RUTLAND HEALTH PROTECTION ANNUAL REPORT

January 2023 – December 2023

PURPOSE OF REPORT

1. The purpose of this report is to provide a summary of the assurance functions of the Leicester, Leicestershire and Rutland (LLR) Health Protection Assurance Board. It also updates the Health and Wellbeing Board on health protection performance, key incidents and risks and other significant matters.

LINK TO THE LOCAL HEALTH AND CARE SYSTEM

2. Health protection assurance is a statutory duty of the local authority, via the Director of Public Health. It is therefore a key element of the Joint Health and Wellbeing Strategy and of Leicestershire County Council's (LCC's) core business. It is an essential element in local health and social care strategies and initiatives including Better Care Together/Sustainability Transformation Plan and to urgent care work streams.

3. Links to LCC strategic plan:

    - Safe & Well: Ensuring people are safe and well protected from harm, by working with partners.
    - Improved opportunities.

RECOMMENDATIONS

4. It is recommended that:

    a. The Health Protection Annual Report 2023 be noted.

    b. That in noting the report, The Health and Wellbeing Board recognise the specific health protection issues that have arisen locally, and the steps taken to deal with them, and the particular areas of focus for the coming year.

POLICY FRAMEWORK AND PREVIOUS DECISIONS

5. On 1st April 2013 implementation of the new NHS and Social Care Act (2012) resulted in most of former NHS Public Health responsibilities being transferred to upper tier and unitary local authorities (LAs) including the statutory responsibilities of the Director of Public Health. Each local authority is now required, via its Director of Public Health to assure itself that relevant organisations have appropriate plans in place to protect the health of the population and that all necessary action is being taken.

6. Integrated Care Boards (ICBs) were legally established on 1 July 2022, replacing clinical commissioning groups (CCGs), taking on the NHS planning functions and absorbing some planning roles from NHS England. The former Public Health England organisation

was abolished in 2022 and a new organisation, the United Kingdom Health Security Agency (UKHSA), established.

7. The key strands of health protection activity are:

   i. Outbreaks and communicable disease (including COVID-19).
   ii. Screening Programmes.
   iii. Immunisation Programmes.
   iv. Healthcare associated infections.
   v. Preparedness and response to incidents and emergencies.

8. The Local Authority does not commission the majority of services which contribute to protecting the health of the population, but the Director of Public Health should be assured that arrangements are robust and that they are implemented in a way which meets the needs of the population for which they are responsible.

9. This is a local leadership function which requires the Director of Public Health and wider public health team to identify issues and advise appropriately; and to work in close liaison and cooperation with other contributing organisations. Responding to the Director of Public Health's information and advice is the responsibility of these other contributing organisations, who will also be accountable should unheeded advice result in any adverse impact.

10. It is considered beneficial for the Health and Wellbeing Board to understand the assurance functions of the Leicestershire, Leicester and Rutland (LLR) Health Protection Assurance Board and an overview of the health protection performance, key incidents and risks and other significant matters which have arisen during 2023.

BACKGROUND

11. The Leicester, Leicestershire, and Rutland (LLR) Health Protection Board reports into each of the three Health and Wellbeing Boards for Leicester, Leicestershire and Rutland and enables local authorities to discharge their health protection assurance responsibilities.

12. Dashboards, reports and/or updates are received and reviewed at the quarterly Board. They cover the key domains identified above. This data is reviewed by the group and if needed, stakeholders are asked to produce more detailed assurance for the group on an exception basis. The LLR Health Protection Board is linked into a number of other Health Protection groups across the local system.

KEY DOMAINS OF HEALTH PROTECTION ASSURANCE

Prevention And Control of Infectious Diseases

<u>Organisational Roles/Responsibilities</u>

13. UK Health Security Agency (UKHSA), formerly Public Health England (PHE) is an executive agency made up of both national specialist teams and regional health protection teams. UKHSA have established programmes to reduce the impact of common infectious diseases through detecting, analysing, responding, delivering, and engaging

with the wider health system. UKHSA lead on 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.

