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

2015 - 2016

PLYMOUTH CITY COUNCIL

one and all / onen hag oll
CORNWALL COUNCIL

TORBAY COUNCIL

1. Introduction

1.1 The following report to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council and the Council of the Isles of Scilly provides a summary of the assurance functions of the Health Protection Committee (of the four Boards) and significant matters considered for the period from 1st April 2015 to the 31st March 2016.

1.2 The report considers the following domains of health protection:

- Communicable disease control and environmental hazards
- Immunisation and screening
- Health care associated infections.

1.3 The report summarises action taken to date against the programme of health protection work priorities established by the committee for the period 2015 to 2016.

2. Assurance Arrangements

2.1 On 1st April 2013 significant changes took place in the health and social care landscape following implementation of the new NHS and Social Care Act (2012). At this time, the majority of former NHS Public Health responsibilities transferred to upper tier and unitary local authorities including the statutory responsibilities of the Director of Public Health.

2.2 With regards to health protection, local authorities through their Director of Public Health, require assurance that appropriate arrangements are in place to protect the public's health. The scope of health protection in this context includes:

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

2.3 The Health Protection Committee (and its Terms of Reference) has been formally mandated by the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council. Cornwall Council and the Council of the Isles of Scilly co-operate in the Committee and may formally join in the future.

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

2.5 Terms of Reference (Appendix 1) for the Committee were agreed by Local Authority Directors of Public Health, their Health Protection Lead Officers as well as representatives from Public Health England (including Consultant in Communicable Disease Control), NHS England Area Team and the Clinical Commissioning Groups.

2.6 By serving four upper tier Local Authorities, the Committee allows health protection expertise from four public health teams to be pooled in order to share skill and maximise capacity. Furthermore, for external partners whose health protection functions serve a larger geographic footprint, this model reduces the burden on them to attend multiple health protection meetings with similar terms of reference and to consider system-wide risk more efficiently and effectively.

2.7 The Committee has a number of health protection subgroups supporting it to identify risks across the system of health protection and agree mitigating activities for which the Committee provides control and oversight. As illustrated in Appendix 2, these include:

- Health Care Associated Infection Programme Group
- Health Protection Advisory Group for wider Devon
- Devon, Cornwall and Isles of Scilly Screening and Immunisation Overview Group
- Local Health Resilience Partnership

2.8 Through the Local Authority Health Protection Lead Officers (Consultants in Public Health), Terms of Reference for each of these groups have been reviewed to ensure they reflect the assurance arrangements overseen by the Health Protection Committee.

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

2.10 Meetings of the Committee between 1st April 2015 and 31st March 2016 were held on 6th May 2015, 5th August 2015, 7th October 2015, 2nd December 2015 and the 3rd February 2016.

2.11 A memorandum of understanding which specifies the roles and responsibilities of the various agencies involved in Health Protection has been drawn up.

3. Prevention and Control of Infectious Diseases

Organisational Roles/Responsibilities

3.1 NHS England has responsibility for managing/overseeing the NHS response to an incident, ensuring that relevant NHS resources are mobilised and commanding/ directing NHS resources as necessary. Additionally NHS England is responsible for ensuring that their contracted providers will deliver an appropriate clinical response to any incident that threatens the public's health.

3.2 Public Health England through its consultants in communicable disease control will lead the epidemiological investigation and the specialist health protection response to public health outbreaks/incidents and has responsibility to declare a health protection incident, major or otherwise.

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

3.4 The Local Authority through the Director of Public Health or their designate has overall responsibility for the strategic oversight of an incident/outbreak impacting on their population's health. They should ensure that an appropriate response is put in place by NHS England and Public Health England supported by the Clinical Commissioning Group. In addition, they must be assured that the local health protection system is robust enough to respond appropriately in order to protect the local population's health and that risks have been identified, are mitigated against and adequately controlled.

Surveillance Arrangements

3.5 Public Health England provide a quarterly centre report for its catchment; Devon, Cornwall and the Isles of Scilly and Somerset. The report provides epidemiological information on cases and outbreaks of communicable diseases of public health importance. A quarterly report is also produced at the Devon County Council, Torbay Council and Plymouth City Council level.

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

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

Tuberculosis

3.8 Devon and Cornwall continue to have a low incidence of Tuberculosis relative to the UK as a whole and to Torbay and Plymouth. The year 2015-16 was a relatively quiet one in Tuberculosis terms with no new outbreaks.

Figure 1: Tuberculosis rate per 100,000 population by upper tier local authority of residence. South West 2014

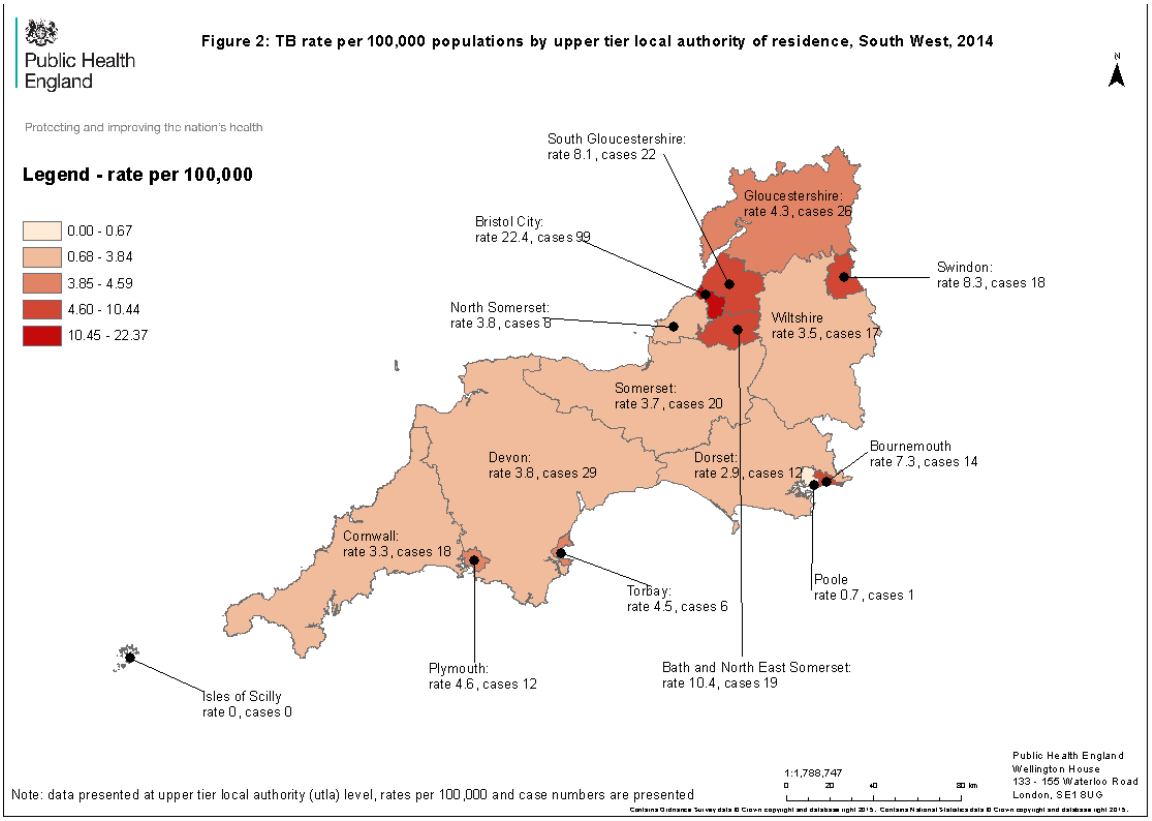


Table 1: Tuberculosis, annual rates by Local Authority 2012-14

	2012	2013	2014
Cornwall	3.3	2.4	3.3
Devon	4.0	3.6	3.8
Plymouth	7.8	4.6	4.6
Torbay	3.8	7.6	4.5

3.9 The incidence rates of Tuberculosis for the local authorities in the far South West are still low compared to national urban rates, although the trend is upwards.

Norovirus 2013-14

3.10 Norovirus is the most common cause of infectious gastroenteritis (diarrhoea and vomiting) in England and Wales and is highly infectious. The illness is generally mild and people usually recover fully within two to three days. Infections can occur at any age because immunity does not last. Historically known as 'winter vomiting disease', the virus is more prominent during the winter months, but can occur at any time of year. Outbreaks are common in semi-closed environments such as hospitals, nursing homes, schools and cruise ships.

3.11 As illustrated in the table below norovirus vomiting, diarrhoea, and gastroenteritis consultation rates overall have been low compared to the average year. In comparison to the five yearly average, laboratory reports for England were 13% less than average and the syndromic surveillance should be seen in this light. The graphics cannot be used to estimate burden of disease as many cases will never be reported.

Figure 2: Weekly counts of laboratory reports of Norovirus in residents of Cornwall, Devon, Isles of Scilly, Plymouth and Torbay Upper Tier Local Authorities, Week 14 2015 (week commencing March 30th 2015) to Week 13 2016 (week commencing March 28th 2016)

