adult Reviews.
- Safeguarding leads and champions in Councils to encourage best practice and offer oversight and reassurance
- We conduct an Annual Overview and Scrutiny of Safeguarding, including a review and de-brief of cases to ensure learning

Priority 2:

- Adult Mental Health and Safeguarding Awareness news has been circulated. A suicide prevention app that was circulated on social media and placed on the wellbeing site. Relationships later in life awareness video has been circulated and we have promoted the Radicalisation campaign and Preventing Exploitation Toolkit, Supporting Safer Devon Partnership communications and campaigns
- Circulation of unseen training and Volunteer Safeguarding training offered out via District and Town councils
- Devon District Safeguarding Officer Network meets regularly to discuss the sharing of public messaging & good practice

Priority 3:

- We engage with the Adolescent Safety Framework and take learning from Young Persons Independent Domestic Violence Advisor in South Devon. Further engagement with Youth Intervention Team and Young Devon over issues such as Housing
- Young Devon's Homeless Prevention Worker (HPW) post jointly funded with DCC ensures the transitions are as positive as possible and provides a balance between both organisations, ensuring joint working and preventing potential arguments regarding who has responsibility for the young person transitioning.

Priority 4:

- Online free Training around safeguarding as well as Safeguarding training for staff and Elected Members and suicide training delivered.
- Sexual Violence Domestic Violence and Abuse (SVDVA) training is offered to housing staff via Splitz -
  Part 1 is Basic awareness raising and domestic abuse; Part 2 is Options for Support and Complex Case workshop
- Promotion of wellbeing and mental health via intranet and weekly newsletter

15. Learning from Safeguarding Adults Reviews (SARs)

The Care Act 2014 specified that it is the duty of a Safeguarding Adults Board (SAB) to commission SARs under the following circumstances:

(1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
b) condition 1 or 2 is met.

(2) Condition 1 is met if –

a) the adult has died, and
b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not It knew about or suspected the abuse or neglect before the adult died)

(3) Condition 2 is met if –

a) the adult is still alive, and
b) the SAB knows or suspects that the adult has experienced serious abuse or neglect

Safeguarding Adult Boards (SABs) can decide to undertake a SAR in any other situations involving an adult in its area with needs for care and support. Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again. The apportioning of blame is not the purpose of the review.

We set out below the summaries of SARs which were completed and published by the Partnership in 2019/ 2020. All published SARs are on the DSAP website. Full publication is not mandatory, and decisions are made on a case by case basis.

To view all full SAR reports, please visit the DSAP website: https://www.devonsafeguardingadultspartnership.org.uk/about/safeguarding-adult-reviews/

Summary of SAR Charles (Published 19th December 2019)

Charles is a 52-year-old man who has a diagnosis of Schizophrenia. He was born in Pakistan where he grew up before moving to England. Charles lived with his mother in a one bed rented flat. Charles slept on the sofa. The home environment was described as very poor. Charles is a sibling of a patient detained at Langdon Hospital under section 3 of the Mental Health Act (MHA). Concerns regarding Charles' physical and mental health were raised by clinicians at Langdon Hospital, although he was not their patient, during a visit to the home to assess the suitability of home leave for his brother. Clinicians at Langdon Hospital raised a safeguarding concern in September 2018 for both Charles and his mother in respect of concerns about their safety and wellbeing in the community. In the referral, clinicians at Langdon Hospital described the difficulty from their perspective, in seeking support for Charles regarding his physical and mental health. Charles was at that time known to a number of agencies. It was difficult to persuade Charles to engage with services and treatment for his leg ulcers given his reluctance to trust professionals.

Charles was detained on Haytor Ward under the MHA in August 2018, having been admitted to the General Hospital for medical and nursing care due to possible infection of leg wounds. On admission to Haytor Ward, it was reported that Charles had ulcers on his legs that were of 2-3cm deep.

Throughout the period of the SAR Charles was an inpatient under the MHA. Although it is noted that there have still been periods of disengagement and self-neglect this has been addressed though care and risk management processes and medical review. At the time of this SAR Charles was said to be making positive progress in terms of his legs. Russell Clinic will ensure that appropriate support is in place and available on discharge.

Summary of SAR Atlas (Published 20th September 2019)

Atlas Care Homes owned 15 care homes, which provided specialist care for adults with learning disabilities whose support needs were described as “complex” and “challenging.” All the homes were registered with the Care Quality Commission to provide residential placements for people with learning disabilities.

Seven of their care homes were in Devon. These were known as Curlews, Gatooma, Hilltop, Kingsacre, Santosa, Stone Cottage and Veilstone. There were 33 people placed within the Devon Care Homes and 1 person was receiving support from the Atlas Personal Care Agency.

In July 2011 Safeguarding concerns were raised about the treatment of a resident at Veilstone. An Individual Safeguarding Enquiry commenced which uncovered further concerns about treatment of people in Veilstone.

In October 2011 Further concerns about the treatment of people in Veilstone led to a multi-agency Whole Service Safeguarding Enquiry. This enquiry identified concerns in other Atlas homes and about staff and managers who worked across homes in the organisation. A Police investigation began. This focused on the experience of 10 adults over a two-year period who were residents of three Atlas care homes in Devon. It identified 2,600 incidents of seclusion with some residents falsely imprisoned up to 400 times.

The court proceedings revealed that Atlas residents were subjected to systemic neglect; seclusion in rooms without food, drinks, heating or access to toilets; physical assaults; and orders from staff to undertake housework and gardening tasks, which were 'tests' to establish their compliance.

16. SAR Learning Points:

1. Communication and Coordination

- Communication and coordination are key to ensuring that the risk and the plans around these are understood by all. This can provide a vehicle for professional curiosity and challenge.
- **Inter-agency working -** the need for a clear process for identifying a lead agency in complex cases where there are many agencies involved in supporting an individual or family.
- The importance of involving the person when working with them and ensuring continuity of care across organisations

2. Safeguarding and Self-Neglect

- There was a missed opportunity to work in a collaborative way under **safeguarding** in relation to **self-neglect.** This would have provided a multi-agency framework. The framework does not give any additional powers to act, however would have brought recognition that management of the risks required **multi-agency collaboration**; clarity on seeking consent to **share information**, or to justify sharing it without consent; **assessment of the level of risk** based on more informed input; and a **shared record** of what had been agreed.

3. Multi-Agency Referral Processes and Criteria

- Staff need to have effective awareness of services available along with threshold levels. Referrals to agencies for SAR Charles did not necessarily provide an accurate reflection of the situation. It is possible that assumptions were made about the level of knowledge agencies had around Charles' situation.

4. Application of the Mental Capacity Act

- Staff understanding of The Mental Capacity Act must improve as it was not properly considered or applied in some cases. Application of the Mental Capacity Act may have been fundamental in understanding the individuals, for example whether or not the issues that appear to be self-neglect are in fact due to a person lacking capacity; to understand the impact that their behaviour is likely to have on their health and wellbeing.

17. Strategic Priorities 2020/2021

Devon Safeguarding Adults Partnership

Vision Statement

'Everybody in Devon has the right to lead a fulfilling life and should be able to live safely, free from abuse and neglect and able to contribute to their own and other people's health and wellbeing'

DSAP Strategic Priorities 2020/2021

DSAP STRATEGIC PRIORITY 1: SAFEGUARDING WITHIN THE COVID-19 PANDEMIC

DSAP AIM:
To work in partnership to ensure continuity of safeguarding adults business

DSAP OBJECTIVE:
Partner Assurance:

- To have regular assurance from DSAP partners that people are safeguarded during the pandemic and that attention to safeguarding continues in accordance with statutory responsibilities, recognising that some people will be put at greater risk during the Pandemic

DSAP STRATEGIC PRIORITY 2: LIVING WELL

DSAP AIM:
The DSAP Board aims to support partners to deliver preventative actions, to safeguard those with care and support needs through learning together and delivering change.

DSAP OBJECTIVES:
Finding the right solution at the right time for people with complex lives:

- To seek assurance that partners work together to establish more effective coordination to achieve person centred solutions.
- Understanding that creative solutions need to be deployed to support people to live well.
- Sharing data and information to help partners develop effective communication and co-ordination to understand how preventative strategies can avoid the need for safeguarding intervention.

Hidden Harm:

- To seek assurance that partners are all uncovering and responding to hidden harm and exploitation.
- Ensuring that all people who work with individuals exercise curiosity and take appropriate action.

