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

1 April 2021 – 31 March 2022

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 2021 to 31 March 2022, for the Health and Wellbeing Boards of Cornwall Council and the Council of the Isles of Scilly, Devon County Council, Plymouth City Council, and Torbay Council.

1.2 The report considers the following key domains of Health Protection:

- Communicable disease control and environmental hazards
- Immunisation and screening
- Health care associated infections and antimicrobial resistance
- Emergency planning and response.

1.3 The report sets out for each of these domains:

- Assurance arrangements
- Performance and activity during 2021/22
- Actions taken to date against health protection priorities identified for 2021/22
- Priorities for 2022/23.

2. Assurance arrangements

2.1 Local authorities, through their Director of Public Health, have an assurance role to ensure that appropriate arrangements are in place to protect the health of their populations.

2.2 The Devon and Cornwall 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 to provide assurance that adequate arrangements are in place for prevention, surveillance, planning, and response to communicable disease and environmental hazards.

2.4 Summary terms of reference for the Committee and affiliated groups are listed at **Appendix 1**.

2.5 A summary of organisational roles in relation to delivery, surveillance and assurance is included at **Appendix 2**.

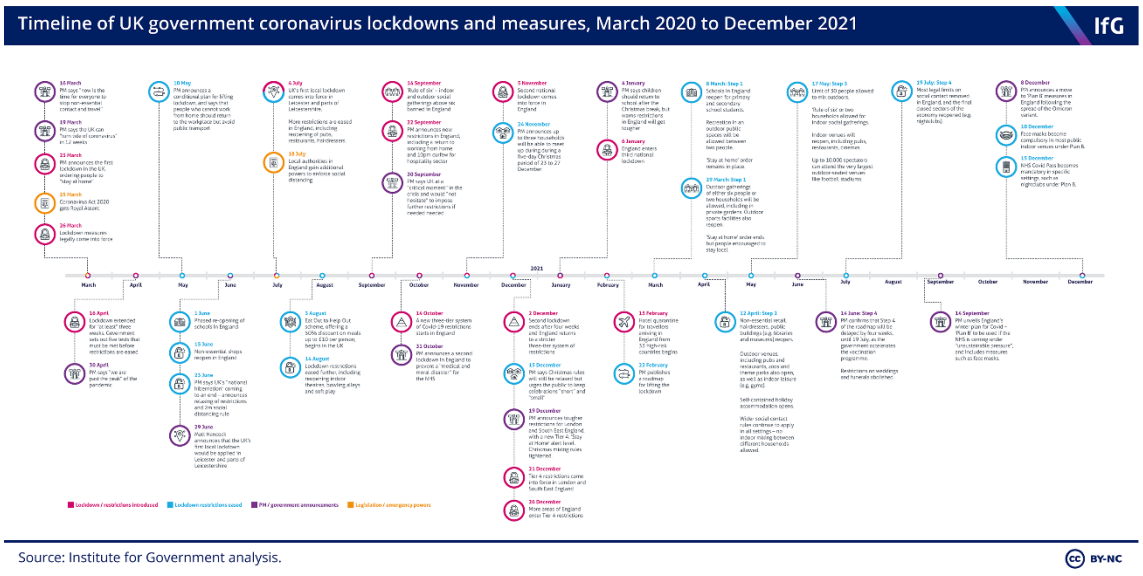
2.6 A major organisational change has been the transition from Public Health England (PHE) to the UK Health Security Agency (UKHSA) which took place in October 2021.

3. Prevention and control of infectious disease

3.1 Since the end of December 2019 when the first cases of COVID-19 were reported in China, to now, the world, Europe, the UK and DCIOS have seen waves and troughs of cases. This is expected to continue.

3.2 From December 2020 the first COVID-19 vaccinations were administered and vaccination programme established. Winter 2021 saw a surge in vaccination due to the emergence of the highly transmissible Omicron variant.

Activity in 2021/22



Jan 2022

Isolation period reduced to 10 days (or 7 days following two negative lateral flow tests 24 hours apart). Fully vaccinated contacts are not required to self-isolate and are advised to take lateral flow tests every day for 7 days, only being required to isolate following a positive result. Unvaccinated contacts will still need to isolate for 10 days.

11th Jan those testing positive using a lateral flow test no longer need to take a PCR test to confirm the result.

The Government reintroduced the Statutory Sick Pay Rebate Scheme which had previously ended on 30 September 2021.

Feb 2022

End of legal restrictions in England.

End of routine contact tracing.

Close contacts who are fully vaccinated no longer required to test and unvaccinated close contacts no longer required to self-isolate.

Care home staff asked to take lateral flow test before their shifts rather than weekly PCR tests.

Outbreak management rules reduced to 14 days from 28 days.

March 2022

18th March – Government removed the remaining international travel restrictions.

31st March Free PCR testing in the community ended.

Targeted Community Testing ended.

Care home staff testing daily using lateral flow tests prior to each shift. All residents test monthly using a PCR test.

3.3 UKHSA, peninsula local authorities and CCGs worked in partnership to support settings with high-risk cases or outbreaks of COVID-19. Common settings where an outbreak response is required include care homes, supported living settings, early year and education settings,

health care settings, workplaces (particularly those associated with national infrastructure or are otherwise high risk) prisons and homelessness settings. Table 1 shows the number of COVID-19 situations recorded on HPZone (UKHSA case management system) by principal context and local authority area in the year 2021-2022. This will be a significant under representation of the number of settings reported as it does not include situations where the local authority led the response. For example, where the local authority led on providing a response to local schools or workplaces these will not be included in the setting figures below.

Table 1 Number of Covid-19 situations recorded on PHE/UKHSA system between 1 April 2021 – 31 March 2022 by Local Authority and setting type

3.4 The table below represents notifications made to UKHSA, and not necessarily situations managed by UKHSA. Many situations (schools and workplaces) were managed locally. Local authorities all developed their own systems to support and manage outbreaks in a range of settings and these figures will not reflect the totality of the work down across the system to support the settings with situations or in outbreak.

Local Authority	Adult Care Home	Educational setting	Workplace	Healthcare	Other
Cornwall*	399	47	12	5	<5
Devon**	529	99	8	<5	7
Plymouth	224	47	8	<5	<5
Torbay ***	127	107	<5 101	<5	<5

*In Cornwall between June 21 and Jan 22 553 businesses were supported with Covid activity within their workforce/customers.
**Devon is much lower as they managed a significant number of their outbreaks locally – without direct involvement from the HPT. The above figures are an underestimation of impact.
*** Torbay managed the majority of outbreaks locally. Figures include education, business and hospitality settings April 2021 – March 2022

3.5 UKHSA regional Health Protection Teams provided the specialist response to other infectious disease and hazard related situations across Devon and Cornwall, supported by local, regional and national expertise.

3.6 Situations responded to alongside management of COVID-19 have included:

- Non-covid related outbreaks in early years, schools and residential care settings
- System pressures (patient flow from acute through to care homes / POC)
- Plymouth shooting
- Bomb threats made to NHS and a secondary school in connection with the Covid 19 vaccination programme
- Major incident declared in December 2021 for mass vaccination booster programme
- G7 summit hosted in Cornwall, 9-11th June 2021

- Boardmasters Festival, 6th-8th August 2021
- Outbreak of GI illness associated with consumption of Oysters (North Cornwall), November 2021

Area of response	Detail
Public Health advice	Throughout 2021/22 public health advice continued to be developed and disseminated in relation to the identification and management of symptoms, case and outbreak response, promotional campaigns, and support for all sectors in relation to the pandemic. Proactive support was provided through a suite of assets and communication tools hosted by local authority, CCG and UKHSA agencies. Examples include early year and education setting regular webinars, care home webinars, flow charts communicating actions to take following possible or confirmed case(s), checklists, and risk assessment tools.
Contact tracing	UKHSA, working with local authority public health teams and NHS Test and Trace, led the process of contact tracing, testing and isolation, interpreting and implementing changing national guidance during the phases of the pandemic. Local Authorities took on more cases over time and adopted Local Zero. Use of a Local number lead to early contact tracing *Area of good practice* Cornwall case review service – bespoke service set-up in advance of the wider national contact tracing service. Dependent upon case incidence large percentage of confirmed Covid 19 cases contacted by in-house Cornwall Council case review team. Intelligence gathered and support offered to schools, early year settings, businesses etc to keep people safe and an employment. This model excelled when working with partner organisation during the G7 summit. The G7 world leaders' event was held in May 2021 at Carbis Bay hotel and Tregenna Castle on the outskirts of St Ives. The event was managed in a way to reduce the risks of Covid infections to delegates, support staff, police, security staff and the general population. It involved liaising with PHE at a national level to determine testing regimens prior to the event for all those attending and working in connection with the event, having testing regimens established and embedded into daily practice during the event and the ability to isolate and contain any cases or outbreaks during the event. Close working practices evolved during the build up to the event and were essential during the 5 day event where there were a small number of cases which were contained as effectively as possible. A surveillance system was established with Field Epidemiology Services to monitor the cases and contacted in relation to the event.

Testing

Area of local good practice

Testing was coordinated across Devon and Cornwall by a regional testing strategist, bringing together clinical, commissioning and public health expertise regularly to review latest guidance and manage implementation in the most effective way for a geographically dispersed population. Testing capacity and capability was targeted to ensure all communities were able to access symptomatic and asymptomatic testing services, taking into account the needs of those without easy access to transport, and vulnerable populations.

Targeted community testing, including deployment of fixed and mobile PCR and LFD testing sites, was used to maximise testing uptake across the peninsula.