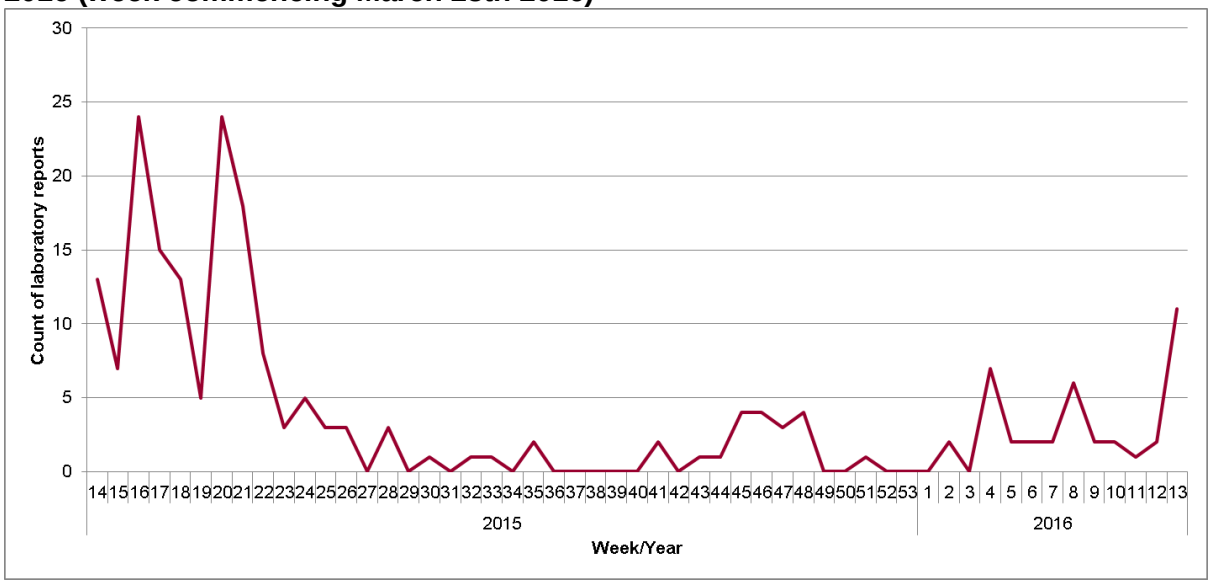
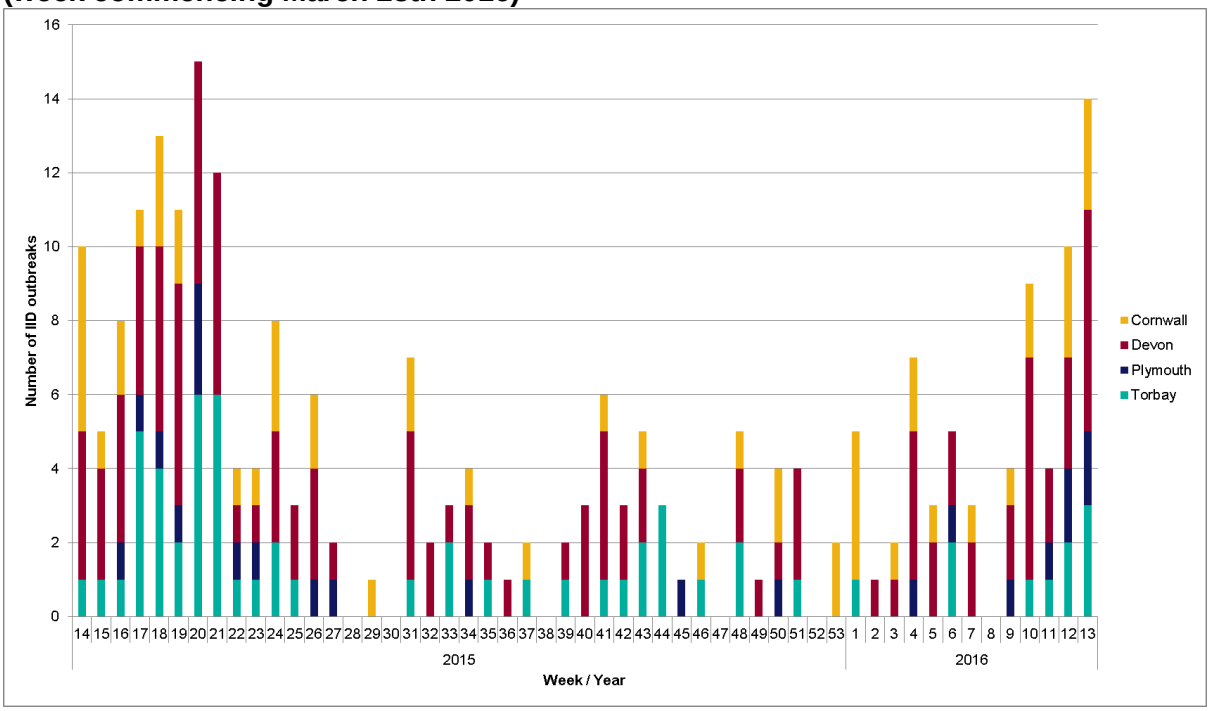


Table 2: Annual numbers of Norovirus isolations by Upper Tier local Authority for the last three years

	April 2013 to March 2014	April 2014 to March 2015	April 2015 to March 2016
Cornwall & Isles of Scilly	116	116	79
Devon	82	149	59
Plymouth	43	39	18
Torbay	44	102	45

Figure 3: Weekly counts of reports of infectious intestinal disease (IID) outbreaks (suspected or laboratory confirmed) by upper tier local authorities, Week 14 2015 (week commencing March 30th 2015) to Week 13 2016 (week commencing March 28th 2016)



3.12 The majority of outbreaks in the winter 2015-16 have occurred in the first three months of 2016 largely paralleling the incidence of symptoms in the community.

Table 3: All reports of infectious intestinal disease outbreaks (suspected or laboratory confirmed) by upper tier local authority, Devon, Torbay, Plymouth, Cornwall and Isles of Scilly combined, 2015 Week 14 - 2016 Week 13

Upper tier lower authority	Total Norovirus outbreaks 2015 -2016
Cornwall & Isles of Scilly	50
Devon	108
Plymouth	20
Torbay	58

Source: Public Health England HNORS & HPZone

Table 4: All reports of infectious intestinal disease outbreaks by month Torbay, Plymouth, Devon, Cornwall and Isles of Scilly, 2015 - 2016.

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No of outbreaks	42	45	23	8	11	5	20	8	11	15	12	36

Table 5: Total number of outbreaks, 2015-16 by setting for the four upper tier Local Authorities

Upper Tier Local Authority	Total Number of IID outbreaks reported March 2015 – April 2016				
	Hospital	Nursing/care home	Education/ nursery	Other	Total
Devon	50	47	28	10	135
Plymouth	3	27	7	0	37
Torbay	17	7	9	4	37
Devon Total	**70**	**81**	**44**	**14**	**209**

3.13 In order to support best practice regarding infection control in the management of norovirus, Local Authority Public Health Teams working with Public Health England cascaded information across health and social care services including care homes before the winter season began.

Scarlet Fever 2015-16

3.14 Scarlet fever is a common childhood infection caused by Streptococcus pyogenes (also known as Group A Streptococcus [GAS]). Some people carry these bacteria in their nose and throat, or on their skin without suffering active infections. Under some circumstances and in some people, GAS can cause infections such as pharyngitis, impetigo and scarlet fever (these are regarded as non-invasive infections). On rare occasions they can cause severe disease, including streptococcal toxic shock syndrome, necrotising fasciitis, and other invasive GAS (iGAS) infection.

3.15 Routine national surveillance data for invasive and non-invasive GAS infections suggests a cyclical pattern with higher incidence peaks evident in notifications approximately every four years. Seasonal trends show that increased levels of GAS infections typically occur between December and April, with peak incidence usually in March.

3.16 Public Health England reported an increased rate of scarlet fever notifications across England (Table 6) in 2013-14 and 2014-15. This pattern of high incidence has been repeated in 2015-2016 with a 12.7% increase in cases nationally between September and April continuing the year-on-year increase. Devon, Cornwall and Somerset have however a slightly lower than average incidence compared to the rest of England and this has shown a less abrupt increase over the two seasons.

Table 6: Scarlet fever, rate of notifications Jan 2014 – Mar 2016 per 100,000 population

	Jan – Mar 2014	April-June 2014	July–Sept 2014	Oct – Dec 2014	Jan – Mar 2015	April–June 2015	July–Sept 2015	Oct–Dec 2015	Jan–Mar 2016
Torbay	3.0	10.5	2.3	3.8	23.3	8.3	1.6	3.0	8.3
Plymouth	4.2	8.0	1.6	2.3	11.8	6.9	3.8	2.7	12.6
Devon	9.7	6.0	1.6	3.0	8.9	7.6	2.6	6.8	13.1
Cornwall	6.4	6.9	1.5	2.9	4.7	5.3	2.9	2.0	11.5

Table 7: Invasive Group A Streptococcal infection per 100,000 population

	Jan–Mar 2014	April–June 2014	July–Sep 2014	Oct–Dec 2014	Jan–Mar 2015	April–June 2015	July–Sept 2015	Oct–Dec 2015	Jan–Mar 2016
Cornwall	1.5	1.1	0.9	0.5	1.1	1.8	0.7	0.7	0.9
Devon	0.9	1.7	2.0	0.7	1.8	2.1	1.2	0.7	1.6
Plymouth	0.4	1.1	1.1	1.5	0.4	0.8	1.1	0.4	1.5
Torbay	1.5	0.8	1.5	2.3	3.8	3.8	2.3	1.5	0.0

3.17 Devon continues to have a relatively high incidence of invasive group A Streptococcal infections.

3.18 Locally, in order to reduce ongoing transmission, Local Authority Public Health Teams wrote again to schools and child care facilities providing information about the increase in cases and reiterating infection control advice. Public Health England wrote to General Practitioners to make them aware of the high incidence and the need to diagnose and treat the infection promptly to minimise spread.

Seasonal influenza

3.19 The winter of 2015-16 was one of moderate flu activity. This year the seasonal 'flu 'A' strain component was a good match to the circulating strain and offered good protection to those vaccinated, the live nasal vaccine for children seems to have been particularly effective. The period of maximal flu activity came late in the winter and was relatively long- lived so caused a substantial burden of disease.

Figure 4: Weekly counts of laboratory reports of Influenza A and Influenza B in residents of Cornwall, Devon, Isles of Scilly, Plymouth and Torbay upper tier local authorities, Week 14 2015 (week commencing March 30th 2015) to Week 13 2016 (week commencing March 28th 2016)

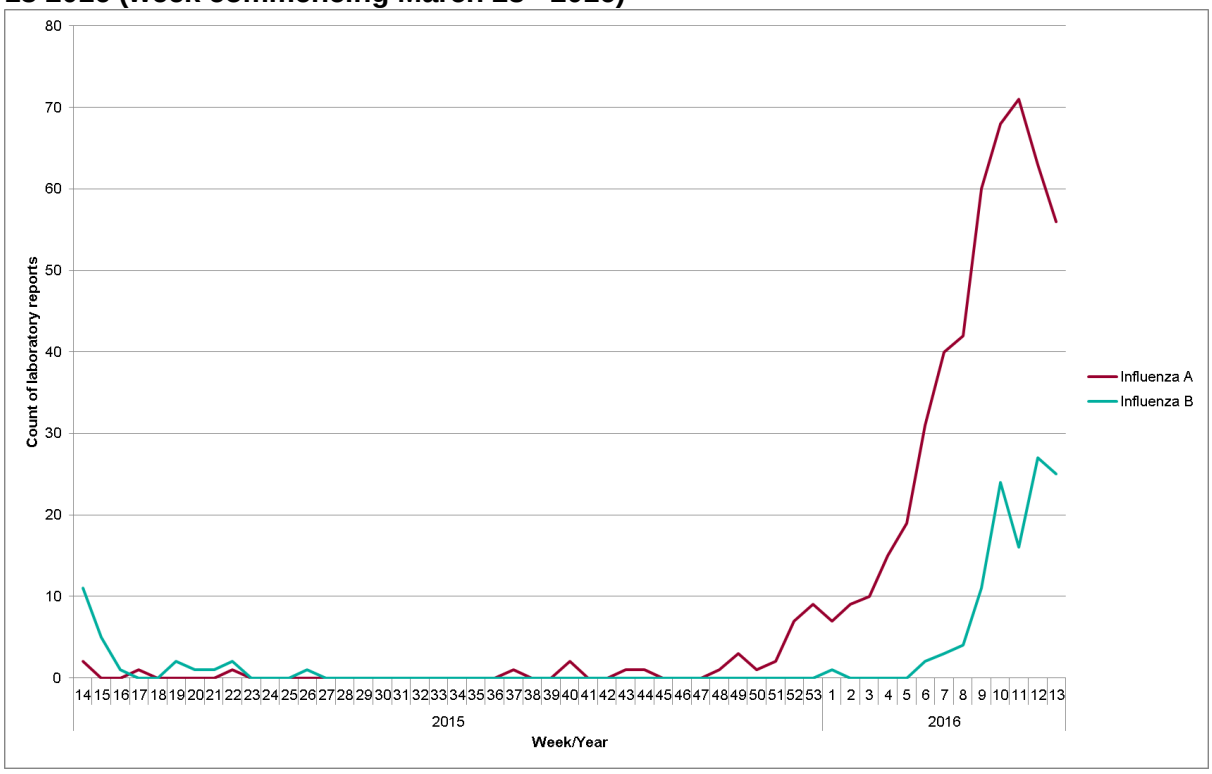


Figure 5: GP (in hours) influenza-like illness consultation rate, Cornwall (including Isles of Scilly), Devon, Plymouth, Torbay and England, Week 14 2015 (week commencing March 30th 2015) to Week 13 2016 (week commencing March 28th 2016)*

