Public Health Devon

Devon County Council

# Health Protection Report for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council

## 2014 - 2015

PLYMOUTH CITY COUNCIL

TORBAY COUNCIL

## 1. Introduction

1.1 The following report to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council provides a summary of the assurance functions of the Health Protection Committee (of the three Boards) and significant matters considered for the period from 1st April 2014 to the 31st March 2015.

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 2014 to 2015.

## 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.

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 and Torbay Council that adequate arrangements are in place for the prevention, surveillance, planning and response 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 three Local Authorities, the Committee allows health protection expertise from three 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
- 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 regularly and 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 2014 and 31st March 2015 were held on 29th April 2014, 20th August 2014, 22nd October 2014, 3rd December 2014, 25th February 2015.

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

## 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).

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 provided a monthly 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 produced for Devon County Council, Torbay Council and Plymouth City Council.

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.

**Outbreak of E.coli VTEC**

3.8 Public Health England staff in the local Centre became aware initially of two cases of VTEC (Vero cytotoxin producing E.coli 0157 – the cause of haemolytic uraemic syndrome) in other parts of the country that appeared to be associated with consumption of unpasteurised milk that had originated from a producer in Devon who markets their milk via the Internet.

3.9 Other cases associated with drinking raw milk from this producer were notified. There has been considerable interest in this outbreak nationally, because of the link with drinking raw milk. Investigation has involved Public Health England, the Dairy Hygiene Inspectorate, North Devon Council, Trading Standards, the Food Standards Agency and the Animal Health and Plant Agency.

3.10 The farm is now supplying milk again having complied with the necessary recommendations.

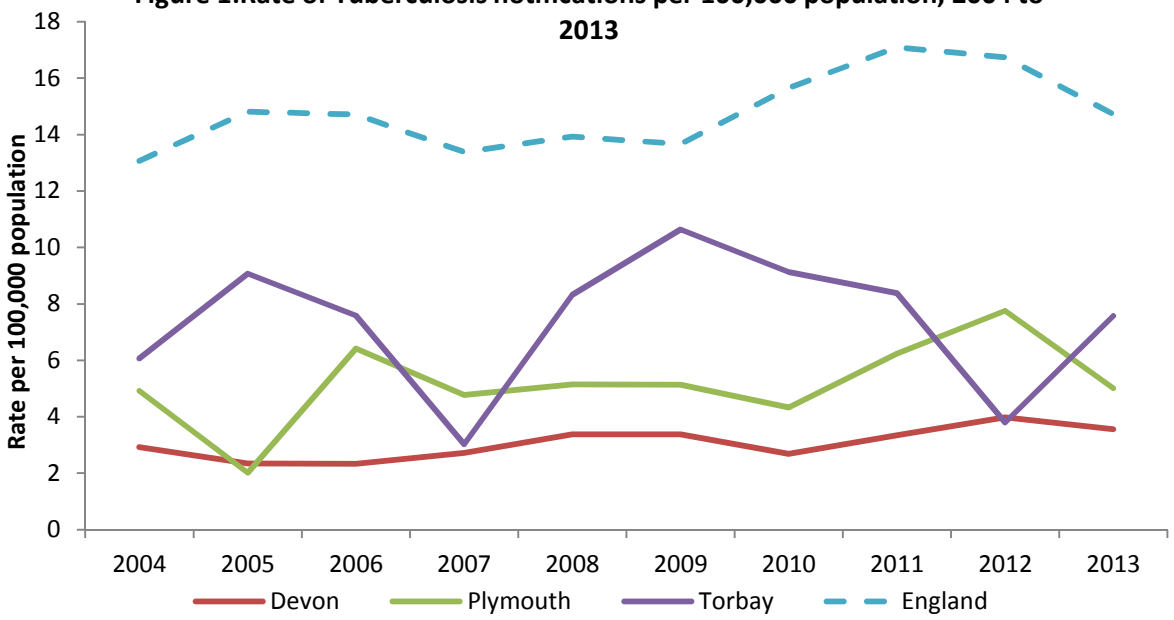
**Tuberculosis incident in Devon School**

3.11 A young person who attended a Devon school was diagnosed with infectious tuberculosis after he had been coughing for several months. Screening of his close contacts identified a high level of infection and one active case of tuberculosis. A case of infectious tuberculosis in another student in a different school year at the

school was also diagnosed and large scale screening at the school has been carried out.

3.12 Devon is seen as a low-incidence area within the UK for tuberculosis, but this conceals a change in the epidemiology from reactive tuberculosis in older people to new infections in younger people contracted in the UK. This also tends to mean that cases have more contacts needing screening and tuberculosis services are being increasingly stretched. It is hoped that the new Tuberculosis Board covering the South West Region will start to develop a strategy to bring tuberculosis under control again. Devon does get outbreaks from time-to-time, therefor TB is a high priority for action.

**Figure 1:Rate of Tuberculosis notifications per 100,000 population, 2004 to 2013**




Data Source: Enhanced Tuberculosis Surveillance (ETS)

**Norovirus 2013-14**

3.13 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.

3.14 As illustrated in Figures 2, 3, and 4 norovirus vomiting, diarrhoea, and gastroenteritis consultation rates overall have been lower 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: GP (In Hours) vomiting consultation rates (all ages), Devon, Torbay, Plymouth and England, 2014 week 14 to 2015 week 13***