Boardmasters was one of only a few music festivals that went ahead in the summer of 2021. It was a four-day event based just outside Newquay which involved music and camping in the evenings and surfing competitions in Newquay during the day. Over 50,000 people attended the events. The Public Health team worked closely with the event organisers to ensure the Covid guidance at that time was followed and also established additional Covid mitigation such as a second Lateral Flow test for all attendees after 2 days at the festival. Despite these mitigations a large number of cases were identified after the event as possibly been transmitted during the event. The learning from the event included the need not to rely on the general public doing unsupervised testing to ensure they able to attend such an event. Learning from the event has been and will continue to be referred to as more events are organised in the future.

Testing teams adapted over time increasingly supporting inclusion health and access wider health protection services allowing area based and targeted solutions to meet local need whilst increasing access to testing.

Vaccination

Area of local good practice

Local authorities continued to work with CCGs to develop an outreach offer, through use of all vaccine partners – CCG, acute trusts, GPs and pharmacies, and use of community settings in areas of high deprivation and low uptake. Inclusion health groups have also been prioritised over the past year along with the evergreen offer for those who have not yet taken up the offer for covid vaccination. During winter 21/22, where possible covid and flu were co-administered and learning from that season will be used for a much wider rollout of co-administration for winter 22/23.

The Devon Health Inequalities (HI) Cell was established early on to address inequalities in uptake of covid vaccinations and focus on priority groups who were least likely to be vaccinated and/or who may be more susceptible to the severe consequences of infection. This group includes representation from a wide range of stakeholders and has been led by a

Consultant in Public Health on behalf of the three Devon Local Authorities. For some time now this group has been expanded to include Flu, focusing on increasing uptake across both vaccination programmes building on the excellent work, outreach programme and relationships that have been established through delivery of the COVID programme. Through the work of the cell, a health inequalities hub and data dashboard have been developed and the learning is being embedded into wider system work to address health inequalities. The work of the cell and its partners has received regional and national recognition, including the NHS Devon Equality and Diversity Award and the National NHS Parliamentary Health Inequalities Award. An example of one project delivered through the work of the cell is below:

Case Study: Devon and Cornwall Chinese Association

- The Chinese community were worrying about deportation when accessing the vaccine centre due to their visa/residency status.
- We met with the Chinese leaders explained them their rights and addressed their worries. To meet Chinese community's needs we organised a focussed 2hr slot for people to attend a vaccine centre/pop up clinic with Chinese volunteers who walked through the process with people having their jabs.
- To alleviate concerns about immigration status, the DCCAcoordinated bookings for vaccination clinics. The DCCAscheduled the vaccines, worked with individuals to make travel arrangements, and relied on DCCAstaff and volunteers to interpret and support people at the clinics.

Variants of concern

UKHSA led the response to investigating single cases and outbreaks of variants of concern, working closely with local authorities to ensure containment and, in the case of Delta and Omicron, mitigate spread.

Settings based prevention & case & outbreak response

Prevention and response programmes were developed for all settings to prevent and control outbreaks:

- Schools and early years
- Care homes and domiciliary care
- Businesses & hospitality
- Places of detention
- Homelessness settings

Excellent collaborative working continued with all sectors to support them to keep staff, clients and students safe, minimise disruption and keep premises open and functioning.

Communications & engagement

Area of local good practice

Local Outbreak Engagement Boards continued in each local authority and brought together stakeholders from health and care, education, business, hospitality, voluntary and community sectors, faith groups, police, and other sectors to feed into local policy and ensure clear communications to all parts of the community.

Covid community champions continued to be a valued source of support and information, acting as trusted voices in promoting key messages with their local networks, and feeding back local issues and concerns.

Across all the LAs, teams worked in a variety of ways to develop and support communications for inclusion health groups. This included door-door leafleting, face-face engagement, targeted social media, and webinars.

Surveillance Arrangements

3.7 UKHSA provides a quarterly report to the Committee containing epidemiological information on cases and outbreaks of communicable diseases of public health importance at local authority level.

3.8 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 UKHSA (South West). UKHSA also provides a list of all community outbreaks all year round.

3.9 The Devon Health Protection Advisory Group and the CIOS Health Protection Group, led by UKHSA and convened quarterly (twicer per year for CIOS), 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.

4 Screening programmes

4.1 This section summarises some of the key developments for the individual screening programmes during 2021/22.

4.2 All screening programmes suffered from the impact of the COVID-19 pandemic to varying degrees with the focus during 2021/22 to support providers to implement detailed recovery plans to safely recommence screening and tackle the backlog that had developed during the pandemic to return programmes back to a business-as-usual footing. For some programmes, this has required significant investment, both regional and national to increase capacity over and above 100% to be able to deliver screening and to offer screening to all those individuals who were affected by the pause in the programmes in as timely a way as possible. As a consequence, this investment has been designed to build in increased capacity to ensure more robust and sustainable services into the future.

4.3 The impact of the COVID pandemic has meant that there have been challenges meeting some national standards (for example, round length and coverage) and for these areas, action plans and improvement plans are in place alongside the recovery plans.

4.4 The text below provides a summary of performance, challenges, and developments during 2021/22 and future developments.

Screening programme:

Bowel

Both routine and surveillance programmes had to be paused at the start of the pandemic due to several factors, including IPC concerns at colonoscopy. Invitations were recommenced in a phased way to enable providers to manage flow of patients through the screening pathway and providers increased invitation rates and colonoscopy capacity (compared to pre-Covid) to recover backlogs. All providers met the national recovery ambition. As part of the national recovery plan, bowel scope screening was paused and then a decision made to cease this programme. Any individuals who were invited to bowel scope screening but were not able to be screened due to the pause of services were invited to bowel screening.

In addition to recovery, nationally, age extension of the bowel cancer screening programme commenced from mid May 2021. This is a 4-year extension programme starting with 56-year olds in 2021-22 to include 50 year olds by 2024-25. All providers have commenced age extension to 56-year olds with a plan to launch age 58 invites in Q1 2022/23 in line with national guidance, subject to regional finance allocations.

It has been agreed that screening of individuals with Lynch syndrome will be introduced in 2023/24 with planning around process, IT systems and finance led nationally in 2022/23.

Recovery Progress / Service Delivery

- All providers have recovered.
- North & East Devon have performance improvement plans in place. QA visit scheduled for 28th September 2022.

Key risks to programme delivery

- Notified in August 2022 that there is a national issue with the bowel prep supply required for the diagnostic tests. Not currently impacting the service and is being monitored, and likely to be resolved by October 2022.

Breast

Recovery Progress / Service delivery

- The SW backlog has had a continued downward trend. Three programmes have recovered their backlog to at least 90% of women being invited within the 36 month round length, with the remaining six programmes expected to achieve this by November 2022.
- Uptake in Q4 21/22 in the South West slightly improved to 56.8% (acceptable standard 70%).

Arising issues of note by exception

- Three radiology fellows have been recruited to the far South -West which should significantly increase capacity. The SW is a national outlier for Radiologists in Breast Screening.
- Task group set up to develop shared, dedicated practice educator roles across SW
- Guidance on smoothing the round received to reduce peaks and troughs. National round length planning tool due to be rolled out to all programmes.
- National Demand & capacity tool does not reflect recovery position of four of our programmes – this has been reported to national team.
- Across the SW, services have been affected by capital delays, arising workforce changes and high levels of sickness absence, compounded by summer holiday annual leave

Key risks to programme delivery

- Workforce challenges locally and nationally continue to significantly affect the South-West further delaying recovery / full restoration. Key staff now retiring post recovery.
- High symptomatic demand

Cervical

Recovery Progress / Service delivery

- Performance Improvement Plan with NBT is looking to sustain this performance.
- Cervical screening in sexual health commissioned across all systems except Cornwall. Currently working with provider Brook to start service in next few months.
- Trusts are starting to submit data for 28-day faster diagnosis standard (currently incomplete data)

Arising issues of note by exception

- Torbay – working through business case to increase capacity/staffing. Trust having conversation with ICB to explore different funding avenues.

Key risks to programme delivery

- Increase in colposcopy referrals as a result of the introduction of primary HPV has stretched colposcopy capacity for the providers in the South West (outside of BNSSG). All providers and CCGs have been contacted about this as the CGGs fund colposcopy
- Negative reaction to Wales' decision to increase interval from 3 to 5 years for younger cohort may affect England's rollout date.

Antenatal/ Neonatal

Recovery Progress / Service delivery

- All antenatal screening programmes are fully recovered. Business as usual governance arrangements are in place with 6monthly programme boards and operational mtgs in between for all providers. Monthly incident review mtgs with SQAS enable close oversight of all incidents through to closure. Quarterly KPI submissions have continued and are reviewed by the team and discussed with providers outside of programme boards to ensure actions are in place and being progressed.

Arising issues of note by exception

- There are open incidents across several of the programmes. All are on track for investigation and closure.
- Concern that staffing pressures in maternity may be starting to have an impact on screening team functions with some trusts having increased number of incidents, poor timeliness investigation of incidents, lack if capacity to submit KPIs, single point of failure for some tasks.

Key risks to programme delivery

- Performance improvement plan in place in, RDE to comply with national standards and key performance indicators

New-born Hearing

Recovery Progress / Service delivery

- All new-born screening programmes are fully recovered. Business as usual governance arrangements are in place with 6 monthly programme boards and operational meetings in-between for all providers and the NBT new-born lab. Monthly incident review mtgs with SQAS enable close oversight of all incidents through to closure. Quarterly KPI submissions have continued uninterrupted and are reviewed by the team and discussed with providers outside of programme boards to ensure actions are in place and being progressed.