14. NHS England is responsible for ensuring that their contracted providers are mobilised to deliver an appropriate clinical response to outbreaks/incidents. This responsibility devolves down to local Integrated Care Boards (ICB) to use contractual arrangements with provider organisations to make relevant resources available (including screening/diagnostic and treatment services).

15. The Local Authority, through the Director of Public Health, has overall responsibility for the strategic oversight of an incident/outbreaks, and to gain assurance that the local health protection system is robust enough to respond appropriately.

COVID-19

16. The first confirmed case of COVID-19 in Rutland was recorded in March 2020. The first national lockdown was announced in March 2020, with schools reopening and certain restrictions easing in June 2020. The Director of Public Health produced a Local COVID-19 Outbreak Control and Prevention Plan to build upon existing health protection plans and response mechanisms put into place to contain any outbreaks. The plan prioritised preventing the spread of COVID-19 and associated disease, early identification and pro-active management of local outbreaks, coordination of capabilities across agencies and stakeholders and assuring the public that this was effectively delivered.
    A second national lockdown was announced in November 2020, a month before the rollout of the largest vaccination campaign in NHS history. A third national lockdown was introduced in January 2021.

17. A summary of COVID-19 cases recorded during the period of increased surveillance from February 2020 until October 2022 is given in Appendix 1. COVID-19 vaccination remains a vital tool in reducing the risk of ill health as a result of COVID-19 infection, particularly in those at higher risk of worse outcomes from infection owing to age, existing illness, or other vulnerability. A spring booster programme will begin in April 2024 for a smaller cohort than the previous winter booster programme.

Measles

18. England saw a resurgence of measles in 2023, with 368 cases confirmed across the Country, 44% of which (160 cases) were in the neighbouring West Midlands, and 8 cases recorded in the East Midlands. The majority of cases were identified from October 2023.

19. Having identified a downward trend in MMR (measles, mumps and rubella) vaccination uptake in June 2023, a local measles elimination group was established in LLR as a pro-active measure. NHS England released their vaccination strategy in December 2023 highlighting similar concerns of a decline in MMR vaccine uptake. Pro-active and preventative measures continue to be implemented in Rutland.

Diphtheria

20. In 2022, an outbreak of diphtheria nationally was reported among migrants arriving in small boats to England. 13 confirmed cases of diphtheria were identified in arrivals to Kent in 2023 with no onward transmission to the wider population linked to this group.

21. UKHSA revised national diphtheria guidelines to update advice on the management of suspected cases. Population based control measures have been in place since mid-November 2022, with mass antibiotic prophylaxis and vaccination recommended within 10 days of arrival for those who have transited through an initial reception centre.

22. An LLR Integrated Care System (ICS) led control centre was established in November 2022 involving a multi-agency group. Vaccination was delivered locally via a mobile vaccination unit. Local communications were developed and shared with primary care.

Immunisation and Screening

Organisational Roles/Responsibilities

23. Integrated Care Boards (ICBs) became legally and operationally established on 1 July 2022. For Section 7A NHS public health functions (Screening (cancer and non-cancer), Immunisations including COVID-19 and Influenza (flu), and Child Health Information Systems) commissioning responsibility currently remains with NHS England. Over the course of 2022/23, national and regional NHS England teams supported progress towards joint working. Formal joint working across ICBs and regional teams continues whilst we await assessment of readiness and final approval for delegation by ministers. Delegation is expected to be completed by April 2025

24. UKHSA is responsible for setting immunisation policy through expert groups (the National Screening Committee and Joint Committee on Vaccination and Immunisation). UKHSA will continue to support the NHS through provision of authoritative clinical guidance and coordinated procurement and supply of vaccines.

25. 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. This includes providing public health information and advice to relevant bodies within the local area, and collaborative activity to maximise vaccination uptake and coverage. Directors of Public Health and teams provide independent scrutiny of the arrangements of NHS England, UKHSA and providers of immunisation services.