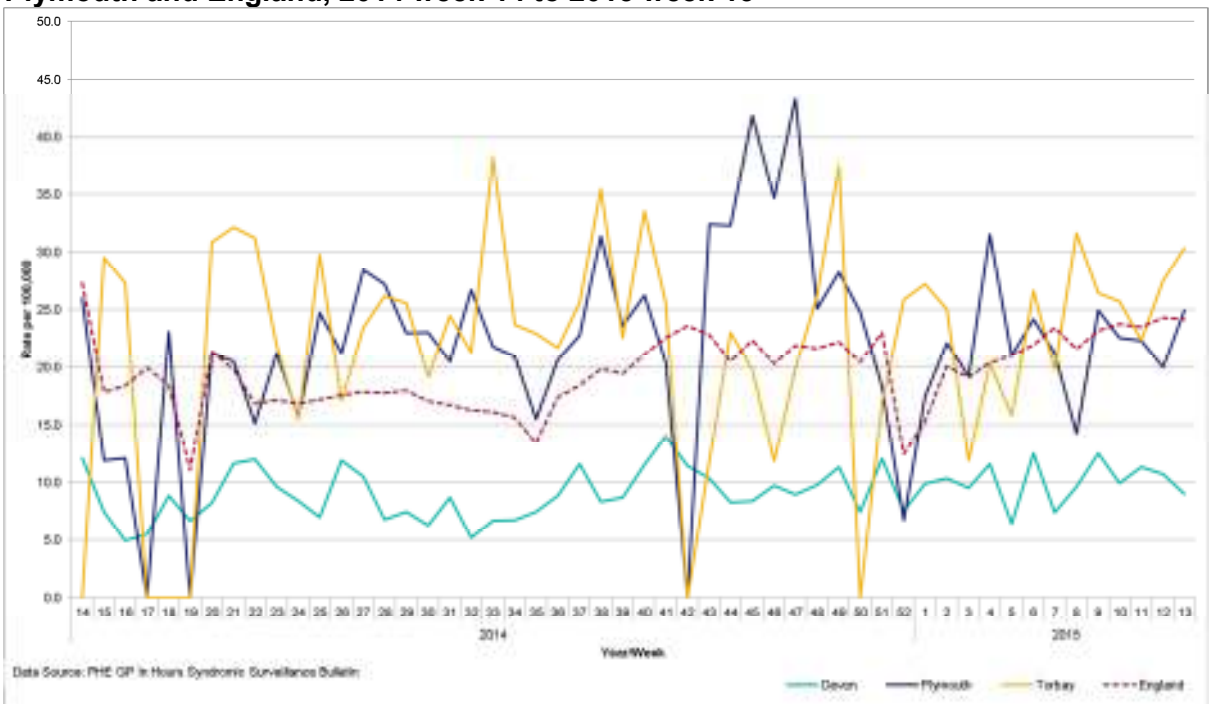
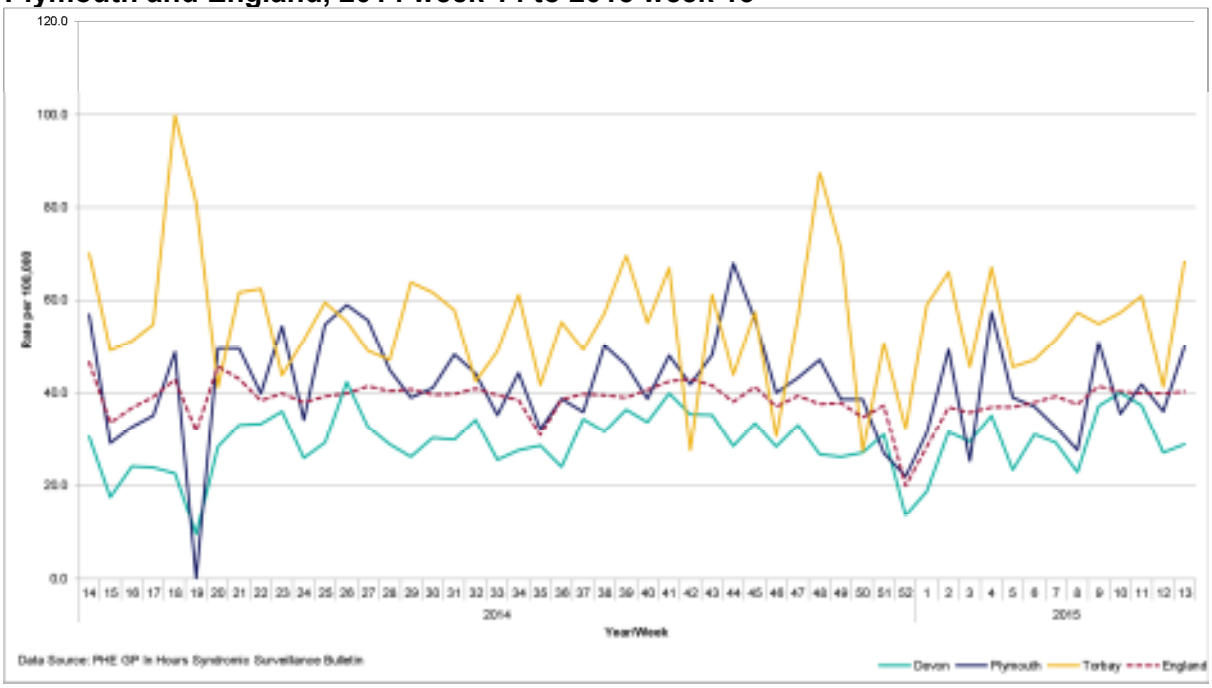
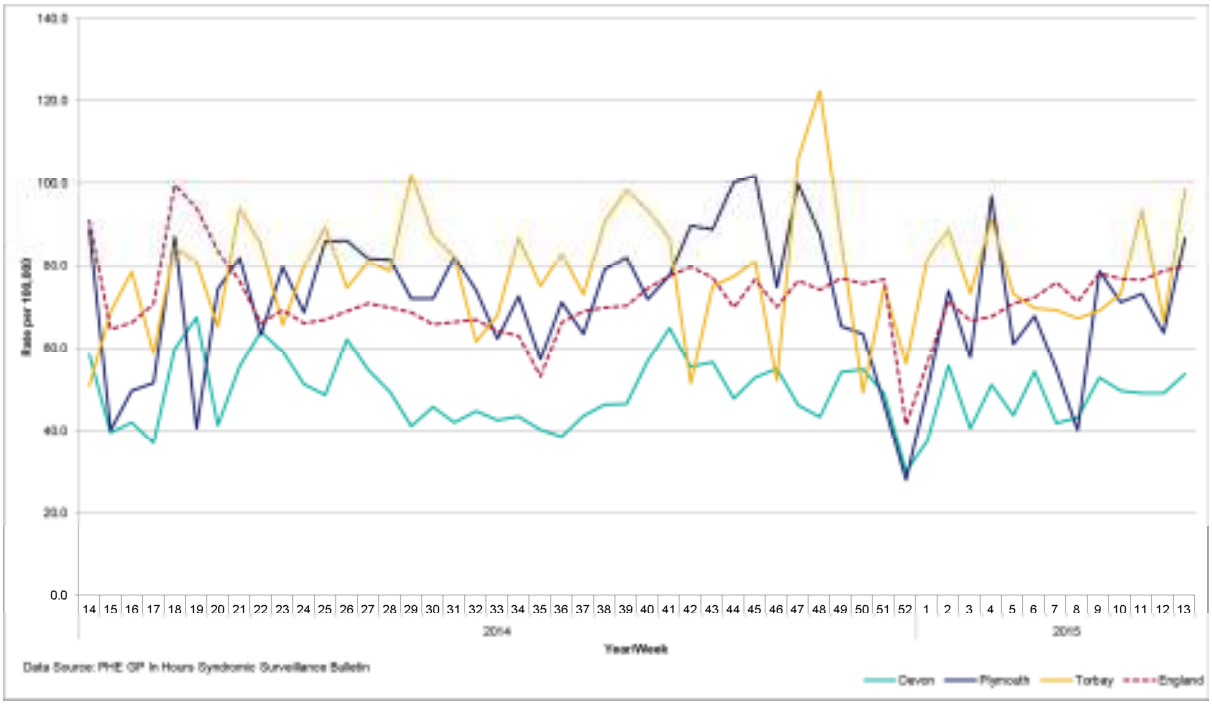



**Figure 3: GP (In Hours) diarrhoea consultation rates (all ages), Devon, Torbay, Plymouth and England, 2014 week 14 to 2015 week 13***




