

# 3.14 Sexual Health

*Sexual health is an issue that concerns the majority of the population. The World Health Organisation defines sexual health along these main parameters:*

- *Enjoyment of sexual relations without exploitation, oppression or abuse*
- *Safe pregnancy and childbirth, and avoidance of unintended pregnancies*
- *Absence and avoidance of sexually transmitted infections (STIs) including HIV.*



In response, there is a need to have in place comprehensive and high-quality sexual healthcare services as well as health promotion campaigns, educational opportunities, especially for young people, and good surveillance of trends in key measures of sexual health, such as rates of sexually transmitted infections.

Under the Public Health Outcomes Framework the main areas of focus for sexual health are:

- Prevention of STIs in particular HIV and Chlamydia
- HIV, in particular to reduce numbers of those presenting late and undiagnosed infections
- Chlamydia diagnosis rates in those aged 15-24
- Under 18 conceptions.

## Current and future arrangements

Since 2010, the [South West Office for Sexual Health](#) has co-ordinated all aspects of sexual health including education, health promotion, prevention, testing and treatment. A collaborative sexual health network led by South West Directors of Public Health oversees this work. This network has a Board chaired by a Director of Public Health. Board members include clinicians, public health professionals, commissioners, Public Health England organisations (such as the Health Protection Agency), Terence Higgins Trust and Brook. Work is under way to strengthen engagement with local government including elected members.

# *The total budget for sexual health in Cornwall and the Isles of Scilly is approximately **£4.4** million.*



From 1st April 2013 commissioning responsibilities for sexual health are as follows:

## **Public Health from April 2013**

Local Authority commissioning: Contraception over and above GP contract; testing and treatment of sexually transmitted infections (excluding HIV treatment); sexual health advice, prevention and promotion.

NHS Kernow: Promotion of opportunistic testing and treatment; termination of pregnancy services (with consultation on longer term arrangements); sterilisation and vasectomy services.

NHS England: Contraceptive services commissioned through GP contract; sexual assault referral services; HIV treatment.

Public Health England: Management of South West Office for Sexual Health; quality assurance and monitoring in each locality; provision of services focused on groups at highest risk of poor sexual health such as young people.

## **Budget and investment**

The total budget for sexual health in Cornwall and the Isles of Scilly is approximately £4.4 million. This is inclusive of genitourinary (GU), community contraception, Chlamydia screening, young people's sexual health services, ad hoc grants, provision of level 2 services etc. In 2006 a decision was made to introduce a Payment by Result (PbR) tariff for GU. This resulted in uplifted budgets for the providers of this service. In Cornwall, the only service that has been successful in obtaining additional funding via PbR is GU at the Royal Cornwall Hospitals Trust. The additional finances were secured via a business case to support the roll out of additional provision in other locations around the county.

## **Where we were in 2005/6**

At this time, services were delivered through a range of providers working collaboratively to agreed objectives. Partnership approach was facilitated by the Sexual Health Local Implementation Group, which was developing partnerships between public health, primary care and specialised services. This work was supported by a number of sub-groups to address health promotion issues.

## The National Strategy for Sexual Health and HIV (2001) defined the priorities for our local services with its aims to:

- Reduce the transmission of HIV and STIs
- Reduce the prevalence of undiagnosed HIV and STIs
- Reduce unintended pregnancy rates
- Improve health and social care for people living with HIV
- Reduce the stigma associated with HIV and STIs.

## **What we knew in Cornwall and the Isles of Scilly:**

- The number of detected STIs had increased from 4,239 diagnoses in 2000 to 5,312 diagnoses in 2004 (25% increase over four years); this was in part due to increased levels of testing for Chlamydia
- Sexual health services were under pressure, many of which operated from temporary or inadequate accommodation
- 11% of females and 13% of males aged 16-25 tested positive for Chlamydia between 2003 and 2005 (high community prevalence)
- Routine testing was available at 57 venues in Cornwall and one-off screening had been held at a further 31 venues
- 70 out of 75 GPs had started screening by January 2006
- The diagnosis of other STIs and HIV was also increasing.

## Developments and key achievements since 2005/6

Department of Health allocated extra funding to PCTs to improve and modernise sexual health services. The target was for 100% of people to be offered an appointment within 48 hours of contacting a GU service by 2008.

The Royal College of Obstetricians and Gynaecologists published Service Standards for Sexual and Reproductive Healthcare (updated in 2011).

### *National 2006 Cornwall*

GU at the Royal Cornwall Hospitals Trust received Payment by Results (PbR) funding.

Local Area Agreement (2006-09) included a target to increase the number of young people aged 15-24 being screened for Chlamydia and reduce the prevalence of Chlamydia in under 20 year olds.

The Sexual Health Local Implementation Group undertook a mapping exercise of sexual health services across the county.

National Screening Programme for Chlamydia was introduced across England.

The British HIV Association published standards for HIV clinical care.

### *2007*

Cornwall had been a pilot for the National Screening Programme for Chlamydia since 2003 and had already tested 15,000 young people.

National Guidelines for HIV Testing were published and the Chief Medical Officer encouraged all UK doctors to adopt them. Testing should be offered in a wider range of settings. Despite this there continue to be missed opportunities for earlier diagnosis of HIV.

The national Human Papillomavirus (HPV) immunization programme was launched, starting with girls aged 12-13 years. Older cohorts of girls were subsequently included.

### *2008*

Sexual Health Strategy for Cornwall and the Isles of Scilly (2008-11) published, with key objectives to:

- Reduce the transmission and prevalence of undiagnosed HIV and STIs
- Ensure appropriate services for all and high uptake for high-risk or underserved groups
- Improve health and social care for those living with or affected by HIV
- Reduce the stigma associated with HIV and STIs and normalise access to sexual health services
- Reduce levels of unplanned teenage pregnancy to improve the sexual health of young people.

The Health and Wellbeing Strategy (2008-20) also included plans to improve access to modernised sexual health services offering effective contraceptive, abortion and STI services, with a particular focus on young people, gay men and over 35s.





Health Protection Agency set up the [South West Office for Sexual Health](#) to provide leadership on all aspects of sexual health including: relationship and sex education; health promotion; preventing the spread of sexually transmitted infections through testing and treatment; reducing teenage and unplanned pregnancy through good access to contraception and abortion services.

Standards for the management of STIs published by the British Association for Sexual Health and HIV. The standards cover all aspects of the management of STIs including the diagnosis and treatment of individuals and the broader public health role of infection control.

National AIDS Trust published a report on HIV partner notification (PN) which reveals missed opportunities for HIV testing, diagnosis and prevention. It recommended that:

- Sexual health clinics should use online technology within their partner notification processes
- Clear national standards for HIV partner notification should be introduced
- Clinics should be properly commissioned and resourced to do high quality partner notification
- Communities most at risk of HIV should be told about the benefits of partner notification.

## 2009

Cornwall Council Community Intelligence Team published a focus paper on sexual health, which found that STIs were increasing, and a lack of equitable provision of sexual health services across the county.

RCHT Business case for Sexual Health Hub recognised need for development of level 3 sexual health services in areas of unmet need.

## 2010

The updated Sexual Health Strategy for Cornwall and the Isles of Scilly (2010-13) included six key objectives and associated actions for strategic delivery:

- 1) To reduce transmission of HIV and STIs and to reduce prevalence of undiagnosed HIV and STIs
- 2) To ensure appropriate levels of service for all service users and service uptake for high risk and underserved groups
- 3) To improve the health and social care for people living with/affected by HIV
- 4) To reduce the stigma associated with HIV and STIs and normalise access to sexual health services
- 5) To reduce levels of unplanned teenage pregnancy
- 6) To improve the sexual health of young people.