Immunisation

26. The complete routine immunisation schedule is published annually by UKHSA and is available here. Counts for Rutland are combined with Leicestershire as the data is collated by the Primary Care Trust (PCT).

27. Coverage of childhood immunisations continues to be relatively high in Rutland, exceeding performance for all childhood immunisations compared to the England average. Good coverage helps ensure that the local population is protected and does not become susceptible to outbreaks of vaccine preventable diseases.

28. The COVID-19 pandemic led to the introduction of physical distancing measures across England, including school closures and advising against non-essential travel. The Joint Committee on Vaccination and Immunisation (JCVI) advised the childhood immunisation programme to continue according to the national schedule throughout the lockdown. Data has shown a national decrease in children receiving routine childhood immunisations since 2019. Leicestershire and Rutland have followed this national trend of reduced coverage, nonetheless, it still remains above the national average.

Human Papillomavirus (HPV)

29. From 1 September 2023, the HPV vaccine programme changed from a 2 dose to a single dose vaccine schedule for eligible adolescents and men who have sex with men (MSM) aged under 25 years, as advised by JCVI. Uptake rates in Rutland are given in the Appendix.

30. A significant decline in HPV vaccine uptake was observed in the 2020/21 academic year due to the impact of COVID-19 lockdowns. The service prioritised flu vaccine delivery over the winter term, and a national lockdown limited delivery of the HPV programme. Year 8 students who missed their 1st dose were offered a catch up at the start of 2021/22.

Seasonal Flu

31. Population flu vaccination coverage was updated for the 2022-23 season, and as with other vaccinations, counts have been combined with Leicestershire. Uptake has improved since the COVID-19 pandemic. In 2019, vaccination coverage in the population aged 65 and over was 74.1%. For the same cohort, this increased to 81.2% for the 2022-23 season, , compared to the England average of 79.9%, and greater than The World Health Organization (WHO) recommendation of 75% coverage.

32. The flu vaccination programme continued to be a priority during the 2022/23 programme, with a return to pre-pandemic cohorts eligible for a free vaccination. Multi-agency arrangements were established across Leicestershire and Rutland to manage the delivery of the seasonal vaccination programmes including both COVID-19 and Influenza. Flu uptake rates for 2022-23 are given in the Appendix.

Key Issues for 2024 (Immunisation)

- Increase uptake of MMR vaccine in line with national strategy.
- Maintaining uptake of influenza vaccine, particularly in at-risk groups including care home residents.
- Increase uptake of HPV amongst boys & girls, to reverse the downward trend in coverage.
- A new LLR immunisation board to be set up from April 2024.
- Delegation of commissioning responsibilities from NHS England to the ICB by April 2025.

Screening

33. The strategic framework of the Major Conditions Strategy focuses on primary prevention, secondary prevention, early diagnosis, prompt and urgent care, and long-term treatment and care. Screening plays a vital role in each of these. The purpose of screening is to detect conditions in the healthy population who have an increased likelihood of developing disease.

34. The framework can be found here: https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2

35. The Health Protection Team monitor and support service providers for the following screening programmes: bowel cancer, cervical and breast. Data is shared in the Appendix. Overall, cervical and breast screening programmes nationally have experienced a downward trend. Locally, Rutland has seen a downward trend in these screening areas, however, a similar or better than England average performance continues. Bowel cancer screening coverage and uptake rates have increased both locally and nationally

Key Issues for 2024 (Screening)

- Changes to the bowel screening eligibility.
- Continue to strengthen multi- agency regional and local plans to target areas of poor uptake and coverage for each of the screening programmes.
- Work with the ICB and Primary Care Networks to improve areas of performance to meet national targets.

Sexual Health

36. Table 1 in Appendix 5 summarises diagnostic and detection rates for the main sexually transmitted infections in Rutland.