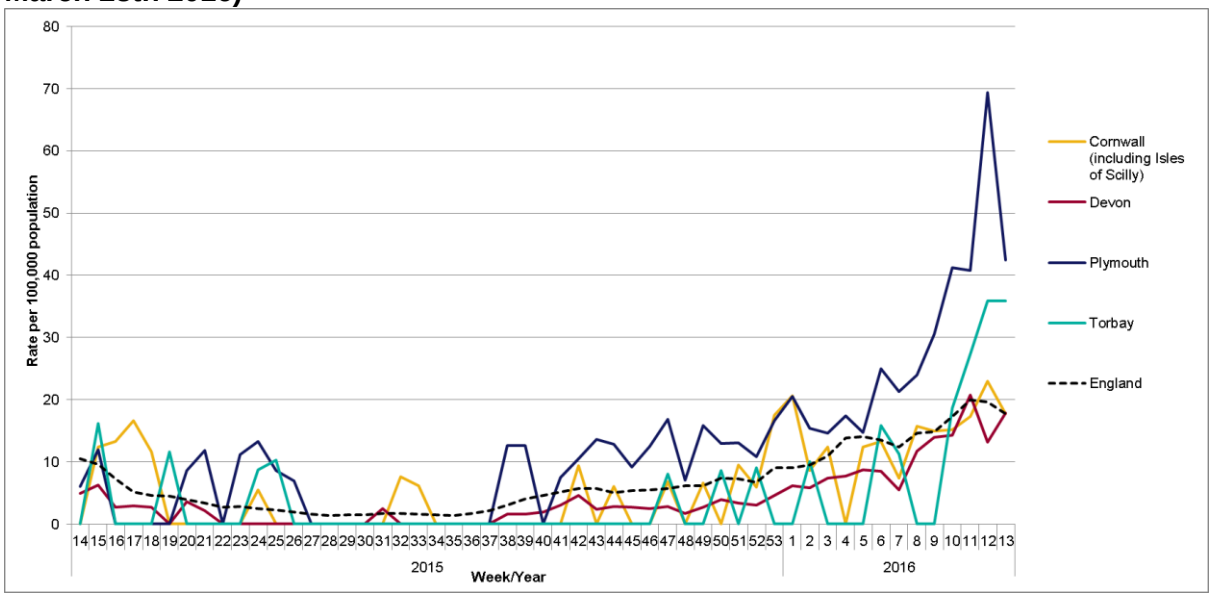


Table 8: Total number of flu outbreaks in 2015-16 by Upper tier Local Authority

	Number of flu outbreaks
Cornwall	6
Isles of Scilly	0
Devon	9
Plymouth	7
Torbay	2

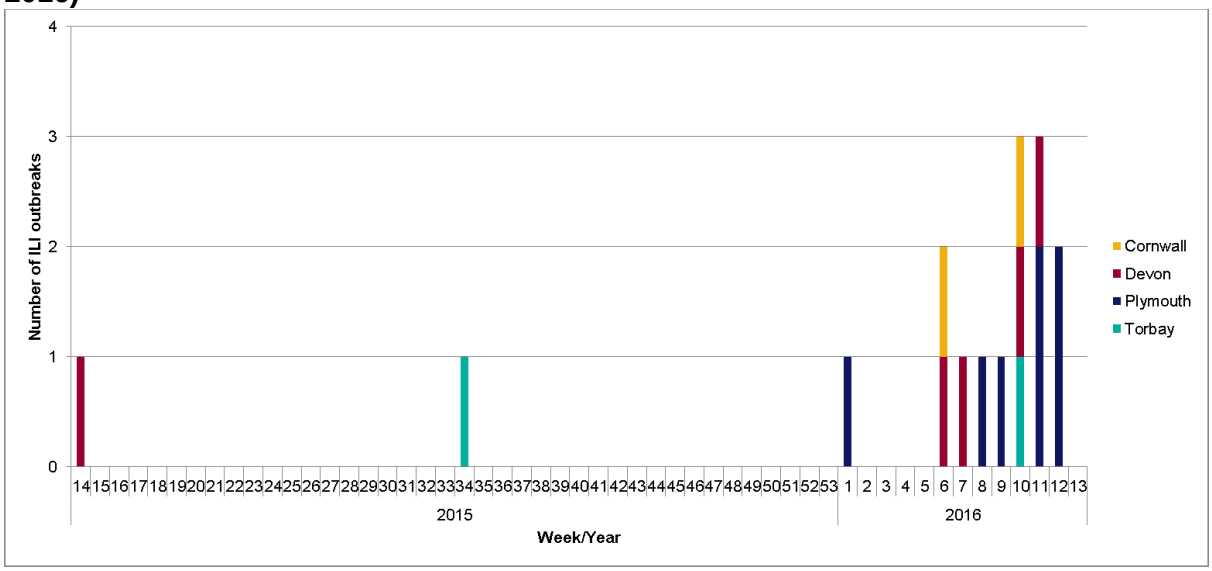
Table 9: Total number of flu outbreaks for 2015-16 by month

Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
No of outbreaks	**1**	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**1**	**5**	**15**

Table 10: Total number of flu outbreaks 2015-16 by setting and Upper tier Local Authority

Upper Tier Local Authority	Total number of influenza-like illness outbreaks reported April 2015 - March 2016				
	Hospital	Nursing/care home	Education/ Nursery	Other	**Total**
Devon	1	1	5	2	**9**
Plymouth	2	0	5	0	**7**
Torbay	0	1	1	0	**2**
Cornwall	2	2	2	0	**6**
Total	**5**	**4**	**13**	**2**	**24**

Figure 6: Weekly counts of reports of influenza like illness (ILI) outbreaks (suspected or laboratory confirmed) by UTLA, Week 14 2015 (week commencing March 30th 2015) to Week 13 2016 (week commencing March 28th 2016)



4. Immunisation and Screening

Organisational Roles/Responsibilities

4.1 NHS England commission most national screening and immunisation programmes through Local Area Teams.

4.2 Public Health England is responsible for setting screening and immunisation policy through expert groups (the National Screening Committee and Joint Committee on Vaccination and Immunisation). At a local level, specialist public health staff employed by Public Health England, are embedded in the NHS Local Area Teams to

provide accountability for the commissioning of the programmes and provide system leadership.

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

Surveillance Arrangements

4.4 Public Health England Screening and Immunisation Coordinators provide quarterly reports for each of the national immunisation and screening programmes. Due to data capture mechanisms (with the exception of the seasonal influenza vaccination programme) real time data are not available for each programme and reports are normally two calendar quarters in arrears. 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.

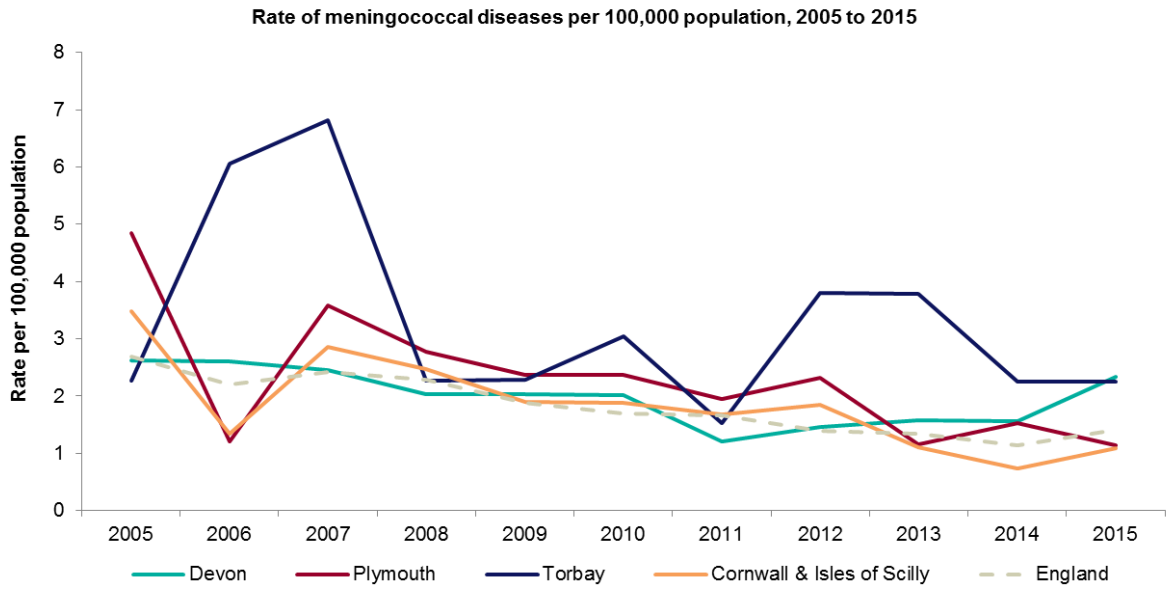
4.5 Incidents that occur in the delivery of programmes should be reported to the Director of Public Health for the Local Authority and to the Health Protection Committee.

4.6 Peninsula Immunisation and Screening Oversight Groups form part of the assurance mechanism to identify risks to delivery across all programmes and are attended by lead Local Authority Consultants in Public Health. In addition, specific programme groups are convened to oversee their development, most notably when changes to a programme have been agreed at a national level.

Immunisation Activity and Changes to the National Immunisation Programme 2015-16

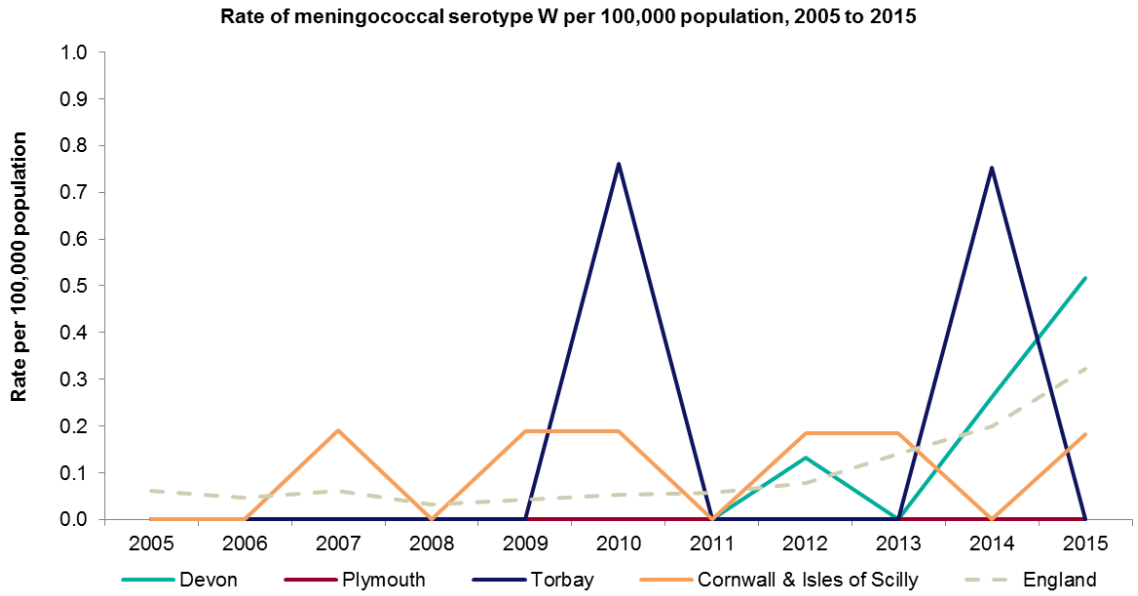
4.7 The period 2015-16 saw significant activity regarding immunisation programmes and changes to the national immunisation schedule. The schedule for the Meningitis C immunisation has been changed, replacing a dose at four months with a booster in adolescence with effect from June 2013. Overall, rates of meningococcal disease have declined over the last few years (Figure 7), but rates of meningococcal Group W disease have increased (Figure 8), particularly in teenagers. In response to this, the final dose of Meningococcal Group C vaccine has been replaced with MenACWY to include Group W to protect children better. The Group B meningitis vaccine was introduced into the childhood immunisation programme in September 2015. The supply situation for BCG vaccine has not improved, and only a few individuals are receiving vaccination. However, a waiting list of eligible vaccinees is being kept, so that if the vaccine supply eases, these individuals can be invited for vaccination.