The NHS Sexual Health Hub opened in Truro, with improved facilities to support 2,500 extra patients per year. This includes GU, HIV, contraception and Chlamydia screening services. Subsequently also hosting RCHT Termination of pregnancy services.

Peer review of sexual health services in Cornwall.

## 2011

The [Willow Centre](#) (Sexual Assault Referral Centre) opened in Truro, supported by Public Health. This multi-agency service offers a highly confidential and holistic approach to all victims of rape and serious sexual assault above the age of 16 years.

Opening of new level 3 sexual health services in Liskeard and Falmouth.

## 2012

Opening of new integrated level 3 sexual health service at St Michaels hospital, Hayle.

Level 3 Saturday clinic in the Hub opens April 2012.





## Monitoring and intelligence

The [Public Health Outcomes Framework](#) will monitor the following outcomes relating to sexual health:

- 1.5 16-18 year olds not in education, employment or training
- 1.12 Violent crime (including sexual violence)
- 2.4 Under 18 conceptions
- 3.2 Chlamydia diagnoses (15-24 year olds)
- 3.3 Population vaccination cover
- 3.4 People presenting with HIV at late stage of infection

Public Health England will continue to provide quarterly data to enable each locality to review their own progress in 21 areas of sexual health including STIs, Chlamydia screening, HIV, GU access, abortions, teenage conceptions, contraception and sexual assault referral centres (SARC).

Progress will be monitored using integrated HIV surveillance data and local audits. This data will be available to commissioners of sexual health services.



HIV	2006	2007	2008	2009	2010	2011	2012
Number of people accessing HIV treatment Source: RCHT	89	105	125	126	139	140	148
New Diagnoses of HIV Source: RCHT	NA	NA	6	5	10	13	11

Chlamydia	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Number of people aged 15-24 tested for Chlamydia Source: Chlamydia Screening Service	10,906	12,271	13,351	21,527	17,556	15,207	13,964
Number of positive diagnoses for Chlamydia Source: Chlamydia Screening Service	1,090	1,104	1,174	1,248	1,176	934	1,191
Diagnostic rate (per 100,000) (National guide = 2,400) Source: Chlamydia Screening Service	1,770	1,792	1,906	2,026	1,909	1,747	1,934

NA = data not available

# 100% of all patients attending GU services are offered an appointment within 48 hours of contacting the service.



Access to sexual health services has improved greatly since 2005/6. In line with the Department of Health's target, since March 2008, 100% of all patients attending GU services are offered an appointment within 48 hours of contacting the service. A monthly patient satisfaction survey of all patients attending RCHT level 3 sexual health services since 2012 shows that over 95% of patients rated services as good or excellent.

The prevalence of HIV is low in Cornwall and the Isles of Scilly compared to other parts of the country, with only 11 new diagnoses in 2012. Late diagnosis tends to be more problematic in low prevalence areas, but this has improved locally in recent years.

Late diagnoses from 2012 are currently being audited for missed opportunities for earlier diagnosis and learning points will be circulated widely within primary and secondary care.

Cornwall's rate of Chlamydia testing is below the national guideline diagnostic rate of 2,400 per 100,000 (aged 15-24), but similar to regional areas with similar populations and rurality. The latest reported national rate is 1,965 per 100,000 and Cornwall's rate is 1,934 per 100,000. However, it seems that we are screening those young people most at risk as 8.5% test positive, compared to 7.9% regionally and 7.3% nationally. This high percentage of positive results indicates that we are testing in the correct areas and age group to maximise the effectiveness and efficiency of the service.



## Evidence of what works

The National Institute for Health and Care Excellence (NICE) has published evidence based public health guidance on sexual health:

[Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection](#)

[Increasing the uptake of HIV testing among men who have sex with men](#)

[Increasing the uptake of HIV testing among black Africans in England](#)

[Prevention of sexually transmitted infections and under 18 conceptions](#)

Further NICE public health guidance on sexual health is planned, but the dates of issue have not been confirmed:

- Personal, social, health and economic education focusing on sex and relationships and alcohol education (TBC)
- Contraceptive services for socially disadvantaged young people (TBC)
- Sexually harmful behaviour among young people (TBC).

NICE has also developed a pathway summarising all of the evidence based recommendations on [HIV testing and prevention](#).

## Where we are now

### HIV

More than half of all HIV diagnoses are 'late' and work is ongoing to tackle this problem. In cases of late diagnosis, the immune system has already been damaged and the individual is 10 times more likely to die within a year of diagnosis and will have a significantly reduced life expectancy. Late diagnosis also results in missed opportunities to prevent spread of infection. We know that in many local cases of late HIV diagnosis there have been missed opportunities for earlier diagnosis. We are committed to improving the process to avoid this happening in the future.

HIV testing needs to be embedded into practice in both primary and secondary care. Healthcare



workers need to be confident in offering testing when appropriate. Opt-out testing sexual health clinics needs to be audited regularly to make sure testing rates are maintained.

The Health Promotion team leads on projects to increase awareness of sexual health and reduce risk-taking behaviours. This work includes the C-Card condom distribution scheme and school-based programmes such as sex and relationships education (SRE) and Speakeasy.

Over the past 2 years GU and HIV services at Royal Cornwall Hospitals Trust have led on a number of initiatives:

- Work with microbiology showed large differences in testing rates between practices. We have worked with GPs in Cornwall and the Isles of Scilly highlighting recent delayed diagnoses, benefits of earlier HIV testing and showing how local test rates varied between practices. Testing rates after this intervention increased by an average of 25%. Further work is needed to see if this rise in rates can be maintained.

- There is ongoing work with colleagues in secondary care – especially in specialties such as haematology, Medical Admissions Unit, gastroenterology, dermatology and respiratory medicine – auditing current practice, developing reminders for staff to test and ensuring local guidelines reflect best practice.
- GU medicine produces a monthly report of testing rates in new patients as part of the Trust's Performance Assurance Framework. This demonstrates that rates are consistently above national targets.

## Chlamydia

Screening must remain universally accessible in order to screen large numbers of young people, increase the diagnosis rate and reduce Chlamydia prevalence. Work is ongoing to ensure that Chlamydia screening is routinely offered at every consultation with sexually active young people in primary care and sexual health services.

Access to testing has consistently improved with the increase of specialist clinics and outreach services spread across the county and all GPs able to offer and advise on Chlamydia testing. A high proportion of testing for Chlamydia takes place in core NHS services where over three quarters of all tests were done between January and March 2012.





However, there is still a stigma surrounding sexual health and it may be difficult for some young people to discuss STI testing with the local family doctor or pharmacist in small towns and villages. In general due to lack of symptoms this age group does not see the need to test, forget to do it annually, or see their life as too busy and they often have a sense of invincibility feeling it won't happen to them. We aim to make services more accessible to young people and remove barriers to testing through our award-winning [EEFO website](#) - it contains information and advice on a wide range of issues that affect young people, including sexual health and relationships.

We are increasingly identifying and testing higher risk young people who have not been tested before. We are continuing to promote through primary care and youth services, annual testing for all who are sexually active.

Awareness and education of both professionals and young people is essential to prevent an increase in Chlamydia and other STIs.

Current projects and services include:

- Improving management of patients and increasing the number of partners who are tested and treated
- Recalling patients who have had Chlamydia for a follow up test
- Liaison with other health professionals, practice nurses, pharmacy, prescribers of emergency hormonal contraception, youth workers, and young people's centres to raise awareness and support young people to test
- Continued availability of the C-Card condom distribution scheme at 120 outlets across Cornwall and the Isles of Scilly
- Increase awareness of the free online postal test service for 15-24 year olds.