37. The integrated sexual health services (ISHS) detect, prevent and treat sexually transmitted infections (STI) in the local population. The service has comprehensive arrangements for STI testing and a variety of testing options for HIV.

38. The ISHS contract covering Rutland covers the period 1 January 2019 to 31 March 2024. From April 2024 the ISHS service provision, is being commissioned as an independent service. Rutland maintains the current agreement for one year to 31 March 2025 with the longer-term service provision to be procured in 2024.

39. The emphasis remains on self-managed care whilst preserving the quality of testing, results notification, and partner notification. The main site of delivery for Rutland services will be delivered from the satellite clinic and Rutland Memorial Hospital, supported by the Loughborough Hub.

40. There is also a separate online service due to commence 1 April 2024. The online service offers a range of testing options for STI and treatment for chlamydia. Online service access has increased since the COVID-19 pandemic and this service will enable those in our most rural areas to access services.

41. A sexual Health Needs Assessment (HNA) for Leicestershire and Rutland was completed in 2023 with several recommendations made around STIs.

Chlamydia Screening

42. It is recommended that work is carried out to better understand the poorer performance on chlamydia screening rates in Rutland, in the age groups 15 to 24 years old, and that appropriate action is taken to bring about improvements. This should be an area of focus for the next commissioning round for sexual health services. In Rutland in 2022, the proportion of 15- to 24-year-old screened for chlamydia, was significantly worse than the England average and on a downward trend.

Key Issues for 2024 (Sexual Health)

- Monitor the STI testing rate (excluding chlamydia aged under 25 years old) per 100,000 (all ages).
- Monitor gonorrhoea diagnostic rates due to recent increasing rates. Whilst an increase in rates can be positive if resulting from increased testing activity, this needs to be monitored locally to better understand the causes. The increase in rates in the latest year mirrors national trends and exceeds pre-pandemic rates and rates since 2012. Rutland still performs significantly better than England on the gonorrhoea diagnostic rate per 100,000 and there is no statistically significant change in trend over the last five years.

- Encourage early diagnosis in heterosexual and bisexual women in particular.

Tuberculosis (TB)

43. Prevalence of TB in Rutland remains lower than the England average, as well as the East Midlands rate.

44. The 2020-22 dataset is missing from the data source.

Key issues for 2024 Tuberculosis (TB)

- Improve BCG and TB screening and vaccination eligibility criteria awareness particularly for those with parents and or grandparents from a non-UK country of origin with a high incidence prevalence.
- Engaging with non-UK born arrivals at an early stage to encourage engagement on TB screening initiatives and uptake of BCG vaccination and screening in line with national recommendations. LLR TB Community Engagement will focus on this.

Health Care Associated Infections

45. Many healthcare associated infections (HCAI) are preventable. When they do occur, they can have a significant impact on patients and on the wider NHS and care systems.

46. LLR ICS is breaching all alert organism trajectories with Clostridiodes difficle (C. diff) at a significantly high number. This has been escalated with providers, and mitigating actions are detailed below along with ongoing routine monitoring, reporting and interventional processes. With the establishment of the ICB, annual trajectories now include community and indeterminate associated cases.

<u>Organisational Roles/Responsibilities</u>

47. The NHS Outcomes Framework (NHS OF) is a set of indicators developed by the Department of Health and Social Care to provide a framework in which to measure and monitor how well the NHS is performing. NHS England hold local ICBs to account for performance against indicators under this domain.

48. UKHSA, through its consultants in communicable disease control, will lead the epidemiological investigation and the specialist health protection response to HCAI outbreaks and has responsibility to declare a health protection incident.

49. The Local Authority through the Director of Public Health has overall responsibility for the strategic oversight of a HCAI impacting on their population's health. See Appendix 7 for information Healthcare Associated Infections Incidence in LLR for January- December 2023.