Arising issues of note by exception

- New-born bloodspot KPIs continue to be a challenge across the region to consistently meet acceptable and achievable standards. NB1 coverage – several factors may have impacted in the past year, including problems with lab (in Q2), postal delays (Christmas and lock down related issues) and the implementation of NEMS (post NEMS, blood spot results are now not received until all 9 tests are completed, whereas previously results would have been received as completed).
- NB2 avoidable repeats - 2020/21 annual lab data confirms that overall performance in NB2 has declined a little in the last year though some providers do meet the standards. All providers have done extensive work in this area over many years and there has been gradual improvement. New national lab criteria are to be introduced (date TBC) and we anticipate that this will increase the number of samples that will be rejected. The South West region average for NB2 is one of the highest and above the England average. The team will be considering whether a new regional project is needed for this area.
- NB4 movers-in coverage – this is a challenging indicator and most parts of the country do not meet the acceptable standard of a result being recorded in CHIS by 21 days of notification of a mover-in. Several factors impact on performance, including small numbers effect, unable to remove parental declines from denominator, challenges for HV making contact with families, referral pathways into paediatric outpatient departments. The team have been working with system colleagues to improve the local pathway and will be publishing updated regional best practice guidance shortly.
- There are open incidents across most of the programmes. All are on track for investigation and closure.

Key risks to programme new-born delivery

- Devon NHSP service transitioning from a community model to a hospital model on the 27th April 2022. This will impact future KPI's as the target for completion moves from 5 weeks to 4 weeks.

Diabetic Eye Screening (DES)

Service delivery

- Health inequalities work progressing with use of HEAT tool reviewing what has gone well in last 12 months and planning for the next 12. A lot of the work will focus on addressing serial DNA patients, understanding reasons, and exploring ways to engage these patients with screening.

Arising issues of note by exception

- National guidance on introduction of Optical Coherence Tomography (OCT) into screening pathway awaited. Early conversations taking place with CCGs who currently fund OCT through Ophthalmology.
- Reduced screening interval changes planned for 2023 with national working group established to meet monthly until implementation.

Key risks to programme delivery

- Capacity within the majority of Hospital Eye Services (HES) continues to be an issue for screening programmes for routine referrals and follow up patients, however this is closely monitored by the programmes and although improving will remain a risk until HES are able to return to pre covid capacity.

Abdominal Aortic Aneurysm (AAA)

Service delivery

- Finished the April 2021 -March 2022 screening cohort in January 2022, two months ahead of schedule.
- Programme now coming to the end of the April 2022-March 2023 cohort.
- No breaches have occurred in the vascular referral pathway, all patients who could have surgery were operated on within the 12 week framework. Any delays were down to allowable patients' factors.
- With GP surgeries now back open issues finding suitable rooms to hold clinics have reduced. Plus, work done during the pandemic to find alternative rooms e.g. rugby clubs and football clubs has helped with the ongoing issues of suitable clinic space.
- All providers requested to complete/refresh HEAT tool

Arising issues of note by exception

- Lone working policy redacted nationally - some programmes disappointed due to extra flexibility offered by policy in rural settings.
- Capital funding for van secured by Cornwall local authority – plans to evaluate impact on inequalities in development.

Key risks to programme delivery

- Vascular capacity to meet 8-week target to surgery challenging given wider pressures within surgery/ITU.
- SIAFs reviewed for every breach post 12 weeks (predominantly due to co-morbidities). All referrals tracked.
- Most indicate complex needs and good examples of where patient needs are being respected in the face of the challenge of meeting the targets.
- Some examples of where if person tests positive for Covid, current guidance indicates surgery should be pushed back at least 6 weeks from positive test. This still stands and may indicate risk assessed delay at the point of the surgery dates within screening referrals.

5 Immunisation programmes

5.1 This section summarises some of the key developments for the individual immunisation programmes during 2021/22.

5.2 National pandemic guidance prioritised the continuation of all immunisation programmes to ensure that public health protection was maintained, and outbreaks of vaccine preventable diseases were prevented.

5.3 The impact of the COVID pandemic has meant that there have been challenges meeting some national standards in some programmes (for example, recommended intervals between doses and coverage) and for these areas, action plans and improvement plans are in place alongside the recovery plans.

5.4 The following table gives a summary of performance, challenges, and developments during 2021/22 alongside future developments.

Targeted Immunisations

- All infants (aged 0 to 12 months) with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000 or greater. Numbers eligible are low.
- Due to the Severe Combined Immunodeficiency pilot in other parts of England vaccinations not given at birth but at 28 days of age or soon afterwards to give time for blood spot result to be received. Still observed in SW even though not part of pilot as baby may have been tested if born elsewhere.
- BCG vaccination cannot be given until the dry blood spot result is available for the patient, but national target is for babies to be offered by 28 days. All SW providers struggle to get babies booked in to such a tight timeframe as they have limited numbers of clinics running due to low number of eligible patients and if parents can't make a specified date the next available is likely after 28 days of age. This issue is being seen nationally not just in SW.

Immunisation programme:
Pre School Immunisations

- On average over last few quarters above optimal threshold of 90% for all immunisation uptake for primary immunisations by the time the child turns 12 months old.
- Rotavirus remains below the optimal standard and has high fluctuations in variation. There are some quarters where this has dipped below 90% but more recently over the last three this has been above.
- Emerging improved variation for primaries and pneumococcal conjugate vaccine (PCV), with PCV above optimum of 95% in Q3

Service Delivery

- The pattern of immunisation uptake across the SW appears to be following normal levels of variation and is comparable to previous years as shown by the Child Health Information Services (CHIS) covid dataset and is also confirmed by the annual 2020/21 COVER data and the latest 2021/22 Q4 data.

- Maximising Uptake Groups are to be relaunched with co-ordinated improvement plans to improve uptake based on national regional and local priorities. Targeted work at a practice level alongside bespoke data analysis will be incorporated into these plans. New routine locality data packs have been created to help support the

identification of practices where uptake is reducing thus enabling more rapid support and intervention. These will be updated quarterly.

Arising issues of note by exception

- Emerging feedback from some GP practices due to potential loss of income in relation to non-achievement of the new QOF targets for childhood immunisations. This is a national issue, and the outcome of these discussions are awaited. Local implications are being managed on a case-by-case basis. An operational working group has been established to investigate the technical aspects of these contractual changes and the outcomes of this workstream will be about identifying opportunities to optimise workload, delivery, recording and reporting, and uptake of immunisations, with the anticipated benefit that this will maximise income for practice within the nationally negotiated contract.
- National Measles and Rubella Elimination Strategy Task and Finish Group commenced to oversee the development and delivery of action plans that take forward the recommendations set out in the UK Measles and Rubella Elimination Strategy (2019).

Development work

- New SW Measles and Rubella Elimination Strategy (MRES) action plan being drafted.
- Maximising immunisation uptake groups improvement plans being developed based on underpinning quality improvement methods to support achievement of aims. Work to address uptake and inequalities will be embedded in the locality work of the team within all systems, with jointly agreed action plans.
- Analysis of CHIS Measles Mumps and Rubella (MMR) data is underway to support a re-fresh of the Measles and Rubella Elimination Strategy project plan and will support local discussions to support targeted interventions. The analysis will be repeated on an up-to-date extract of CHIS data for all 0–19-year-olds enabling a population view of coverage and GP practice-based analysis.
- In view of the lower uptake of the preschool booster, analysis of CHIS preschool booster will shortly be commenced using data for all 0–19-year-olds enabling a population view of coverage in addition to the GP practice-based analysis.
- Baseline assessment tool for vaccine uptake in general population has been completed to evaluate whether NHSE screening and immunisations team (SIT) team is meeting recommendations set out in NG218 and its application to the maximising immunisation uptake groups.
- Vaccine confidence project underway in collaboration with University of Bristol & National NHSEI team to develop a training resource to support health, social care and other practitioners to have conversations with individuals to encourage take-up of vaccinations. Initial focus is covid and flu vaccinations and this will be piloted in Devon with a few to expanding to cover other routine vaccinations.

Primary childhood immunisations:

All practices continued to deliver the routine child immunisation programmes throughout the pandemic. Routine data collections that monitor uptake and coverage (COVER) do not provide timely data, so the SW Screening and Immunisation Team worked with the Child Health Information Services to develop new real-time data sets that have enabled close monitoring of the impact of the pandemic. These have shown that uptake of primary immunisations has been maintained. Annual Cover of Vaccination

Evaluated Rapidly COVER data for 2021/22 is also reassuring. The real-time datasets however do show that for immunisations at 12 months of age and at 3 years 4 months a larger proportion of children are not immunised as close to the age of eligibility as is recommended. Further investigations will be taking place and improvement plans put in place as necessary.

School-aged immunisations

The school-aged immunisation programme has been severely impacted by the pandemic due to the initial lockdown, the second wave of school closures, and ongoing outbreaks that have prevented immunisation teams attending schools for clinics. These factors prevented the 2019/20 programme being completed in the Spring and Summer terms 2020 and have continued to impact delivery of the 2020/21 programme. In addition, the COVID vaccination programme for 12-15s and the expanded flu vaccination programme has impacted the 2021/22 programme. Both Devon, Cornwall and Isles of Scilly (DCIOS) providers restarted immunisation clinics during the first COVID lockdown have worked hard to deliver as much of the routine programme as possible as well as catch-up clinics over the summer periods. The aim is to complete the routine programme for those in 2019/20, 2020/21 and 2021/22 cohorts by the end August 2022.

The Cornwall programme had nearly completed the routine programme at the time of the first lockdown in 2020 and was able to achieve expected uptake levels for the 2019/20 cohort. Uptake for the 2020/21 cohort is also good.

The Devon programme was significantly disrupted by the first lockdown and had large numbers of catch-up clinics in the Spring/Summer 2020 terms. The provider was also heavily impacted by involvement in the delivery of the covid programme for 12-15s. Uptake at this stage is therefore lower and it is hoped will improve by the end of August 2022. Work is still underway to complete HPV for the 2020/21 cohort, which is the clinical priority and some second doses may extend into the coming academic year.