## Looking to the future

### HIV

An audit of HIV partner notification (PN) rates in Cornwall is underway, with results expected in the autumn, using new guidance from the National AIDS Trust. Partners of people with HIV are a group with very high prevalence of HIV, and PN is an opportunity to test this population and reduce late diagnosis.

Sexual Health RCHT will also be implementing an opt-out texting service for higher risk individuals, to invite for regular HIV tests and STI screening.

Sexual Health RCHT will be working with Health Promotion, [Healthy Gay Cornwall](#) and other local organisations to promote testing in high risk, hard to reach groups, and will be developing an outreach role for sexual health nurses to trial point-of-care testing using new technologies.

We need to ensure that Post Exposure Prophylaxis for Sexual Exposure (PEPSE) is easily available and promoted, especially following changes in NHS from April 2013.

Teaching and training will continue to be a priority.

### Chlamydia

Future priorities for prevention of Chlamydia include:

- Increased testing of young people in general practice; indications for testing include change in sexual partner, multiple concurrent partners and not tested for over 12 months
- Increased awareness of the need to test annually by sexually active young people
- Continued and increased confidential access to testing
- Reduction of stigma of sexually transmitted infections
- Increased testing of partners
- Ongoing training and empowerment of health care and youth staff to work well with young people in promoting good sexual health.



The National Chlamydia Screening Programme recommends that commissioners and providers should work together to support the disinvestment in outreach services and reinvestment in core services. For the last four years NCSP guidance has been to increase testing in core services (primary care and sexual health) and reduce outreach services. The target for 2012 is to have 70% of testing done in 'core services' and Cornwall currently exceeds this.

Doing so has not given the increase in the number of positive tests that has been demonstrated in urban areas. It has delivered a consistent rate of positive diagnoses, which the national programme suggests should offer control of Chlamydia prevalence and so reduce the number of cases of Chlamydia-related chronic health problems. Investment in core services needs to continue, including:

### RCHT sexual and reproductive health services

Increasingly contraception and GU services are becoming co-located and there is an ongoing programme to dual train staff at all levels.

All sexual health staff have been trained in cervical cytology; this is being offered in all settings allowing opportunistic testing of women who are not accessing the service elsewhere. We hope this will help to address the relatively low levels of testing in women aged 25-30 in whom cancer rates are increasing.

Confidential sexual health services are already provided for large numbers of sexually active young adults with appropriately trained staff experienced in discussing sexual health issues with this age group.

Long acting contraception methods are promoted in all settings.

### General practice

Around 75% of young adults visit their GP every year, providing an ideal opportunity to offer an annual Chlamydia screen. Staff training is designed to reduce stigma, increase confidence and competence in raising sexual health in a non-sexual health consultation. There are clear management

pathways for both positive patients and their partners that are well established across the county.

### Abortion services

Chlamydia screening should be part of all Service Level Agreements with abortion service providers, to ensure testing continues to be offered to all women undergoing abortion. If the abortion service provider cannot provide full management of positive cases (partner notification, testing and treatment to prevent re-infection), patients should be referred on appropriately.

### Community pharmacy

Pharmacists are already established providers of sexual health services (e.g. pregnancy tests, emergency contraception provision) and Chlamydia screening is an appropriate addition to these services.

## Links

[\*British Association for Sexual Health and HIV\*](#)

[\*Savvy \(formerly EEFO\): Sexual Health\*](#)

[\*Free Test Me\*](#)

[\*Kernow Positive Support\*](#)

[\*Terence Higgins Trust\*](#)





# 3.15 Immunisations and Communicable Diseases

*Immunisation is a simple and effective way of protecting children and groups of vulnerable adults from potentially life threatening diseases which can be easily passed from person to person. This includes measles, mumps, rubella, diphtheria, tetanus, pertussis (whooping cough), pneumococcal infection, polio, meningitis, human papillomavirus (HPV), tuberculosis (TB) and influenza.*

As well as protecting the individual person, high immunisation rates within communities can also minimise the spread of diseases; this is known as 'herd' or 'population' immunity. Immunisation is also often referred to as vaccination. The difference is that vaccination is the process of providing an injection but immunisation means both receiving a vaccine and becoming immune to a disease, as a result of being vaccinated.

Vaccination programmes have helped to eradicate diseases such as smallpox and polio from the western hemisphere and further improvements to uptake rates could see the eradication of others during the 21st Century.

Complacency is not an option. We have seen all too frequently how low immunisation rates can lead to outbreaks of diseases such as measles, mumps and more recently of whooping cough and we must maintain uptake rates to prevent these potentially life threatening diseases re-establishing a foothold in our communities.

## Current and future arrangements

PCTs were responsible for commissioning and oversight of national vaccination programmes for target populations. The programmes themselves are predominantly delivered in partnership with GPs, although some vaccinations are delivered by TB nurses and consultant community paediatricians. Unlike other areas in the SW peninsula, there are no school or community based programmes in Cornwall and the Isles of Scilly. The Director of Public Health is ultimately responsible for the assurance and challenge relating to immunisation programmes to ensure high coverage rates and good overall protection for local populations. The DPH is supported by trained consultants and specialists in immunisation co-ordination.

# *we must maintain uptake rates to prevent these potentially life threatening diseases re-establishing a foothold in our communities.*



From 1st April 2013, responsibility for commissioning national immunisation programmes falls to NHS England under a section 7a agreement within the Health and Social Care Act 2012. Area teams will take responsibility for commissioning services from providers covering the Devon, Cornwall and the Isles of Scilly area. Teams from NHS England will be supported by specialists employed by Public Health England, who will advise on existing and emerging programmes and how they might best be delivered.

The DPH will still retain a scrutiny and challenge role within the LA to ensure that maximum coverage is being attained and population health is protected. This will require input into Health and Wellbeing Boards as well.

From 1st April 2013 the responsibilities for immunisations and communicable diseases will be as follows.

## Public Health from April 2013

NHS Kernow: Treatment of infectious diseases; co-operation with PHE and local authorities on outbreak control and related activity.

NHS England: Immunisation programmes; flu and pneumococcal vaccination programmes; co-operation with PHE and local authorities on outbreak control and related activity; some specialist infectious diseases services.

Public Health England: Current functions of the Health Protection Agency in this area; public oversight of prevention and control, including co-ordination of outbreak management (with supporting role for local authorities); pandemic influenza preparedness (supported by local authorities).

## Where we were in 2005/6

At the start of 2005, there were three separate PCTs covering the population of Cornwall and the Isles of Scilly – West of Cornwall, Central Cornwall, and North and East Cornwall PCTs. Each PCT had its own Director of Public Health with responsibility for protecting the health of their local populations and their own teams of immunisation co-ordinators.

National programmes were required to be delivered by all three PCTs though there were some locally determined differences in the way that programmes were run, for example each PCT was responsible for its own seasonal flu programme and publicity campaigns. COVER data was collected and reported for each individual PCT area rather than the county as a whole, even though there was only one child health information system from which the data was being extracted.

By October 2006, emphasis was on transition to a single PCT for Cornwall and the amalgamation of separate data sets and ways of working, to produce a more joined up approach to immunisations across the county. Focus at this time was predominantly on improving MMR uptake rates and working towards influenza vaccine targets of 70% for over 65s.

## What we knew in Cornwall and the Isles of Scilly:

- Childhood immunisation programmes were operating around the county
- Immunisation rates were similar to regional and national levels
- The recent mumps outbreak in Cornwall (2004-05) highlighted the importance of increasing uptake of the MMR vaccine
- Three quarters of people aged 65 and over received an influenza vaccine each winter.