Improving Involvement and Engagement with people in receipt of safeguarding services:

- To seek assurance that all partners are involving and listening to people about their experience of safeguarding.
- Ensuring that all partners are listening to, valuing and responding to what relatives, friends and people in communities.
- Involving the person to ensure that safeguarding is person-led and outcome-focussed.
- Increasing public awareness of adults safeguarding.

Agenda Item
Devon Health and Wellbeing Board
8th October 2020

Prevention Concordat for Better Mental Health
Report of the Chief Officer for Communities, Public Health, Environment and Prosperity

Recommendation: That the Health and Wellbeing Board support work to develop an action plan that focusses on supporting the emotional health and wellbeing of the Devon Population during and following the Covid -19 pandemic

1. Context

1.1 Poor mental health and wellbeing has a considerable impact on the quality of life and is a major contributor to premature death. This is highlighted in 'Healthy and Happy Communities', Devon's Joint Health and Wellbeing Strategy for 2020-25, which sets a priority to focus on mental health and build good emotional health and wellbeing, happiness and resilience.

1.2 The Prevention Concordat for Better Mental Health was developed by Public Health England as a mechanism for promoting good mental health and providing a focus for cross-sector action to increase the adoption of public mental health approaches.

1.3 The Devon Health and Wellbeing Board and Devon County Council signed up to the prevention Concordat in early 2020, however the Covid-19 pandemic has meant that the action plan has not been developed as public health staff and partner agencies have been focussed on responding to the pandemic.

1.4 During the response period of the pandemic, the mental health and wellbeing of workforces has been a priority.

2. Impact of Covid -19 on Mental health and Wellbeing

2.1 Whilst there has been some positive outcomes as a result of the pandemic; increased sense of social cohesion through people volunteering within their communities and more people accessing green spaces etc, It is expected that mental ill health will increase widely as a result of the direct impact of Covid -19 infection and through its impacts upon the wider determinants of health.

2.2 Whilst there may have been an increased collective spirit initially (we are all in this together) Moore et al (2004) report that this feeling may shift in that later phases of the disaster cycle; initial feelings of unity and mutual support may give way to feeling of disillusionment and anger.

2.3 During the first month of lockdown; the equivalent of 7.4 million people (14.3%) of the population said that their wellbeing was affected by being lonely, however, ONS analysis suggests that 'chronic Loneliness hasn't changed as a result of lockdown.

2.4 The health and social effects of the previous decade of austerity means that already disadvantaged groups are even more vulnerable to the socioeconomic impacts of the pandemic. It has been estimated that 1.1 million more people could face poverty at the end of 2020, bringing the total number of children living in poverty in the UK to 4.5 million, an increase of nearly 5%. Unemployment is expected to reach just under 10% by the end of 2020. A report by the mental health foundation highlights the mental health effects of financial inequalities, noting that employment is one of the most strongly evidenced determinants of mental health

2.5 Existing evidence on the health impacts of recessions show that they have negative impacts upon people's health and wellbeing, Janke et al (2020) have modelled the impact of economic shocks on chronic health conditions which suggests that people with pre-existing poor mental health will be particularly vulnerable to the effects of an economic downturn. If the impact of the predicted economic downturn is similar to that of 2008, then the number of working age people suffering poor mental health would increase by 500,000. evidence suggests that periods of economic recession increase overall suicide rates, modelling research by Janke et al (2020) showed that each 10% increase in the number of unemployed men was significantly associated with a 1.4% increase in male suicides.

2.6 Research by the Early Intervention Foundation highlights the impact of lockdown and social distancing on the delivery of early intervention and early help services. They noted that the ability of services to support children and families have been seriously affected at a time when they are facing even greater challenges. They anticipate that there is likely to be a rapid increase in referrals to childrens social care, acute services and early help as lockdown eases.

2.7 Figure 1 illustrates the potentially longer lasting impact of pandemic on population mental health

Figure 1, Expected COVID -19 burden of disease over time

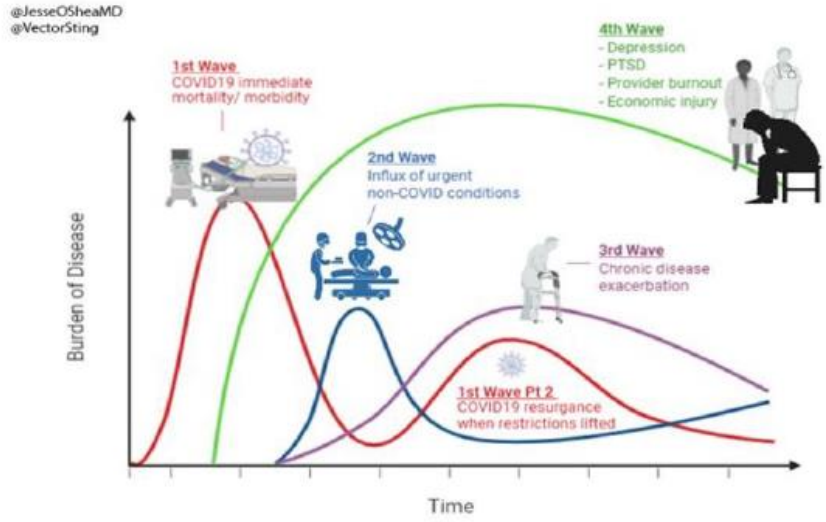


Figure 1. Expected COVID-19 burden of disease over time (credited to Tseng, Victor [@VectorSting])

3. Conclusions and Next Steps

3.1 In light of the mental health challenges highlighted in the Joint Strategic Needs Assessment and Health and Wellbeing Outcomes Report, and the prioritisation of mental health in the Joint Health and Wellbeing Strategy, adopting the Prevention Concordat for Better Mental Health in Devon should provide a local focus to local partnership work on preventive approaches to mental health. Following the precedent set by others, sign-up by the Health and Wellbeing Board could be useful in encouraging a cross-sector approach.

3.2 It is recommended that the Health and Wellbeing Board support work to develop an action plan through their constituent organisations, and sign-up to the Prevention Concordat for Better Mental Health.

3.3 The focus has been on supporting the emotional health and wellbeing of DCC staff during the lockdown period support has also been offered to staff working in Care Homes.

4. Risk Management Considerations
Not applicable.

5. Options/Alternatives
Not applicable.

6. Public Health Impact
Poor mental health is a major public health issue, and work to develop a more preventive approach and promote good mental health should have a positive impact.

Dr Virginia Pearson
CHIEF OFFICER FOR COMMUNITIES, PUBLIC HEALTH, ENVIRONMENT AND PROSPERITY
DEVON COUNTY COUNCIL

Electoral Divisions: All
Cabinet Member for Adult Social Care and Health Services: Councillor A Leadbetter and Cabinet Member for Community, Public Health, Transportation and Environmental Services: Councillor R Croad

Contact for enquiries: Simon Chant, Room 148, County Hall, Topsham Road, Exeter. EX2 4QD
Tel No: (01392) 386371

Background Papers: Nil

Agenda Item CX/10/.
Devon Health and Wellbeing Board
8th October 2020

Healthy and Happy Communities: Devon Joint Health and Wellbeing Strategy Update

Report of the Chief Officer for Communities, Public Health, Environment and Prosperity

Recommendation: That the board note the addition of the new sub-priority in the Joint Health and Wellbeing Strategy, and review board champion roles for the four main priority areas

1. Context

1.1 'Healthy and Happy Communities', Devon's Joint Health and Wellbeing Strategy for 2020-25 was approved by the Board in October 2019 and adopted from January 2020 onwards.

1.2 During 2020, the coronavirus pandemic has had a considerable impact in relation to health and wellbeing, the economy and wider society. The July 2020 Health and Wellbeing Board included a session on these impacts and a review of Joint Health and Wellbeing Strategy priorities to ensure the strategy is fit for purpose.

2. Changes to Joint Health and Wellbeing Strategy

2.1 Discussion at the July 2020 Health and Wellbeing Board confirmed that the existing strategy, with its priorities around creating opportunities for all, supporting communities, focusing on mental health and maintaining good health for all, remains fit for purpose. The impacts of the pandemic in relation to employment, mental health and loneliness, access to education and health inequalities were identified as being particularly areas of focus which relate to themes already included within the strategy.

2.2 The board agreed to a further sub-priority (4e) to be added under priority four 'maintain good health for all' to reflect the importance on public health measures in controlling the spread of infectious disease:

Promote public health interventions to prevent the spread of infectious disease

The online version of the strategy https://www.devonhealthandwellbeing.org.uk/strategies/ has been updated to reflect this.