Business cases are being developed to expand the provider workforce to achieve the ambition to complete the routine programme for those in 2019/20, 2020/21 and 2021/22 cohorts by the end of August 2022.

Vaccinations in pregnancy

- Vaccinations in Pregnancy include Flu, Pertussis and COVID. COVID vaccination is not a Section 7a programme.
- The Vaccines in Pregnancy Network meets quarterly to review and address issues across systems. The South West Maternity Collaboration for COVID vaccination in pregnancy meets once a month to discuss point of care access, ways to support staff to have vaccine confidence conversations and to develop regional communications materials. It is likely that there will be one

"vaccines in pregnancy" meeting for each system, monthly, from September.

- There are significant data issues including:
- denominator definition
- data uploading between systems, vaccination programmes and providers
- administration workload to ensure accurate data
- reporting delays

There are inconsistent and inequitable pertussis vaccination delivery models across the South West. A business case to commission all maternity services to provide pertussis is being prepared. Delivery of vaccination in maternity settings has been affected by poor capacity, lack of space, and Trust demands to redeploy stock or staffing to support vaccination elsewhere (i.e. healthcare workers, mass vaccination clinics). Plans for the flu season were developed to include more frequent meetings with Trusts, a checklist as part of the support pack for key lines of enquiry (KLOEs) to acute Trusts, and align flu, COVID and pertussis better.

Older people Immunisations

Recovery Progress / Service delivery

- New Quality and Outcomes Framework (QOF) indicator for Shingles: The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years. Payment thresholds 50-60%. On average all systems meet this, however there may be more likely to be below threshold, reducing in likelihood when the cohort now 78 turns 80.
- Shingles communications issued to all GPs who are within the lowest 20% within the CCG for Shingles uptake in aged 78 over Q1/Q2 2020/21. Possible issues with the data now reported for practices on TPP (electronic health record platform) however no current feedback over error from practices (and few on SW on TPP). Updated data now received – light review to see if this changes any practice assumptions.
- Shingrix has been available to offer to all those who are age 70-80 who are immunocompromised (and so not eligible for Zostavax) since Q2 2021/22. Data is under investigation – quality issues of overall data set and review if GPs are coding correctly for this cohort.

Key updates

- All practices reminded that shingles is an active call at age 70, and all persons eligible for Shingrix can be actively called for the programme. This was distributed via the GP bulletin, practice networks and will be used in specific ICARS responses where this is appropriate as part of feedback (i.e. excess Zostavax in a cold chain).

Flu immunisations

The flu vaccination programme has continued to be a priority during the 2020/21 and 2021/22 programmes with extension to the eligible groups (2021/22 addition of years 8-11 and those aged 50-64byears) placing pressure on GP practices and Schools immunisation providers at the same time as delivering the COVID

vaccination programme. Delivery through community pharmacy has expanded to support the programme.

Multi-agency arrangements were established in Devon and Cornwall to manage the delivery of the seasonal vaccination programmes including both COVID-19 and influenza.

6 Health Care Associated Infections

6.1 The following table summarises the key performance position and developments for health care associated infections over 2021/22. Note that targets were relaxed due to the pandemic.

Infection type:	
MRSA	*Devon:* There were 8 cases over 2020/21, for an overall rate of 0.68/100,000. The majority or MRSA cases were community-associated and unlinked. *Cornwall:* There was a total of 1 case over 2021/22, an overall rate of 0.17/100,000. There was no prior MRSA history and no clear source for infection identified in the post infection investigation process and therefore the case was deemed unavoidable.
MSSA	*Devon:* There were 312 cases over 2020/21, for an overall rate of 26.4/100,000. MSSA bacteraemia rates continued to be steady, with higher variability in North Devon Healthcare NHS Trust (NDHT) and Torbay and South Devon NHS Foundation Trust (TSDFT) due to the smaller population in these areas. *Cornwall:* There were a total of 164 cases over 2021/22, with an overall rate of and 28.7/100,000. 26 cases above the incidence of previous year 2020-21.
C. difficile Infection	*Devon:* There were 311 cases over 2020/21, for an overall rate of 26.3/100,000. During 2020/21 there was limited scope for investigation and analysis of community cases, despite the new team set up to do so; this is due to that team having to pivot to offering pandemic support. Cases did not rise significantly during this year. *Cornwall:* There were a total of 216 cases over 2021/22, an overall rate of 37.9/100,000, a total of 48 cases above trajectory. Cornwall system is involved in NHS EI collaborative improvement and each C. diff case is investigated to provide learning.
E. coli Bacteraemia	*Devon:* There were 1009 cases over 2020/21, for an overall rate of 85.0/100,000. Projects for *E. coli* reduction have been limited by the necessities of the pandemic response. *Cornwall:* There were a total of 448 cases over 2021/22, an overall rate of 78.5/100,000. 10 cases above the incidence of previous year 2020-21, however, 58 cases below trajectory for this year.

Antimicrobial resistance	*Devon:* AMR group meetings recommenced in the latter half of 2020/21, however the Chair and primary care lead for the group stood down during 2020/21 and this, along with the impact of the pandemic, limited action during the year. *Cornwall:* The AMR planning and delivery group continues to meet with group members attending from acute, community, local authority, NHSE and ICB. Cornwall Antibiotic Resistance Group (CARG) continues to operate as a 'one health' group with representation from human and animal health sectors.

6.2 The key challenges for 2022/23 include strengthening the antimicrobial resistance programme, continuing to support the COVID-19 response, implementing *E. coli* & *C. difficile* reduction strategies, and ensuring consistent information and analysis from community infections.

7. Emergency Planning and Response

7.1 Emergency planning continued to be dominated during 2021-2022 by the response to the pandemic. This involved a very substantial amount of work during the year and substantially challenged our systems to deliver. In summary the response involved:

- Activation of emergency structures
- A strategic co-ordinating group was established to manage the local response in support of the UK's response to COVID-19. This SCG structure ensured the effective co-ordination of the Local Resilience Forum and other specialist resources.
- To maximise co-ordination across the Peninsula, one Tactical Co-ordinating Group for DCIOS was established rather than four across the area.
- Organisations across DCIOS stood up their incident management structures and held desk-top exercises.
- With the need for local multi-agency working groups to respond to COVID-19 below the level of the LRF-wide Tactical Co-ordinating Group (TCG), local Operational Incident Cells were also established.
- Logistical supply chains were set up for obtaining and co-ordinating PPE supplies.
- The South West Regional Strategic Coordination Group instigated in response to the pandemic will be further developed as a concept post COVID-19.

7.2 In addition to the pandemic response there were a number of other events during 2021/22:

- System pressures (patient flow from acute through to care homes / POC)
- Plymouth shooting
- Bomb threats made to NHS and a secondary school in connection with the Covid 19 vaccination programme
- Major incident declared in December 2021 for mass vaccination booster programme
- G7 summit hosted in Cornwall, 9-11th June 2021
- Boardmasters Festival, 6th-8th August 2021
- Outbreak of GI illness associated with consumption of Oysters (North Cornwall), November 2021

7.3 Despite the pandemic, local and regional exercises were held over the period, these included exercises for G7, Boardmasters festival and Short Sermon (Devonport Dockyard).

7.4 It is safe to say that the year 2021/22 saw unprecedented challenges across health and social care systems. The primary focus was on responding and adapting to the issues and risks that arose, from which substantial learning, improvement and good practice has been, and continues to be, identified.

8. Work Programme Priorities 2021/22- Progress

8.1 Progress against 2020/21 priorities is set out below.

	Priority	Progress on delivery
1	Maintain response to COVID-19 and ensure preparedness and resilience to respond to future pandemics or health protection emergencies. As part of this, lead efforts to target vaccination inequalities	Throughout the course of the pandemic, DCIOS local authorities put in place health protection response systems to respond to COVID19 outbreaks. These worked in collaboration with a wide range of partners to support settings to respond to C19 outbreaks. This is currently being maintained at a level which reflects current activity but with surge plans in place to ensure that we are ready to respond to an escalation in covid cases or another pandemic. Devon is running a regular training and CPD programme to ensure that health protection skills and knowledge maintained across the wider Public Health Team. Other teams are similarly working to maintain resilience with a significantly reduced core workforce. Winter preparedness exercise completed and plans in place. System wide winter vaccination plan/comms plan agreed. Continue to identify communities with low uptake of vaccine using Core 20+5 framework via targeted communications, pop ups, bespoke clinics and adapted delivery models.
2	Recover screening and immunisation programme delivery, coverage and uptake	Most services are recovered and now need to focus on improving uptake School aged immunisations providers implementing recovery plans to catch up COVID backlogs following investment being agreed Maximising immunisations uptake groups forming to address challenges in uptake, especially MMR and preschool booster

		Collaborative working arrangements between system partners on interdependencies within cancer pathways and improving immunisation uptake are being strengthened
3	Embed and strengthen community infection management services to prevent and respond to infections throughout the community	As a result of COMF funding, IPC in person site visits to non-health and care settings were able to provide valuable insight identifying issues and poor practice, as well as support to provide advice and guidance to make improvements. A variety of resources, which supplement national guidance, have been published to support education settings, homelessness settings, workplaces and events and where relevant translated into different languages. Checklists have been developed to support specific settings in meeting IPC settings in a practical and pragmatic way. Having fit tester skills and competency (to ensure mask fit for staff members) in the team enable us to help minimise hospitals delays where staff in the community required to be fit tested for respiratory protective equipment.
4	Work to reduce the incidence of healthcare associated infections and to tackle antimicrobial resistance across our communities	International Infection Prevention week and World Antimicrobial Awareness Week campaigns have been used to celebrate and shine a light on the good work of the IPC community protecting everyone in their everyday lives as well as highlighting the relevance of IPC behaviours to prevent Sepsis and tackle AMR. A dedicated resource using Microsoft SharePoint was developed to keep the DCC HP Team updated with all relevant IPC information and resources. Similarly, CIOS have information sharing protocols in place. Work is under way to consider the consolidation of Devon and CIOS antimicrobial resistance groups, with the aim of creating create a peninsula action plan aligning with the national plan