## Developments and key achievements since 2005/6

Health Protection Agency published National Minimum Standards for Immunisation Training.

*National*  
**2005**  
*Cornwall*

**2006**

In response to the recent MMR outbreak (2004-05) GPs were encouraged to vaccinate children and students in the affected age groups. School and college based sessions were run to offer MMR to unvaccinated students.

Department of Health published Tuberculosis prevention and treatment: a toolkit for planning, commissioning and delivering high quality services in England.

Department of Health published Pandemic flu: a national framework for responding to an influenza pandemic – updated in 2011.

**2007**

Review of local TB services. Full time TB service team leader employed to work alongside existing TB workers.

National programme introduced to tackle HPV infections linked to cervical cancer.

**2008**

Outbreak of measles in Cornwall. In response to a cluster of cases among young children in Camborne a campaign to increase MMR coverage was implemented, including offering MMR immunisations in schools and GP practices and raising awareness through the media, posters and school newsletters. The immunisation rate increased by 20% over the same period the previous year, resulting in an additional 500 children immunised, mainly between the ages of 3 and 11 years.

PCT and HPA strengthened local TB services due to increasing levels, including extra TB nurses.

HPV vaccination programme launched in Cornwall





Department of Health announced MMR catch-up programme to immunise children between the ages of 5 and 18 who had not received the recommended scheduled doses.

Department of Health published the [UK Influenza Pandemic Preparedness Strategy](#) which introduced a new UK approach to the phases of the pandemic response. The phases are not numbered and it is possible to skip back and forth and repeat phases. The stages are Detection, Assessment, Treatment, Escalation and Recovery.

In response to rising numbers of whooping cough cases and neonatal deaths, the Department of Health recommended that all pregnant women in the later stages of pregnancy should be offered whooping cough vaccine to protect their newborn babies.

2009

2010

2011

2012

Pandemic flu caused problems for the NHS and local partners. This was dealt with in three stages:

1. Containment – all possible cases were treated
2. Treatment through antivirals – a large network of antiviral collection points was developed
3. Vaccination – priority was given to high risk groups such as pregnant women and those with underlying health conditions

Cornwall and Isles of Scilly Health Inequalities Strategy (2011-16) highlighted groups of people who are less likely to be immunised and therefore at greater risk:

- Children in care
- Young people who have missed previous immunisations
- Children with physical or learning difficulties
- Children of lone parents
- Children not registered with a GP
- Children in larger families
- Children who are hospitalised
- Minority ethnic groups
- Vulnerable adults and children such as asylum-seekers and the homeless

Royal Cornwall Hospitals Trust produced a Pandemic Influenza Plan, its purpose to ensure a co-ordinated response to an outbreak of pandemic flu, minimise loss of life and reduce the health impact of pandemic flu to staff, patients and carers.

## Monitoring and intelligence

The [Public Health Outcomes Framework](#) will monitor the following outcomes relating to immunisations and communicable diseases:

- 3.3 Population vaccination coverage
- 3.4 People presenting with HIV at a late stage of infection
- 3.5 Treatment completion for tuberculosis (TB)
- 4.15 Excess winter deaths

Vaccination programmes are very closely monitored by the [Health Protection Agency](#) on behalf of the [Department of Health](#) and this is Public Health England's responsibility from April 2013. Quarterly data is extracted from local information systems and used for national, regional and CCG



comparisons. This data has been collected for many years and provides a useful tracking tool for vaccination rates. Similarly, each year, flu vaccination rates are monitored and reported to the Department of Health on a monthly basis during the flu season.

Vaccinations (see table below for definitions of what they protect against)	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12
5-in-1 (DTaP/IPV/Hib) % of children immunised by their 1st birthday	Not given as 5-in-1	93%	94%	94.4%	94.2%	94.4%	95.3%
Meningitis C % of children immunised by their 1st birthday	93% 94% 92%	93%	93%	93.8%	93.8%	94.1%	94.9%
Pneumococcal disease (PCV) % of children immunised by their 1st birthday	NA	NA	85%*	93.9%	94.3%	94.3%	95.1%
MMR % of children immunised by their 2nd birthday	87% 87% 85%	87%	86%	88.0%	88.4%	88.5%	91.3%
4-in-1 (DtaP/IPV) % of children immunised by their 5th birthday	Not given as 4-in-1	84%	83%	88.4%	88.6%	87.2%	87.7%
3-in-1 (Td/IPV) Number of vaccinations given to school leavers (RCHT data)	Not given as 3-in-1	Not given as 3-in-1	5,124	5,257	8,170	4,593	4,861
Influenza % of persons aged 65 and over immunised during autumn/winter	75% 73% 75%	73%	71%	71.9%	70.0%	70.0%	72.5%

2005/6 data presented for three PCTs: Central, N/E and West in that order.

\*marked as experimental data

Source of all data: [NHS Information Centre](#)



Childhood immunisation programmes across Cornwall and the Isles of Scilly are generally performing very well, and producing uptake rates that are generally equal to national and regional figures.

The HPV programme was introduced in the academic year 2008/9 for year 8 girls (12-13 year olds), with a catch-up for 14-18 year olds the following year. HPV infection is common in young women, and is generally asymptomatic and self-limiting. However, infection can lead to cervical (and other related) cancers after a number of years of persistent infection. It is estimated that vaccination could help prevent around 70% of all cervical cancers caused by the 16 and 18 high-risk sub-types of HPV.

The HPV vaccination programme in Cornwall is under review, and plans are being put in place to move to a school-based system to increase the level of uptake. This will be re-procured by NHS England during 2013/14, and commence in autumn 2014.

Influenza vaccination rates for people aged 65 and over remain comparable with the national and regional average (73%). Flu vaccination rates for younger people in a clinical risk group are also comparable with regional and national figures

(52%). Challenging targets have been set to achieve 75% uptake rates for all risk groups including pregnant women by the winter of 2013-14. This is a particular challenge for pregnant women; currently only one in three comes forward for vaccination.

## Evidence of what works

The National Institute for Health and Care Excellence (NICE) has published evidence-based public health guidance on immunisations and communicable diseases:

[\*Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection\*](#)

[\*Identifying and managing tuberculosis among hard to reach groups\*](#)

[\*Increasing the uptake of HIV testing among men who have sex with men\*](#)

[\*Increasing the uptake of HIV testing among black Africans in England\*](#)

[\*Reducing differences in the uptake of immunisations\*](#)

[\*Prevention of sexually transmitted infections and under 18 conceptions\*](#)



## Where we are now

The following vaccinations are routinely offered to everyone in the UK for free by the NHS at the ages shown.

Age	Vaccination
2 months	5-in-1 (DTaP/IPV/Hib) vaccine – this single jab contains vaccines to protect against five separate diseases: diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib, a bacterial infection that can cause severe pneumonia or meningitis in young children) Pneumococcal (PCV) vaccine Rotavirus vaccine
3 months	5-in-1 (DTaP/IPV/Hib) vaccine, second dose Meningitis C Rotavirus vaccine, second dose
4 months	5-in-1 (DTaP/IPV/Hib) vaccine, third dose Pneumococcal (PCV) vaccine, second dose
Between 12 and 13 months	Hib/Men C booster, given as a single jab containing meningitis C (second dose) and Hib (fourth dose) Measles, mumps and rubella (MMR) vaccine, given as a single jab Pneumococcal (PCV) vaccine, third dose
2 and 3 years	Flu vaccine (annual)
3 years and 4 months, or soon after	MMR vaccine, second dose 4-in-1 (DTaP/IPV) pre-school booster, given as a single jab containing vaccines against diphtheria, tetanus, whooping cough (pertussis) and polio
Around 12-13 years	HPV vaccine, which protects against cervical cancer (girls only) – three jabs given within six months
Around 13-18 years	3-in-1 (Td/IPV) teenage booster, given as a single jab which contains vaccines against diphtheria, tetanus and polio
Around 13-15 years	Meningitis C booster
65 and over	Flu (every year) Pneumococcal (PPV) vaccine
70 years	Shingles vaccine



We are focussed on improving HPV vaccination rates for 12-13 year old girls and exploring re-configuring the service to provide a school based option. Discussions are underway with midwives to promote the benefits of the flu vaccine and to encourage vaccination of pregnant women.