2.3 Further to this, a review is required to the Health and Wellbeing Board champions listed against each priority in the strategy, who advocate for work in these areas and provide a link to other partnerships, given that two previous champions are no longer members of the board. The current allocations exist for existing board members is as follows:

Priority	Health and Wellbeing Board champion(s)
1. Create opportunities for all	Cllr Leadbetter
2. Healthy, safe, strong and sustainable communities	Cllr Croad, Dr Virginia Pearson, Jeremy Mann
3. Focus on mental health	
4. Maintain good health for all	Dr Paul Johnson

3. Conclusions and Recommendations

3.1 Board members should note the addition of the new sub-priority to the Joint Health and Wellbeing Strategy.

3.2 The board should review the Health and Wellbeing champions allocated to strategy priorities and update as required.

4. Risk Management Considerations

Not applicable.

5. Options/Alternatives

Not applicable.

6. Public Health Impact

Priorities in the strategy are focused on reducing health inequalities, protecting the health of the population and improving the wider determinants of health.

Dr Virginia Pearson
CHIEF OFFICER FOR COMMUNITIES, PUBLIC HEALTH, ENVIRONMENT AND PROSPERITY
DEVON COUNTY COUNCIL

Electoral Divisions: All
Cabinet Member for Adult Social Care and Health Services: Councillor A Leadbetter and Cabinet Member for Community, Public Health, Transportation and Environmental Services: Councillor R Croad

Contact for enquiries: Simon Chant, Room 148, County Hall, Topsham Road, Exeter. EX2 4QD
Tel No: (01392) 386371

Background Papers: Nil

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

one and all CORNWALL COUNCIL

Council of the ISLES OF SCILLY

Contents

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

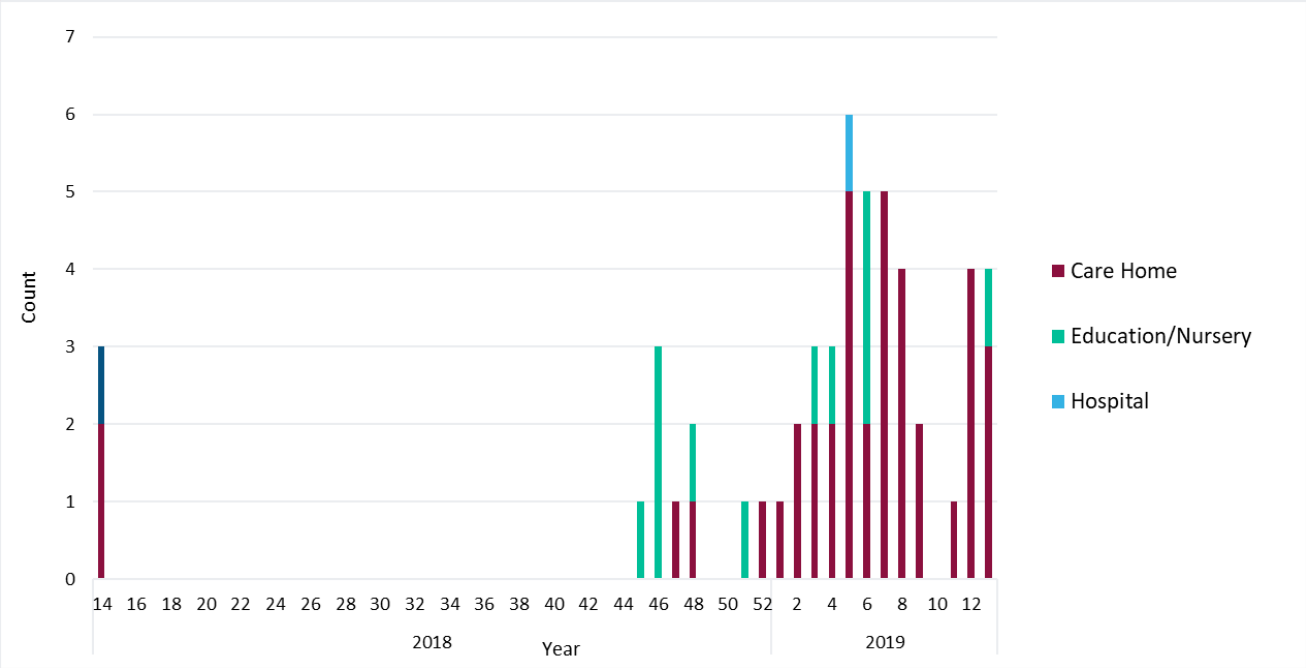


Table 1: All reports of influenza-like illness outbreaks/clusters (suspected or confirmed) by setting, Cornwall (including Isles of Scilly), Devon, Plymouth and local authorities, 2018/2019‡
Source: HPZone

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

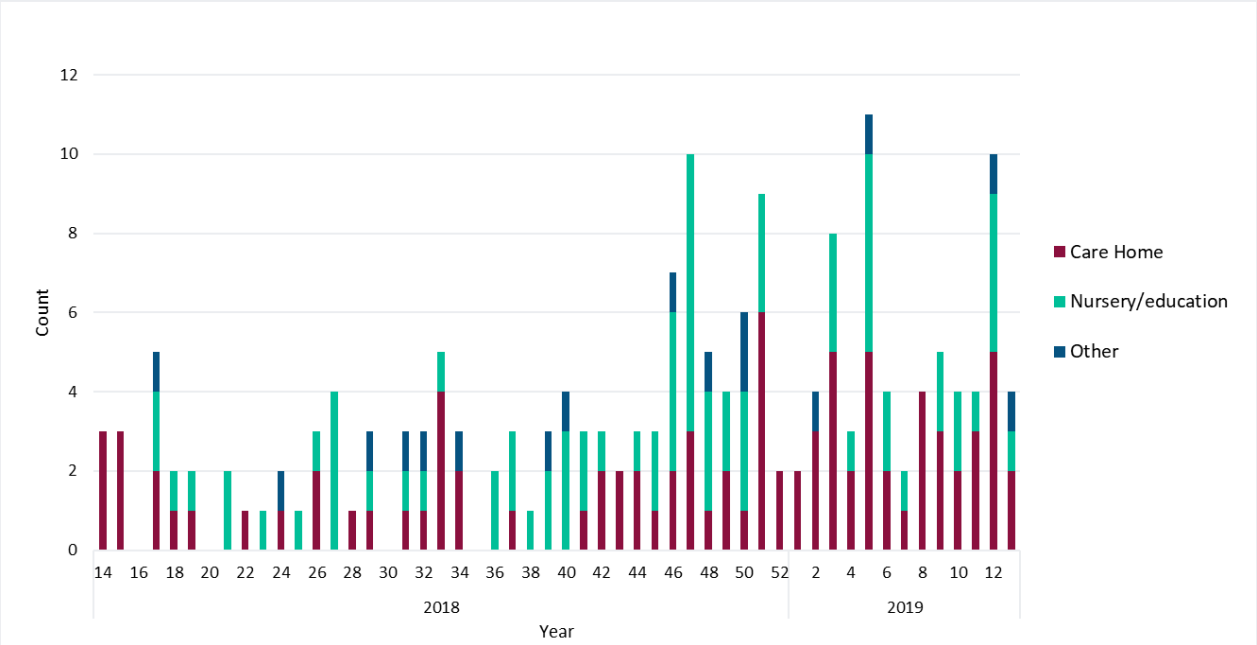


Table 2: All reports of clusters/outbreaks of Infectious Intestinal Disease (suspected or laboratory confirmed), by setting, Cornwall (including Isles of Scilly), Devon, Plymouth and Torbay Local Authorities, 2018/19‡
Source: HPZone and HNORS

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.

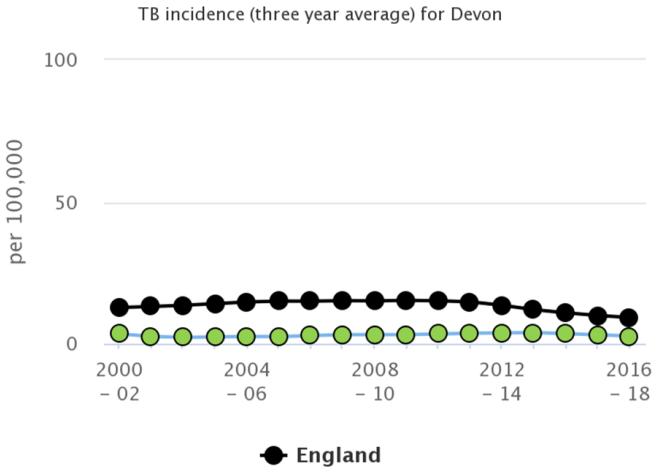
HNORS reports were extracted and analysed on date entered.