Source: Public Health England GP In Hours Syndromic Surveillance Bulletin

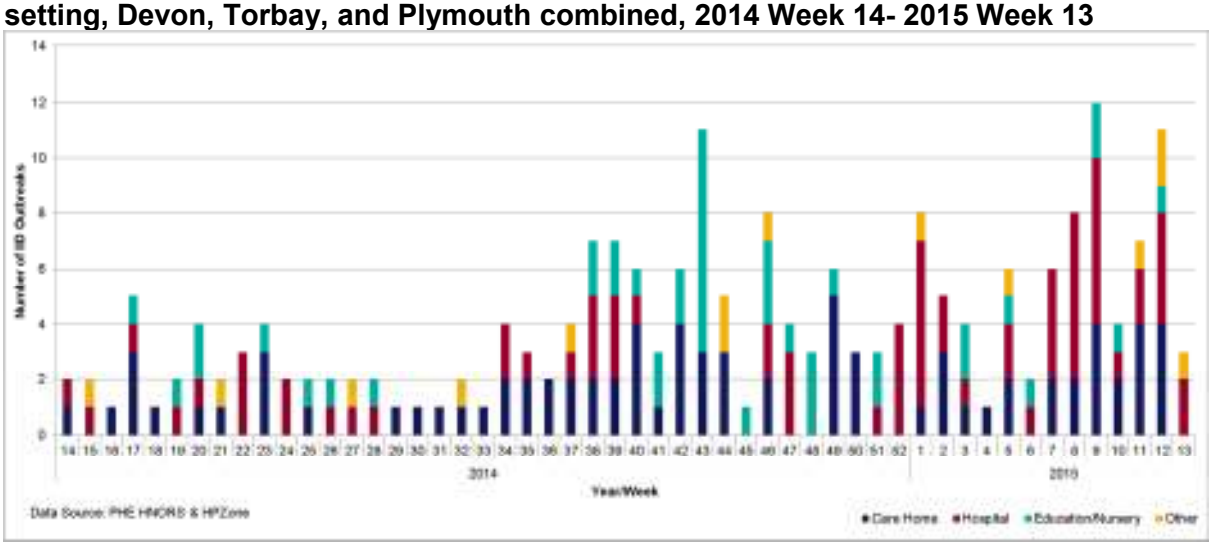
**Figure 4: GP (In Hours) gastroenteritis consultation rates (all ages), Devon, Torbay, Plymouth and England, 2014 week 14 to 2015 week 13**




Source: Public Health England GP iIn Hours Syndromic Surveillance Bulletin

3.17 The majority of outbreaks in the winter 2014-15 have occurred in the first three months of 2015 largely paralleling the incidence of symptoms in the community. (Figure 5)

**Figure 5: All reports of IID outbreaks (suspected or laboratory confirmed) by setting, Devon, Torbay, and Plymouth combined, 2014 Week 14- 2015 Week 13**




Source: Public Health England HNORS & HPZone

**Table 1: Infectious intestinal disease (IID) outbreaks Mar 2014/Apr 2015**

| Upper Tier Local Authority | Total number of IID outbreaks reported March 2014 - April 2015 | | | | |
|---|---|---|---|---|---|
| | Hospital | Nursing/care home | Education/ Nursery | Other | **Total** |
| Devon | n/a | 50 | 47 | 28 | **10** |
| Plymouth | n/a | 3 | 27 | 7 | **0** |
| Torbay | n/a | 17 | 7 | 9 | **4** |
| **Devon Total** | **70** | **81** | **44** | **14** | **209** |

3.18 Many Norovirus isolations are now strain typed. The dominant strains since July 2011 have been GII – 4, and most outbreaks in England have been associated with these strains (219/296, 74%). The most common GII – 4 strain over the last two seasons has been Sydney 2012 and this has been the strain associated with all outbreaks where Norovirus was identified and characterised.

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

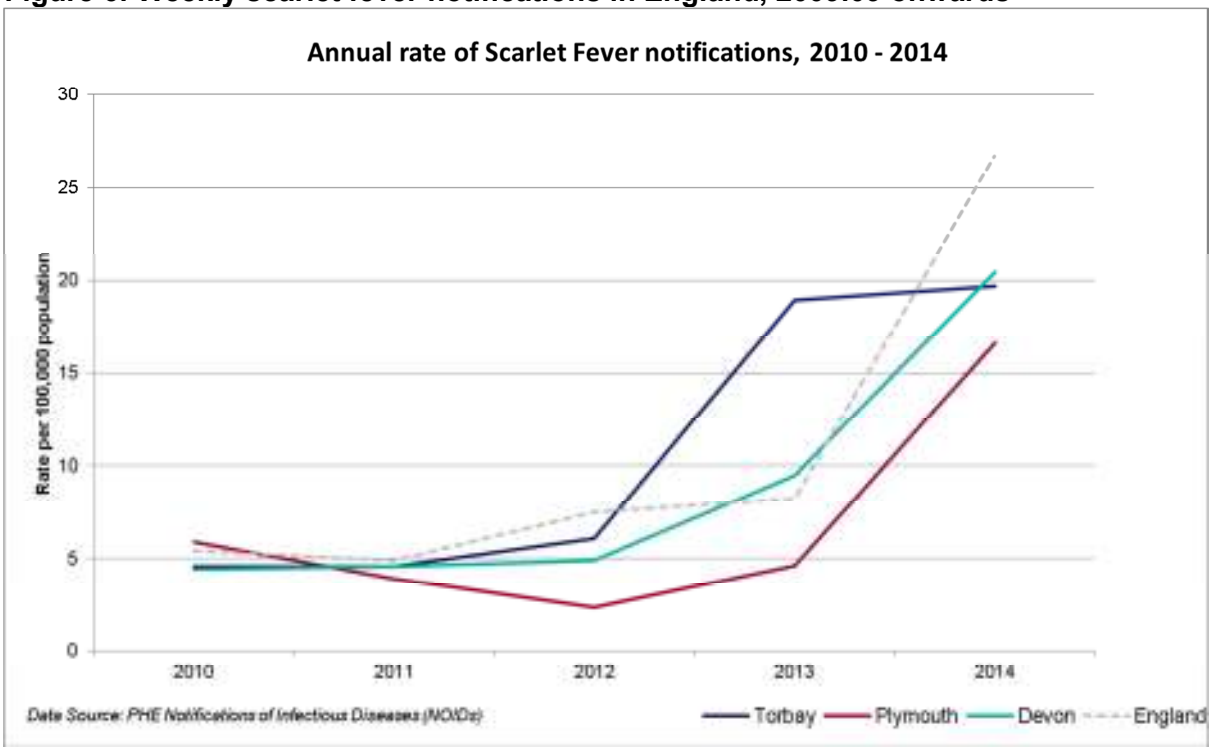
**Scarlet Fever 2014-15**

3.20 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.

3.21 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.