5	Focus efforts to address health inequalities, in particular health protection pathways for migrant and homeless communities	In CIOS, a Population health fellow appointed to work on gypsy & traveller needs assessment and gap analysis. One main focus will be on increasing uptake of cervical screening. Integrated homeless health project funding awarded and will run over the next 3 years with a focus on integrated health and care delivery. This will include improving screening and immunisations uptake alongside other activities such as GP registration. A multi-agency approach was taken when temporary hotel settings were set up to support people arriving in Devon and Torbay, including guidance for the hotels around IPC measures, Covid testing via the Devon public health outreach teams and support for staff to understand routes for escalating any health protection concerns. Health screening for all new refugees and those seeking asylum was expanded to include health protection checks and led by local primary care teams in each area, with translation and other support available. TB screening clinics were also mobilised in support. Practitioners and host families were offered trauma informed training to recognise the traumatic situations many refugees had experienced. Regular public health nursing (PHN) clinics to support families were established and the relationships PHN were able to build with residents was also valuable in being able to share health protection guidance, infection prevention and control advice and also pick up and direct any concerns to either public health or primary care. Support was also provided to help people settle in the areas, to access local services around health, education, and local activities. Community groups were also keen to be involved supporting by sourcing clothes, toys and offering support around language lessons, example support for GP registration; skin care advice; hepatitis C advice and wider support offers such as dental care and pet care
6	Maintain a focus on local action to address the climate emergency.	Public health inputs to the Climate Emergency infrastructure via the Devon, Cornwall and the Isles of Scilly Climate Impacts and Adaptation Group, the Devon Climate Emergency Response Group, and Devon Tactical Group. The Cornwall

Carbon Neutral Plan was published in July 2019 and the Devon Carbon Plan published in September 2022. These provide a road map for partnership working. Examples of good practice have been the establishment of the Devon Food Partnership which supports the development of a localised, sustainable food system that tackles the issues of food-poverty, diet-related ill health, food waste and unsustainable farming practices.

Plymouth City Council published its Climate Emergency Action Plan 2022- the third of 11 action plans in the City Council's annual Climate Emergency Action Plan series. The action plan addresses the following five themes: Buildings; Mobility; Power and Heat; Waste and Engagement & Responsibility

Cornwall and Devon Public Health consultants have begun a piece of Sector Lead Improvement work to establish and share Public Health and Climate Emergency good practice.

9. Work Programme Priorities 2022/23

9.1 Priorities agreed by Health Protection Committee members for 2022/23 are to:

1 Maintain response to COVID-19 in line with current guidance, resourcing and activity.

2 Ensure preparedness and system wide resilience to respond to future pandemics or health protection emergencies, including sharing learning to inform future approaches.

3 Continue recovery of screening and immunisation programmes including launch of the Maximising Immunisation Uptake Groups and a renewed focus on addressing health inequalities in uptake, including a focus on flu and covid uptake amongst vulnerable and inclusion health groups.

4 Embed and strengthen community infection management services to prevent and respond to infections throughout the community, ensuring that there is IPC support for all settings, aligning to the broader SW IPC Strategy Work.

5 Continue work to reduce the incidence of healthcare associated infections and to tackle antimicrobial resistance across our communities

6 Work towards continuous improvement in all areas of health protection through audit, peer review, training, and development. Specifically address improvement areas highlighted by the Sector Led Improvement self-assessment and the UKHSA Gap Analysis/Action Planning tool.

7 Maintain a focus on local action to address the climate emergency, building on the findings of the SW sector-led improvement Climate and Public Health work.

8 Refresh health protection governance structures in line with integrated care board and integrated care system strategy development including a review of existing meetings and terms of reference.

9 Advocate for a rolling CPD and training programme to ensure a robust and resilient system which can respond to major incidents and emergencies.

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Health Protection Committee

11. Glossary

AMR	Antimicrobial resistance
CCG	Clinical Commissioning Group
E. coli	Escherichia Coli
HPV	Human papillomavirus testing (for risk of developing cervical cancer)
IPC	Infection Prevention and Control
MMR	Measles, Mumps and Rubella (immunisation)
MRSA	Methicillin resistant Staphylococcus aureus
MSSA	Methicillin sensitive Staphylococcus aureus
NEW Devon CCG	Northern, Eastern and Western Devon Clinical Commissioning Group
NHSEI	NHS England and NHS Improvement
NIPE	New-born Infant Physical Examination
PHE	Public Health England
PPE	Personal Protective Equipment
SCID	Severe Combined Immunodeficiency
UKHSA	UK Health Security Agency

12. Appendices

Appendix 1 Health Protection Committee terms of reference & affiliated groups
Appendix 2 Roles in relation to delivery, surveillance and assurance
Appendix 3 Screening performance 2021/22
Appendix 4 Immunisation performance 2021/22

Appendix 1

Health Protection Committee
Summary terms of reference & affiliated groups

Membership of the Committee:

- Local Authority Public Health
- Public Health England (PHE), now UK Health Security Agency (UKHSA)
- NHS England & Improvement (NHSEI)
- NHS Devon and Cornwall Clinical Commissioning Groups (CCG).

Meetings of the Health Protection Committee are held quarterly.

A number of groups sit alongside the Health Protection Committee with remits for:

- Infection Prevention and Control
- Antimicrobial Stewardship
- Immunisation
- Screening
- Seasonal vaccination
- Emergency planning (including Local Resilience Forums)
- Migrant and Refugee health
- TB & Hepatitis.

All oversight groups have Terms of Reference and clear escalation routes to ensure accountability both within NHS England and Public Health England / UKHSA and into individual partner organisations.

NHSE, PHE / UKHSA and CCG provide quarterly performance, surveillance, and assurance reports to the Health Protection Committee.

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.

Appendix 2

Definition of roles and arrangements in relation to delivery, surveillance and assurance

Prevention and control of infectious disease

Normal working arrangements are described in the paragraphs below. During the pandemic there has been an enhanced response to infectious disease, with additional responsibilities taken on by Local Authority Public Health teams in relation to COVID-19 tracing, isolation and containment, funded in part through the national Contain and Outbreak Management Fund.

Public Health England (now UKHSA) health protection teams lead the epidemiological investigation and the specialist health protection response to public health outbreaks or incidents. They have responsibility for declaring a health protection incident, major or otherwise and are supported by local, regional and national expertise.

NHS England / Improvement is responsible for managing and overseeing the NHS response to any incident that threatens the public's health. They are also responsible for ensuring that their contracted providers deliver an appropriate clinical response.

Clinical Commissioning Groups ensure, through contractual arrangements with provider organisations, that healthcare resources are made available to respond to health protection incidents or outbreaks.

Local Authorities, through the Director of Public Health or their designate, has overall responsibility for 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 NHSE/I and UKHSA, supported by the local Clinical Commissioning Group. In addition, they must be assured that the local health protection system response is robust and that risks have been identified, are mitigated against, and adequately controlled.

Public Health England / UKHSA provides a quarterly report to the Committee containing epidemiological information on cases and outbreaks of communicable diseases of public health importance at local authority level.

Surveillance information on influenza and influenza-like illness and infectious intestinal disease activity, including norovirus, are published during the Winter months. These bulletins report information for the Public Health England Centre geography (Devon, Cornwall and the Isles of Scilly, and Somerset). Public Health England also provides a list of all community outbreaks all year round.

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.

Screening and Immunisation

Population Screening and Immunisation programmes are commissioned by NHS England and Improvement under what is known as the Section 7A agreement. There are 20 population immunisation programmes and 11 population screening programmes. These programmes cover the whole life course from antenatal to elderly persons and, in any one year, approximately 70% of the population will become eligible for at least one immunisation or screening test. These programmes are a core element of prevention and early diagnosis and offer opportunities for accessing populations to improve wider health and wellbeing.

NHS England is the lead commissioner for all immunisation and screening programmes except the six antenatal and new-born programmes that are part of the CCG Maternity Payment Pathway arrangements, although NHS England remains the accountable commissioner.

Public Health England has been 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 NHSE/I, work alongside NHS England Public Health Commissioning colleagues to provide accountability for the commissioning of the programmes and system leadership.

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 NHSE/I in efforts to improve programme coverage and uptake.

The South West Screening and Immunisation Team provides quarterly reports to the Health Protection Committee for each of the national screening and immunisation programmes. Reports are considered by lead Local Authority Consultants in Public Health and any risks identified are considered with NHSE/I specialists to agree mitigating activities.

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.

Locality Immunisation Group activity was suspended during the pandemic but is being re-introduced from 2022 and badged as Maximising Immunisation Uptake Groups.

Separate planning and oversight groups are in place for seasonal influenza and covid.

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.

All the oversight groups have Terms of Reference and clear escalation routes to ensure accountability both within NHS England and Improvement and into individual partners.

Healthcare associated infections

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 Area 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 Clostridium difficile infection (CDI).

UKHSA, 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.

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. NHS Devon Clinical Commissioning Group deploys this role through the Nursing and Quality portfolio. 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.

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.

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.

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.