Meningococcal Disease

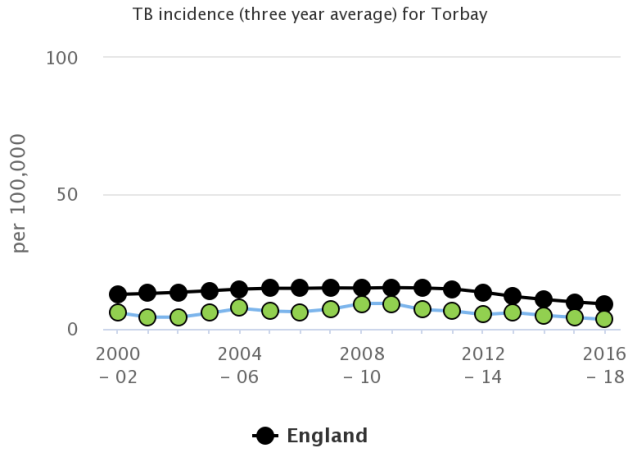
In 2018-2019 there were nine confirmed or likely cases of meningococcal disease in Cornwall, 15 in Devon, five in Plymouth and less than five in Torbay. These figures are consistent with data from the previous three years.

Tuberculosis

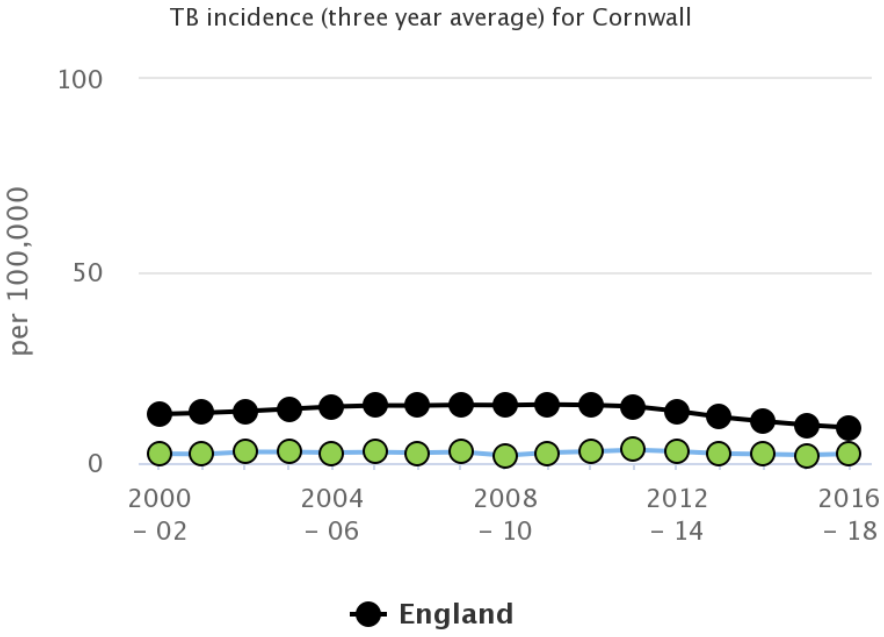
Figure 3: TB Incidence (three-year average)
Source: PHE Fingertips



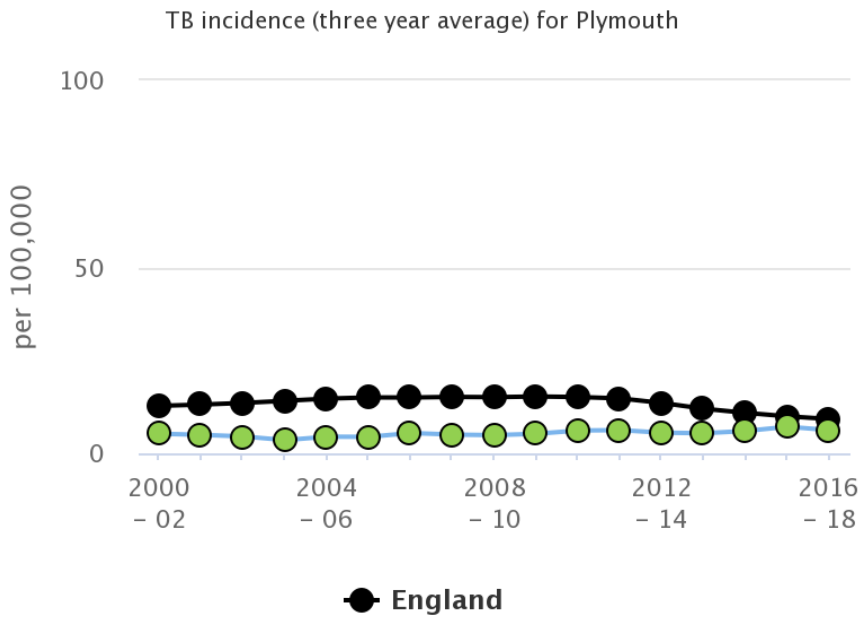
The three-year average incidence of TB in Devon was 2.7/100,000 population per year for 2016-18 compared to 3.1 for 2015-2017.



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.

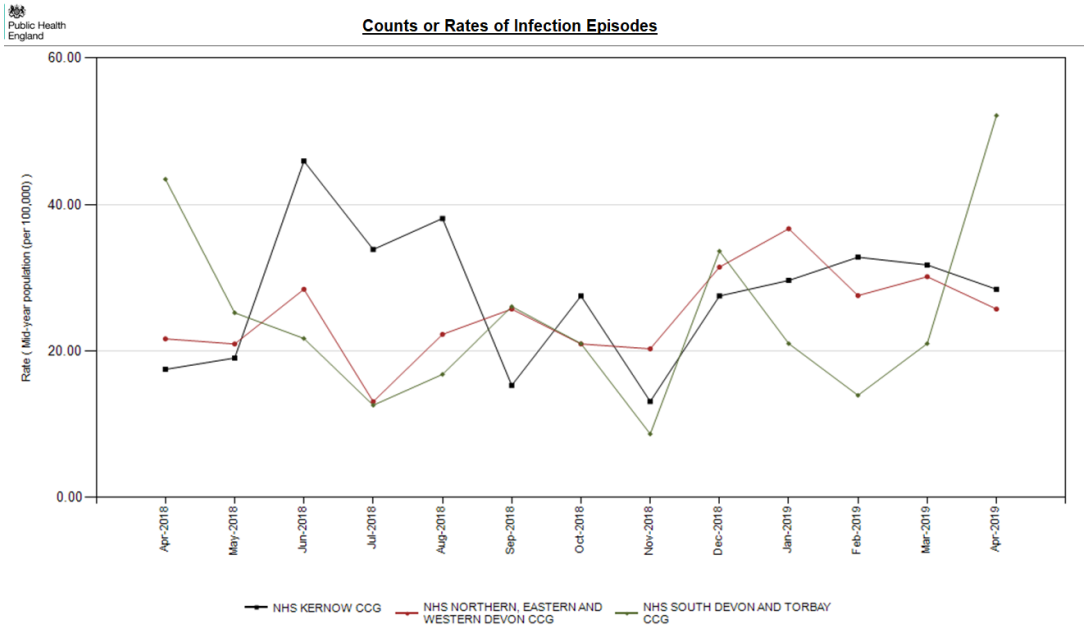
1.3 There have been no cases in Plymouth since December 2018, and only one case across the rest of Devon.