We currently work with all partners involved in the delivery of vaccination services to ensure that uptake rates are as high as possible. Action to increase uptake includes making sure that our information systems are accurate, and that all eligible patients are offered the right to vaccinations as part of the NHS constitution patient rights. Efforts are needed to ensure that vulnerable, hardly reached groups have easy access to information and services.

Local health protection services also remain vigilant to potential outbreaks of vaccine preventable diseases.

In October 2012, in response to rising numbers of whooping cough cases and neonatal deaths, the Department of Health recommended that all pregnant women in the later stages of pregnancy should be offered whooping cough vaccine to protect their newborn babies. This is based on immunity being transferred to the unborn child while still in the womb and offers protection until the child receives its first vaccinations. This programme is intended as a temporary measure until whooping cough cases subside and the risks are reduced.



## Looking to the future

During the current period of transition for public health services, we need to ensure that robust arrangements are in place so that vaccination services continue to be delivered effectively and efficiently and that patients are not put at risk by organisational changes within the NHS. We also need to be ready to implement new vaccination programmes for eligible groups, for example flu vaccinations for healthy children will be offered in the very near future. Equally we need to remain vigilant to emerging threats such as pandemic flu and the potential spread of diseases not normally seen in the UK that may be attributed to climate change.

Public Health England, NHS England and the Department of Health have announced a national catch-up programme to increase MMR uptake in children and teenagers. Its aim is to prevent measles outbreaks by vaccinating as many unvaccinated and partially vaccinated 10-16 year olds as possible in time for the next school year. The catch-up programme sets out a national framework within which local teams – led by NHS England area teams, working alongside directors of public health in local government, supported by PHE centres – will produce tailored plans to identify and give MMR to unvaccinated and partially vaccinated 10-16 year olds through GPs and/or school programmes.

## Links

[Department of Health: Immunisations](#)

[Department of Health: The Green Book](#)

– latest information on vaccines and vaccination procedures for all the vaccine preventable infectious diseases that may occur in the UK.



# 3.16 Sustainable Development

*Sustainable practices can have a positive effect on the economy, the environment and the community. Sustainability is central to the health and prosperity of Cornwall and the Isles of Scilly.*

The natural environment is an important component of a healthy society, something that needs to be both protected and developed. There is an increasing understanding of how these resources contribute to our health, wellbeing and happiness. This means making the best use of the resources without jeopardising their availability for future generations. Public sector organisations (such as local authorities and the NHS) should lead the way in lowering carbon consumption and other pollutants with potential health implications.

## Current and future arrangements

Public Health is responsible for supporting public sector organisations to develop and adopt sustainable development management plans. Steady progress has been made with both acute and mental health sectors in Cornwall, and we now need to embrace the new commissioning organisation(s), and through the contracting process, their provider networks. The next phase involves looking beyond healthcare and formalising sustainable development management plans across other areas of the public sector.

This work is overseen by the [Health and Wellbeing Board](#), the [Cornwall and Isles of Scilly Local Nature Partnership](#) and the [Local Enterprise Partnership](#), with their shared vision for a healthier, more sustainable and prosperous future. This three-way partnership is designed to promote the 'triple bottom line' – in other words to ensure that public sector organisations operate in ways that are socially responsible, environmentally sound and economically viable.

Public Health will help commissioners to formalise and advocate organisational sustainable development management plans. It is important to ensure that all new contracts and monitoring mechanisms within the NHS incorporate the fundamentals of sustainable development; this will enable the development of resilient and resource-efficient services.



Sustainable development influences other areas of public health and, fundamentally, should underpin the development of all our services to maximise the health benefits. As Public Health moves into the local authority, we will be in a stronger position to integrate sustainable development priorities into other areas of work such as housing development, fuel poverty, transport and spatial planning.

## Where we were in 2005/6

In 2005/6, the focus within the NHS was on reducing carbon emissions. The UK's carbon emissions were rising by more than 2% per year, despite the Labour Government's 20% reduction target. The NHS had a similar target to reduce estate-related carbon dioxide emissions by 15% between 1999 and 2010.

The Department of Health predicted the following consequences of climate change by 2050: a decline in winter deaths; an increase in summer deaths; more cases of food poisoning; an increase in water-borne and vector-borne diseases; the possibility of indigenous malaria; and increased risk from gales and coastal flooding. Therefore it was clear that a broader approach was needed to increase sustainability and build resilience to these potential demands on Public Health.

## What we knew in Cornwall and the Isles of Scilly

- National NHS carbon emissions for NHS England were 21 million tonnes CO<sub>2</sub> pa, broadly relating to 59% procurement, 24% estates and 17% travel (NHS SDU)
- The distribution of Cornwall and the Isles of Scilly NHS carbon emissions seemed to be similar (we understood the impact of estates locally, but not procurement or travel)
- Active travel was already part of the local transport policy, but reliance on cars was high and public transport was underused
- Most of the food produced in Cornwall was distributed outside the county
- Alternative energy supply such as wind farms was growing
- Individual and employer action to tackle climate change was limited
- A single comprehensive strategy for the county was needed





## Developments and key achievements since 2005/6

### *National* **2006** *Cornwall*

Cornwall Food Programme was developed between 2006 and 2009 as an asset capable of providing local, healthy food within local NHS services.

Carbon Reduction Commitment (CRC) Energy Efficiency announced by Government in the Energy White Paper.

### **2007**

Review of key energy data systems resulted in a major overhaul and upgrade, something still in place and fit for purpose in 2013.

### **2008**

Natural England published [The State of the Natural Environment](#) in the South West, which identified threats to the landscape and biodiversity and ways to address those threats. Suggested responses included a network of Marine Protected Areas, green farming schemes, and the development of Green Infrastructure Networks.

The [Climate Change Act](#) was introduced to ensure the UK cuts its carbon emissions by 80% by 2050. This included a commitment for the NHS to take its share of responsibility for reducing global emissions.

The Sustainable Community Strategy for Cornwall identified strategic issues and outcomes to ensure a more sustainable future – relating to individuals, communities, culture, environment, economy, location and communication.

The Sustainable Community Strategy for the Isles of Scilly included priorities to promote healthy and inclusive communities; promote economic vitality; protect our outstanding environment; meet the local transport needs of our community.





NHS Carbon Reduction Strategy published. [Saving Carbon, Improving Health](#) highlighted key areas for action:

- Energy and carbon management
- Procurement and food
- Travel and transport
- Water
- Waste
- Designing the built environment
- Organisational and workforce development
- Partnerships and networks
- Governance
- Finance

The [NHS Forest](#) project started, with the aim of planting 1.3 million trees on NHS estates, to increase access to green space for patients, staff and communities. This project will help to promote biodiversity and physical activity in the natural environment.

[Fair Society, Healthy Lives](#)

(Marmot Review) published. Sustainable development was an area of priority under policy objective E: Create and develop healthy and sustainable places and communities. The recommendations included policies and interventions that reduce both health inequalities and climate change by:

- Improving active travel across the social gradient
- Improving the availability of good quality open and green spaces across the social gradient
- Improving the food environment in local areas across the social gradient
- Improving energy efficiency of housing across the social gradient.

