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

2020/2021

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 2020 to 31 March 2021, for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council and the Council of the Isles of Scilly.

1.2 Due to the time lag in receiving the annual reporting data for 2020/21, the report contains some information in relation to activities undertaken in 2021/22, to provide a more timely picture of progress.

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 2020/21
- Actions taken to date against health protection priorities identified for 2020/21
- Priorities for 2021/22.

1.5 The health protection agenda in 2020/21 was dominated by the COVID-19 pandemic. This report therefore focuses on the response to the pandemic, the impact on wider health protection activity, and work to recover screening and immunisation coverage for our population.

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. This is outside the timescale for this annual report but for practical purposes the organisation is referred to as PHE/UKHSA throughout.

3. Prevention and control of infectious disease

3.1 At the end of December 2019, Wuhan Municipal Health Commission, China, reported a cluster of cases of pneumonia. The situation escalated rapidly and on 30 January 2020 the Director-General of the World Health Organisation declared the novel coronavirus outbreak a public health emergency of international concern (PHEIC) as sporadic cases were now being seen across countries outside of China.

3.2 By the end of January 2020 the first two cases of coronavirus (2019-nCoV) in the United Kingdom were confirmed and, over the course of February, single and linked cases were being identified across the UK and outbreaks were being confirmed across Europe, notably Italy, France and Spain.

3.3 By mid-March 2020, as the UK Chief Medical Officers raised the risk to the UK from moderate to high, the first COVID-19 cases and situations in Devon and Cornwall involving single cases, schools and care homes were being identified. On 26 March 2020, the UK went into lockdown with the instruction to Stay at Home, Protect the NHS, Save Lives.

Activity in 2020/21

3.4 PHE/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 (PHE/UKHSA case management system) by principal context and local authority area in the year 2020-2021. 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 2020 – 31 March 2021 by Local Authority and setting type

Local Authority	Adult Care Home or Setting	Educational setting (inc residential)	Workplace	Healthcare	Other
Cornwall	225	32	35	6	9
Devon	341	72	42	15	20
Plymouth	133	36	18	5	14
Torbay	96	<5	14	<5	5

3.5 The above includes the first Covid-19 Outbreak in the South West which occurred in Torbay in early March 2020, during the initial containment phase of the national pandemic response.

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

- Gastro-intestinal outbreaks in early years, schools and residential care settings
- Environmental exposures
- Exposure to Brucella Canis from contact with infected canines
- TB in the workplace

Are of response	Detail
Public Health advice	Public health advice was 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 PHE/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	PHE / 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
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.
Vaccination	*Area of local good practice* 

	COVID-19 and flu vaccination programmes were co-managed as a seasonal vaccination programme, channelling resource and expertise in the most effective way. A particular focus was the work to identify and target areas of vaccine inequality. Health equity audits were undertaken to identify groups and areas of practice to be addressed. An infection control site toolkit was developed, and bespoke vaccination sessions were organised for people who were homeless, people with a learning disability, and people with complex lives. A community engagement officer, and a vaccine hesitancy nurse, were appointed by the CCG to support this work. Local authorities worked with the CCG to develop the 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.
Variants of concern	PHE/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.
Infection prevention & control	*Area of local good practice 1*  The Devonwide Community Infection Management Service commenced in April 2020 and has been central to the COVID response across the whole of Devon as well as to developments in wider infection prevention and control. The service operates a hub and spoke model with expertise based in each of the four acute hospitals in Devon reaching out to support the care sector. This approach enabled more intensive specialist support for outbreak prevention and control than would be been possible before. One particular area of innovative practice was the development of 'virtual infection control tours' where the team was able to walk round a care home via the Manager's iPAD, and to advise on infection control measures in a much more practical way, for example cleaning, and PPE donning and doffing arrangements. *Area of local good practice 2* 

