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

September 2014

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 since its inaugural meeting on 15th October 2013.

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) was 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 foot-print, 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 Supporting the Committee are a number of health protection subgroups support the Health Protection Committee in order 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 An inaugural meeting of the Committee was held on October 15th 2013 followed by further meetings on 9th December 2013, 4th February 2014, April 29th 2014 and 20th August 2014.

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 provides 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.

Tuberculosis (TB) Cluster – Teignbridge Area

3.8 The last decade saw an increase in TB cases in the South Devon area. In 2000-01 there was an outbreak of TB in Newton Abbot in a social group. Cases with the same 'strain' of TB are still being diagnosed in the wider community and recent cases appear to be linked to this earlier outbreak.

3.9 During December 2013, a small number of confirmed cases of active pulmonary TB were identified in the wider Teignbridge area.

3.10 An initial incident control meeting led by Public Health England was held which included attendance from Devon County Council's lead Consultant in Public Health on behalf of the Director of Public Health. A total of four incident meetings were held to monitor progress and to maintain good communication between partners.

3.11 To further reduce the risk of ongoing transmission by seeking to identify additional cases of active TB infection, the Incident Control Team decided to hold two direct access TB screening clinics at a community hospital in December 2013. These clinics were run collaboratively between respiratory teams at Royal Devon and Exeter NHS Foundation Trust Hospital and South Devon Healthcare NHS Foundation Trust Hospital. In addition, in January 2014, children and teaching staff at a primary school were also screened.

3.12 No further cases of active TB infection were identified through the screening activities undertaken. A small number of individuals were screened positive for latent (inactive and non-infectious) TB and were supported accordingly.

3.13 Organisationally, the incident highlighted a lack of clarity about who should pay for mass community TB screening which has now been considered in the draft Health Protection Committee-led Memorandum of Understanding between relevant partners.

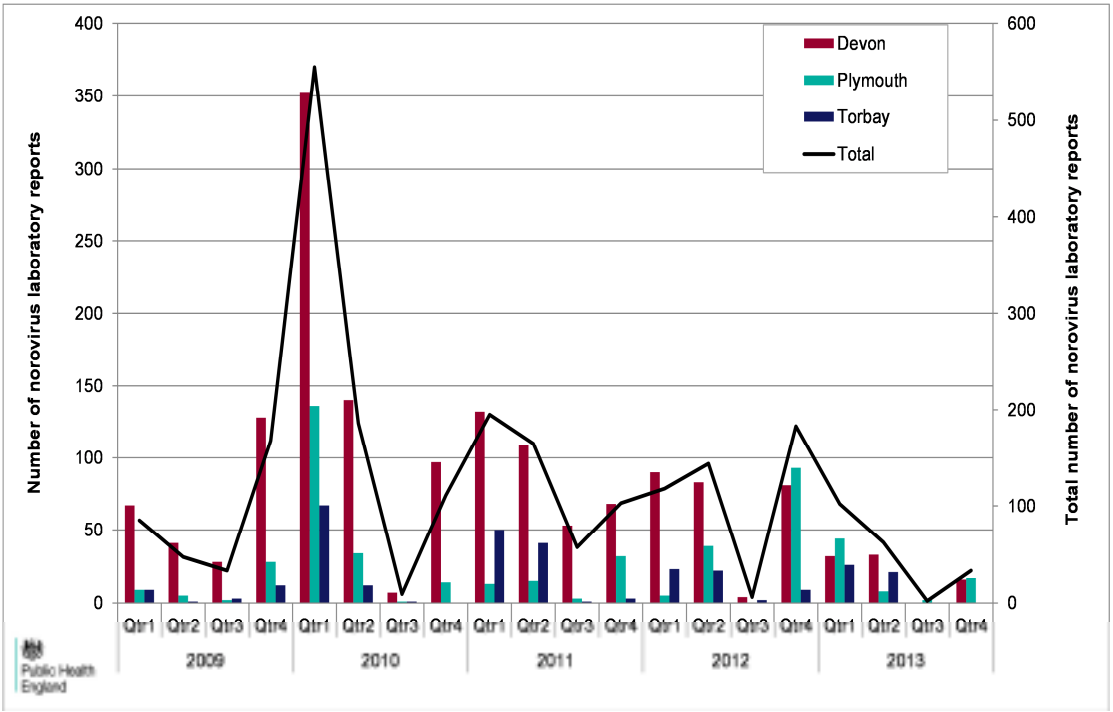
3.14 Additionally, the incident reminded partners of the need for ongoing awareness raising by public health colleagues to health-care professionals and the public about TB.

Norovirus 2013-14

3.15 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.