Figure 7: Rate of meningococcal disease per 100,000 population 2005 to 2015 by upper tier local authority for Devon, Torbay, Plymouth, Cornwall and the Isles of Scilly



Data Source: Enhanced Surveillance of Meningococcal disease database 2005-2013 and HPZone 2014-2015

Figure 8: Rate of Group W meningococcal infection per 100,000 population, 2005 to 2015 by Upper tier local authority



Data Source: Enhanced Surveillance of Meningococcal disease database 2005-2013 and HPZone 2014-2015

4.8 Childhood flu vaccination for all two and three year olds was extended to four year olds in the Winter of 2014-15, and in the winter of 2015-16 this was extended to children in school years 1 and 2.

4.9 The booster dose of Pertussis for pregnant women has been continued, and is due to continue for the foreseeable future. However, although the rate of Pertussis infection

in the population has declined from the peak in 2012, but after declining in 2013 and 2014, the incidence now seems to have levelled out at a high level. The booster dose in pregnancy is being retained to continue the protection of neonates, who are most vulnerable to Pertussis.

Table 11: Pertussis notification rates Jan 2014 – Mar 2016 per 100,000 population

	Jan–Mar 2014	April–June 2014	July–Sept 2014	Oct–Dec 2014	Jan–Mar 2015	April–June 2015	July–July 2015	Oct–Dec 2015	Jan–Mar 2016
Cornwall	0.9	0.5	0.5	0.4	0.4	0.7	2.0	2.7	2.4
Devon	0.7	2.1	2.5	2.1	0.7	2.7	5.7	4.1	3.0
Plymouth	1.5	0.4	1.5	1.1	0.8	1.9	1.9	4.2	1.5
Torbay	1.5	0.0	0.8	0.0	0.0	1.5	3.8	3.8	9.0

4.10 A priority area identified by the Health Protection Committee was to increase uptake of seasonal influenza vaccine, especially in groups under 65 years of age considered at risk due to underlying health conditions and who are eligible for free vaccination through the national programme. This was on the basis of poor uptake in this cohort following the 2014-15 programme reported at Clinical Commissioning Group level.

Table 12: Public Health England Seasonal flu vaccination figures 1 September 2015 – 31 January 2016 by Upper Tier Local Authority

	2015-16 season %					
	2 year olds	3 year olds	4 year old	Pregnant women	Under 65 at risk	Over 65
Cornwall	31.6	36.2	38.8	38.1	45.6	69.4
Devon	42.7	42.5	33.9	43.4	42.0	69.8
Plymouth	32.0	38.0	30.7	42.9	44.9	71.5
Torbay	32.8	39.4	32.4	36.6	40.6	66.4

Table 13: Seasonal flu vaccination figures 1st September 2015 – 31 January 2016 by CCG

Clinical Commissioning Group	% of practices responding	65+ % vaccinated	6m-65 at risks % vaccinated	Pregnant women % vaccinated
NEW Devon	99.2%	70.3%	43.1%	43.0%
South Devon & Torbay	97.1%	67.6%	40.3%	40.7%
NHS Kernow	98.5%	69.4%	45.6%	38.1%
England	99.8%	71.0%	45.1%	42.3%
Target	100%	75%	75%	N/A

Source: ImmForm, Public Health England, Public Health England weekly bulletin

Table14 : Flu vaccine uptake in Pre-school children by CCG

Children						
Age/risk	**Age 2**	**Age 2 at risk**	**Age 3**	**Age 3 at risk**	**Age 4**	**Age 4 at risk**
NHS Kernow	39.8%	49.6%	40.7%	55.8%	36.5%	50.4%
NEW Devon	33.6%	43.2%	39.1%	55.4%	30.7%	48.8%
South Devon & Torbay	31.2%	45.7%	35.6%	53.8%	33.3%	45.1%
England	35.0%	48.3%	37.0%	52.3%	29.1%	47.3%

4.11 Compared to last year the uptake of flu vaccine has fallen for children across the age spectrum. This may in part be due to uncertainty about the provider of this vaccination in the 2015-16 season. This should be more settled in 2016-17.

Table 15: School aged Children's flu vaccinations by Upper tier local authority 2015 -2016

	Age 5 -6	**Age 7- 8**
Kernow	30.3%	25.2%
Isles of Scilly	77.8%	87.5%
Devon	36.3%	32.9%
Plymouth	31.7%	28.9%
Torbay	49.6%	44.6%
England	54.4%	52.9%

4.12 There is a major initiative to increase flu vaccine uptake amongst frontline healthcare workers, in recognition of the benefits this brings both in reducing risk to patients, and in improved business resilience.

Table 16: Flu vaccine uptake 2015 – 16 by Employer

Trust	**Uptake % Frontline workers**
South Devon Foundation Trust	51.0
Northern Devon Healthcare Trust	38.4
Royal Cornwall Hospitals Trust	39.5
Royal Devon and Exeter Foundation Trust	50.5
Cornwall Partnership Trust	20.9
Plymouth Hospitals Trust	53.4
Devon Partnership Trust	55.3
South West Ambulance Service Trust	42.5
NHS Area Health Care Works Average	43.1

4.13 In Devon local authority 122 staff were immunised for the 2014-15 season, a significant improvement on the previous year. In the 2015-16 season only 64 front-line staff were immunised.

4.14 Learning from the programme is being fed into plans to support flu vaccination uptake in 2016-17 across Devon Cornwall and Isle of Scilly's and Bristol, Gloucester and Wiltshire areas. Issues around the effectiveness of the vaccine, and the timing and visibility of the national media campaign, were identified as barriers to improving uptake locally, and addressing these will be crucial if uptake is to be sustained or increased in 2016-17.

5. Health Care Associated Infections

Organisational Roles/Responsibilities

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

5.2 Public Health England through its consultants in communicable disease control will lead the epidemiological investigation and the specialist health protection response to wider community non-hospital outbreaks, unless multiple hospital sites are affected simultaneously, and has responsibility to declare 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 and Western Devon and South Devon and Torbay Clinical Commissioning Groups employ a lead nurse for health care associated infections. This is an assurance and advisory role. In addition, they 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 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 impacting on their population's health. They should ensure that an appropriate response is put in place by NHS England and Public Health England supported by the Clinical Commissioning Group.

Health Care Associated Infection Programme Group

5.5 The group was formed as a sub group of the Health Protection Committee. Its function is to work towards the elimination of avoidable health care associated infections (HCAI) for the population of Devon, Cornwall and the Isles of Scilly including the Unitary Authorities of Plymouth and Torbay, receiving health and social care interventions in clinical, home and residential care environments, through the

identification of risks, the planning of risk mitigation actions and the sharing of best practice in the field.

5.6 It is a cross-agency forum involving Acute and Community NHS Trusts, Ambulance and Out of Hours Doctors, Public Health, Public Health England, Medicines Optimisation and NHS England Area Team. The group met for the first time in March 2014 and has since convened three times a year through a single workshop event and two teleconference calls.

6. Healthcare Associated Infections

6.1 Health Care Associated Infections (HCAIs) is a key indicator of safe and effective patient care and is represented in the NHS Outcomes Framework 2015-16 under outcome 5 'treating and caring for people in a safe environment and protecting them from avoidable harm'.

6.2 This report includes data from April 2015 - Mar 2016, unless otherwise stated.

MRSA

NEW Devon Clinical Commissioning Group

6.3 Five cases in NEW Devon Clinical Commissioning Group as at the end of March 2016. Four were community acquired and one in an acute hospital none of the five cases were connected. All cases have had Post Infection Reviews (PIRs) completed and lessons learned shared with relevant involved teams.

NHS Kernow Clinical Commissioning Group

6.4 Ten cases in Cornwall patients for 2015-16. Two acute assigned, three clinical commissioning groups assigned, four third party assigned and one case in arbitration at the time of reporting. One patient accounted for three cases and three other cases were in IV drug users.

South Devon and Torbay Clinical Commissioning Group

6.5 **Table 17: Actual Numbers to date 2015-16 (Ambitions 2015-16)**

MRSA bacteraemia	Apr-Jun 2015	Jul-Sept 2015	Oct-Dec 2015	Jan-Mar 2016
Torbay and South Devon Foundation Trust (0pa)	0	1	0	0
Clinical Commisioning Group (0pa)	0	0	0	2

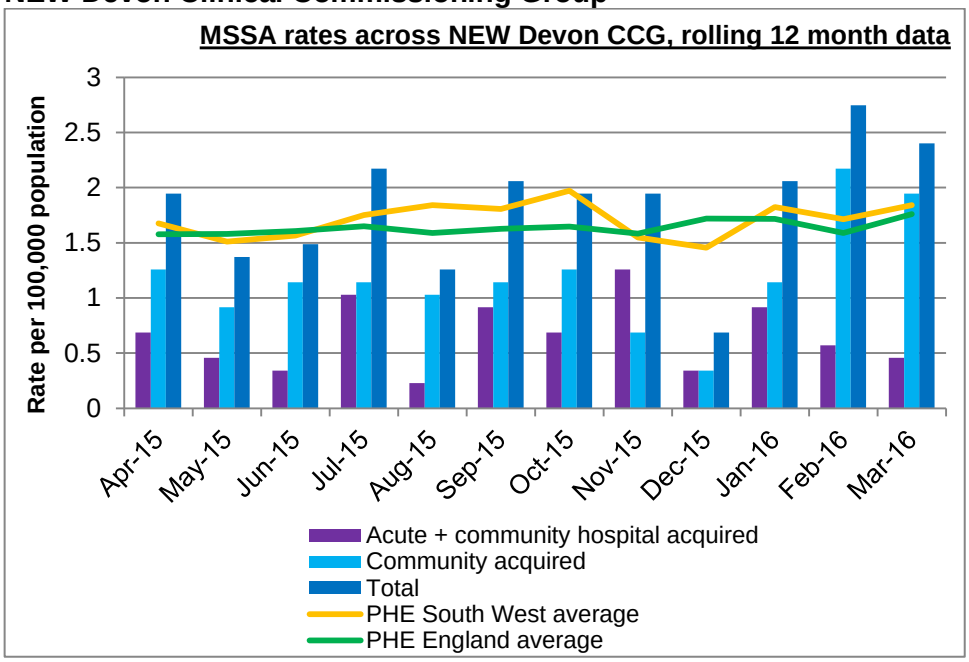
Actual Numbers to date 2015-16 reportable on MESS but no External targets (Internal KPI stated)

MSSA

NEW Devon Clinical Commissioning Group

6.6 MSSA bacteraemia rates for the NEW Devon Clinical Commissioning Group population have fluctuated above and below the Public Health England, England and South West average rate lines. Providers of hospital and community services provide information to the clinical commissioning group as part of their performance reporting obligations. In hospital bacteraemias will be targeted for more local investigation by providers as part of their 2016-17 Health Care Associated Infections Reduction Plan in order to identify any learning that might be used to reduce rates. The GP significant event audit process as described in the December 2015 HPC report is the only current method of learning about these infections in the community and developing strategy to reduce their incidence.