	A small team of two infection prevention and control nurses was employed by Devon, Plymouth and Torbay local authorities, hosted by Devon, and gave infection control advice to a range of non-NHS settings to support the COVID response. This reached out to settings such as businesses, schools, factories, and homeless hostels. The practitioners developed a range of IPC resources including checklists, posters and guidance documents as well as delivering training and education to these settings to complement national resources. These included: • 'Ready for Anything', a full IPC guide to support workplaces and businesses beyond the pandemic, which was added to the Heart of the South West Growth Hub. • IPC information posters for events • IPC self-assessment checklists to support the COVID-19 vaccination clinics, temporary accommodation for homeless settings, bridging hotels and education settings.
PPE	*Area of local good practice*  The Devon Public Health team took a lead role, in partnership with PHE/UKHSA, in developing South West wide guidance in the use of PPE for non NHS settings. This enabled decisions to be made to protect both staff and residents at a time when national guidance was not yet available to guide local practice.
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 New and productive relationships were built 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 in each local authority 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 Champions' networks were established to influence communications and share key messages around COVID safe behaviours through professional, social and community networks. THE PLYMOUTH GOOD NEIGHBOURS SCHEME

Surveillance Arrangements

3.8 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.

3.9 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.

3.10 The Devon Health Protection Advisory Group, led by UKHSA 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.

4 Screening programmes

4.1 This section summarises some of the key developments for the individual screening programmes during 2020/21.

4.2 All screening programmes suffered from the impact of the COVID-19 pandemic to varying degrees with the focus during 2020/21 to support providers to safely pause programmes where this was necessary or required, for example due to infection, prevention and control reasons, and then to develop and 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 in a COVID-19 secure manner (for example, longer appointments to follow PPE and IPC procedures) 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 following table gives a summary of performance, challenges and developments during 2020/21 and future developments.

Screening programme:	
Bowel	Both routine and surveillance programmes had to be paused at the start of the pandemic due to a number of 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) in order 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.
Breast	All services were affected by the pandemic with routine screening paused initially at the start of the pandemic due to a number of factors, including IPC concerns on the mobile screening vans. Screening for those at high-risk continuing throughout. As part of the national recovery plan, the national Age Extension breast screening trial ceased recruiting. The national recovery ambition is for all providers to recover by end March 2022. Based on current trajectories, 2 Devon providers are on track to recover within this timeline, one within a few weeks of this date and the other July 2022. Women waiting longest have been invited first and at the time of this report providers are inviting women within approximately 8 weeks of their due date. Provider recovery plans have required significant new investment, both regional and national, to increase capacity sufficiently above 100% to offer screening to all individuals delayed screening within the national timeline. This has been able to address pre-COVID-19 issues in staffing levels and aging equipment that will ensure more robust and sustainable services into the future. Until the backlog is cleared and round length is fully recovered, it is not possible fully to determine the impact of the pandemic on uptake and coverage. This is being closely monitored and text messaging has been introduced in all programmes as an additional reminder to women and to help to reduce wasted slots. Work also continues with GP practices to encourage ladies to attend when due. A project has been started to see whether an online booking solution can be developed. Providers will be completing the PHE/UKHSA Health Equity Assessment Tool during 2022/23 and developing action plans.