3.16 As illustrated in Figure 1, norovirus laboratory reports have been lower during the 2013-14 season compared to previous seasons. The graphic cannot be used to estimate burden of disease as many cases will never be reported.

Figure 1: Quarterly laboratory reports of norovirus for the Local Authority areas of Devon County Council, Plymouth City Council and Torbay Council 2009-13.



3.17 During the season, a regional field epidemiologist from Public Health England (PHE) advised that weather-related factors such as humidity, rainfall and temperature have been implicated in the transmission of other viral Gastroenteritis and is it likely that they also have a role to play in norovirus transmission. As the winter period was deemed atypical as it had been wet but not overly cold, these conditions may have been responsible for the low norovirus activity. Seasonal influenza was also very low in the UK but in contrast, in parts of the United States which experienced a very cold winter the level of influenza activity was high.

3.18 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.

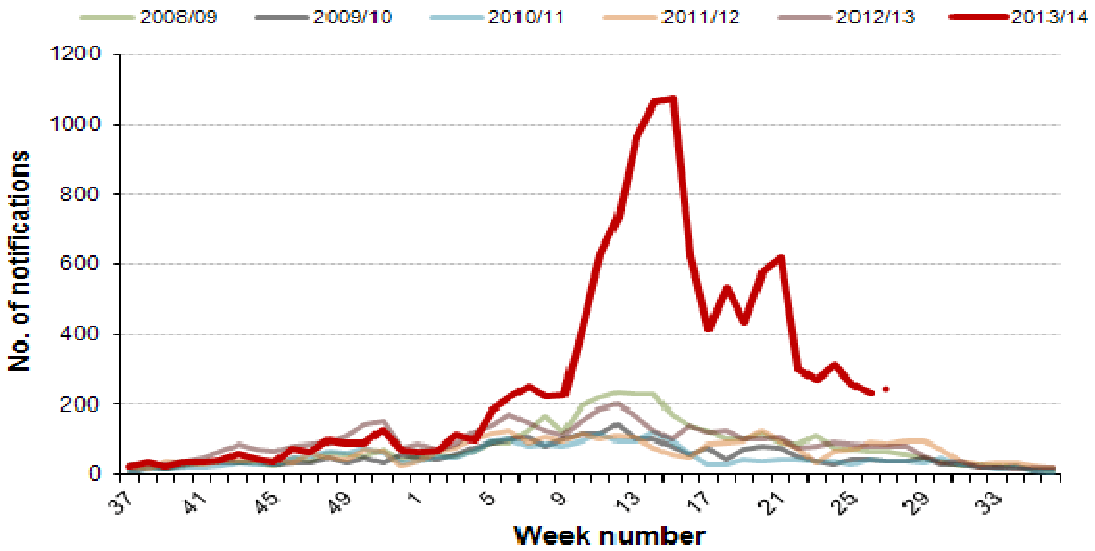
Scarlet Fever 2013-14

3.19 Scarlet fever is a common childhood infection caused by Streptococcus pyogenes (also known as group A streptococcus [GAS]). These bacteria are found on the skin or in the throat, where they can live without causing problems. Under some circumstances GAS can cause non-invasive infections such as pharyngitis, impetigo and scarlet fever. On rare occasions they can cause severe disease, including streptococcal toxic shock syndrome, necrotising fasciitis, and invasive GAS (iGAS) infection.

3.20 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. Incidence of invasive disease tends to mirror that of superficial manifestations of GAS infection in many but not all years. As such, monitoring scarlet fever cases nationally can provide an early warning of increases in invasive disease. Seasonal trends show that increased levels of GAS infections typically occur between December and April, with peak incidence usually in March.

3.21 Public Health England (PHE) reported elevated levels of scarlet fever notifications across England (Figure 2). Between 9th September 2013 and 30th June 2014, a total of 12,121 cases were notified peaking at the beginning of April 2014.

Figure 2: Weekly scarlet fever notifications in England, 2009.09 onwards



3.22 Locally, there were 110 notifications of scarlet fever between September 2012 and July 2013 for Devon County Council, Plymouth City Council and Torbay Council combined. For the period September 2013 to July 2014, there were 208 notifications, an increase of 89%.

3.23 Over the period of increased scarlet fever activity, no significant increase in notifications of invasive group A streptococcus was observed.

3.24 Public Health England (PHE) are currently leading investigations to identify the reasons for the unusual escalation in scarlet fever, including microbiological investigation of causative strains.

3.25 Locally, in order to reduce ongoing transmission, Local Authority Public Health Teams wrote to schools and child care facilities providing information about the increase in cases and reiterating infection control advice. Public Health England published interim guidance for the public health management of scarlet fever outbreaks in schools and nurseries and other childcare settings to be deployed by local acute response centres.

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. At time of writing, these processes are being reviewed to ensure they are fit for purpose.