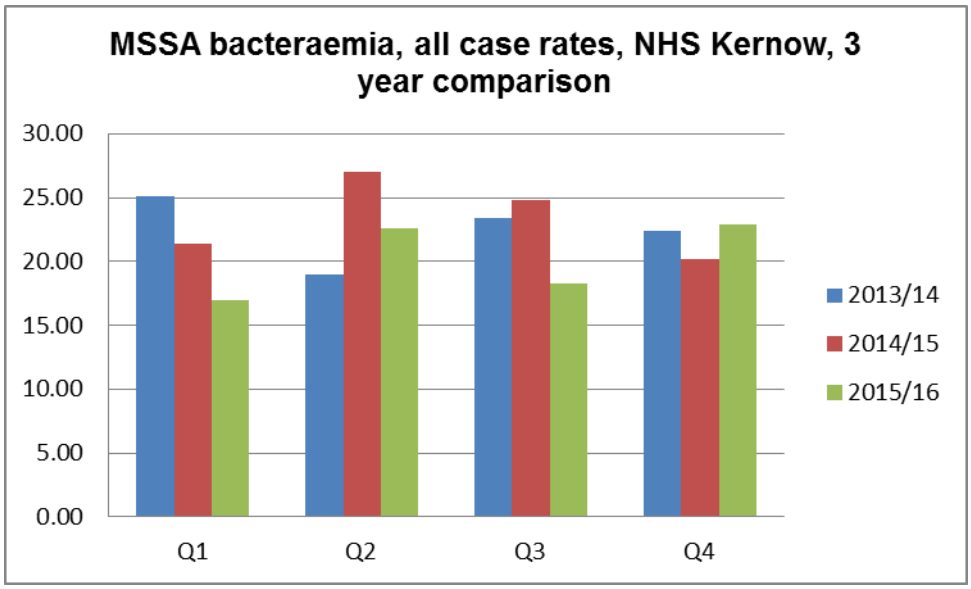
Figure 9: Methicillin sensitive staphylococcus aureus bacteraemias by month for NEW Devon Clinical Commissioning Group



NHS Kernow Clinical Commissioning Group

6.7 MSSA features in reduction plans for acute and community services. The GP significant event audit process as described in the December 2015 Health Protection Committee report has not begun in Cornwall to date.

Figure 10: Methicillin sensitive staphylococcus aureus bacteraemia, all ages, 2013 – 2016 NHS Kernow



South Devon and Torbay Clinical Commissioning Group

6.8 **Table 18: Actual Numbers to date 2015-16 reportable on MESS but no External targets (Internal KPI stated**)

MSSA bacteraemia*	Apr-Jun 2015	Jul-Sept 2015	Oct-Dec 2015	Jan-Mar 2016
Torbay Hospital (local target 12)	4	1	3	0
Clinical Commissioning Group (local target 45)	13	12	10	16

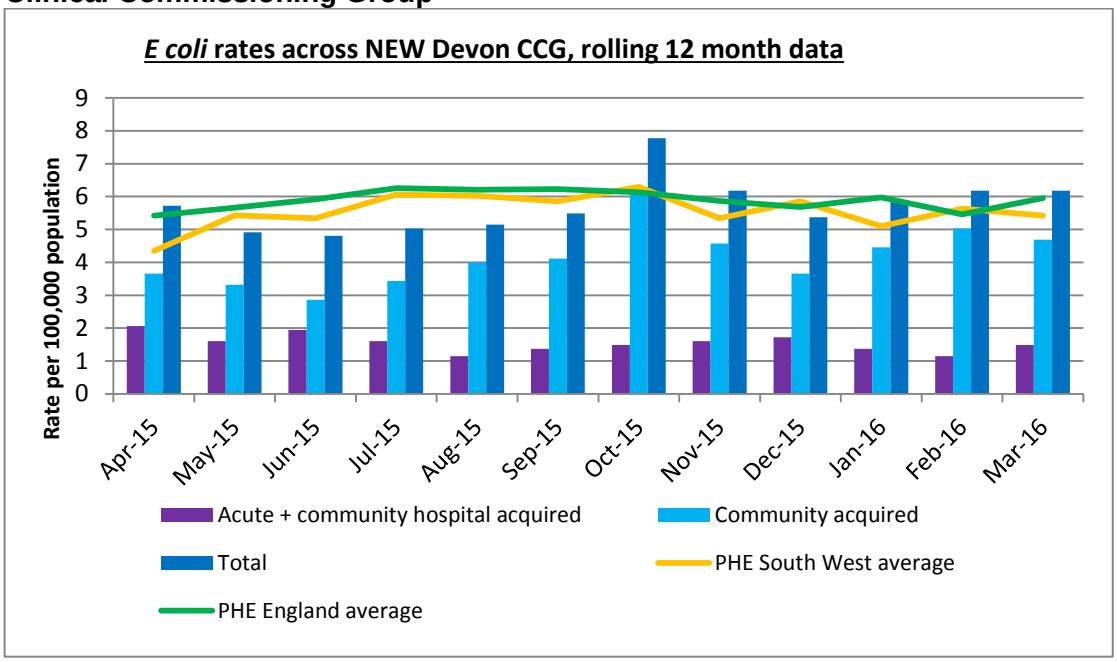
*Denotes internal target not a DH target

E.coli bacteraemia

NEW Devon Clinical Commissioning Group

6.9 E. coli bacteraemias for the NEW Devon Clinical Commissioning Group hospital sector and clinical commissioning group population in the rolling 12 months as shown in the graph below broadly track the averages provided by Public Health England for England and the South West. The Clinical Commissioning Group Health Care Associated Infection Team monitor data by locality and hospital to scrutinise trends and enable performance to be questioned as required. E. coli bacteraemias like MSSA should be subject by Trusts to identify learning to reduce rates as part of their Health Care Associated Infections Reduction Plan in 2016-17.

Figure 11: Rates of E.coli bacteraemia, by month, 2015 – 2016 for NEW Devon Clinical Commissioning Group



NHS Kernow

6.10 An increase in Ecoli rates has been noted locally.

Figure 12: E.coli bacteraemias, NHS Kernow all ages 2013-2016

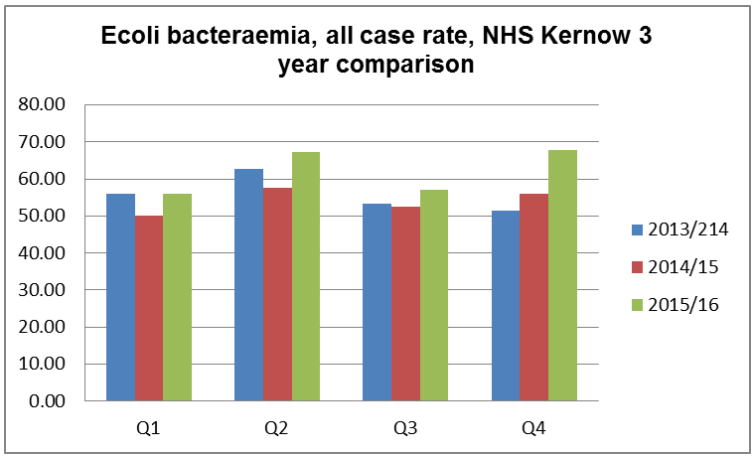
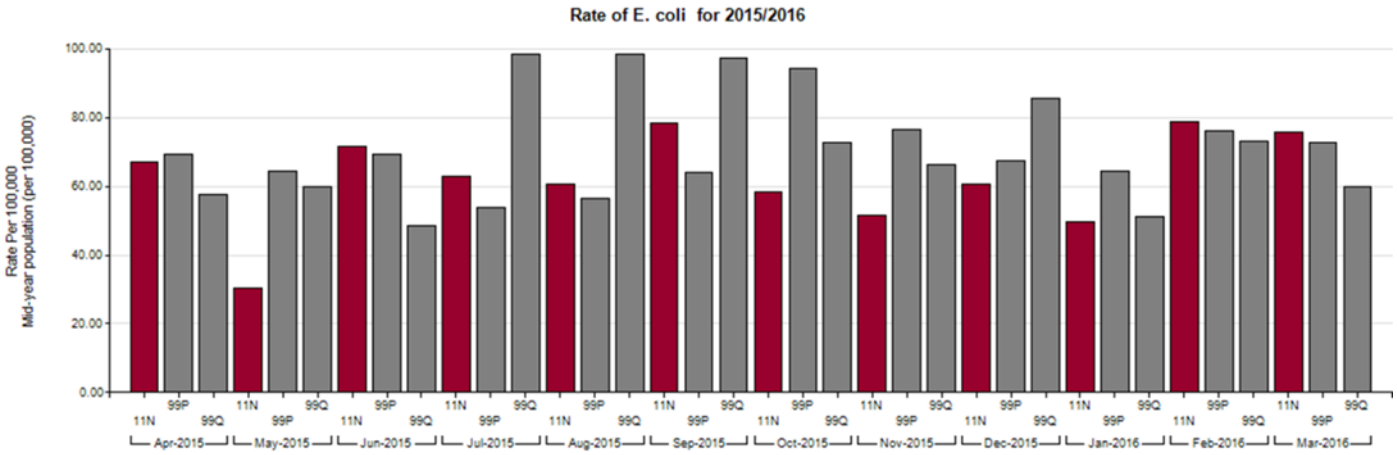


Figure 13: The benchmarking graph below shows a varied picture across the patch.



South Devon and Torbay Clinical Commissioning Group

Table 19: Actual Numbers to date 2015-16 reportable on MESS but no External targets (Internal KPI stated).