3.22 Public Health England reported an increased rate of scarlet fever notifications across England (Figure 6). Between 9th September 2013 and 30th June 2014, a total of 12,121 cases were notified peaking at the beginning of April 2014. This pattern of high incidence has been repeated in 2014-2015 with a 103% increase in cases nationally between September and April. 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.

**Figure 6: Weekly scarlet fever notifications in England, 2009.09 onwards**




3.23 Across the Public Health England Centre Devon Cornwall and Somerset there has been around a 50% increase in cases compared to the 2013-14 season. However, this relates to a low number of cases; in the last six weeks there have been an average of 3.8 cases notified per week in Plymouth and the same in Torbay, and seven per week in Devon.

**Table 2: Cases of Scarlet fever by week**

| | Week 1 | Week 2 | Week 3 | Week 4 | Week 5 | Week 6 | Average |
|---|---|---|---|---|---|---|---|
| **Devon** | 16 | 10 | 6 | 4 | 3 | 3 | 7 |
| **Torbay** | 3 | 8 | 6 | 3 | 2 | 1 | 3.8 |
| **Plymouth** | 2 | 4 | 3 | 7 | 0 | 7 | 3.8 |

3.24 Over the period of increased scarlet fever activity, no similar increase in notifications of invasive group A streptococcus was observed. However, Devon continues to have a relatively high incidence of invasive group A Streptococcal infections.

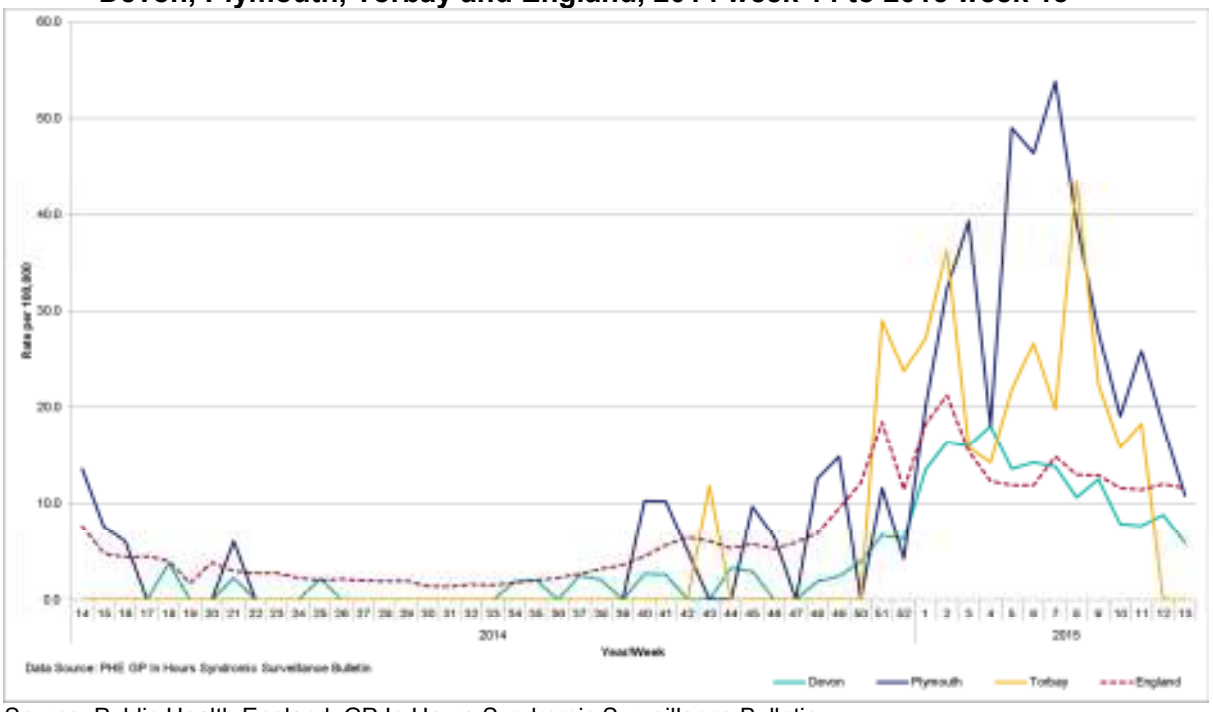
3.25 Public Health England is currently leading investigations to identify the reasons for the unusual escalation in scarlet fever, including microbiological investigation of causative strains.

3.26 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. They also 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**

3.37 The winter of 2014-15 was one of moderate flu activity (Figure 7). Unfortunately one of the seasonal 'flu 'A' strain components was not a good match to the circulating strain due to antigenic 'drift' since the vaccine was produced. The period of maximal flu activity also coincided with the coldest weather of the winter and a high number of excess deaths, some of which would have been contributed to by influenza infection.

**Figure 7: GP (In Hours) Influenza-Like Illness consultation rates (all ages), Devon, Plymouth, Torbay and England, 2014 week 14 to 2015 week 13*^**




Source: Public Health England, GP In Hours Syndromic Surveillance Bulletin

**Table 3: Reports of Infectious intestinal disease (IID) outbreaks (suspected or confirmed) by setting and Upper Tier Local Authority, April 2014 - March 2015**

| Upper Tier Local Authority | Total number of influenza-like illness outbreaks reported April 2014 - March 2015 | | | | |
|---|---|---|---|---|---|
| | Hospital | Nursing/care home | Education/ Nursery | Other | **Total** |
| Devon | 1 | 4 | 0 | 1 | **6** |
| Plymouth | 0 | 2 | 0 | 0 | **2** |
| Torbay | 0 | 1 | 0 | 0 | **1** |
| **Devon Total** | **1** | **7** | **0** | **1** | **9** |

As expected, the majority of detected 'flu outbreaks took place in care or nursing homes where susceptible people are concentrated.

## 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 Arrangements for reporting 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.

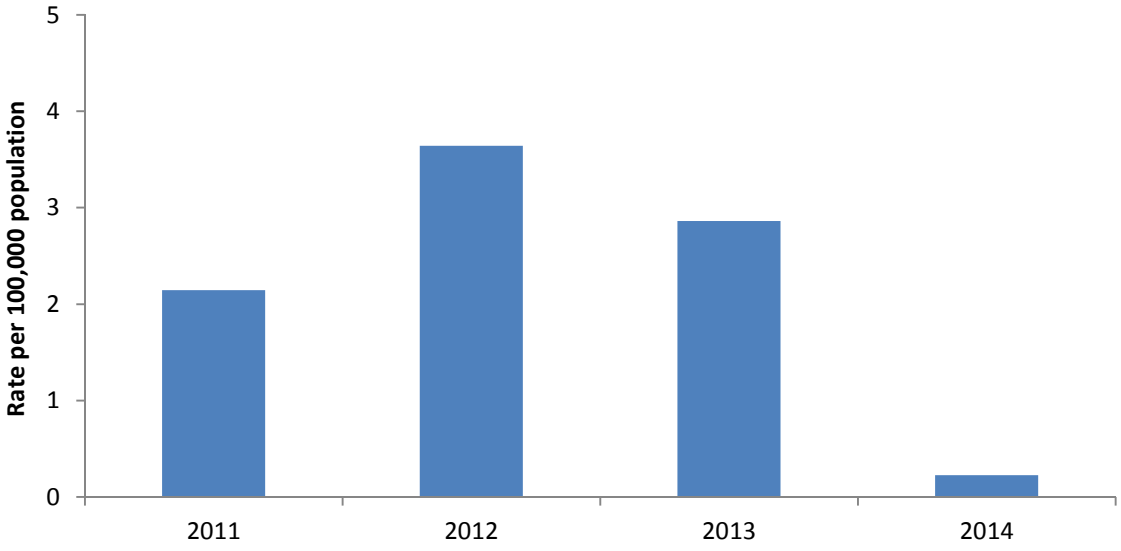
4.6 Peninsula Immunisation and Screening Oversight Groups form part of the assurance mechanism to identify risks to delivery across all programmes and are attended by lead Local Authority Consultants in Public Health. In addition, specific programme groups are convened to oversee their development, most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