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)

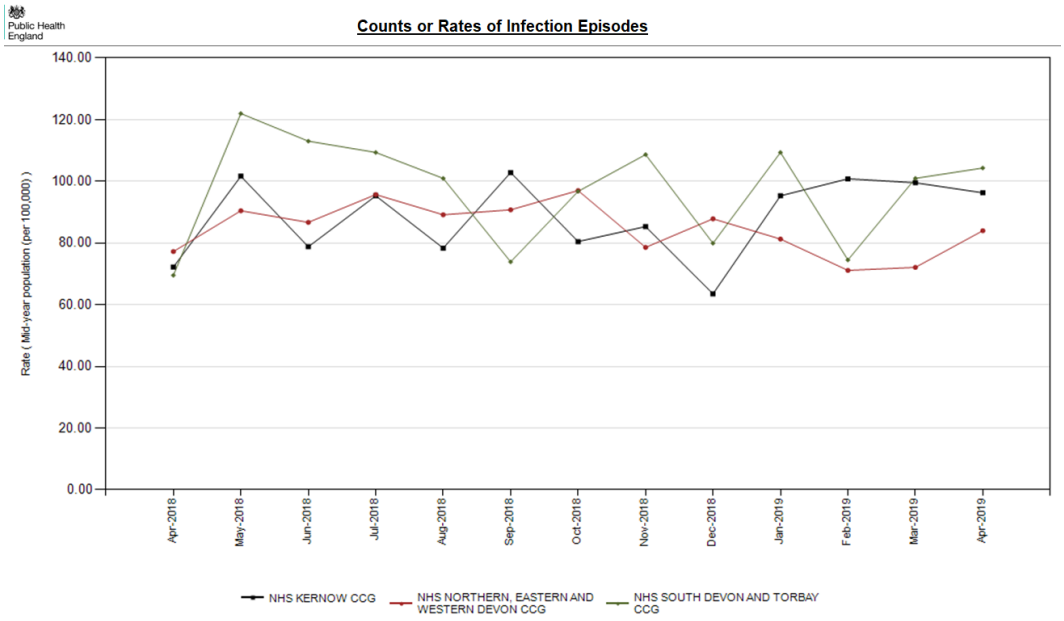
1.5 In NHS Devon CCG, MSSA bacteraemia rates remain stable with minor variation. SDTCCG has a smaller population so the rate is more volatile. Individual providers across Devon are undertaking pieces of work to understand and modify their in-hospital MSSA rates.

NHS Kernow CCG

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

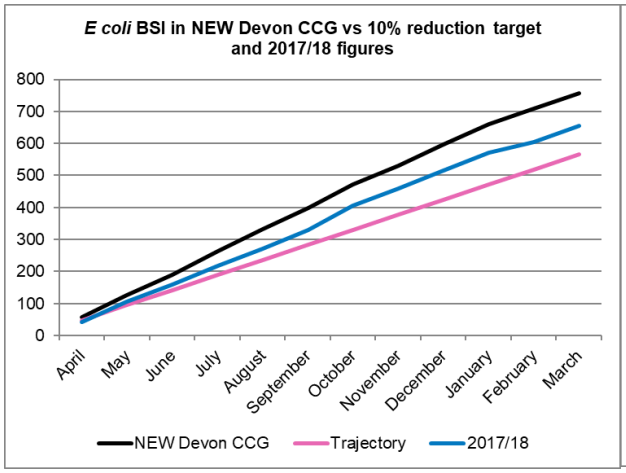
E.coli bacteraemia

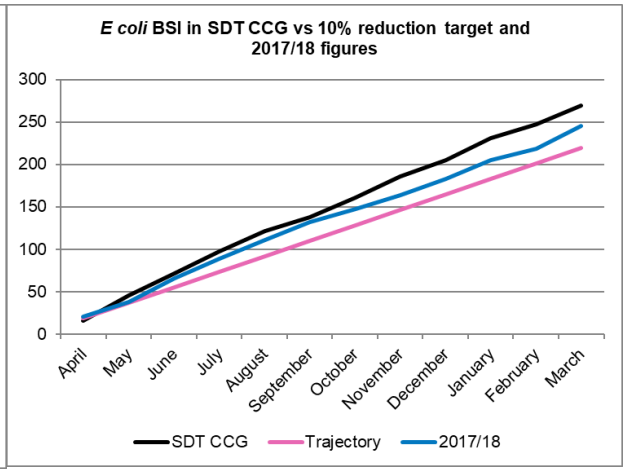
NHS Devon CCG



(The above graph courtesy of Public Health England)

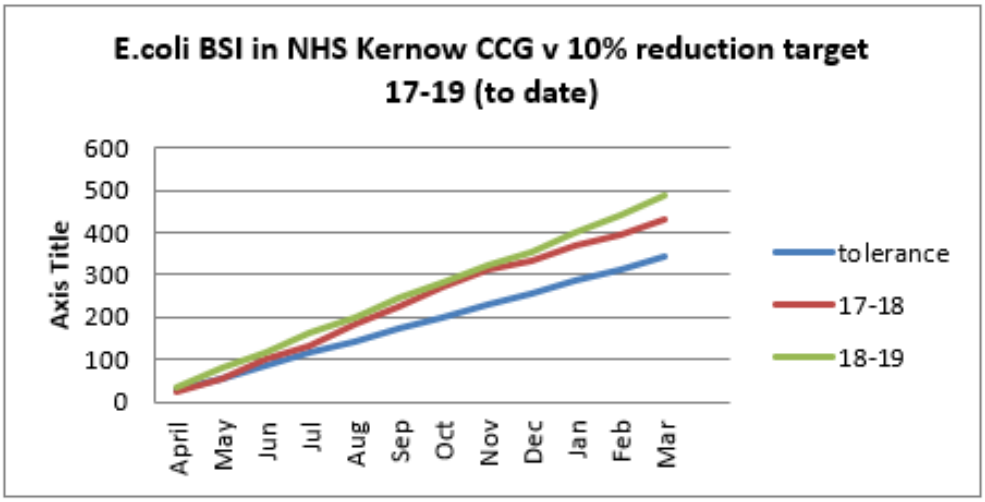
1.7 E.coli bacteraemia rates across both Devon CCGs broadly track the averages provided by Public Health England (PHE) for England and the South West.





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

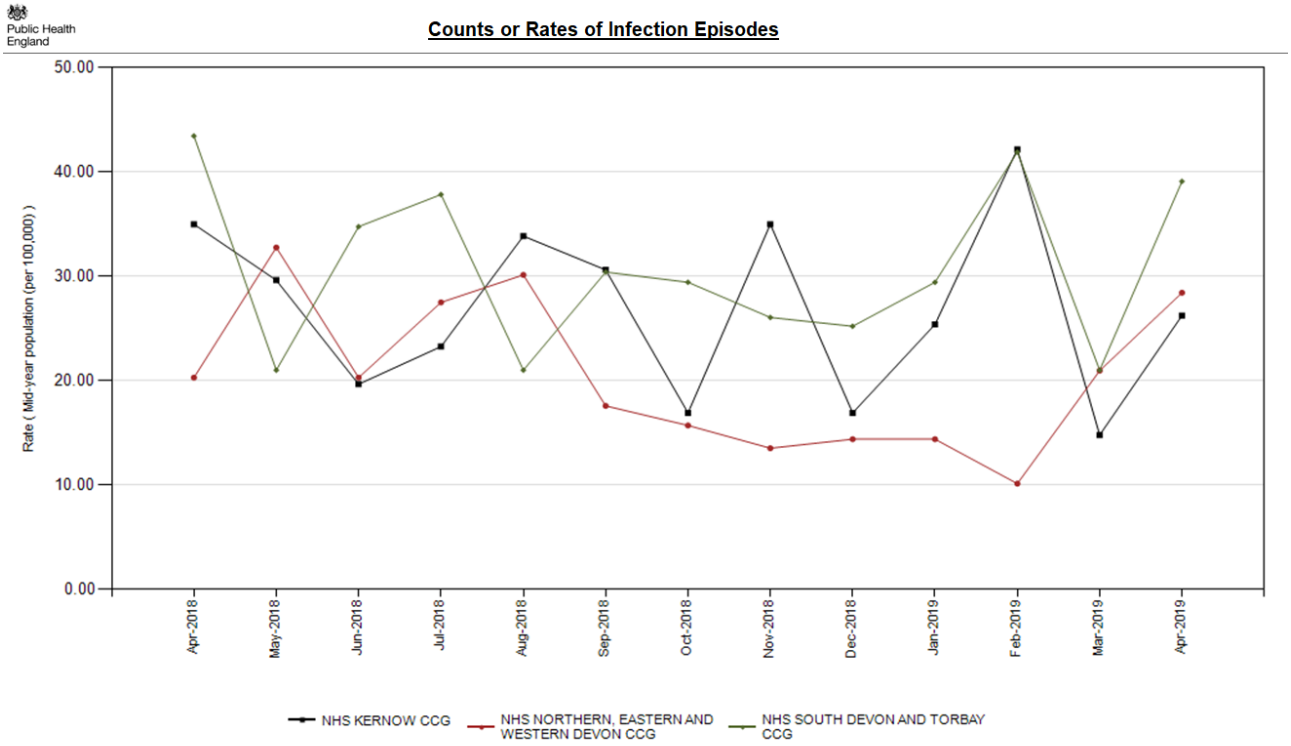
expertise; the videos will be available from March and will be distributed via hospital discharge teams, practice nursing teams and care home QAIT teams.