E.coli bacteraemia*	Apr-Jun 2015	Jul-Sept 2015	Oct-Dec 2015	Jan-Mar 2016
Torbay Hospital (local target 22)	6	5	12	4
CCG (local target 169)	31	51	42	31

*Denotes internal target not a DH target

C. difficile infection

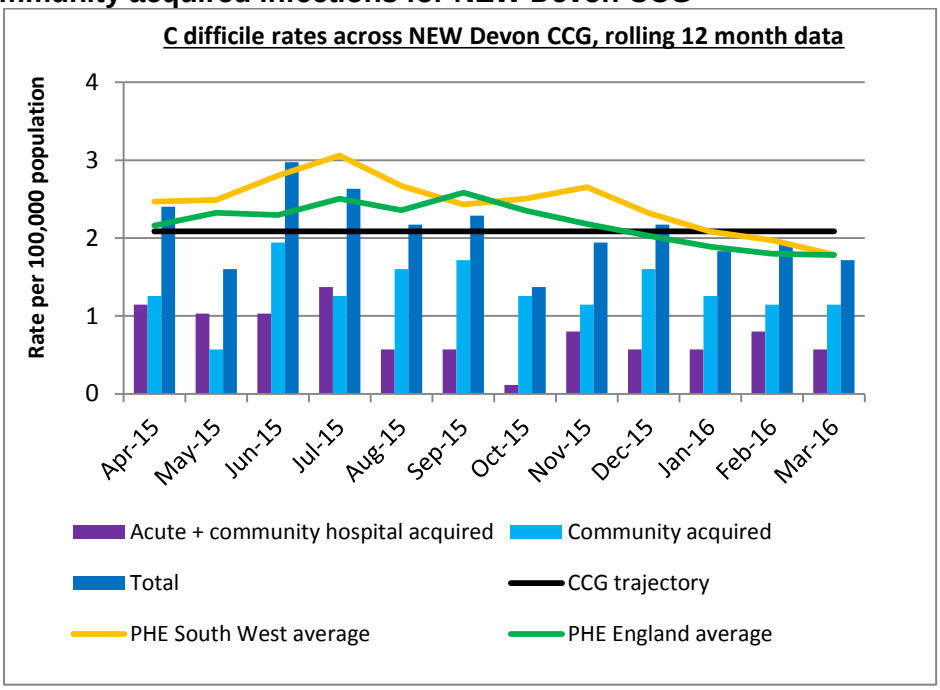
NEW Devon Clinical Commissioning Group

6.11 The graph below shows community acquired infection (CAI) and hospital acquired infection (HAI) cases of C. difficile infection. The community acquired infection cases, which make up the larger proportion of the population cases, are not scrutinised for avoidability like those in acute and community hospitals. A system to inform General Practices of these cases and request Significant Event Audits (SEAs) on behalf of NHS England South, South West is in place.

6.12 The Clinical Commissioning Group exceeded its nationally set trajectory of 219 cases with a total of 221 cases though given that the rates are normally less than the England and South West averages it is reasonable to conclude that C. difficile infection is reasonably under control.

6.13 To reduce community rates would require investment of time and money in antimicrobial stewardship into the community, either through GP antimicrobial pharmacists or clinical commissioning group commissioned Microbiologist outreach services. The Clinical Commissioning Group will not be offering a local CQUIN to Acute Trusts on the exploration of value of a community infection management service as raised in the previous report. The Clinical Commissioning Group will only be offering national CQUINs in 2016-17 for Acute Trusts due to the overarching situation of the Success Regime.

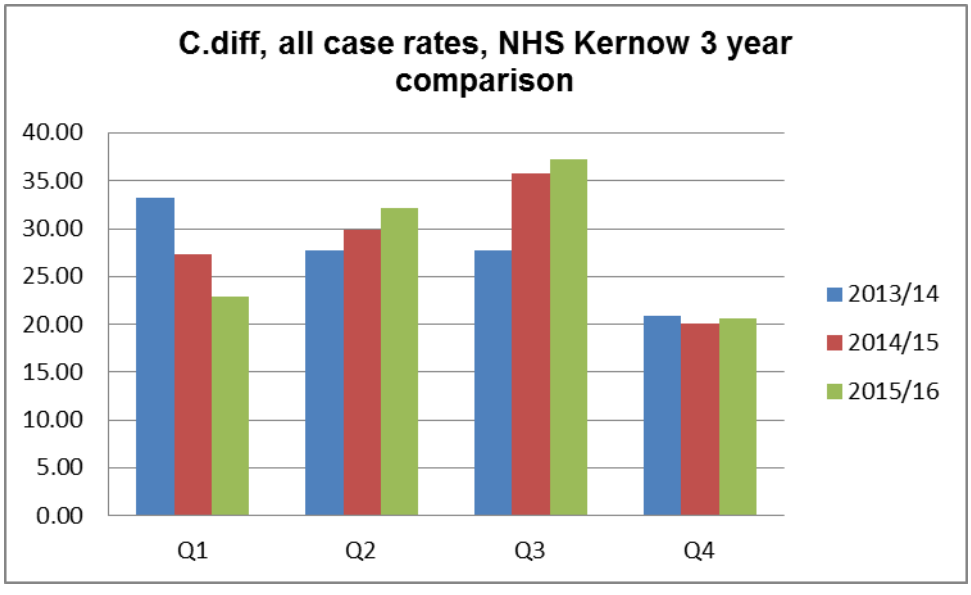
Figure 14: Rates of C.difficile infection, by month, 2015–16 for hospital and community acquired infections for NEW Devon CCG



NHS Kernow Clinical Commissioning Group

6.14 The Clinical Commissioning Group exceeded the 2015-16 objective of 25.00 with an outturn of 28.12 (per 100,000 population) which is below the SW figure of 29.23. The majority of acute cases being assessed as avoidable via the lapse in care system.

Figure 15: C.difficile infection rates by quarter for NHS Kernow between 2013 and 2016



South Devon and Torbay Clinical Commissioning Group

6.15 C.difficile cases remain above the set trajectory and are among the highest in the South West. The c.difficile group is reviewing the number of stools tested per bed

days. Initial investigations show that Torbay Hospital test more stools per bed days than other hospitals in Devon.

6.16 The South Devon and Torbay Clinical Commissioning Group multi-agency Antimicrobial Stewardship group held its first meeting.

6.17 Torbay Hospital is reviewing acute cases of c.difficile initial diagnosis. On first review a number were admitted with an initial diagnosis of sepsis.

Table 20: Actual Numbers to date 2015-16 (Ambitions 2015-16)

C.DIFFICILE	Apr-Jun 2015	Jul-Sept 2015	Oct-Dec 2015	Jan-Mar 2016
Torbay Hospital (national target 18)	11 (Five Lapses in Care)	8 (Four Lapses in Care)	4 *(One Lapse in Care)*	3 (no lapse in care)
Community beds (local target 44)*	1	2 (One Lapse in Care)	1	
Clinical Commissioning Group (97pa)	29	30	31	

*Denotes internal target not a DH target

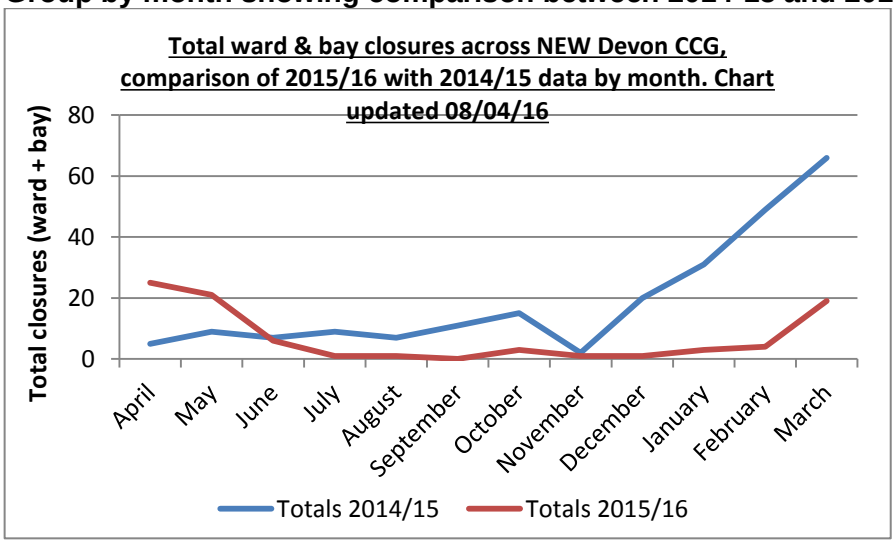
6.18 We have also had an incident where a single case of c.difficile from a community hospital was attributed to the acute trust. At this time Public Health England were unable to change this to the correct reporting trust.

Outbreaks

NEW Devon Clinical Commissioning Group

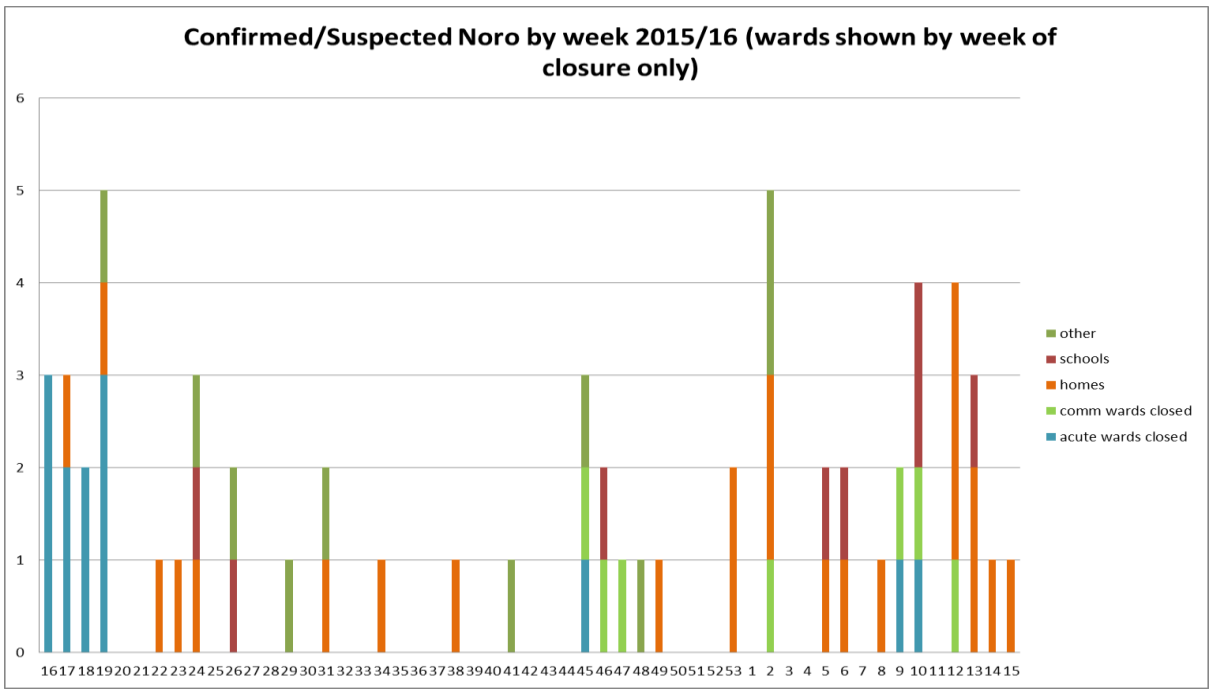
6.19 The following outbreaks graph shows the amount of ward and bay closures occurring in NEW Devon Clinical Commissioning Group hospitals as a proxy for the impact on service. The influenza season presented late in accounting for some of the upturn in February and March 2016.

Figure 16: Ward and Bay closures across NEW Devon Clinical Commissioning Group by month showing comparison between 2014-15 and 2015-16



NHS Kernow Clinical Commissioning Group

6.20 **Figure 17: The chart below shows combined hospital and community outbreaks with limited acute activity despite some community outbreaks.**



South Devon and Torbay Clinical Commissioning Group

6.21 In this period (January–March 2016) South Devon and Torbay Clinical Commissioning Group have had five bay closures, one ward closures and one community hospital closure due to Norovirus. One ward was closed due to influenza.

6.22 There have been one outbreak (diarrhoea and vomiting) in a local school, one in a nursery, four in a residential homes and three in hotels. All were reported as diarrhoea and vomiting.

Health Care Associated Programme Group

6.23 The Health Care Associated Infection Programme Group held a telecall on 24th March 2016. New risks were identified to the healthcare system which was antimicrobial resistance and influenza outbreaks and precautions causing service impact.