Cervical	At the start of the pandemic, a national decision was made to temporarily pause invitations to cervical screening. All other components of the cervical screening pathway continued throughout albeit at reduced capacity for a short period. Due to social distancing and IPC requirements, local colposcopy teams paused seeing women with low grade referrals for a short period. Letter invitations for Devon and Cornwall recommenced on 05/06/2020 and the programme has been running as expected since that time, with some fluctuation in laboratory turnaround time due to temporary staff sickness/self-isolation throughout the pandemic. This has been a national issue with all labs affected to some degree. Uptake data suggests that this has been stable and a project has been carried out to review GP practice level data and provide support and resources to those with lower uptake. A national pilot of self-sampling has commenced.
Antenatal/ Neonatal	All antenatal screening programmes were maintained throughout COVID as a core part of routine maternity care. All providers continue to provide a full service and are in the main meeting BAU national standards. Newborn and infant examination (NIPE) and Newborn bloodspot screening (NBBS) were also maintained as core part of maternity and neonatal care. An initial impact on the NIPE 6-week hip scan for at risk babies was fully recovered by the Autumn 2020. The enhanced newborn targeted Hepatitis B vaccination programme was successfully implemented on 01/04/2021 in all providers, meeting the national deadline. Non-invasive Perinatal Testing (NIPT) was successfully implemented on 01/06/2021 in all maternity providers, meeting the national deadline. The national evaluative Severe Combined Immunodeficiency (SCID) programme went live on 01/09/2021. The SW is not part of this evaluative roll-out so babies born in the SW will not be screened for SCID and providers only need to be aware of implications for babies that move in at this stage. All the required changes in maternity, the newborn lab, CHIS and BCG providers have been implemented. Key implications are that BCG vaccination will be given around 28 days after checking the SCID result, and GP practices must check for a SCID result before giving Rotavirus vaccination (live vaccine).
New-born Hearing	There was significant disruption from COVID to the delivery of newborn hearing services affecting Devon and Cornwall due to the community model. The backlog due to COVID has been fully recovered. A further NHSP national assurance exercise took place during August 2021 and confirmed that recovery has been maintained. The Devon Local Authority Health Visitor Service gave notice to cease providing the first newborn hearing screen from end March 2022. A new provider has been identified for Devon and enhanced contracts agreed for Plymouth and Torbay providers. Mobilisation work is progressing, led by Devon CCG, to take over the service from the 01/04/2022.
Diabetic Eye	All services were affected by the pandemic as most venues for screening are in the community and GP surgeries, which had to close for long periods

	of time. Routine screening was paused initially, however screening for those at high-risk continued throughout. The national recovery ambition is for all providers to recover by end March 2022 (plus 6 weeks) and all providers are on track to recover within this timeline, and are training their own staff in Slit Lamp Bio-microscopy to ensure these patients are also seen in a timely way by April 2022. Hospital Eye Service capacity is a long-standing issue compounded by the impacts of COVID. Potential programme changes are being considered at a national level to address this including the introduction through Section 7a of Optical Coherence Tomography. National meetings are taking place to discuss extending the screening interval for low-risk patients from one year to two years. All programmes have completed the PHE/UKHSA Health Equity Assessment Tool and action plans are being developed.
Abdominal Aortic Aneurysm (AAA)	All services were affected by the pandemic as most venues for screening are in the community and GP surgeries, which had to close for long periods of time. Routine screening was paused initially and screening for those at high-risk continued throughout. The national recovery ambition is for all eligible men in the 2021/22 cohort to be invited for screening by end March 2022 (+2 months) in line with the national standard and all providers are on track to recover within this timeline. Investment to support recovery has led to increased capacity through funding additional staff, equipment and venue hire. All programmes have tracked the progress of each referral made to vascular surgery and taken action actively to manage any delays to assessment or subsequent treatment. However, meeting national quality targets is challenging due to ongoing pressures in Acute Trusts, including theatre space and ICU beds. All programmes have completed the PHE/UKHSA Health Equity Assessment Tool and action plans are being developed.

5 Immunisation programmes

5.1 This section summarises some of the key developments for the individual immunisation programmes during 2020/21.

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 2020/21 and future developments.