50. LLR Trusts continue to investigate HCAI alert organism cases, conducting Post Infection Reviews and Root Cause Analyses (RCAs) when required, cascading learning outcomes to relevant teams. Public Health Infection Prevention and Control (IPC) colleagues conduct reviews of C. diff cases within care homes, where necessary. If learning outcomes involve General Practice, the ICB IPC team support communication and escalate actions where necessary.

51. The ICB IPC team continue to provide operational support for General Practice, including assistance with community bacteraemia RCAs where necessary. Alert Organism guidance is advised and relevant shared learning from community RCAs discussed at ICB IPC Question and Answer (Q&A) sessions and forums for GP IPC Leads and Link Practitioners.

52. System IPC Leads continue to monitor respective bacteraemia cases and convene review meetings to discuss LLR bacteraemias, including source origins, possible interventions, and mitigations for improvement. This has included focus on antimicrobial prescribing practice (including avoidance of broad-spectrum antibiotic use except where necessary), operational groups to review monthly C. diff data and develop reduction action plans.

Meticillin-resistant Staphylococcus aureus (MRSA)

53. NHS Improvement has continued to set healthcare providers the challenge of demonstrating a 'zero' tolerance of MRSA blood stream infections (BSI), however, in March 2018 NHS Improvement announced a change in how MRSA BSI cases were to be reviewed. From April 2018 University Hospitals of Leicester (UHL) and LLR ICB were exempt from completing a formal post infection review as this was now only for organisations with the highest rates of infection.

Meticillin susceptible Staphylococcus aureus (MSSA)

54. Mandatory reporting of all Meticillin Sensitive Staphylococcus Aureus (MSSA) has been a requirement for provider organisations since January 2011. However, to date national trajectories to reduce these cases have not been set. Locally, the ICB continue to hold providers to account for the number of reported MSSA cases.

C.Diff Infection

55. NHS providers are required to input information to the UKHSA data capture system relating to information prior to admission to hospital. This information is intended to allow the categorisation of non-hospital onset cases based upon the timing of prior admissions to the reporting Trust. Locally, the ICBs continue to hold providers to account where, following a review of individual cases, a lapse in care was identified that may have contributed to the person acquiring a C. diff infection. During 2023-2024 both UHL and the ICB breached their nationally set trajectories.

56. The ICB IPC team have facilitated C. diff education sessions with the UHL C. diff Nurse Specialist at both Primary Care Webinars and IPC Lead/Link Practitioner Forums. There

are plans for collaborative working with the ICB IPC team and other stakeholders on community C. diff strategies.

Escherichia Coli (E. Coli) Bacteraemia

57. E.coli bacteraemia rates, chiefly community acquired, were static or increasing during the year and are a focus for ongoing IPC work. Efforts continue to engage the whole local health and social care economy continue to assess the overall approach to reducing E.coli blood stream infections.

Key Issues for 2024 HCAI

- For the year 2023/2024, the LLR ICS has a combined national trajectory of 204 C. diff cases (incorporating all 3 ICB Sub Sectors). This trajectory includes all healthcare, community, and indeterminate associated cases. Currently LLR ICS has an actual total of 266 C. diff cases (April 2023 to January 2024).
- The ICB IPC team and Local Authority Public Health IPC teams are in the process of sharing education resources, to expand IPC learning access for both General Practice and care home staff (including sessions on C. diff and Carbapenem Resistant Organisms).
- A new ICS IPC Community of Practice has been convened with relevant stakeholders and is in the process of identifying current system issues and developing/ co-ordinating relevant strategies.

Emergency Planning and Response (including severe weather and environmental hazards)

<u>Organisational Roles/Responsibilities</u>

58. Emergency planning has been a Local Authority function since before the Health and Social Care Act (2012), however with Public Health in the Authority there are additional opportunities to consider around the health protection aspects of this function.

59. The local authority continues to engage with the Local Resilience Forum in undertaking their annual exercise programme, responding to incidents, and undertaking learning as required.