6.24 The Health Care Associated Infection Programme Group annual summer workshop was held on 5th July 2016. Attendance was low but the quality of discussions were high. Two potential new risk areas were identified to add to the Group's list for onward sharing with the Health Protection Committee:

- No community infection management service
- No community infection prevention and control service

6.25 The Group held its annual workshop on 5th July 2016 where risks and mitigations were debated in relation to the two new risks (as above) and sepsis, which remains a high priority.

6.26 Influenza activity in Trusts has declined after a winter period of high activity causing ward and part ward closures. Between mid-January until the end of February Plymouth Hospitals Trust had 15 wards affected by flu restrictions with one ward being affected for six weeks continuously. Royal Devon & Exeter had five wards affected during the same period

6.27 Seasonal outbreak reports are requested from Trusts where normal operating capacity was compromised under Serious Incident Reporting (SIRI) arrangements.

- Antimicrobial Resistance Group; need to ensure this programme is expanded and reported upon.
- Review Locality Immunisation Groups (governance structure).
- Childhood Flu review.
- Antimicrobial Resistance Group; need to ensure this programme is expanded and reported upon.
- Review Locality Immunisation Groups (governance structure).
- Childhood Flu review.

Ebola Virus Disease

6.28 The outbreak of Ebola virus disease (EVD) in West Africa first reported in March 2014 has ended, with a total of 28,616 cases and 11,310 deaths at June 2016.

6.29 Much has been learned about the virus, including how it can re-activate in survivors, and be transmissible in semen for months after recovery.

Outbreaks and Incidents

6.30 There was a relatively high level of influenza A activity late in the year, and there were flu outbreaks in both Dartmoor and Exeter prisons.

6.31 A Plymouth primary school suffered an outbreak of influenza which affected about a third of its pupils.

6.32 There was an outbreak of food poisoning at a Birthday party held at a local outdoor facility due to Clostridium perfringens thought to be from beef.

6.33 A small number of acute Hepatitis B cases have occurred which are thought to be linked to sex between men.

6.34 There was an outbreak of confirmed Measles infection in the Ashburton/Buckfastleigh area which involved nine confirmed, three probable and two possible cases. The infection was originally imported and then spread in a community where immunisation rates were relatively low.

Emergency planning and Exercises

Exercise Mallard

6.35 A pandemic flu multi-agency exercise was held in October 2015. The aim of the exercise was to test the local pandemic influenza plans of the health community and partners in Devon, Cornwall and the Isles of Scilly area. This was a scenario based exercise, with feedback on the key challenges faced at each stage, and discussion

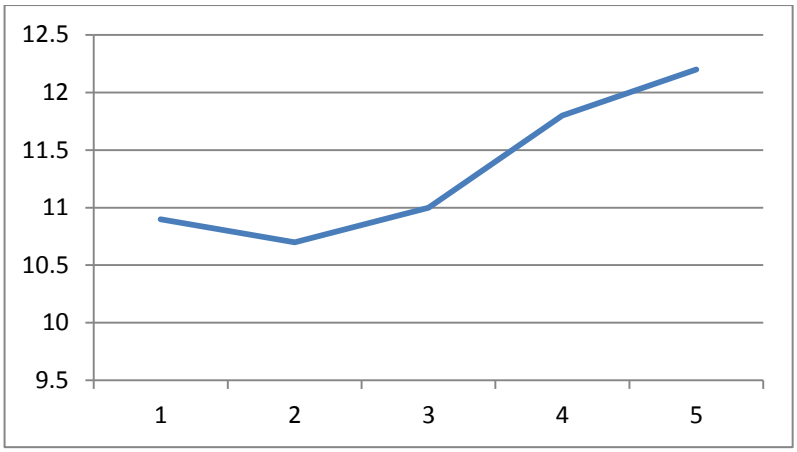
on how some of these challenges might be overcome. A debrief was held which allowed agencies to identify and rectify any identified shortcomings in plans.

Exercise Leda

6.36 This was an internal Devon County Council exercise run to test fitness for purpose of internal plans and to check business continuity readiness.

6.37 **Antimicrobial resistance** – a successful antimicrobial resistance steering group is established in Cornwall and this approach has now begun in Devon. A first exploratory telecall was held on the 14th January 2016, since then draft terms of reference have been drawn up and development of the group, in discussion with the group in Cornwall will be pursued in 2016-17. A brief report of the Cornwall group's activity in the last year is attached below. Torbay are also planning a group, but this group has yet to meet. Antimicrobial resistance continues to increase, as illustrated by the following graphs:

Figure 18: Percentage resistance to cefotaxime by E.coli in bacteraemias from 2011–15



6.38 Cefotaxime is a third generation cephalosporin, used to treat meningitis and septicaemia, typhoid and other Salmonella bacteraemias. Significant resistance would severely limit the use of this antibiotic and force the use of 'last resort' antibiotics.

Figure 19: Percentage resistance by E.coli bacteraemias to Ampicillin/ clavulanate combination

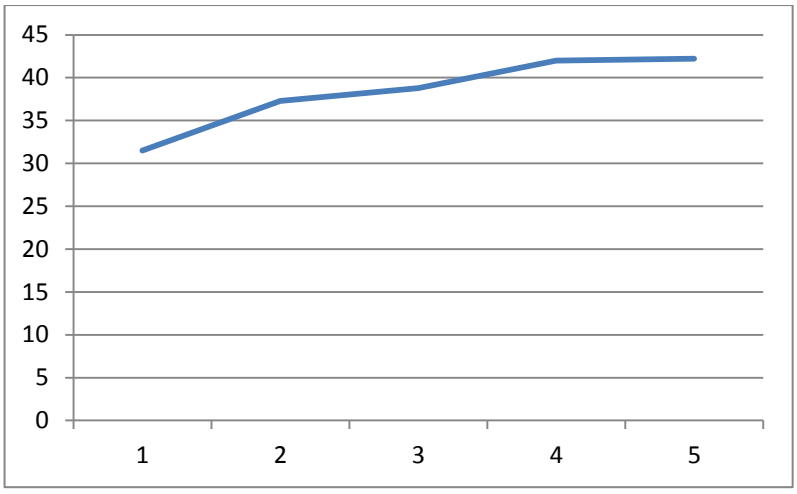
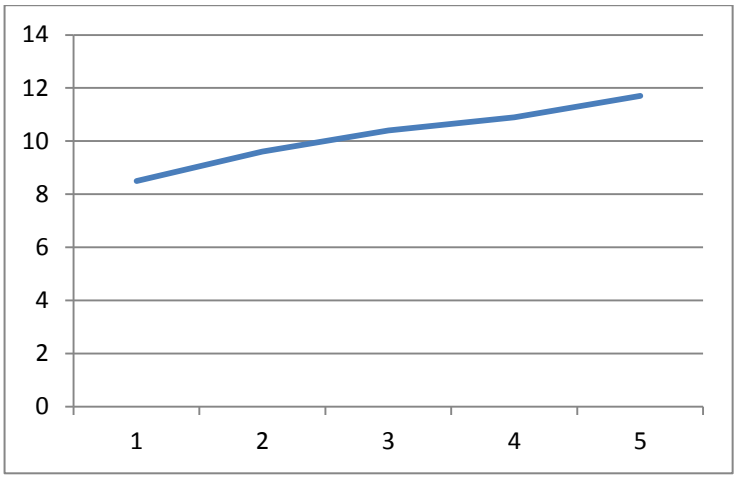


Figure 20: Percentage resistance of E.coli bacteraemias to piperacillin/ tazobactam



6.39 Clavulanate and tazobactam are beta lactamase inhibitors which allow broad spectrum antibiotics such as ampicillin/amoxicillin and piperacillin to be used against bacteria which produce a beta lactamase which degrades the penicillin group of antibiotics. They are extremely useful and widely used antibiotics and if resistance becomes too high other antibiotics will need to be used. This process continues, and useful antibiotics become useless as 'first line' treatments for serious infections as the risk of failure becomes unacceptable. Unfortunately, the supply of new antibiotics is not keeping pace with antibiotic resistance, so the use of antibiotics is under increasing threat. For 2016-17 the NEW Devon Clinical Commissioning Group Medicines Optimisation Team have identified co-amoxiclav prescribing as an area of focus because some local outliers in community prescribing have been identified.

6.40 There needs to be a constant effort to reduce inappropriate use of antibiotics and to focus antibiotic therapy as much as possible.

Report from Cornwall Antimicrobial Resistance Group (CARG) – Neil Powell

6.41 In response to the UK Five Year Antimicrobial Resistance Strategy (2013 to 2018) key stakeholders within Cornwall have set up the Cornwall Antimicrobial Resistance Group (CARG) to implement the strategy locally. The first meeting took place on 23rd January 2014. The group is chaired by Denis Cronin, Public Health Consultant and convenes five times a year.

6.42 The 2015 Cornwall Antimicrobial Resistance Group outputs have included exploring novel diagnostics, education and training, antibiotic consumption analysis, veterinary surgeon and dental representation and antibiotic resistance surveillance.

6.43 The group reviewed the evidence for, and the feasibility of introducing point of care 'C' reactive protein (POC CRP) testing in to GP surgeries. Kernow out-of-hours GP service trialled this diagnostic in 2015 which indicates an active disease process. A funding source for wider roll out to GP surgeries was unsuccessful. A community hospital with an attached urgent care centre expressed an interest however in this point-of-care diagnostic and a work plan is underway.

6.44 A business case for state of the art diagnostic technology (MALDI-TOF MS) and procalcitonin testing, which is a specific marker for bacterial infection was submitted for consideration at the Royal Cornwall Hospital.

AMR

6.45 Antibiotic prescription numbers in primary care dropped by 6.7% between 2014 and 2015 as a result of the Clinical Commissioning Group delivered NHS Quality Premium. These successes were not replicated in the secondary care setting but work is underway to reduce antibiotic prescribing at the Royal Cornwall hospital to meet the 2015-16 antibiotic stewardship CQUIN targets.

6.46 The group now has good veterinary representation from the Animal and Plant Health Agency (APHA) and the Cornwall Veterinary Association. Farmer working groups are to be set up to provide farmers with peer support around antibiotic practices in farms and will form part of a University of Bristol veterinary surgeon PhD.

6.47 The group has successfully sought dental representation with plans to audit dental prescribing and gather baseline dental antibiotic prescribing.

6.48 Resistance to penicillin and erythromycin in *Streptococcus pneumoniae* isolated from blood cultures in Cornwall between 2013 and 2015 remains static at (6% and 11% respectively). Resistance in the Gram negative organism *Klebsiella pneumoniae* isolated from blood samples between 2013 and 2015 has remained broadly stable; 9.5% resistance to ciprofloxacin, 6.4% to third generation cephalosporins, 5.5% to gentamicin and 0.26% to carbapenems. Between 2013 and 2015 there was statistically significant increases in *Escherichia coli* resistance to gentamicin (9.4%) but resistance to quinolones has remained broadly stable at 11.2%.

7. Work Programme 2015-16 - Progress

Influenza vaccine for key staff

7.1 2015-16 the uptake of seasonal flu vaccine by frontline workers at Devon County Council was only 19 vaccines, 51 other people accessed flu vaccine because they were eligible under another priority group.

Hepatitis C Strategy and Implementation

7.2 Hepatitis C is a blood borne virus which is a significant preventable and treatable cause of liver disease. The most common means of transmission in the United Kingdom is through intravenous drug use with shared equipment – it is estimated that nine out of 10 cases of Hepatitis C in this country are caused by injecting illegal drugs.