Department for Environment, Food and Rural Affairs (DEFRA) published the Natural Environment White Paper, [The Natural Choice: securing the value of nature](#). This included plans to establish Local Nature Partnerships, Nature Improvement Areas and Green Infrastructure Partnerships

2009

The NHS in Cornwall and the Isles of Scilly adopted a Carbon Management Strategy and took action on these key issues:

- Learning from European partners – good practice from communities like Freiburg in Germany, including partnership working between local authority, transport, health and planning
- Appointing a new Head of Low Carbon Programme within Public Health to reinforce partnership working and promote good practice
- Carbon reduction initiatives such as:

Biomass – Cornwall NHS invested in the largest retrofit biomass boiler in any UK hospital. By sourcing local wood from sustainable sources, this is worth over £200,000 per year to the local economy.

Local food – Cornwall Food Production Unit employed 28 people and supplied 40% of the food used by Royal Cornwall Hospitals Trust using locally grown and sourced ingredients.

The NHS Forest – Falmouth Hospital took part in a national pilot, planting 120 trees at the back of the hospital site. Further development of the NHS Forest has taken place across a number of other areas of Cornwall, which to date has resulted in the planting of over 1,000 trees.

2010

Cornwall Council published 'Future Cornwall' Sustainable Community

Strategy (2010-2030) which stated the following medium term priorities for 2010-2015:

- Improve the resilience and self-sufficiency of communities
- Bring Cornwall out of the recession focussing on the low carbon economy
- Improve health through the radical redesign of health and social care services
- Minimise waste, increase local generation of sustainable and affordable energy and reduce consumption
- Achieve a balanced housing market that meets local needs.

2011

Cornwall and Isles of Scilly Health Inequalities Strategy (2011-16) highlighted the importance of sustainable development to 'create and develop healthy and sustainable places and communities'. Sustainable development is key to tackling health inequalities and climate change.

[Connecting Cornwall: 2030](#)

(Local Transport Plan) detailed plans to tackle climate change whilst developing an excellent transport system. It aims to:

- Reduce reliance on fossil fuels and support the introduction of low carbon technologies
- Support communities to live locally and reduce the need to travel
- Adapt and improve the transport network to ensure resilience to climate change.

2012

Cornwall and the Isles of Scilly Local Environmental Partnership was launched, after being chosen by the Government as one of the country's first Local Nature Partnerships.

Cornwall Council published [A Green Infrastructure Strategy for Cornwall](#) to inform the planning and delivery of a green infrastructure including: green places (parks, woodlands, informal open spaces, allotments, street trees, multi-use trails, churchyards and other publicly accessible open rural and urban spaces); blue places (rivers, waterways, canals and lakes); yellow places (beaches); postindustrial mining areas.

Key principles under the health and wellbeing theme include:

- Active travel and physical activity
- Social inclusion
- Local food production.

A Green Infrastructure Planning Tool has been developed in partnership to support this.

Research collaboration with the Sustainability, Society and Health Research Group at Plymouth University – looking at sustainable procurement and holistic ways to reduce healthcare waste.



## Monitoring and intelligence

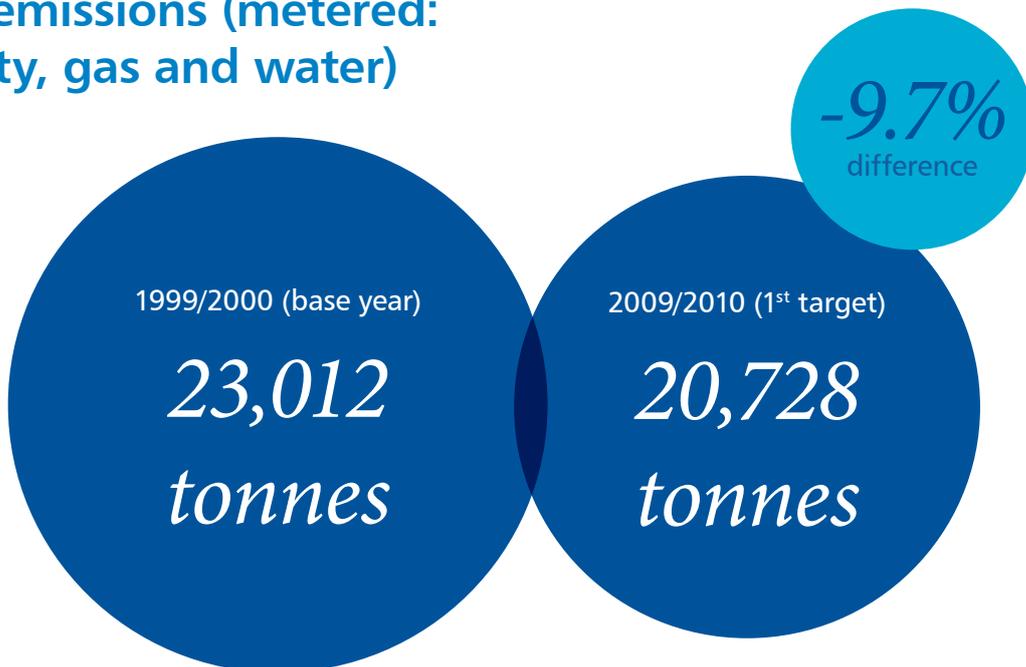
The [Public Health Outcomes Framework](#) will monitor the following outcome relating to sustainable development:

### 3.6 Public sector organisations with a board approved sustainable development management plan

This outcome requires Public Health to support and monitor public sector organisations in developing board approved sustainable development management plans. Public Health is actively working with the [NHS Sustainable Development Unit](#) to develop practical tools to help boards take on this duty effectively. This will be part of the development of new organisations such as NHS Kernow, as well as established agencies in the wider public sector.

The following table shows how Cornwall NHS has reduced its carbon emissions between 1999/2000 and 2009/10 in line with the Department of Health target (10% reduction). These figures only relate to estates energy.

## Energy/estate related carbon emissions (metered: electricity, gas and water)



## Evidence of what works

The National Institute for Health and Care Excellence (NICE) has published evidence based guidelines in which a sustainable approach is advocated:

[\*Obesity: working with local communities\*](#)

[\*Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation\*](#)

[\*Physical activity and the environment\*](#)

In 2012, the King's Fund published an evidence-based report on the environmental impacts of health and social care:

[\*Sustainable health and social care: Connecting environmental and financial performance\*](#)

## Where we are now

Green Cornwall is Cornwall Council's overarching programme to co-ordinate our efforts to reduce our carbon emissions and strengthen our wider leadership role within Cornwall. Given the current local, national and international drive to reduce impacts on the environment, the role of Green Cornwall in bringing together our combined resources to achieve this goal is crucial. The council is leading by example, providing leadership in reaching Cornwall-wide targets and the transformation to a low carbon economy.



The Cornwall and Isles of Scilly Local Nature Partnership is part of the Government's Local Nature Partnership collective. Its main aim is to help the Health and Wellbeing Board and Local Enterprise Partnership to promote sustainable development, and to achieve the 'triple bottom line' of social, environmental and economic benefits. It will help local areas to manage the natural environment for the benefit of nature, people and the economy. The partnership includes representatives from the Council of the Isles of Scilly, Cornwall Wildlife Trust, Natural England, Cornwall AONB Partnership, the Environment Agency, Cornwall Council, Cornwall and the Isles of Scilly NHS and Volunteer Cornwall. It has identified the following key objectives:

- To provide a fully integrated view of the environment across Cornwall and the Isles Scilly – drawing together expertise in landscape, biodiversity, land management, marine, cultural history, health etc.
- Bringing together existing partnerships to speak with a common voice for the environment

- Planning for the environment at a strategic level and over the long term – by identifying area-wide actions of strategic importance
- Building an understanding of how the environment can work harder for people and prosperity – resulting in a prosperous economy, social vibrancy and a high quality environment
- Retaining and enhancing the strong sense of place that defines Cornwall and the Isles of Scilly.