60. The Local Health Resilience Partnership (LHRP) is co-chaired by LLR ICB and Local Authority Public Health. The LHRP provides a strategic forum for local healthcare organisations to facilitate preparedness and planning for health emergencies at a suitable system and Local Resilience Forum (LRF) level. The LHRP also supports NHS England, local Government and UKHSA, to ensure member organisations develop and maintain effective health planning arrangements for major emergencies and major incidents.

Key Issues for 2024 (Emergency Planning)

- Ensure partners are clear on the response structure to major incidents, the causes of delays in action and on the coordination of groups.
- Ensure that there is an on-going approach to learning from experience and that issues identified from real events are acted upon.
- Continue to review contingency plans as appropriate according to national and local guidance and ensure further testing response arrangements.

- Changes in average temperatures as well as an increased likelihood of extreme weather events, including prolonged hot periods, as well as heavier downpours.

Air Quality

61. Poor air quality is the largest environmental risk to the public's health, leading to significant levels of morbidity and premature mortality. Research in 2023 estimated that 48,625[1] adults die prematurely each year in the UK due to particulate matter pollution. The health risk is disproportionate in certain groups within the population, such as children and young people and older adults, and those that are pregnant or have long term health conditions. [1] https://www.ucl.ac.uk/news/2023/oct/uk-air-pollution-regulations-will-reduce-deaths-do-little-protect-ecosystems

62. The Pollution Control Team developed an Air Quality Annual Status Report (ASR). Rutland County Council does not currently have any declared Air Quality Management Areas (AQMAs). A local air quality strategy is being developed to prevent and reduce polluting activities.

63. Relationships have also been developed with LLR Air Quality Forum and a Public Health representative to link this research to the work of the Air Quality Partnership.

64. The LLR Respiratory Working Group, chaired by the ICB plays a key role in linking air quality monitoring data, health data and clinical colleagues and processes together (alongside housing).

Key Issues for 2024 (Air Quality)

- Continue to consult and monitor planning applications that may have a significant impact on air quality in Rutland.
- To provide local support and relevant information to encourage potential sustainable behavioural change and increased understanding of air quality in Rutland.

CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

65. Overall, the Rutland Director of Public Health is assured that the correct processes and systems are in place to protect the health of the population. Areas to continue to focus further progress on include:

    - Ensuring local health and care systems have the capacity to respond to major incidents (national issue), including emergency planning and response.

    - Maintaining and improving progress on key health protection indicators particularly relating to:

        - Communicable disease.
        - Screening.
        - Immunisation.
        - Hospital Acquired Infections.

BACKGROUND PAPERS

- Rutland Joint Health and Wellbeing Strategy 2022-2027: **https://www.rutland.gov.uk/sites/default/files/2023-10/Health%20and%20Wellbeing%20Strategy%202022-2027_0.pdf**

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APPENDICES

- Appendix 1 – COVID-19 Surveillance Report
- Appendix 2 - Childhood immunisations uptake
- Appendix 3 - Seasonal flu vaccine uptake
- Appendix 4 - Screening uptake
- Appendix 5 - Rutland Sexual Health Indicators
- Appendix 6 - TB
- Appendix 7 - Healthcare Associated Infections Incidence

CONSULTATION

There is no requirement for consultation in relation to this report.

RELEVANT IMPACT ASSESSMENTS

The JSNAs give due regard to the equality and human rights of different population groups, with particular focus within the JSNAs. Sources of inequalities and recommendations are designed to alleviate issues created through identified inequalities.

EQUALITY AND HUMAN RIGHTS IMPLICATIONS

There are no equality implications arising from this report. The report would seek to have a positive impact overall and would not have an adverse effect on any section of the community.

Certain socially excluded groups are at greater risk of environmental hazards e.g., poor air quality in areas of socio-economic deprivation. Some groups are at increased risk of particular infectious diseases e.g., TB in some migrants and asylum seekers. Certain groups

and individuals are also less likely to avail of the protection afforded by immunisation and screening e.g., in areas of socio-economic deprivation.

There are no human rights implications arising from this report.