7.3 RISE Hepatitis C pathways, direct referral pathways are set for Exeter, Torbay and Derriford. Barnstaple is still requiring a GP referral. However, there are plans to improve the accessibility of the service in North Devon for Barnstaple RISE clients. There are about 50 hepatitis C positive clients in North Devon that are currently not accessing treatment and improving access could change this.

7.4 Tuberculosis strategy objective is to continue to work with Public Health England on the new Tuberculosis Board to implement a strategy for the control of Tuberculosis in the South West. The Board is now established, and cohort review is established and running in both the East and the West of Devon.

7.5 South East and South West England have joined up to form the 'South Tuberculosis Control Board'.

Tuberculosis Strategy. 'Areas for action' – an update on progress

7.6 **Improve access to services and ensure early diagnosis:**

- Awareness raising work is underway with development of literature, Videos and animation.
- Royal College of General Practice's Tuberculosis e-learning module is being updated to include latent Tuberculosis infection.
- Working with Tuberculosis alert to update and provide support material for latent Tuberculosis infection programmes.
- Work to better understand delays from symptom onset to treatment onset is being undertaken by the national surveillance team using enhanced Tuberculosis system and local Tuberculosis register data.

7.7 **Provide universal access to high quality diagnostics:**

- Public Health England are currently reviewing Tuberculosis laboratory services, once complete, a 'task & finish' group will be established to take forward this 'area for action'.
- Tuberculosis is a priority area for the implementation of Whole Genome Sequencing (WGS) technology for both Public Health England and NHS England; and work is underway to introduce Whole Genome Sequencing for Tuberculosis in 2016.

7.8 **Improve treatment and care services:**

- National Tuberculosis service specification is drafted and circulated for use by Tuberculosis Control Boards, Clinical Commissioning Groupss and clinicians.
- This service specification can be used in the commissioning of Tuberculosis services, development of key performance indicators and assessment of local Tuberculosis services.
- Tuberculosis Control Boards are working with local Tuberculosis stakeholders to support Tuberculosis clinical networks, and are encouraged to reflect on the British Tuberculosis Society 'model Tuberculosis networks' document. In the far South West, there are two Tuberculosis networks, covering the West and the East.
- Public Health England have undertaken a Tuberculosis Health Needs Assessment and a strategy and action plan is being written.

7.9 **Ensure comprehensive contact tracing:**

The national Tuberculosis service specification has added clarity to the expectations of contact tracing.

7.10 **Improve BCG vaccination uptake:**

BCG vaccination is a continuing problem due to problems with supply, but subject to availability there is a commitment to improve uptake.

7.11 **Reduce drug-resistant Tuberculosis:**

Public Health England is working with NHS England on a needs assessment of facilities for the public health management of multi-drug resistant Tuberculosis patients, this work will contribute to the review of the Infectious Diseases Service Specification that the NHS England Specialised Commissioning Team aims to carry out in mid-2016.

7.12 **Tackle Tuberculosis in under-served populations:**

A work stream is planned for 2016, a task & finish group is being established.

7.13 **Systematically implement new entrant latent Tuberculosis screening:**

This has been the focus of much of the national team and newly formed Latent Tuberculosis Boards work since the summer; however this is not yet being implemented in the low incidence areas of the far South West.

7.14 Procurement of the latent tuberculosis infection test analysis has been completed and clinical commissioning groups and the successful providers are working on implementation.

7.15 NHS England will review 2015-16 activity and performance of Clinical Commissioning Groups Latent Tuberculosis Infection Programmes as part of its review for support into 2016-17.

7.16 A national suite of materials to support latent Tuberculosis infection testing and treatment has been written by Public Health England and NHS England and is available on the Tuberculosis screening webpage.

7.17 **Strengthen surveillance and monitoring**

The Tuberculosis Strategy Monitoring Indicators, available via the Public Health England Fingertips tool, have been updated with 2014 data.

7.18 **Ensure an appropriate workforce to deliver Tuberculosis control:**

- A Review of the Tuberculosis nursing workforce was commissioned by Public Health England and published in July 2105. Public Health England has established a nursing workforce development group to take forward the recommendations of the Tuberculosis nursing workforce report.
- A piece of work is planned for 2016 with the Centre for Workforce Intelligence (CfWI) that will review the non-clinical Tuberculosis workforce. Two national Tuberculosis workforce development study days are planned for 2016.

7.19 **Key next phases:**

- Tuberculosis Control Boards will increasingly engage with local stakeholders.
- Tuberculosis Control Boards will assess local Tuberculosis services against a locally adapted Tuberculosis service specification, identify any gaps in provision and develop plans to meet these gaps.

- The new entrant latent Tuberculosis infection testing and treatment programmes in the 58 high incidence clinical commissioning groups will be rolled out. Monitoring and reporting systems for the latent Tuberculosis programme will be established.
- Tackling the needs of the under-served will be taken forward, awareness raising work and work to improve treatment and care services will continue.

7.20 **Work programme 2016-17**

- Involvement with Short Sermon this year is an exercise year and Plymouth and Cornwall will be involved in Exercise short sermon.
- Antimicrobial resistance – Cornwall have succeeded in establishing a flourishing and successful group and Plymouth, Devon and Torbay need to emulate this.
- Review locality Immunisation groups and the childhood flu programme – the locality groups have just been reformed to ensure that they remain relevant and fit-for-purpose, they need to be connected into local authorities and providers as well as Public Health England. The childhood flu programme now covers a range of ages and is delivered by a variety of providers in a number of settings, which lends itself to evaluation to see which is most effective and efficient.
- Childhood Flu review – now that there is a diversity of provision of the childhood flu programme, there is an opportunity to evaluate the most successful approaches.
- Port Health Review – following the Ebola outbreak, it has become clear that the variety of small ports in the South West do not have Port Health plans to allow them to know how to respond in an unfamiliar situation. Teignbridge council, in association with Public Health England have produced a framework plan which ports can customise for their needs.
- Lyme disease – Exmoor, Dartmoor and the Blackdown Hills are relatively high in ticks and every year people catch Lyme disease from tick bites. It is proposed to run a local awareness campaign in National tick week with the support of Public Health England.

7. Authors

Dr Mark Kealy
CONSULTANT IN PUBLIC HEALTH
Devon County Council

Andrew Kingsley
LEAD NURSE – HEALTHCARE ASSOCIATED INFECTIONS
Northern Eastern and Western Devon Clinical Commissioning Group

Denis Cronin
CONSULTANT IN PUBLIC HEALTH
Cornwall Council

Ruth Harrell
CONSULTANT IN PUBLIC HEALTH
Plymouth City Council

Linda Churm
ACTING CONSULTANT IN PUBLIC HEALTH
Torbay Council

Lisa Johnson
LEAD NURSE INFECTION CONTROL
Kernow Clinical Commissioning Group

APPENDIX 1

Terms of Reference for the Health Protection Committee of 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. Aim, Scope & Objectives

Aim

1.1 To provide assurance to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council and the Council of the Isles of Scilly that adequate arrangements are in place for the prevention, surveillance, planning and response required to protect the public's health.

Scope

1.2 The scope of health protection to be considered by the committee will include prevention and control of infectious diseases, immunisation and screening, health-care associated infections, non-infectious environmental hazards and emergency planning and response (including severe weather, environmental and non-environmental hazards).

Objectives

1.3 To provide strategic oversight of the health protection system operating across Devon, Plymouth, Torbay, Cornwall Council and the Council of the Isles of Scilly.

1.4 To oversee the development, monitoring and review of a memorandum of understanding that outlines the roles and responsibilities of the Public Health England Centre, NHS England Area Team, Clinical Commissioning Groups (Northern Eastern and Western Devon & South Devon & Torbay and Kernow) and upper tier/lower tier / unitary authorities in relation to health protection.

1.5 To provide oversight of health protection intelligence reported to the committee and be appraised of risks, incidents or areas of underperformance.

1.6 To review and challenge the quality of health protection plans and arrangements to mitigate against any risks, incidents or areas of under-performance.

1.7 To share and escalate risks, incidents and under-performance to appropriate bodies (e.g. Health and Wellbeing Boards / Local Health Resilience Partnership, NHS England) when health protection plans and arrangements are insufficient to protect the public. The escalation route will depend on the risk or area of under-performance.

1.8 To agree an annual programme of work to further improve local health protection arrangements as informed by the respective Health and Wellbeing Strategies for Devon, Plymouth, Torbay, Cornwall Council and the Council of the Isles of Scilly and

their Director of Public Health's Annual Report and Joint Strategic Needs Assessments.

1.9 To review and challenge arrangements for the delivery of existing and new national screening and immunisation programmes or extensions to existing programmes.

1.10 To promote reduction in inequalities in health protection across Devon, Plymouth, Torbay and Kernow.

1.11 To oversee and ratify an annual Health Protection Committee annual report.

2. Membership

Chair: Director of Public Health

Members: *Chair – Health Protection Advisory Group (Public Health England CCDC/Health Protection Consultant)

*Chair - Devon, Cornwall and Isles of Scilly Screening & Immunisation Oversight Group – Consultant in Public Health
*Chair – Local Health Resilience Partnership

*Chair – Health Care Associated Infections Programme Board
Consultants in Public Health / Health Protection Lead Officers – (Devon County Council, Plymouth City Council, Torbay, Cornwall Council)

Head of Public Health Commissioning (Area Team – NHS England)

Head of Emergency Planning Resilience & Response – (Area Team – NHS England)

Chief Nursing Officer – (Northern Eastern and Western Devon Clinical Commissioning Group)

Director of Quality Governance – (South Devon and Torbay Clinical Commissioning Group)

3. Meetings & Conduct of Business

3.1 The Chairperson of the Health Protection Committee will be a Director of Public Health from either Devon County Council, Plymouth City Council, Torbay or Cornwall Council. Directors of Public Health serving these councils will review this position annually.

3.2 The quorum of the meeting will comprise the Chairperson of the Health Protection Committee or their deputy, the Chairperson of each of the four groups listed in 2 above (*) or their representative with delegated authority to make decisions on their behalf, at least one Local Authority Consultant in Public Health (Health Protection Lead Officer) and at least one of either the Chief Nursing Officer (Northern Eastern

and Western Devon Clinical Commissioning Group or the Quality and Safety Lead (South Devon and Torbay Clinical Commissioning Group).

3.3 All meeting papers will be circulated at least seven days in advance of the meeting date.

3.4 The agenda (standing items listed in 3.6 below) and minutes will be formally recorded. Minutes listing all agreed actions will be circulated to members and those in attendance within 14 working days of the meeting.

3.5 Meetings will be held bi-monthly.

3.6 Standing agenda items will include the following:

- *Screening and Immunisation performance and risk monitoring*
- *Health Protection Report for the Health Protection Committee*
- *Work-programme update*
- *Any other business.*

3.7 A report of the meeting will be forwarded to members of the Health and Wellbeing Boards for Devon County Council, Plymouth City Council and Torbay Council and Cornwall and the Isles of Scilly Council and Local Health Resilience Partnership.

3.8 Terms of reference will be reviewed annually.

4. Author

Mark Kealy
CONSULTANT IN PUBLIC HEALTH
Devon County Council

Reviewed 5th August 2015

APPENDIX 2

Health Protection Committee Reporting to the Devon, Plymouth, Torbay, Cornwall and Council of the Isles of Scilly Health & Wellbeing Boards and its Relationship to Existing or Planned Health Protection Partnership Forums