A sustainable development management Framework has been developed for organisations to put sustainable development into their day-to-day business. This framework is being actively promoted to public sector organisations across the county. To date Royal Cornwall Hospitals Trust and Cornwall Foundation Trust have both adopted sustainable development management plans.



Public Health is working with NHS Kernow and Peninsula Community Health to promote the use of the Sustainable Development Management Framework via the Cornwall Health Environment Committee.

Public Health also supports Cornwall Together, a community collective energy-buying group designed to bring down energy costs. Another aspect of its work is the long term ambition to help local renewable schemes to deliver wider community benefits. It also intends to support jobs in Cornwall by using schemes such as super-fast broadband to develop opportunities beyond the county border.

## Looking to the future

We will be working with the [NHS Sustainable Development Unit](#) to adapt the health products such as the Good Corporate Citizen Assessment Tool to have a greater relevance to the broader public sector.

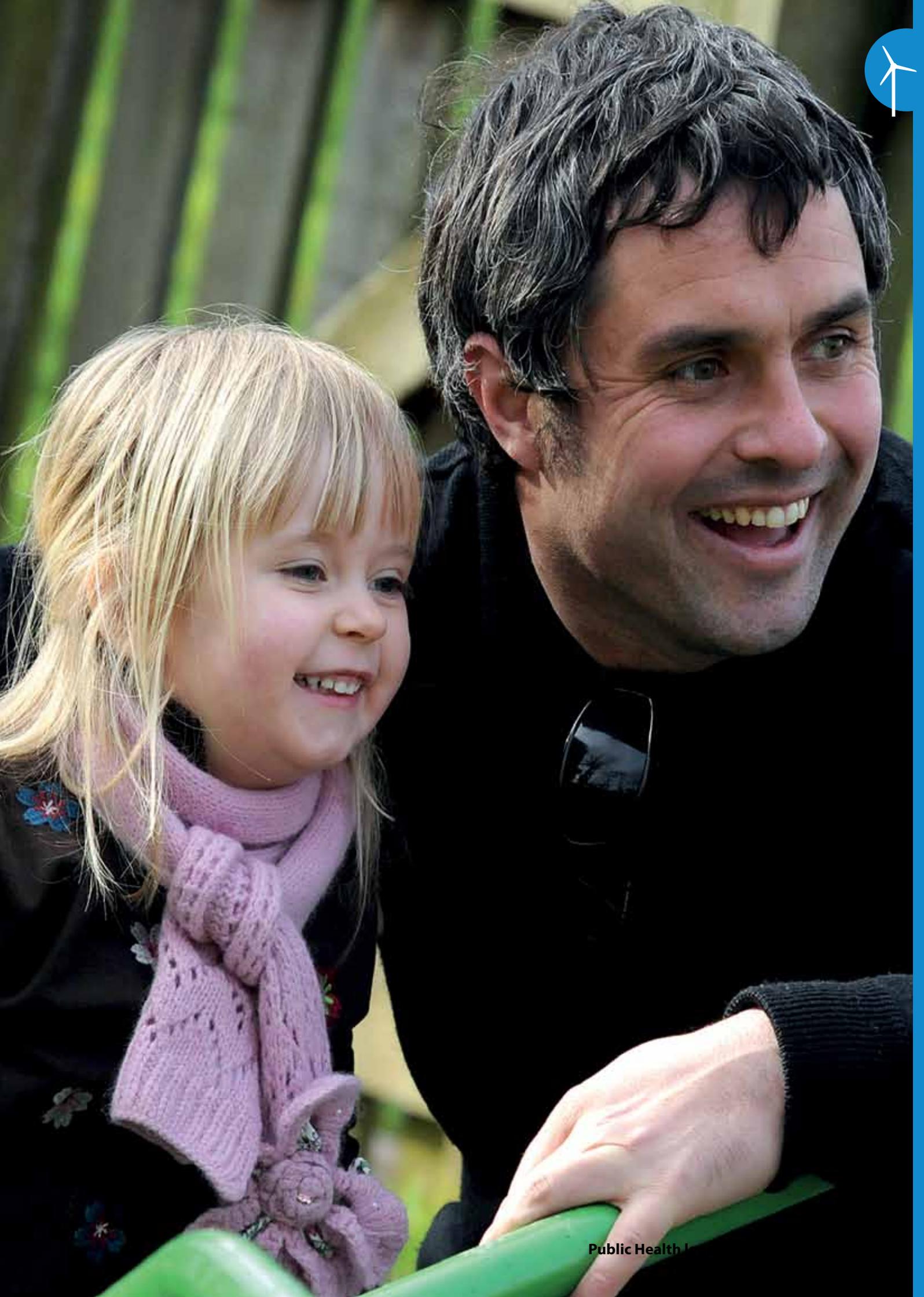


The [Cornwall Local Plan](#) will establish the context for future growth and development within Cornwall and will set the framework for all subsequent development plan documents. This plan will set out strategic land use policies to meet Cornwall's economic, environmental and social needs and aims for the future. Public Health contributes to a number of different work strands that feed into the Cornwall Local Plan, influencing programmes to achieve improvements in the health and wellbeing of our communities whilst striving to reduce inequalities that still exist in some areas of the Cornish population.

We plan to further develop the Cornwall Food Programme using the comprehensive range of assets available in Cornwall to achieve economic, environmental and health benefits. This work will be linked to the Healthy Weight programme of activities and programmes such as the Soil Association's Food 4 Life initiative. For example, we are working with Fifteen Cornwall, Cornwall Development Company and partners in the agricultural sector to develop a food education programme for primary schools – teaching children to choose, prepare, cook and trade food.

The changes being championed in Cornwall also offer great opportunities to build evidence about what approaches work best when developing a sustainable community. It is important that high-quality research, development and evaluation is a central part of the project aims. Not only can this improve the quality of our interventions but also build a reputation for Cornwall as a living laboratory for development that meets essential human, environmental and economic needs.

We know that we have a number of challenges. These include climate change (adaptation) and carbon reduction (mitigation) against an increasing demand on both natural and financial resources. As a society we will have to learn to do more with less, something that will be achieved by working smarter and in creative partnerships. For the NHS and the wider public sector, this means making better use of limited resources and adopting new ways of working, something that will positively increase organisational efficiency and resilience. For our communities, the carbon reduction agenda offers an opportunity to consider and adopt healthier lifestyles that increase active travel, and promote local and less processed foods. By integrating the objectives of the Local Enterprise Partnership, the Cornwall and Isles of Scilly Local Nature Partnership, and the Health and Wellbeing Board, there is real opportunity to operate intelligently in a manner that secures multiple outputs whilst making positive contributions to the 'triple bottom line' of social, environmental and economic benefits.





# 3.17 Responding to Incidents

*An important part of our public health system is the way that it plans for and responds to a wide range of incidents and emergencies, such as an infectious disease outbreak, road or rail accidents, acts of terrorism and the impacts of climate change.*



Major incidents can occur without warning and can have both long term and short term negative impacts on health and wellbeing. The swine flu pandemic of 2009 left many people unwell and put great pressure on public health and NHS services at both the national and local level. The flooding events in Cornwall in recent years also illustrated the need for an effective local response.