Immunisation programme:	
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 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 SAI 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 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 are also good. The Devon programme was significantly disrupted by the first lockdown has had large numbers of clinics due in the Spring/Summer 2020 terms and due to the ongoing challenges with delivery of the routine programme and catch-up clinics. 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 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 August 2022.
Vaccinations in pregnancy	Vaccination has continued throughout the pandemic in maternity and GP setting, however, maternity providers have reported significant challenges in delivering vaccines due to ongoing workforce pressures with staff regularly diverted to cover clinical duties. As a consequence,

	flu vaccines delivered in antenatal settings are below levels in previous years. There are also ongoing challenges with data quality as vaccinations given in maternity need to flow to GP practices so these can be recorded in the medical record and captured in IMMFORM that is the source of routine reporting. Most Trusts are now using NIVS for flu vaccinations that helps with data flows to GPs however this is not the case for pertussis vaccinations. Work to improve data flows is ongoing.
Older people immunisations	Singles and pneumococcal immunisations for older people have been maintained throughout the pandemic. However, as this group was advised to self-isolate (and many will have been in the group recommended to shield) the offer of these vaccinations is likely to have been disrupted. To mitigate against this the eligibility for the vaccination was temporarily extended nationally for those that would have turned 80 during 2020/21 to enable them to access the vaccination. The Screening and Immunisation Team has undertaken work to identify practices with lower uptake, developed a toolkit to support improving uptake and has run a communications campaign to encourage those aged 70-80 years old to attend for vaccination. This work is ongoing. Low levels of pneumococcal vaccinations continue due to global shortages of vaccine, and national prioritisation advice is in place to support GP practices.
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 2020/21. 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 were a total of 5 cases over 2020/21, an overall rate of 0.89/100,000. Two cases were inpatients with previous MRSA history and the remaining three cases were unlinked.

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 NDHT and TSDFT due to the smaller population in these areas. *Cornwall:* There were a total of 138 cases over 2020/21, with an overall rate of and 24.5/100,000. 11 cases below the incidence of previous year 2019-20.
***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 192 cases over 2020/21, an overall rate of 34.1/100,000, a total of 44 cases above threshold. Limited scope for investigation due to COVID-19 pandemic pressures, employment of C. diff investigative members of staff started in February 2021.
***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 438 cases over 2020/21, an overall rate of 77.7/100,000. General GNBSI and E. coli reduction were limited due to system pressures and COVID-19 pandemic.
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 held two meetings in 2020/21, but due to system pressures and COVID-19 pandemic were not held as regularly as hoped. Cornwall Antibiotic Resistance Group (CARG) continued to operate during 2020/21 where possible, as a 'one health' group with representation from human and animal health sectors.

6.2 The key challenges for 2021/22 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 was dominated during 2020/21 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 2020/21:
- Large fire in Cornwall which required a health and public health response
- Flash flooding in Barnstaple
- XR day of action event.

7.3 Despite the pandemic, local and regional exercises were held over the period.

7.4 It is safe to say that the year 2020/21 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. Our EPRR professionals have met this challenge.

8. Work Programme Priorities 2020/21- Progress

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

	Priority	Progress on delivery
1	Continue to support the COVID-19 pandemic through national, regional and local response, preventing disease transmission and responding to situations and outbreaks. Locally this will be delivered through the Local Outbreak Management Plans and associated local Health Protection and Local Engagement Boards.	The whole system worked together to deliver a comprehensive COVID-19 prevention and response programme. Local Outbreak Management Plans were developed and revised through each pandemic phase, guiding local action.
2	Support the implementation of emerging interventions aimed at reducing COVID-19 transmission.	This work has focused on the vaccine roll out programme, ensuring high levels of uptake across the population and specifically in target groups where uptake is traditionally lower. Work has also continued to promote and support delivery of the community testing