**Immunisation Activity and Changes to the National Immunisation Programme 2014-15**

4.7 The period 2014-15 observed significant activity regarding immunisation programmes and changes to the national immunisation schedule.

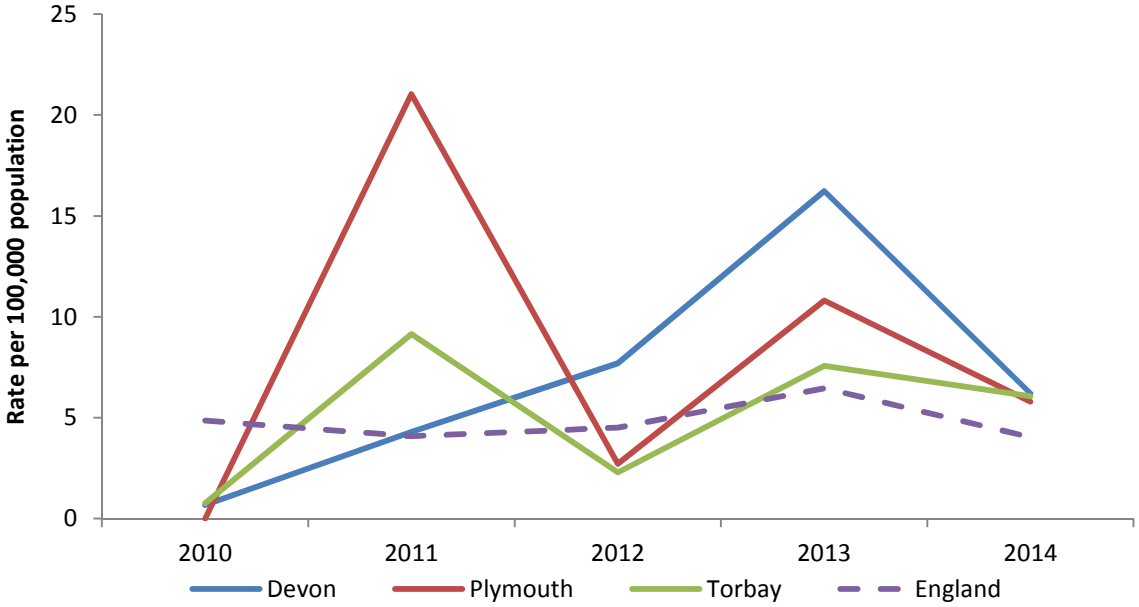
4.8 During the spring of 2013 and in response to a large outbreak in South Wales and smaller outbreaks in the North East and North West of England, a national emergency MMR catch-up campaign was launched to vaccinate unprotected children against measles, mumps and rubella. The impact of that campaign can be seen from the graphs illustrating the incidence of Measles and Mumps over the last two years.

**Figure 8: Rate of measles per 100,000 population, England 2011 to 2014**




Data Source: HPZone Dashboard

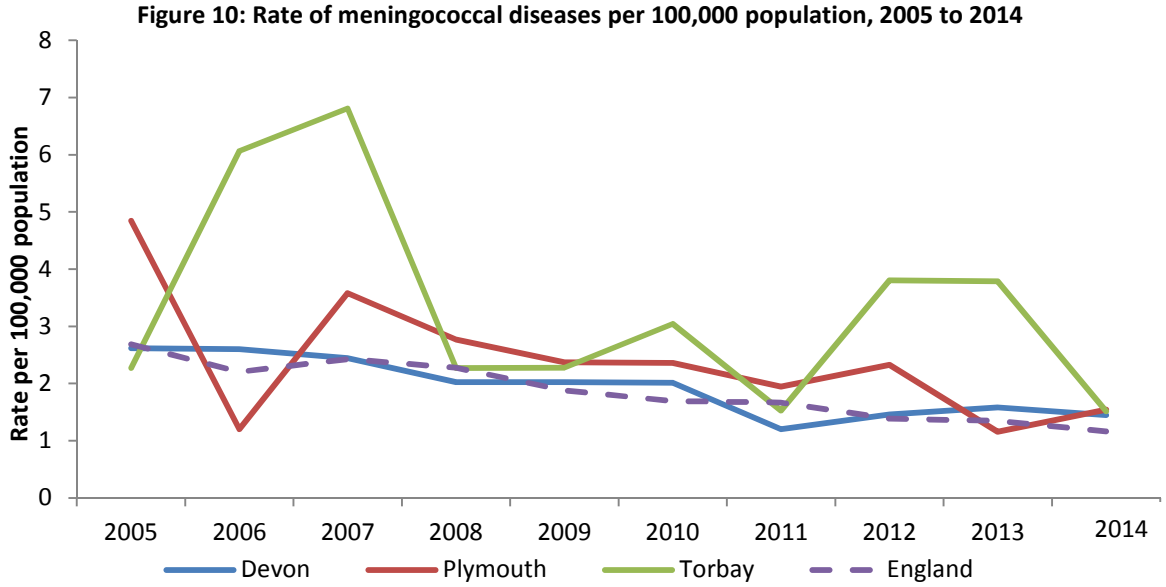
**Figure 9: Rate of mumps per 100,000 population, 2010 to 2014**