Emergency planning and response

Local resilience forums (LRFs) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency, and others. These agencies are known as Category 1 Responders, as defined by the Civil Contingencies Act. The geographical area the forums cover is based on police areas (Devon, Cornwall and the Isles of Scilly).

The LRFs aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

The Local Health Resilience Partnership (LHRP) is a strategic forum for organisations in the local health sector. The LHRP facilitates health sector preparedness and planning for emergencies at Local Resilience Forum (LRF) level. It supports the NHS, Public Health England (PHE) and local authority (LA) representatives on the LRF in their role to represent health sector Emergency Planning, Resilience and Response (EPRR) matters.

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

APPENDIX 3: CANCER SCREENING COVERAGE

Annual cancer screening coverage trends DEVON

Source: PHOF, PHE

Key:

- Significantly better than the national average
- Similar to national average
- Significantly worse than the national average

[1] Lower threshold based on the 2018-19 Public Health Functions Agreement

[2] Standard is the clinical standard required to control disease and ensure patient safety.

* This indicator was first introduced in December 2015

NHS England South West

Indicator	Lower threshold[1]	Standard[2]	Geography	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2.20i - Cancer screening coverage - breast cancer (%)	70	80	Devon	79.2	80.4	80.1	80.0	79.1	79.1	78.8	78.3	78.3	78.2	78.1	69.2
			England	76.9	77.1	76.9	76.3	75.9	79.2	78.9	78.5	78.3	78.2	77.6	64.1
2.20ii - Cancer screening coverage - cervical cancer age 25-49 (%)	75	80	Devon	79.1	78.0	77.0	75.2	75.7	76.1	75.3	74.9	75.1	76.7	77.2	75.2
			England	78.0	77.6	77.2	75.2	75.2	74.9	74.4	74.0	73.8	75.0	75.6	68.0
2.20ii - Cancer screening coverage - cervical cancer age 50-64 (%)	75	80	Devon	82.6	82.2	81.6	81.1	80.2	80.1	79.8	79.0	78.1	78.2	78.4	77.3
			England	81.5	82.3	82.0	81.6	81.1	80.4	80.1	79.4	78.5	78.6	78.8	74.7
2.20iii - Cancer screening coverage - bowel cancer (%)*	55	60	Devon						60.5	62.6	64.2	64.2	65.4	69.0	71.4
			England						62.0	62.7	63.6	63.4	64.1	67.9	65.2

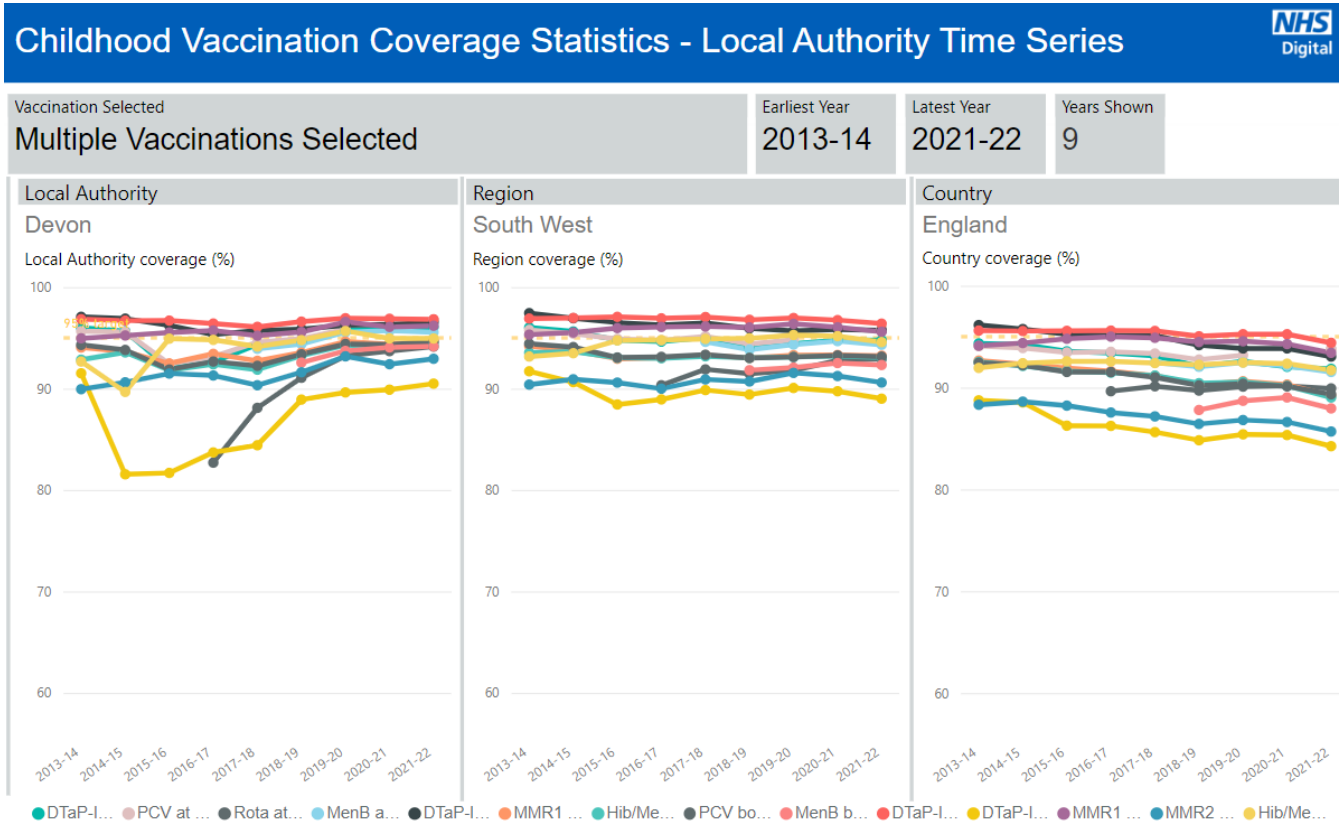
Annual cancer screening coverage trends CORNWALL

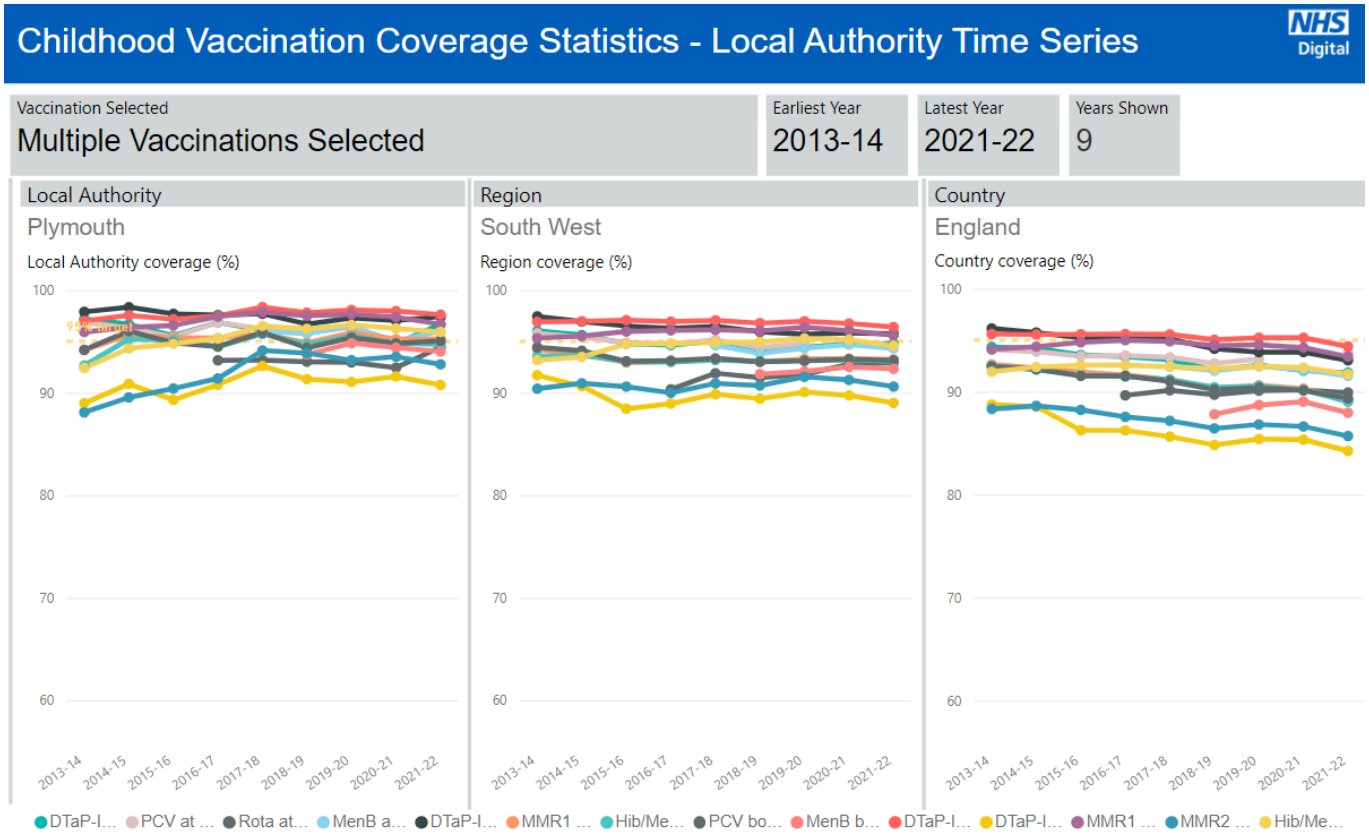
NHS England South West

Indicator	Lower threshold[1]	Standard[2]	Geography	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2.20i - Cancer screening coverage - breast cancer (%)	70	80	Cornwall	80.0	79.8	79.3	79.9	80.1	80.3	80.0	79.3	78.4	78.2	78.1	72.1
			England	76.9	77.1	76.9	76.3	75.9	79.2	78.9	78.5	78.3	78.2	77.6	64.1
2.20ii - Cancer screening coverage - cervical cancer age 25-49 (%)	75	80	Cornwall	78.2	75.4	75.7	74.0	74.8	75.2	74.3	73.4	73.6	75.0	75.9	72.9
			England	78.0	77.6	77.2	75.2	75.2	74.9	74.4	74.0	73.8	75.0	75.6	68.0
2.20ii - Cancer screening coverage - cervical cancer age 50-64 (%)	75	80	Cornwall	80.0	79.7	80.0	79.4	78.8	78.2	77.8	77.2	76.3	76.1	76.0	74.6
			England	81.5	82.3	82.0	81.6	81.1	80.4	80.1	79.4	78.5	78.6	78.8	74.7
2.20iii - Cancer screening coverage - bowel cancer (%)*	55	60	Cornwall						58.3	60.5	61.7	61.5	62.7	66.6	67.9
			England						62.0	62.7	63.6	63.4	64.1	67.9	65.2