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



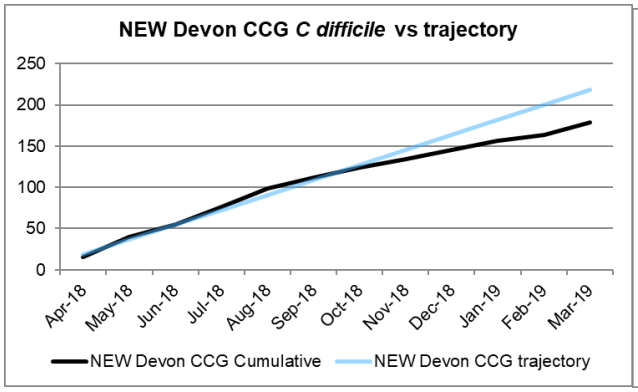
(The above graph courtesy of Public Health England)

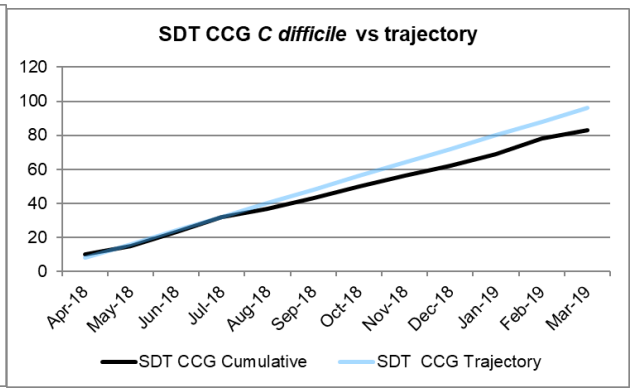
1.14 The graph above shows all cases of *C difficile* within the joint Devon CCGs and NHS Kernow CCG. The community acquired cases, which make-up the larger proportion of the population cases, historically have not been scrutinised for avoidability like those in acute and community hospitals.

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.

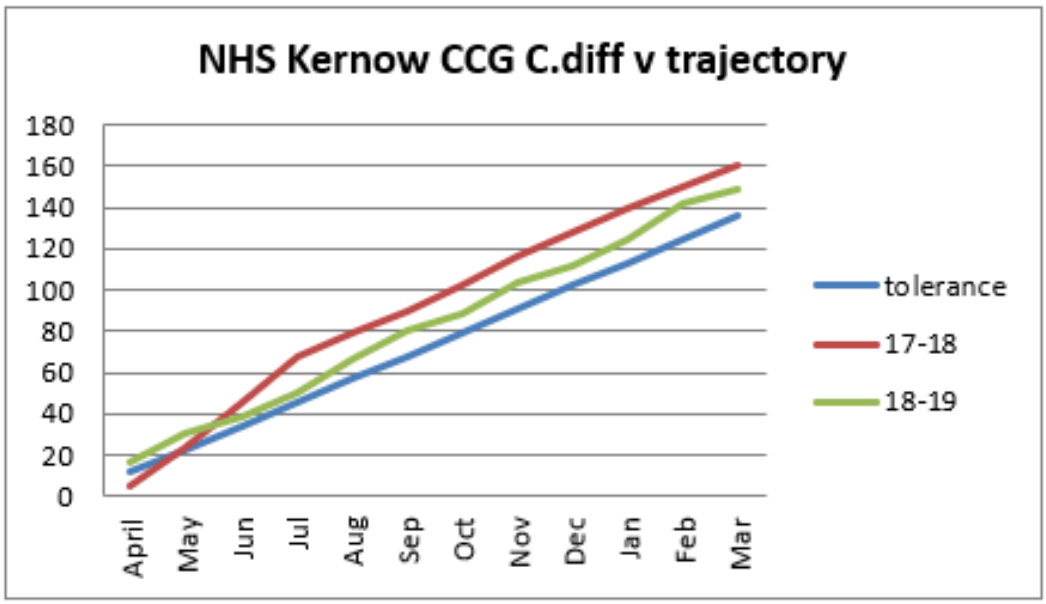
1.17 The case numbers for NEW Devon CCG and SDT CCG both ended the year under the nationally set trajectory.





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]

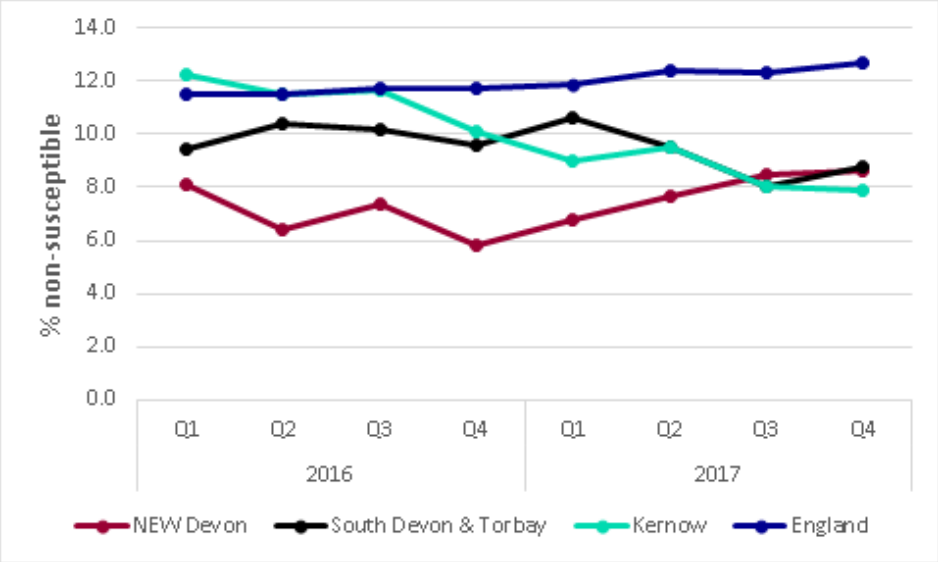


Figure 3: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to gentamicin, by quarter
Source: PHE AMR local indicators[1]

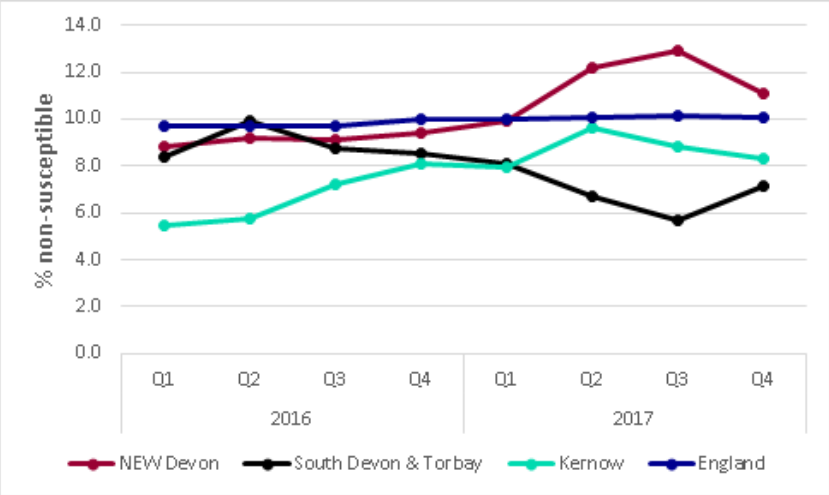


Figure 4: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to piperacillin/tazobactam, by quarter
Source: PHE AMR local indicators[1]