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 2013-14

4.7 The period 2013-14 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. This involved significant collaboration between Public Health England, NHS England and Local Authority Public Health teams.

4.9 Additionally, the schedule for the Meningitis C immunisation was changed, replacing a second priming dose at four months to a booster in adolescence with effect from June 2013. 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 (to be extended to children and young people from two years of age up to 16 over the coming years) was introduced.

4.10 The capacity required to oversee these changes has resulted in limited capacity across the health protection system to drive service improvement / development initiatives which are now prioritised for the period 2014-15.

Information Sharing

4.11 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.

4.12 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.

4.13 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

4.14 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 1).

Table 1: Public Health England Seasonal provisional flu vaccination figures 1 September 2013 – 31 January 2014

Clinical Commissioning Group	% of practices responding	65+ % vaccinated	6m-65 at risks % vaccinated	Pregnant women % vaccinated
NEW Devon	100%	72.2%	49.2%	40.3%
SD & Torbay	100%	69.1%	47.6%	38.2%
England	99.8%	73.2%	52.3%	39.8%
Target	**100%**	**75%**	**75%**	**N/A**

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

4.15 A programme of work is being led by a Specialty Registrar in Public Health based at Devon County Council. The objectives of this programme of work are:

- 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

4.16 The work is being carried out on a collaborative basis involving all key stakeholders.

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*.

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 is scheduled to meet quarterly.

***Clostridium difficile* - Performance 2013-14**

5.7 The Northern Eastern & Western Devon Clinical Commissioning Group population objective including Acute Trust allocated cases was 264. End of year performance was within this at 215. The 2014-15 objective is 204 (rate 23.6 per 100,000 population)

5.8 In the Northern Eastern Western Devon Clinical Commissioning Group area Plymouth Hospitals NHS Trust over ran its nationally set objective. The Trust having earlier in the year recognised potential difficulties in compliance with the national objective had requested and received a review led by the Clinical Commissioning Group from which an action plan was drawn up and is being implemented.

5.9 The South Devon and Torbay Clinical Commissioning Group population objective was 95. End of year performance was within this at 86. The 2014-15 objective is 81 (rate 29.8 per 100,000 population).

5.10 Based on 2013-14 performance Southern Devon Healthcare NHS Foundation Trust and Plymouth Hospitals NHS Trust and both Clinical Commissioning Groups are at risk of not meeting the 2014-15 targets. However new guidance released in time for 2014-15 will enable Clinical Commissioning Groups to decide if cases are to be considered 'unavoidable' will help to mitigate against the risk in relation to acute Trust performance as such unavoidable cases do not have to be counted for the purposes of sanction implementation.

MRSA - Performance 2013-14

5.11 MRSA remained subject to a zero tolerance national objective with a requirement for Post Infection Reviews (PIRs) on every case of MRSA bacteraemia that occurred.

5.12 Northern Eastern & Western Devon Clinical Commissioning Group ended the year with seven cases of which five cases were attributed to two of the three Acute trusts and the remaining two occurred in the wider community and therefore attributed to the Clinical Commissioning Group.

5.13 South Devon and Torbay Clinical Commissioning Group ended the year with one case which occurred in the Acute Trust.

5.14 All cases were subject to Post Infection Reviews.

6. Work Programme 2014-15

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 Seasonal Influenza (as outlined in 4.14 to 4.16).

Hepatitis C Strategy and Implementation

6.3 Hepatitis C is a blood borne virus which is an important 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.

6.4 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. It is envisaged that Public Health England in partnership with Local Authority Public Health Teams will provide overarching leadership of the strategy and will identify priority actions for the period 2014-15.

TB Service Review

6.5 Following the TB cluster outlined in this report a number of issues were raised with regards to the hospital-based services commissioned to manage the treatment, contact tracing and screening of active cases of TB. These included:

- the capacity of providers to screen large cohorts over and above their existing service provision and agreement of meeting the additional costs required
- limited capacity to provide peripatetic / outreach work to communities historically harder to engage with
- limited capacity to provide directly observed therapy (DOT) on an outreach basis

6.6 It was also noted how well the TB teams from South Devon Health Care NHS Foundation Trust and Royal Devon and Exeter NHS Foundation Trust collaborated together and pooled expertise and capacity because the catchment area affected crossed the boundary of both providers.

6.7 These issues require consideration alongside the draft Collaborative Tuberculosis Strategy published in March 2014 and priority actions there within. The proposed formation of TB Boards outlined in the strategy, at the appropriate geographic spatial level, may provide the appropriate forum for considering local issues raised here as well as a broader review of services alongside lead Clinical Commissioning Group Commissioners.

6.8 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

6.9 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 CQC 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.