The Department of Health, Public Health and local healthcare systems must provide a seamless and co-ordinated response to the challenge of natural hazards, accidents, outbreaks and the enduring threat of worldwide terrorism. This requires a robust, integrated system that enables everyone to play their full part in protecting local communities and the nation.

## Current and future arrangements

The Health and Social Care Act 2012 strengthened arrangements for Emergency Planning, Response and Recovery (EPRR) which came into effect from April 2013. Responsibilities have been delegated to new organisations such as NHS Kernow and NHS England. Existing response plans and arrangements continue to be tested alongside those of new partner organisations.

From 1st April 2013 commissioning responsibilities for responding to incidents are as follows:



# An important part of our health system is the way that it **plans** for and **responds** to a wide range of incidents and emergencies

## Public Health from April 2013

NHS Kernow: Emergency planning and resilience remains part of the core business for the NHS.

NHS England: Mobilising the NHS in the event of an emergency.

Public Health England: Current functions of the Health Protection Agency; emergency preparedness including pandemic flu preparedness (supported by local authorities); on call rota supported by Public Health.

The Director of Public Health and Consultants in Public Health will continue to chair the Science and Technical Advice Cell (STAC).

Further details about these roles and responsibilities can be found in [Arrangements for health emergency preparedness, resilience and response](#) (DH 2012).

A key feature of the new arrangements is the formation of Local Health Resilience Partnerships (LHRPs) and a resource pack has been produced to support this. LHRPs will provide strategic forums for joint planning for emergencies for the new health system. Our forum is the Devon, Cornwall and Isles of Scilly Local Resilience Forum (LRF). These forums are not statutory organisations and accountability for emergency preparedness and response remains with individual organisations.

## Where we were in 2005/6

At that time, the main focus for the PCT was to ensure that the core duties under the recently invoked Civil Contingencies Act were being met, and the standards outlined in NHS Emergency Planning Guidance 2005 were being implemented. Pandemic flu was identified as a significant threat due to the cyclical nature of its occurrence, which meant we were expecting the emergence of a new strain of flu at any time. In reality it was not until 2009 that a new strain emerged. Concerns were also raised about the more deadly avian flu virus being detected in the Far East.

Research conducted on behalf of the Department of Health predicted that, by 2050, climate change would lead to greater risk of major natural disasters caused by gales and flooding in the UK. Having experienced recent events such as the flooding at Boscastle in 2004, it was important to prepare for more future events.

## What we knew in Cornwall and the Isles of Scilly:

- Cornwall and the Isles of Scilly are susceptible to increases in sea level and natural disasters caused by extremes of weather
- Susceptible to flash floods like at Boscastle
- Nuclear facilities at Devonport Dockyard
- Flight path for migrating birds with potential for avian flu cases
- Coastal pollution risks from shipping incidents
- Susceptible to foot and mouth outbreaks
- Vulnerable to fuel disruption.





## Developments and key achievements since 2005/6



The July 2007 terrorist attacks in London and Glasgow were a grim reminder of the increased threat to the UK and the importance of having local strategies and procedures in place.

Government published guidance on [Provision of scientific and technical advice in the strategic co-ordination centre: guidance to local responders](#). Guidance to local responders on the establishment of a Science and Technical Advice Cell (STAC) in the event of an emergency where there is likely to be a requirement for co-ordinated scientific or technical advice.

Strategic Command Arrangements for the NHS During a Major Incident.

Annual publication of [Heatwave Plan](#) intended to raise public and professional awareness on how to prepare in case of severe hot weather and potential heatwaves (most recent update February 2013).

*National*  
**2006**  
*Cornwall*

**2007**

Mass fatalities and mass casualties planning activities increased. Local Resilience Forum (LRF) level plans developed. LRF STAC plan developed and staff trained.

**2008**

Refresh of local heatwave plans in place.

Pandemic flu plans signed off.



Swine flu pandemic in the UK – the local and national responses to this are described in the immunisations section of this report.

The [Health and Social Care Act 2012](#) states that local authorities have a duty to assess, plan and advise communities during an emergency. It outlines local authority functions in relation to planning for and responding to emergencies that present a risk to public health. It also sets out the roles and responsibilities of NHS England, Clinical Commissioning Groups and providers of NHS funded services in relation to assuring NHS emergency preparedness and response.

Department of Health published [Arrangements for health emergency preparedness, resilience and response](#), which takes effect from April 2013.

The Highways Agency [Make Time For Winter](#) campaign encourages people to check their vehicles are ready and equipped for winter conditions and to check the weather forecast before embarking on a journey.

## 2009

Containment phase implemented, national algorithms for swabbing and treating patients operationalised. Antiviral treatments delivered in response to school outbreaks. Antiviral collection points established across the county. Mass vaccination programmes implemented.

## 2010

Cornwall Council Emergency Management Service published guidance on developing a **community emergency plan**.

Severe winter weather led to various incidents around the county, which emergency responders worked in partnership to deal with.

## 2011

Cornwall Council published its own [Emergency Management and Business Continuity Plan](#). The plan provides the council with a framework of functional teams, together with their responsibilities, in order to respond to, manage and recover from a civil emergency which affects the county and/or the council's most important public services.

## 2012

Cornwall Council published the Strategic Overview to the Emergency Management and Business Continuity Plan.



## Monitoring and intelligence

The [Public Health Outcomes Framework](#) will monitor the following outcome:

### 3.7 Comprehensive, agreed inter-agency plans for responding to public health incidents

This indicator has not yet been clearly developed or defined.

Local responses to major incidents are captured in debrief reports compiled after every event. This includes the response to and recovery from the incident and captures what went well and where further improvements can be made. Debrief reports are often available for public scrutiny and can be found on websites such as the [Local Resilience Forum \(LRF\)](#).

Incidents that the PCT has been involved in include:

- Penhallow Hotel Fire August 2007
- Coastal Flooding March 2008
- Pandemic flu 2009
- Lean Quarry Fire June 2010
- Flooding and severe weather November 2010
- Athena fishing vessel fire November 2010
- Flooding November 2012.

We also track progress by reviewing the community risk register which identifies our planning and preparation, and reducing the potential impacts of threats and hazards. Providers of NHS funded care will also in the future be performance measured against nationally set assurance frameworks.

## Evidence of what works

There is no public health guidance from the National Institute for Health and Care Excellence (NICE) on responding to incidents and emergencies.

The core principles of emergency planning are based on integrated emergency planning, which is in effect a reflective cycle of risk assessment, planning, training and responding to incidents. Incidents are followed by debriefs to capture

learning and best practice, which is built into the cycle of planning and training for similar types of incidents that may arise in the future.

## Where we are now

National EPRR guidance is being used locally to ensure that the new systems are designed to be both effective and responsive to local population threats and hazards. At the same time, health organisations remain ready to respond to incidents whenever and wherever they occur.

Recent investments into EPRR include funding from the Strategic Health Authority for Incident Control Centres which aimed to bring all Primary Care Trust incident rooms to a core specification. There was also funding nationally for satellite phones to strengthen telecommunications resilience. Acute trusts have benefited from investments in decontamination equipment. Investment in training has also been delivered including core professional standards such as the Diploma in Health Emergency Planning (DipHep).

## Looking to the future

Local systems will need to be tested and exercised to ensure that the NHS and partner agencies such as Public Health England and local authorities can continue to respond in an effective and co-ordinated manner. New working groups will begin to shape the future direction of EPRR for the local population.

### *Links*

*[Government: Terrorism and national emergencies](#)*

*[Intergovernmental Panel on Climate Change: Managing the risks of extreme events and disasters to advance climate change adaptation](#)*

*health organisations remain ready to respond to incidents whenever and wherever they occur*