		programme, ensuring PCR and LFD testing is available and signposted for symptomatic and asymptomatic individuals. UKHSA and Local Authority public health teams have also supported surveillance initiatives such as waste water testing, and variant response including surge testing.
3	Work with our partners across the system to identify, mitigate and monitor for the effects of COVID-19 on the health protection system and the services it delivers.	Under the Local Authority COVID-19 Health Protection Boards, all partners worked collaboratively to put in place systems for prevention, early identification, advice and guidance, response and engagement. Monitoring of COVID-19 impact has taken place at a number of levels, through daily system business information reporting, identification of trends, and information to monitor impact and inform the pandemic recovery.
4	Work with our partners across the health protection system to support the restoration of key health protection public health services and activities disrupted by COVID-19.	The pandemic continued in acute phase throughout 2020/21, with recovery activities largely postponed into 2022. However the joint work on the COVID response laid foundations for greater post pandemic resilience and effective partnership working to address all areas of health protection. Work to recover screening and immunisation services progressed during the year and all services have returned to normal operation or are on track to do so. New systems to tackle foodborne diseases were put in place via an MoU between UKHSA and Local Authority Environmental Health teams, and new systems to identify and manage infectious disease outbreaks in care homes are being introduced.
5	Work with our partners across the health protection system to support the restoration of the screening programmes disrupted by COVID-19.	NHSEI and the PHE Screening and Immunisation Team worked closely with all screening providers to ensure that backlogs were cleared by the national recovery targets. Apart from a few exceptions this has been achieved ahead of, or will be achieved by, these targets. Progress is being actively monitored and plans are in place.
6	Work with our partners across the health protection system to support the recovery of the immunisation programmes disrupted by COVID-19.	
7	Continue efforts to ensure high uptake of flu vaccinations locally, particularly amongst at risk groups and frontline health and social care	The system ran a very successful flu vaccination programme with higher rates of uptake in all groups in all localities. This sat

	workers, and to support effective roll-out to the Year 7 primary school cohort and other additional cohorts that may be recommended. Efforts will be directed through regional and local flu groups and networks.	alongside the COVID-19 vaccination programme which also achieved high uptake.
8	All members support the ongoing local action following declaration of a climate change emergency.	All areas continued with strong organisational commitment to the delivery of published plans to address climate change, working with statutory, voluntary and commercial partners across local systems.

9. Work Programme Priorities 2021/22

9.1 Priorities agreed by Health Protection Committee members for 2021/22 were to:

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

2 Recover screening and immunisation programme delivery, coverage and uptake

3 Embed and strengthen community infection management services to prevent and respond to infections throughout the community

4 Work to reduce the incidence of healthcare associated infections and to tackle antimicrobial resistance across our communities

5 Focus efforts to address health inequalities, in particular health protection pathways for migrant and homeless communities

6 Maintain a focus on local action to address the climate emergency.

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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 Immunisation performance 2020/21

Appendix 4 Screening performance 2020/21

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.

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

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).

Public Health England, through its consultants in communicable disease control, leads the epidemiological investigation and the specialist health protection response to wider community non-hospital outbreaks, and is responsible for declaring a health protection incident.

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

Immunisation Performance 2020/21

Childhood Immunisations		Devon	Plymouth	Torbay	Cornwall and IoS	South West	England
12M	Cohort	*6,536*	*2,776*	*1,162*	*4,878*	*53,163*	***610,509***
	DTaP/IPV/Hib/HepB %	95.9	94.7	96.4	93.4	94.8	**92.0**
	MenB %	95.7	95.0	96.3	93.3	94.7	**92.1**
	Rota %	93.7	92.4	92.6	91.6	92.8	**90.2**
24M	Cohort	*6,926*	*2,906*	*1,282*	*5,134*	*55,376*	***630,876***
	DTaP/IPV/Hib/HepB %	96.3	97.0	95.9	95.1	95.8	**93.8**
	Hib/MenC %	94.1	94.8	93.4	91.9	93.2	**90.2**
	MenB/booster %	94.1	94.4	92.4	90.7	92.5	**89.0**
	MMR %	94.4	95.2	93.6	92.1	93.3	**90.3**
	PCV %	94.3	94.8	93.4	92.2	93.3	**90.1**
5Y	Cohort	*7,836*	*3,279*	*1,446*	*5,936*	*62,245*	***693,928***
	DTaP/IPV %	89.9	91.6	90.1	87.7	89.7	**85.3**
	DTaP/IPV/Hib %	96.9	98.0	97.4	96.5	96.8	**95.2**
	Hib/MenC %	94.9	96.3	96.1	95.0	95.2	**92.3**
	MMR1 %	96.1	97.4	96.7	95.5	96.0	**94.3**
	MMR2 %	92.4	93.5	91.6	90.2	91.2	**86.6**