Appendix 4: Immunisations

PRESCHOOL

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NHS Digital
Vaccination Selected
Multiple Vaccinations Selected
Earliest Year
2013-14
Latest Year
2021-22
Years Shown
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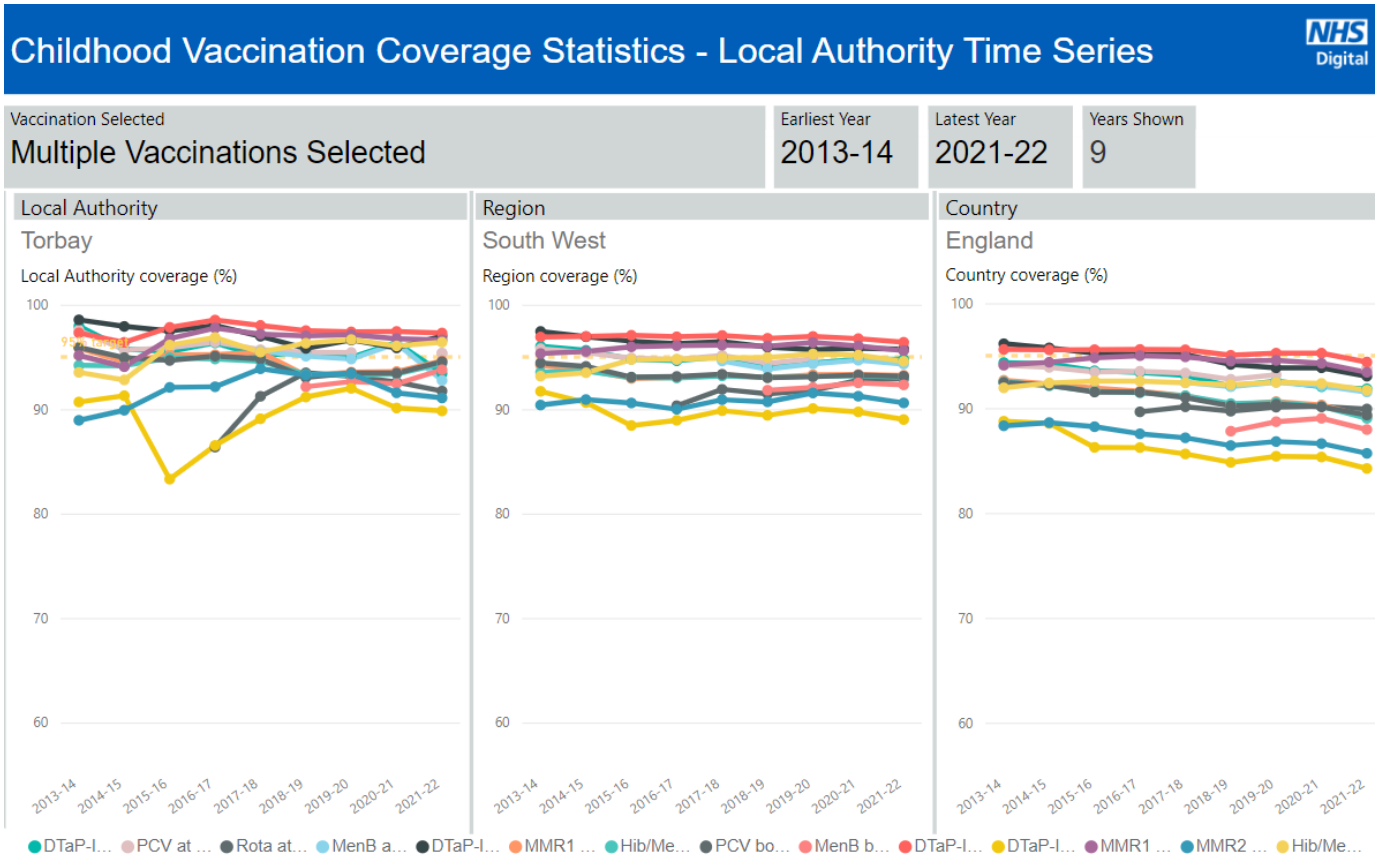
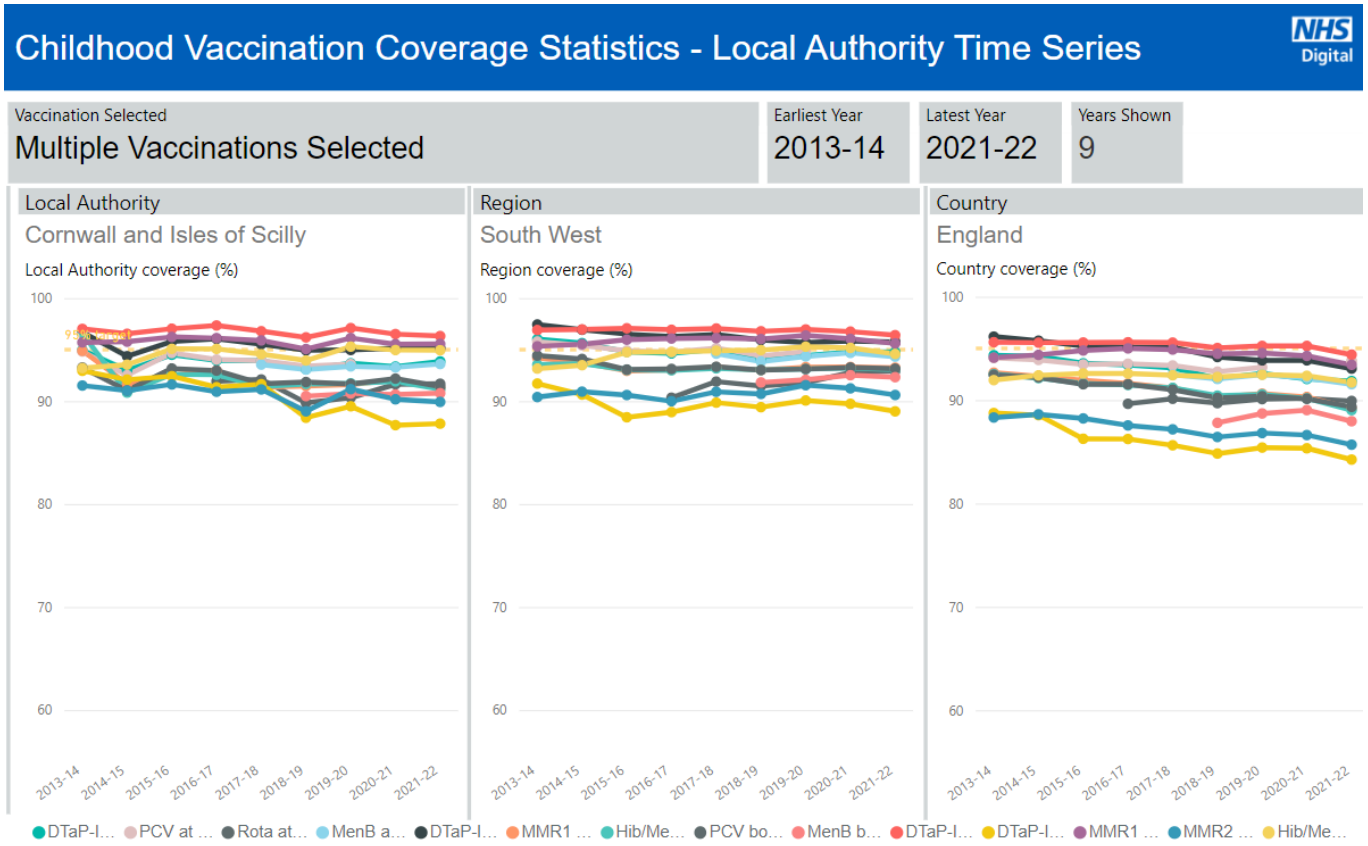
Local Authority
Plymouth
Local Authority coverage (%)
Region
South West
Region coverage (%)
Country
England
Country coverage (%)
100
90
80
70
60
2013-14
2014-15
2015-16
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
DTaP-I...
PCV at ...
Rota at...
MenB a...
DTaP-I...
MMR1 ...
Hib/Me...
PCV bo...
MenB b...
DTaP-I...
DTaP-I...
MMR1 ...
MMR2 ...
Hib/Me...