6.10 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.

6.11 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.

7. Authors

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APPENDIX 1

Proposed 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 (PHE CCDC/Health Protection Consultant)

*Chair - Devon, Cornwall and Isles of Scilly Screening & Immunisation Oversight Group – Consultant in Public Health *(group under development)*

*Chair – Local Health Resilience Partnership

*Chair – Health Care Associated Infections Programme Board *(group under development)*

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:

3.6.1 *Performance report;*
3.6.2 *Risk register and action plan review;*
3.6.3 *Serious incidents requiring investigation;*
3.6.4 *Work-programme update;*
3.6.5 *Policy / evidence/guideline updates (All);*
3.6.6 *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

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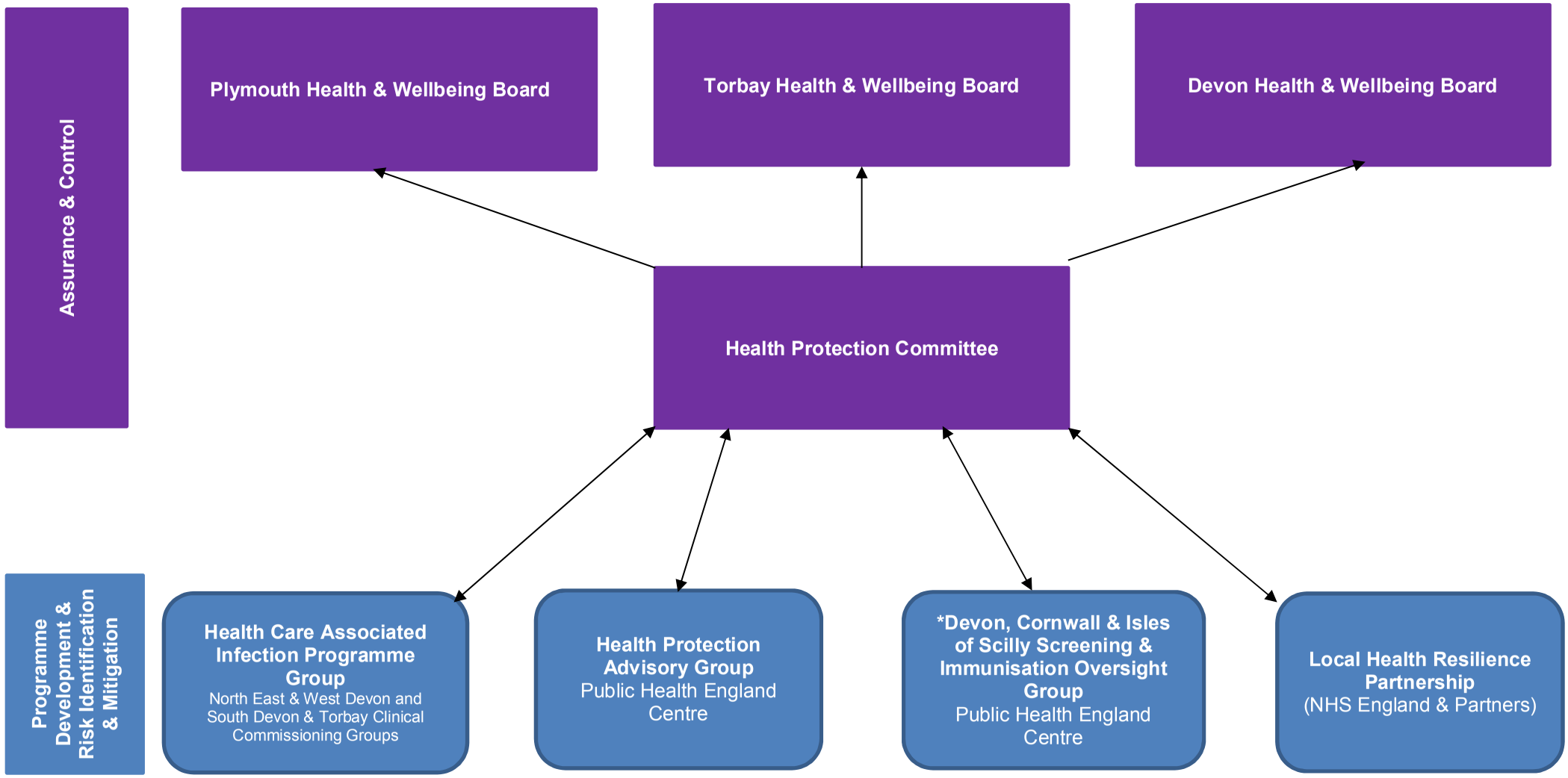
APPENDIX 2

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



***Group in development / Terms of Reference to be agreed.**