Shingles vaccination						
Cohort	**England**	**Local authority**				NHS DEVON
		Devon	**Torbay**	**Plymouth**	**Cornwall IoS**	
Turning 71 and over	4,185,341	91,557	14,690	17,601	**61,413**	123,848
Vaccine coverage (%)	61.4%	61.8%	57.5%	59.8%	**59.1%**	61.0%
Cohort	**England**	**Local authority**				NHS DEVON
		Devon	**Torbay**	**Plymouth**	**Cornwall IoS**	
Turning 71-78 (routine cohort)	3,606,055	78,938	12,703	15,231	**53,431**	106,872
Vaccine coverage (%)	62.7%	63.0%	58.4%	61.3%	**60.1%**	62.2%
Cohort	**England**	**Local authority**				NHS DEVON
		Devon	**Torbay**	**Plymouth**	**Cornwall IoS**	
Turning 79 and 80 (catchup cohort)	579,286	12,619	1,987	2,370	**7,982**	16,976
Vaccine coverage (%)	53.3%	54.7%	52.1%	50.2%	**52.5%**	53.7%

Seasonal flu vaccine uptake 1/9/2020-28/2/2021							
		Devon	**Plymouth**	**Torbay**	**Cornwall IoS**	**South West**	**England**
65+	Cohort	*211,769*	*42,787*	*39,100*	*143,812*	*1,270,751*	***10,448,410***
	Coverage	82.8	81.2	79.8	80.3	82.8	**80.9**
6months -65 years clinical risk groups	Cohort	*109,527*	*37,118*	*21,610*	*80,907*	*794,012*	***8,098,035***
	Coverage	58.1	52.3	54.8	54.2	57.2	**53.0**
Pregnant	Cohort	*6,027*	*2,401*	*1,253*	*3,786*	*52,184*	***606,540***
	Coverage	50.5	45.0	43.8	32.6	46.4	**43.6**

Appendix 4

Screening Performance 2020/21

Cancer screening programmes

Indicator	Lower threshold	Standard	Geography	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
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
			England	76.9	77.1	76.9	76.3	75.9	79.2	78.9	78.5	78.3	78.2	77.6
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
			England	78.0	77.6	77.2	75.2	75.2	74.9	74.4	74.0	73.8	75.0	75.6
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
			England	81.5	82.3	82.0	81.6	81.1	80.4	80.1	79.4	78.5	78.6	78.8
2.20iii - Cancer screening coverage - bowel cancer (%)*	55	60	Devon						60.5	62.6	64.2	64.2	65.4	69.0
			England						62.0	62.7	63.6	63.4	64.1	67.9

Indicator	Lower threshold	Standard	Geography	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
2.20i - Cancer screening coverage - breast cancer (%)	70	80	Plymouth	79.9	80.6	80.1	78.7	78.4	79.1	79.3	79.0	78.2	78.2	77.4
			England	76.9	77.1	76.9	76.3	75.9	79.2	78.9	78.5	78.3	78.2	77.6
2.20ii - Cancer screening coverage - cervical cancer age 25-49 (%)	75	80	Plymouth	75.2	74.3	74.6	73.5	73.9	73.7	72.6	71.7	71.5	73.1	73.7
			England	78.0	77.6	77.2	75.2	75.2	74.9	74.4	74.0	73.8	75.0	75.6
2.20ii - Cancer screening coverage - cervical cancer age 50-64 (%)	75	80	Plymouth	81.2	80.7	80.9	80.6	80.2	79.3	78.7	77.7	76.2	75.9	76.0
			England	81.5	82.3	82.0	81.6	81.1	80.4	80.1	79.4	78.5	78.6	78.8
2.20iii - Cancer screening coverage - bowel cancer (%)*	55	60	Plymouth						61.3	61.6	61.1	61.6	61.9	66.5
			England						62.0	62.7	63.6	63.4	64.1	67.9