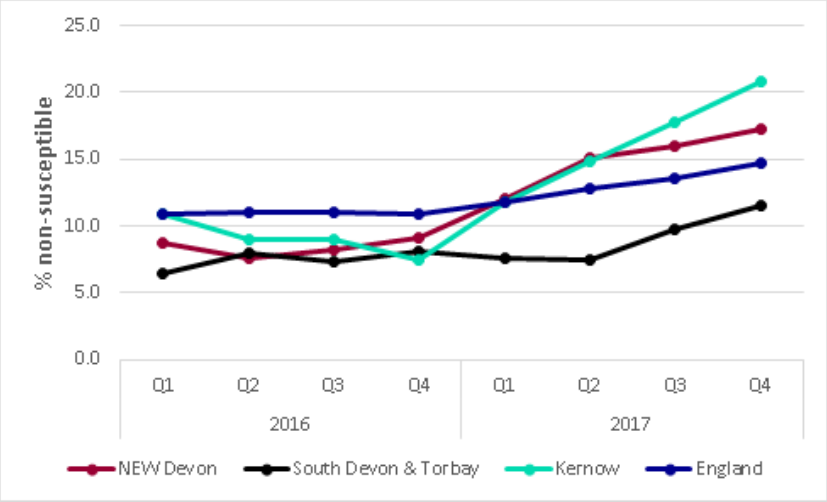
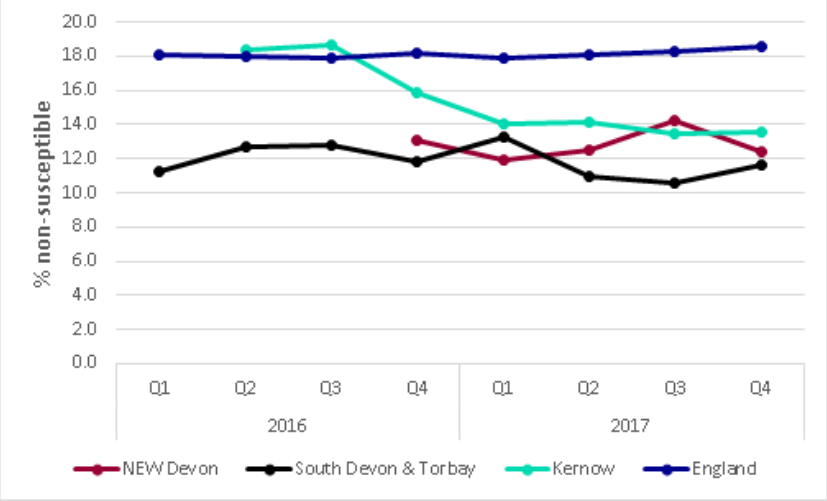


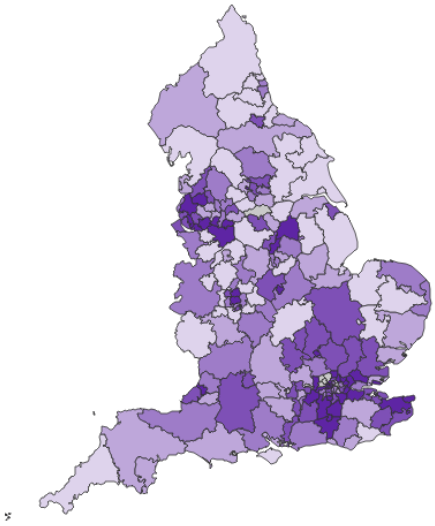
Figure 5: Rolling quarterly average proportion of *E. coli* blood specimens non-susceptible to ciprofloxacin, by quarter*
Source: PHE AMR local indicators[1]



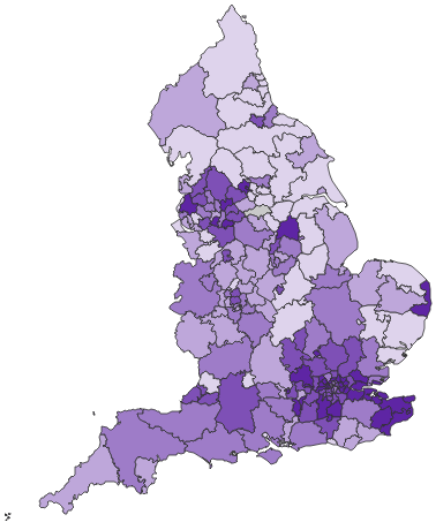
*Where less than 70% specimens have been tested for a particular CCG the results have been suppressed for data quality reasons.

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]

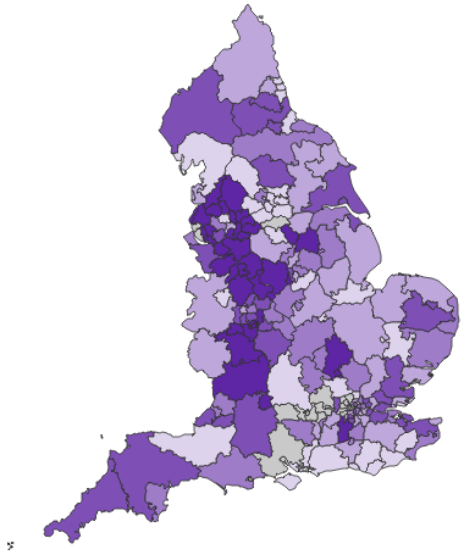
A



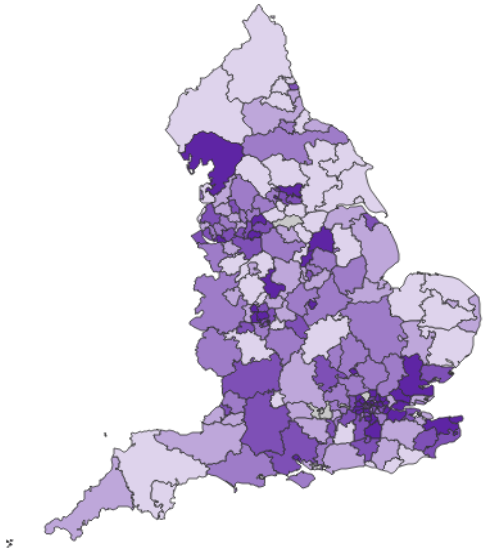
B



C



D



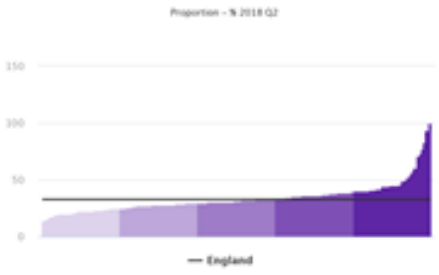
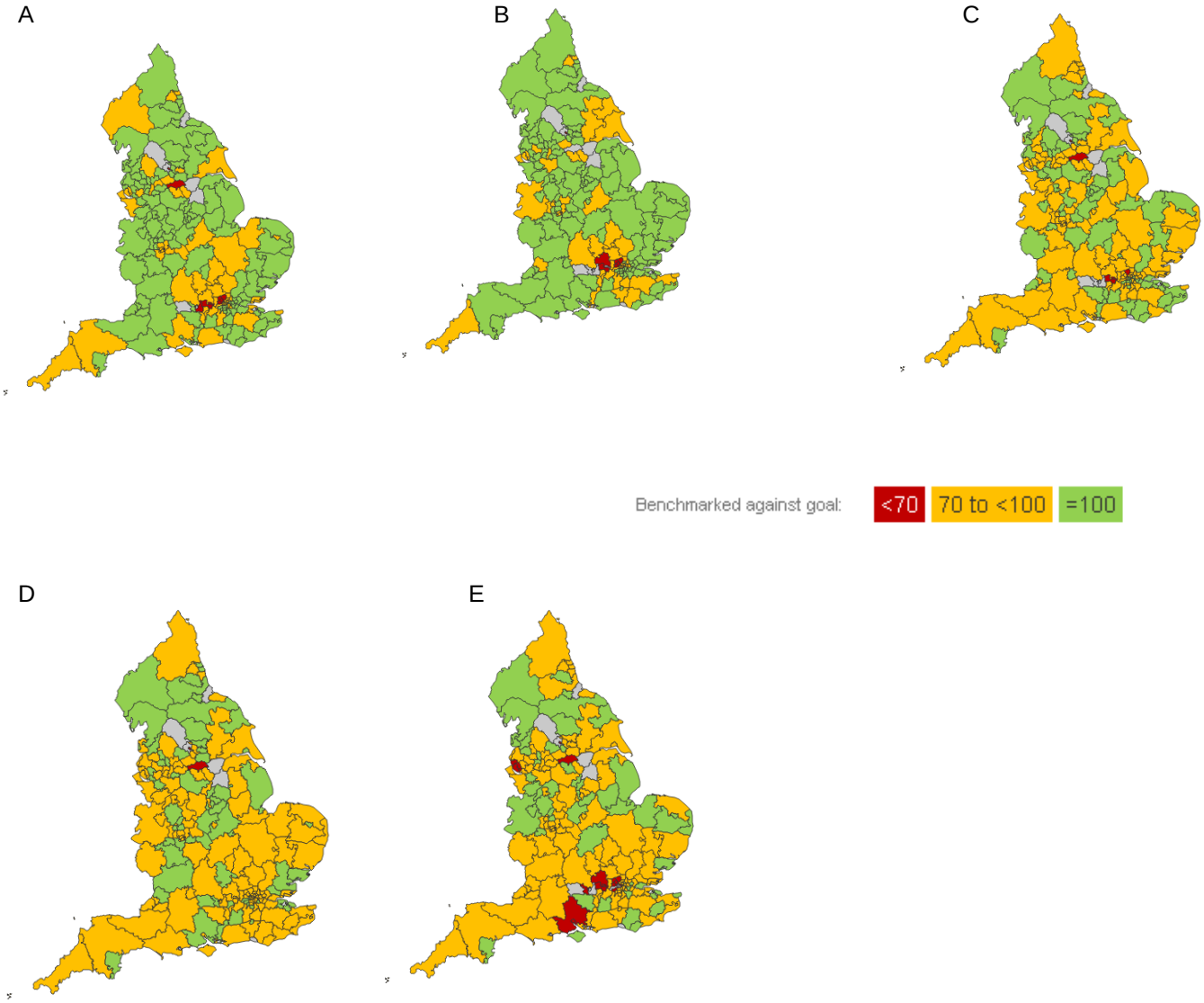