Childhood Vaccination Coverage Statistics - Local Authority Time Series
NHS Digital
Vaccination Selected
Multiple Vaccinations Selected
Earliest Year
2013-14
Latest Year
2021-22
Years Shown
9
Local Authority
Torbay
Local Authority coverage (%)
Region
South West
Region coverage (%)
Country
England
Country coverage (%)
100
90
80
70
60
2013-14
2014-15
2015-16
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
DTaP-I...
PCV at ...
Rota at...
MenB a...
DTaP-I...
MMR1 ...
Hib/Me...
PCV bo...
MenB b...
DTaP-I...
DTaP-I...
MMR1 ...
MMR2 ...
Hib/Me...


Childhood Vaccination Coverage Statistics - Local Authority Time Series
NHS Digital
Vaccination Selected
Multiple Vaccinations Selected
Earliest Year
2013-14
Latest Year
2021-22
Years Shown
9
Local Authority
Cornwall and Isles of Scilly
Local Authority coverage (%)
Region
South West
Region coverage (%)
Country
England
Country coverage (%)
100
90
80
70
60
95% target
2013-14
2014-15
2015-16
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
DTaP-I...
PCV at ...
Rota at...
MenB a...
DTaP-I...
MMR1 ...
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MenB b...
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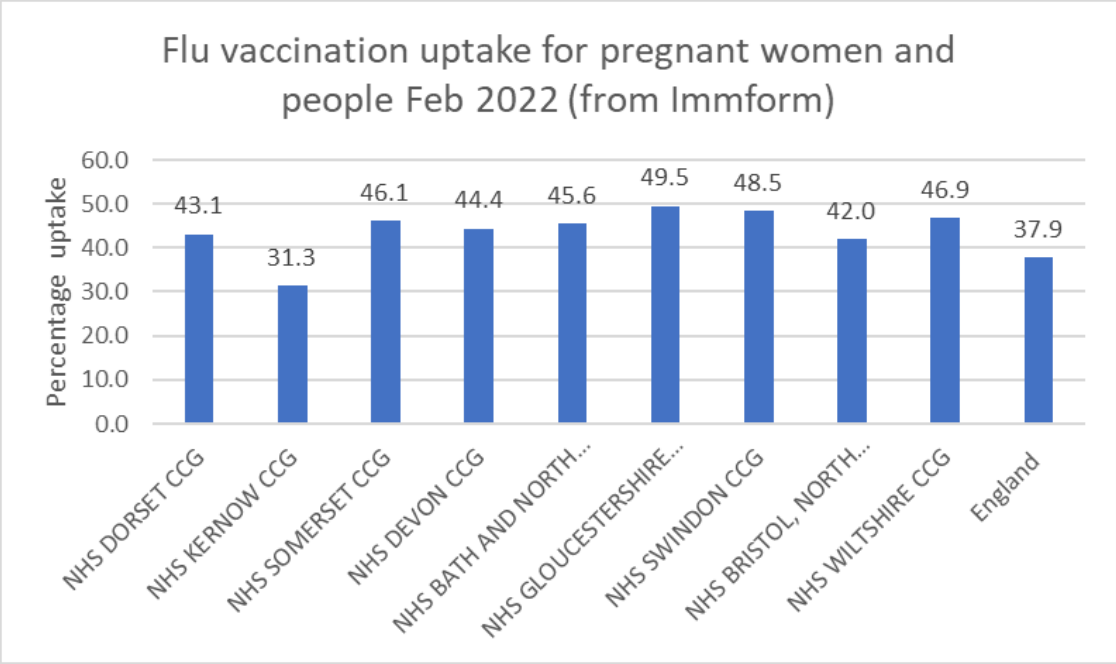
DTaP-I...
MMR1 ...
MMR2 ...
Hib/Me...

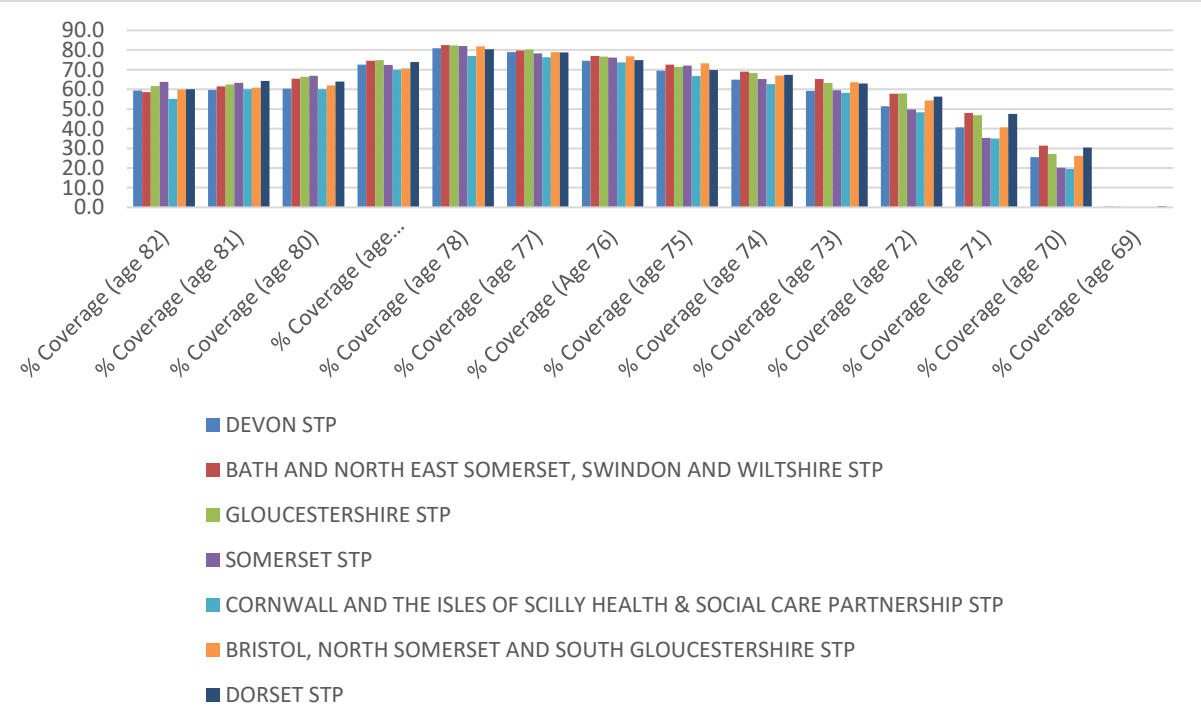
PREGNANCY


Flu vaccination uptake for pregnant women and people Feb 2022 (from Immform)
Percentage uptake
60.0
50.0
40.0
30.0
20.0
10.0
0.0
43.1
31.3
46.1
44.4
45.6
49.5
48.5
42.0
46.9
37.9
NHS DORSET CCG
NHS KERNOW CCG
NHS SOMERSET CCG
NHS DEVON CCG
NHS BATH AND NORTH...
NHS GLOUCESTERSHIRE...
NHS SWINDON CCG
NHS BRISTOL, NORTH...
NHS WILTSHIRE CCG
England

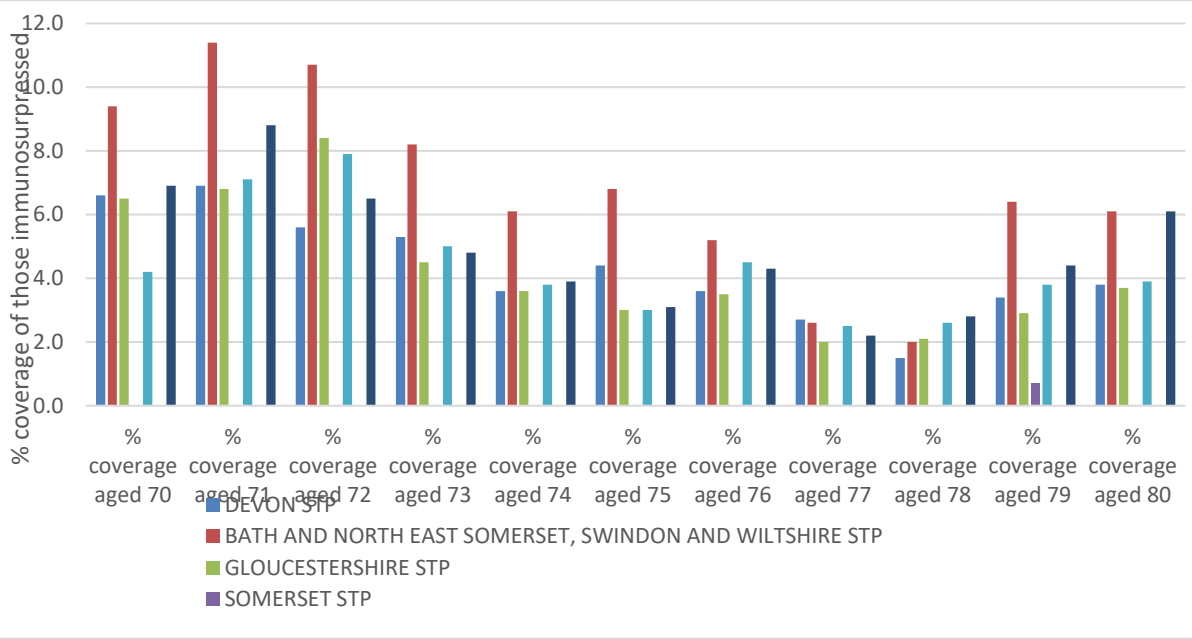
OLDER PEOPLE

Shingles

Total Shingles vaccine coverage - cohort vaccinated at any time who are of this age between 01/04/2021 and 23/03/2022



Uptake of Shingrix - cohort vaccinated with dose 1 of Shingrix at any time who are of eligible age and recorded immunosuppressed between 01/04/2021 and 23/03/2022



Caution – Potential Data Quality Issues

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