Indicator	Lower threshold	Standard	Geography	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
2.20i - Cancer screening coverage - breast cancer (%)	70	80	Torbay	79.2	78.6	76.9	77.0	76.5	76.7	74.7	74.1	74.4	74.2	77.0
			England	76.9	77.1	76.9	76.3	75.9	79.2	78.9	78.5	78.3	78.2	77.6
2.20ii - Cancer screening coverage - cervical cancer age 25-49 (%)	75	80	Torbay	75.4	75.0	75.1	73.4	74.0	73.9	72.7	71.9	71.5	73.4	74.3
			England	78.0	77.6	77.2	75.2	75.2	74.9	74.4	74.0	73.8	75.0	75.6
2.20ii - Cancer screening coverage - cervical cancer age 50-64 (%)	75	80	Torbay	80.5	79.4	79.5	79.4	79.4	79.1	78.1	76.9	75.2	75.0	75.2
			England	81.5	82.3	82.0	81.6	81.1	80.4	80.1	79.4	78.5	78.6	78.8
2.20iii - Cancer screening coverage - bowel cancer (%)*	55	60	Torbay						62.0	61.4	61.8	61.1	62.1	65.4
			England						62.0	62.7	63.6	63.4	64.1	67.9

Indicator	Lower threshold	Standard	Geography	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
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
			England	76.9	77.1	76.9	76.3	75.9	79.2	78.9	78.5	78.3	78.2	77.6
2.20ii - Cancer screening coverage - cervical cancer age 25-49 (%)	75	80	Cornwall	76.2	75.4	75.7	74.0	74.8	75.2	74.3	73.4	73.4	75.0	75.9
			England	78.0	77.6	77.2	75.2	75.2	74.9	74.4	74.0	73.8	75.0	75.6
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
			England	81.5	82.3	82.0	81.6	81.1	80.4	80.1	79.4	78.5	78.6	78.8
2.20iii - Cancer screening coverage - bowel cancer (%)*	55	60	Cornwall						58.3	60.5	61.7	61.5	62.7	66.6
			England						62.0	62.7	63.6	63.4	64.1	67.9

Non cancer screening – diabetic eye screening

Standard 7-KPI DE1 Uptake; 75 & 85%

				Quarterly											
				Q2 18-19	Q3 18-19	Q4 18-19	Q1 19-20	Q3 19-20	Q4 19-20	Q1 20-21	Q2 20-21	Q3 20-21	Q4 20-21	Q1 21-22	Q2 21-22
Standard 7-KPI DE1 Uptake; 75 & 85%	CORNWALL AND THE ISLES OF SCILLY HEALTH & SOCIAL CARE PARTNERSHIP (STP)	Cornwall	Numerator	20,893	20,939	21,373	22,528	24,053	24,002	38	2,025	5,692	9,024	13,833	16,934
			Denominator	27,469	27,824	28,427	29,220	30,378	31,225	41	2,480	7,183	11,795	17,594	21,217
			%	76.1%	75.3%	75.2%	77.1%	79.2%	76.9%	92.7%	81.7%	79.2%	76.5%	78.6%	79.8%
	DEVON STP	Devon	Numerator				48,941	51,372	51,841	42,273	30,898	29,663	33,719	48,063	55,708
			Denominator				56,495	59,915	60,776	49,436	35,900	34,522	40,373	56,079	64,489
			%				86.6%	85.7%	85.3%	85.5%	86.1%	85.9%	83.5%	85.7%	86.4%