Data Source: HPZone and HPZone

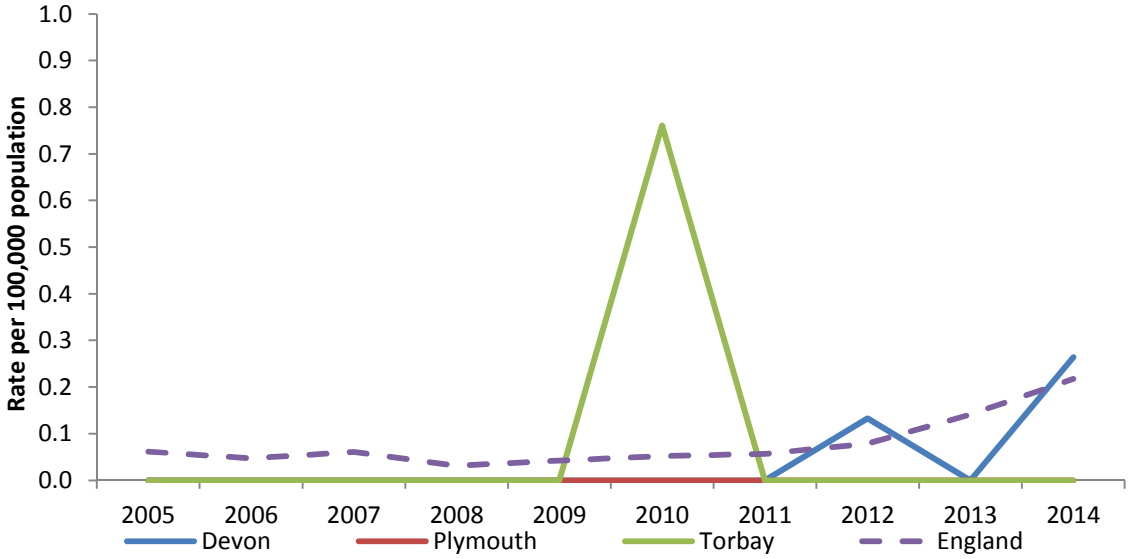
4.9 The schedule for the Meningitis C immunisation has been changed, replacing a dose at four months with a booster in adolescence with effect from June 2013. Overall, rates of meningococcal disease have declined over the last few years (Figure 10), but rates of meningococcal Group W disease have increased (Figure 11)

**Figure 10: Rate of meningococcal diseases per 100,000 population, 2005 to 2014**




Data Source: Enhanced Surveillance of Meningococcal disease database and publically available data from

**Figure 11: Rate of meningococcal serotype W per 100,000 population, 2005 to 2014**

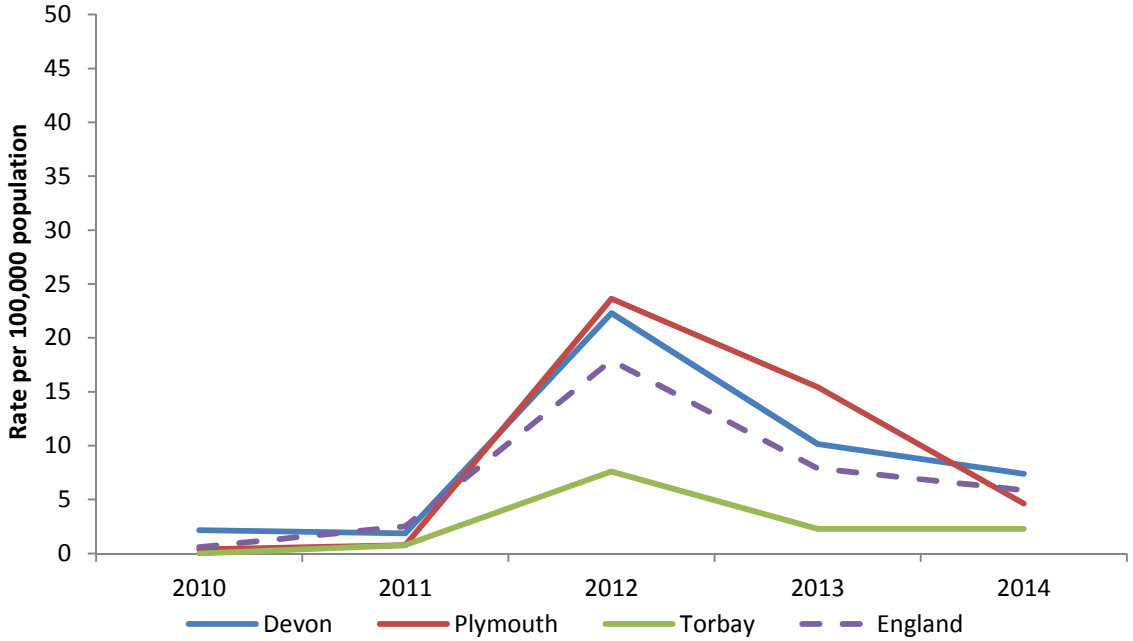



Data Source: Enhanced Surveillance of Meningococcal Disease database and publically available data from

4.10 Immunisation against Rotavirus was introduced to the childhood schedule in July 2013, shingles for people aged 70 years (and a catch-up cohort at 79 years) was introduced from September 2013 and a childhood flu vaccination for all two and three year olds which was extended to four year olds in the Winter of 2014-15.

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

**Figure 12: Rate of pertussis per 100,000 population, 2010 to 2014**




Data Source: HPZone and HPZone

### Screening

4.12 Developments in the cancer screening programmes in 2014-15 have been to commence Bowel endoscopy screening in March 2014, the Royal Devon and Exeter accepted the business case in January 2015 and are rolling this out. The laboratories processing cervical smear samples upgraded to be able to test all samples for HPV in May 2014.

4.13 Neonatal blood spot screening was expanded in 2015 to include four additional rare, but serious inherited metabolic disorders: maple syrup urine disease, isovaleric acidaemia, glutaric aciduria type 1 and homocystinuria.

### Information Sharing

4.14 Over the period and following transition of public health teams to Local Authorities, a number of issues pertaining to access to, reporting of and sharing data between organisations that were not fully considered within the Health and Social Care Act 2012 have provided a significant challenge to health protection assurance functions locally, most notably within the area of screening and immunisation.

4.15 Public Health England have access to data sources that can be used to identify variation in uptake of immunisation and screening programmes at useful spatial levels (e.g. at GP practice level) but have limited analytical capacity to report on such variation, required to inform the assurance function of the Health Protection Committee and local collaborative improvement programmes.

4.16 Locally, and in line with agreement between the Lead Official for Statistics of Public Health England and the President of the Association of Directors of Public Health, information is now being shared on a product by product basis when it is required to support the day-to-day management / operation of an organisation and its decision

making and on an urgent basis when this information is required to protect the population's health.

**Seasonal Influenza**

4.17 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 2013-14 programme reported at Clinical Commissioning Group level (Table 4).