Figure 7: Proportion of *E.coli* from blood tested for susceptiblity to: A (a carbapenem), B (a 3rd generation cephalosporin), C (ciprofloxacin), D (gentamicin), E (piperacillin/tazobactam). Data presented by CCG for quarter four 2017
Source: PHE AMR local indicators[1]



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
8 October 2020

NHS Devon Clinical Commissioning Group Update

Report of the Clinical Chair, NHS Devon Clinical Commissioning Group.

Recommendation: that Health and Wellbeing Board be asked to note the report.

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1. Restoration and Recovery

1.1. Work is progressing on Devon's third phase of the NHS response to COVID-19. We're taking a system-wide approach to ensure the plan is comprehensive, consistent and addresses the requirements of the national guidance, which outlines the need to:

- Accelerate the return to near-normal levels of non-COVID-19 health services, making full use of the capacity available between now and winter
- Prepare for winter demand pressures, while continuing to be ready for potential increases in coronavirus cases
- Learn from the first phase of coronavirus to embed beneficial changes and tackle fundamental challenges

1.2. Our draft plan was submitted to NHS England and NHS Improvement on 1 September 2020 and we are currently refining this to take account of feedback received.

1.3. Devon's winter plan is also in development, overseen by the Devon Urgent Care Programme Board and with a focus on local system planning, including demand and capacity planning and escalation.

1.4. Our key objectives in terms of the restoring elective (planned) activity as we move into phase three includes:

- Continuing to maximise our use of independent sector capacity
- Accelerating the development of patient-initiated follow-ups (PIFU)
- Expanding diagnostic capacity through use of the NHS Nightingale Hospital Exeter.

2. Teignmouth and Dawlish

2.1. We held our first online public consultation meeting on the future shape of health and care services in the Teignmouth and Dawlish area on Friday 11 September.

2.2. With COVID-19 still circulating, the consultation is taking place in a different way with six live meetings held online so that the risks of public gatherings are avoided.
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2.3. We're also delivering the consultation document and survey to 16,000 local people and offering telephone conversations with someone from the NHS for those without the internet.

2.4. We are asking people to consider a proposal for moving services from Teignmouth Community Hospital, given that a new £8million Health and Wellbeing Centre is due to be built in the heart of Teignmouth.

2.5. The centre will bring GP services, community health and care and voluntary sector services together under one roof in the centre of town, meaning that care can be much more easily coordinated for each patient.

3. Integrated Care System (ICS) Partnership Board

3.1. The ICS Partnership Board met in shadow form on 2 September. The ICS Partnership Board will be key in ensuring we maintain a system focus for both commissioners and providers, and health and local authority.

3.2. The development of informal structures for working "at place" is at an early stage with different approaches and levels of progress in each of the 5 Local Care Partnership (LCP) areas.

3.3. There is a clear commitment across the county that place arrangements need to be suited to the circumstances and priorities of each place and there will be no centrally imposed governance structure.

3.4. However, it is important that each place is able to demonstrate that it has the capacity and capability to deliver on its objectives before it's accountability and budgetary responsibility can be increased. Each LCP has a Development Lead who is co-ordinating and supporting this work.

4. Devon People Plan

4.1. We are developing a Devon People Plan to grow, train and support our workforce, while introducing new ways of working to improve patient care. Developed in collaboration with health providers across Devon, our plan will outline our ambitions and commitments to deliver change for our people through four key priorities:

1. Looking after our people
2. Belonging in the NHS
3. New ways of working and delivering care
4. Growing for the future

4.2. Building on our learning from the COVID-19 response, our plan will ensure we can attract the brightest and best new talent to our system while continuing to develop our existing fantastic staff.

4.3. Our local plan is being developed in response to the national NHS People Plan, which sets out practical actions for employers and systems, as well as the actions that NHS England and NHS Improvement and Health Education England will take.

5. NHS Devon CCG - Senior leadership structure

5.1. We are now in the next phase of recruitment for this combined role of System Lead Executive and CCG Accountable Officer Recruitment.

5.2. The job is now out to advert and Gatenby Sanderson are managing this process on our behalf. Interviews are planned for 18 November.

5.3. Following the merger of our CCGs and our coronavirus response, we made some transitionary changes to our Accountable Officer direct reports with effect from Monday 14 September. Evolving our current structures will help us to mirror the commissioning cycle as we move towards becoming a strategic commissioner as part of an Integrated Care System (ICS) next year.

6. Think 111 First

6.1. The Think 111 First Programme Board and clinical workstream is underway and the programme Board is working towards launch in October.

6.2. Workstreams are considering clinical pathways, direct bookings to emergency departments, minor injury units and primary care, impact assessments and a public promotion campaign.

6.3. The Devon approach aims to redefine and improve urgent care pathways by ensuring that patients receive the right care in the most appropriate setting with the lowest level of risk of acquiring a hospital or healthcare-related infection.

6.4. This need has been brought into focus during the COVID-19 pandemic, particularly given the capacity in our A&Es, the need to meet nationally targets for treatment and bed occupancy, while maximising the use of capacity to respond to winter pressures and plan for surge.

6.5. Taking learning from the Cornwall and Isles of Scilly Health and Care Partnership, who are an early adopter in this approach, we will be seeking to understand the learning from this to build upon areas of good practice for our population.

Name: Dr Paul Johnson, Chair, NHS Devon Clinical Commissioning Group.

Electoral Divisions: All

HEALTH AND WELLBEING BOARD – FORWARD PLAN

Date	Matter for Consideration
Thursday 21 January 2021 @ 2.15pm	**Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund - frequency of reporting TBC JSNA / Strategy Refresh Children's Social Care Services OFSTED update (look at report) Population Health Management & and Integrated Care Management (Presentation) Strategic Approach to Housing Gap in employment rate for those with mental health Homelessness Reduction Act Report - 12 month update CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information
Thursday 8 April 2021 @ 2.15pm	**Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund - frequency of reporting TBC Devon Smokefree Alliance JSNA / Strategy Refresh CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information
Thursday 15 July 2021 @ 2.15pm	**Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund - frequency of reporting TBC CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information
Thursday 28 October 2021 @ 2.15pm	**Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund - frequency of reporting TBC Adults Safeguarding annual report CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information

Thursday 13 January 2022 @ 2.15pm	**Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund - frequency of reporting TBC CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information
Thursday 7 April 2022 @ 2.15pm	**Performance / Themed Items** Health & Wellbeing Strategy Priorities and Outcomes Monitoring Theme Based Item (TBC) **Business / Matters for Decision** Better Care Fund - frequency of reporting TBC CCG Updates **Other Matters** Scrutiny Work Programme / References, Board Forward Plan, Briefing Papers, Updates & Matters for Information
Annual Reporting	Adults Safeguarding annual report (September / December) Joint Commissioning Strategies – Actions Plans (Annual Report – December) JSNA / Strategy Refresh – (June)
Other Issues	Equality & protected characteristics outcomes framework