**Table 4: Public Health England Seasonal provisional flu vaccination figures 1 September 2014 – 31 January 2015**

| Clinical Commissioning Group | % of practices responding | 65+ % vaccinated | 6m-65 at risks % vaccinated | Pregnant women % vaccinated |
|---|---|---|---|---|
| **NEW Devon** | 100% | 71.6% | 45.9% | 42.1% |
| **SD & Torbay** | 100% | 68.2% | 45.0% | 37.5% |
| **NHS Kernow** | 98.6% | 70.4% | 49.4% | 36.8% |
| **England** | 99.7% | 72.8% | 50.3% | 44.1% |
| **Target** | 100% | 75% | 75% | N/A |

**Source: ImmForm, Public Health England, Public Health England weekly bulletin 7 March 2014**

**Table 5: Flu vaccine uptake in Children**

| Children | | | | | | |
|---|---|---|---|---|---|---|
| **Age/risk** | **Age 2** | **Age 2 at risk** | **Age 3** | **Age 3 at risk** | **Age 4** | **Age 4 at risk** |
| **NHS Kernow** | 35.7% | 58.6% | 36.5% | 51.2% | 29.8% | 45.7% |
| **NEW Devon** | 40.7% | 59.2% | 43.0% | 55.8% | 34.6% | 54.8% |
| **South Devon & Torbay** | 40.4% | 50.6% | 40.9% | 63.6% | 31.8% | 53.3% |
| **England** | 38.1% | 53.7% | 40.7% | 56.4% | 31.9% | 52.3% |

4.18 A programme of work was undertaken by a Specialty Registrar in Public Health based at Devon County Council. The objectives of this programme of work were:

- To identify areas of comparatively low uptake of influenza vaccination (by geography and by patient group).
- To review the literature around best practice in optimising vaccination uptake.

- To audit highest and lowest practice performance against a checklist of good practice.
- To develop a strategy to improve uptake in lower uptake areas and overall.
- To evaluate the impact of any changes.

4.19 The work was carried out on a collaborative basis which involved all key stakeholders. Although the project was successfully completed and implemented, the outcome results were disappointing with little improvement in uptake. However, the campaign and resulting uptake within the front-line staff group at Devon County Council was a success and won a National award, 122 staff were immunised for the 2014-15 season, a significant improvement on the previous year.

4.20 All elements of the development programme were completed and an evaluation is currently being undertaken. Initial feedback indicates that the support programme was well received by practices and other stakeholders although disappointingly, uptake in target groups was not increased. Learning from the programme is being fed into plans to support flu vaccination uptake in 2015-16 across both 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 2015-16.

## 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 health care associated infection outbreaks 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 Group's 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 (Acute hospitals and Torbay and Southern Devon Community) are robust enough to respond appropriately in order 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 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 met quarterly.

5.7 HCAI is a key indicator of safe and effective patient care and is represented in the NHS Outcomes Framework 2014-15 under outcome 5 'treating and caring for people in a safe environment and protecting them from avoidable harm'.

This report includes data from February and March 2015.

**Clostridium difficile infection (CDI)**

5.8 NEW Devon Clinical Commissioning Group population objective including the total 76 for Acute Trusts allocated cases is 204. As at end of March 2015 the NEW Devon Clinical Commissioning Group total cases stood at 220, which is 16 cases more than trajectory. As at the end of March 2015 Acute Trusts have had 79 cases and two Acute Trusts have exceeded their individual trajectories (total cases avoidable and unavoidable).

5.9 The agreed Clinical Commissioning Group process for reviewing CDI cases with Acute Trusts and apportioning them as either 'avoidable or unavoidable' has been viewed positively from both provider and commissioner perspectives. The process will continue in 2015-16 with the agreed addition of further scrutiny around 'lapses in care'. Despite two Trusts exceeding their national objective the Clinical Commissioning Group is confident that Acute Trust Infection Control teams are in control of their local situations as evidenced by the low number of 'avoidable' cases.

5.10 The avoidability case split by Acute Trust for CDI is:

| | **Annual Objective (avoidable cases only)** | **Trajectory Total (as at end March 2015)** | **Avoidable** | **Unavoidable** | **Cases Awaiting Review** |
|---|---|---|---|---|---|
| **PHNT** | 30 | 35 | 5 | 30 | 0 |
| **RD&EFT** | 30 | 35 | 6 | 29 | 0 |
| **NDHT** | 16 | 9 | 1 | 8 | 0 |

5.11 The larger burden of CDI is in the wider population under primary care. A rise in the Clinical Commissioning Group eastern locality between August – November 2014

appears to have caused the trajectory overshoot, however the locality figures have returned to previous expectations.

5.12 South Devon and Torbay Clinical Commissioning Group population Numbers of cases continue to rise in the community (77 cases: target 70) and acute (17 cases: target 12) trusts. On analysing the data 44% of cases have been under acute care in the last 30 days and 19% are recurrent cases. It was agreed to review the recurrent cases. On initial examination no links could be found.

**MRSA**

5.13 NEW Devon Clinical Commissioning Group has had one MRSA bacteraemia case as at the end of March 2015 which has been subject to the Post Infection Review (PIR) process.

5.14 South Devon and Torbay Clinical Commissioning Group has had three MRSA bacteraemia cases as at the end of January 2015.

**Outbreaks**

5.15 Diarrhoea and vomiting activity during February and March affected North Devon District Hospital (NDDH) and Royal Devon & Exeter in particular. North Devon District Hospital had six wards affected by diarrhoea and vomiting with one ward under restrictions for seven weeks. Royal Devon & Exeter had 16 wards affected with one ward having a continuous five weeks of restrictions. Community hospitals were mostly unaffected by restrictions in the February to March 2015 period.

5.16 Influenza activity in Trusts has now 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

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

**Other Bacteraemias**

5.18 South Devon and Torbay had eight MSSA and 23 E.coli bacteraemias in 2014-15.

**Exercise Cygnus**

5.19 Exercise Cygnus was a six week rising tide pandemic influenza exercise developed and led by Public Health England. It involved multiple agencies throughout the Local Resilience Forum (LRF), and included three Strategic Command Group (SCG) meetings. In Plymouth City Council, a 'People' Directorate Response Team (which includes the Office of the Director of Public Health and Communications), was formed led by Public Health. The Exercise was due to culminate in a day long scenario. However, Exercise Cygnus was terminated early due to the decision nationally to divert attention to the increased risk of Ebola Virus Disease.

5.20 Considerable attention had been focused on the earlier stages of the rising tide incident and therefore it was felt that many key learning points had already been highlighted by the time the exercise was halted. The exercise was run as a People Directorate level response, based on Plymouth's major incident response plan (this

includes members of the People directorate and of the Office of the Director of Public Health (ODPH), as well as involving external partners such as the Plymouth Hospitals Trust Emergency Planning Lead. It was chaired by the consultant in Public Health responsible for disease prevention. A number of areas were highlighted as particularly susceptible to the challenges that this type of incident might generate:

- Children's social care
- Adult social care
- Bereavement services

**Torbay**

5.21 It was felt that there were two fundamental requirements that needed to be balanced in the response to Pandemic Influenza:

- Keeping people working for the council, or on its behalf, safe, giving advice and provision of PPE for staff/commissioned staff.
- Ensuring that those in the population receive the service they require.

**Devon County Council**

5.22 The Cygnus exercise offered an opportunity for the organisation to exercise its business continuity plans and to consider, as a whole, what its core functions would be in an ongoing major incident where increased areas of demand coincided with staff shortages. Although the 'rising tide' experience provided by the National exercise was felt to be useful and raised awareness of Pandemic 'flu as an issue, the exercise was discontinued before the 'Pandemic' had a serious effect on Council resources, and indeed, the exercise scenario as suggested would have been unlikely to really tax existing Business Continuity Plans.

5.23 It has therefore been agreed that a County Council internal pandemic flu exercise will be conducted in the early autumn, using a scenario that will stretch existing plans and hopefully improve the resilience of essential services.

**National**

**Ebola Virus Disease**

5.24 The outbreak of Ebola virus disease (EVD) in West Africa first reported in March 2014 continues, with in excess of 21,600 cases and 8,600 deaths at January 2015.

5.25 The first imported case was 29th December 2014 and since then there have been two further cases. Public Health England continue to work with UK government colleagues, the World Health Organisation and other partners to coordinate the appropriate follow-up of humanitarian workers attending affected countries and potentially exposed through their work.

5.26 Screening for travellers is taking place at country of origin in affected countries, and also at ports of entry into the UK, where anyone with clinical signs (e.g. a temperature) is assessed, and travellers are given advice on what to look out for and how to get medical support if necessary.

## 6. Work Programme 2014-15

*(Short summary of the aims and objectives of each activity)*

6.1 The Health Protection Committee is providing oversight over the following programmes of work agreed as priority areas for the period 2014-15.

**Seasonal Influenza**

6.2 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 2013-14 programme reported at Clinical Commissioning Group level (Table 6)

**Table 6: Flu vaccination for children, percentage uptake by CCG and age**

| Group | Title | 2013-14 season % | 2014-15 season % |
|---|---|---|---|
| **2 year olds** | NEW Devon CCG | 45.7 | 41.3 |
| | Torbay & South Devon | 41.9 | 40.7 |
| **3 year olds** | NEW Devon CCG | 41.2 | 43.6 |
| | Torbay & South Devon | 35.4 | 41.8 |
| **4 year old** | NEW Devon CCG | | 35.7 |
| | Torbay & South Devon | | 32.7 |
| **Pregnant women** | NEW Devon | 40.3 | 42.1 |
| | Torbay & South Devon | 38.2 | 37.5 |
| **Under 65 at risk** | NEW Devon | 49.2 | 45.9 |
| | Torbay & South Devon | 47.6 | 45.0 |
| **Over 65** | NEW Devon | 72.2 | 71.6 |
| | Torbay & South Devon | 69.1 | 68.2 |
| **Carers** | NEW Devon | 45.5 | 45.2 |
| | Torbay & South Devon | 32.3 | 31.8 |

.

6.3 A literature search was carried out, and areas of best practice identified and circulated to all GP practices. Additionally, considerable additional publicity was added to the Devon local authority care worker campaign, using peer models to increase awareness of the availability of the vaccine for workers, and how it could be accessed.

Seasonal Influenza (as outlined in 4.17 to 4.20 above)

**Hepatitis C Strategy and Implementation**

6.4 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.

6.5 The control of Hepatitis C provides a challenge to the health sector from prevention through to treatment and aftercare and requires a coordinated response. To that end a strategy for the geographical catchment of North, East and West Devon and South Devon and Torbay Clinical Commissioning Groups was drafted in 2013 which requires review and adoption by the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council. This is in the process of being formally adopted and developing an implementation plan

**Tuberculosis Service Review**

6.6 The draft Collaborative Tuberculosis Strategy was published in March 2014. The proposal for the South West is a single Tuberculosis Board for the South West. However, at least for now, the local Tuberculosis forum which currently meets across Devon, Cornwall and Somerset will continue to meet to share and promote best practice. It is anticipated that the Tuberculosis Board is unlikely to be functional until the end of 2015, so until then, the other aims of the Tuberculosis strategy will have to be pursued through existing fora.

6.7 Local Authority Health Protection lead consultants will work with Public Health England to oversee this programme of work on behalf of the Health Protection Committee.

**Health & Social Care**

6.8 It has been observed by the Health Care Associated Infections Programme Group that services to support health and social care services in community settings are limited across the geographical catchment served by the Health Protection Committee. Such services through their registration to the Care Quality Commission (CQC) are responsible for internal infection control policies and procedures and Care Quality Commission is in turn responsible for ensuring compliance. However specialist support to provide training as well as a programme of audit against best practice are not routinely available across the geographical catchment served by the Health Protection Committee and this poses a risk to local assurance arrangements.

6.9 The Public Health England Acute Response Centre provides advice and information in response to community outbreaks in these settings. However, proactive and preventing work is not routinely available.

6.10 The Health Care Associated Infection Programme Group will be considering this as part of its own work programme for 2014-15 and will report formally to the Health Protection Committee. This group has now been constituted and has met and is holding an inaugural workshop at the beginning of July.

**Work Programme for 2015-16**

6.11 Tuberculosis strategy – continue to work with Public Health England on the new Tuberculosis Board to implement a strategy for the control of TB in the South West.

6.12 Influenza immunisation – use the lessons learned from the work done in 2014 to improve on the levels of staff immunisation in the 2015-16 season.

6.13 Hepatitis C – the Hepatitis C strategy needs review in light of new treatment strategies and implementation needs to continue.

6.14 Screening – continue to pursue the theme of inequalities in screening, obtaining the necessary data from Public Health England.

6.15 Bacteraemias – despite success in reducing MRSA, MSSA and E.coli septicaemias have not reduced in the same way. The Health Care Associated Infections Programme Group will need to look at this and the issue of antimicrobial resistance.

6.16 Emergency planning – following on from participation in exercise Cygnus, Public Health England is leading a further pandemic flu exercise in the autumn, Exercise Mallard.

## 7. Authors

**Dr Mark Kealy**
**CONSULTANT IN PUBLIC HEALTH**
**Devon County Council**

**Linda Churm**
**ACTING CONSULTANT IN PUBLIC HEALTH**
**Torbay Council**

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

**Ruth Harrell**
**CONSULTANT IN PUBLIC HEALTH**
**Plymouth City Council**

# APPENDIX 1

# Terms of Reference for a Health Protection Committee of the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council

## 1. Aim, Scope & Objectives

**Aim**

1.1 To provide assurance to the Health and Wellbeing Boards of Devon County Council, Plymouth City Council and Torbay Council 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 and emergency planning and response (including severe weather and environmental hazards).

**Objectives**

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

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 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 and Torbay 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 and Torbay.

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 and Torbay 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 or Torbay 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:

- *Performance report;*
- *Risk register and action plan review;*
- *Serious incidents requiring investigation;*
- *Work-programme update;*
- *Policy / evidence/guideline updates (All);*
- *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 Local Health Resilience Partnership.

3.8 Terms of reference will be reviewed annually.

## 4. Author

**Mike Wade FFPH**
**CONSULTANT IN PUBLIC HEALTH**
**Devon County Council**

# APPENDIX 2

**Health Protection Committee Reporting to the Devon, Plymouth and Torbay Health & Wellbeing Boards and its Relationship to Existing or Planned Health Protection Partnership Forums**