COMMUNITY SAFETY IMPLICATIONS
This report has no community safety implications.

ENVIRONMENTAL IMPLICATIONS
No environmental implications

PARTNERSHIP WORKING AND ASSOCIATED ISSUES
Partnership working across health, local authorities, police, fire, districts etc remains essential to ensure robust health protection and emergency planning arrangements are in place.

FINANCIAL IMPLICATIONS
Most Health Protection actions and interventions are the financial responsibility of partners outside of Rutland County Council. This report has no implications for finance.

DATA PROTECTION IMPLICATIONS
A Data Protection Impact Assessments (DPIA) has not been completed as data presented is not patient identifiable.

APPENDIX 1: COVID-19 Surveillance Report

Weekly COVID-19 Surveillance Report in Leicestershire

Leicestershire County Council

Cumulative data from 27/02/2020 - 29/10/2022

Breakdown of testing by Pillars of the UK Government's COVID-19 testing programme:

Pillar 1 + 2
combined data from both Pillar 1 and Pillar 2 of the UK Government's COVID-19 testing programme

Pillar 1
data from swab testing in PHE labs and NHS hospitals for those with a clinical need, and health and care workers

Pillar 2
data from swab testing for the wider population, as set out in government guidance

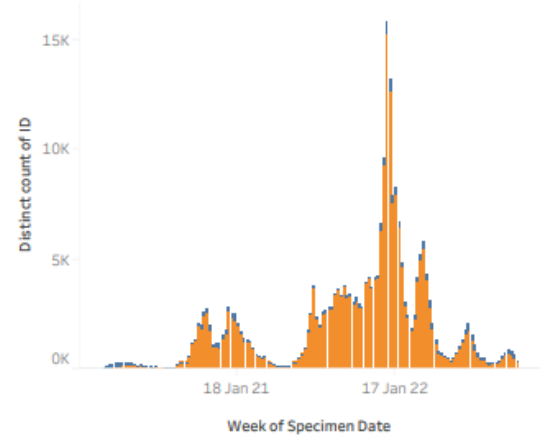
COVID-19 cases | Cumulative data from 27/02/2020 - 29/10/2022

254,660 cases | 16,009 Pillar 1 cases | 238,651 Pillar 2 cases

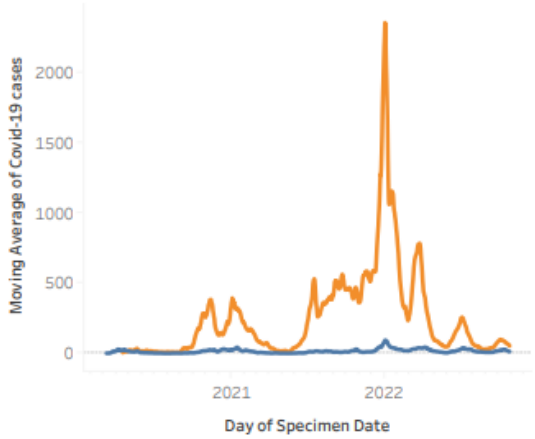
COVID-19 cases | Monthly data from 02/10/2022 - 29/10/2022

2,820 cases | 611 Pillar 1 cases | 2,209 Pillar 2 cases

Cases per week



Moving average of cases per day



APPENDIX 2: Childhood immunisations uptake

Quarterly Childhood Immunisations by Local Authority (Rutland)

Cohort	Indicator	Lower threshold[1]	Standard[2]	Key	Geography	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2023/24 Q1	2023/24 Q2	2023/24 Q3
12 months	12m Denominator	N/A	N/A	N/A	Rutland	113	94	73	96	96	103	80	73	74	87	90	78	117	84	87	81	73	82	62	72	80	76	82	79	81	75	93	70	72	70	73
					England	#####	#####	#####	#####	#####	#####	#####	#####		#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	151,101	#####
	12m DTaP/IPV/Hib % [4]	90	95	< 90 90 - 95 ≥ 95	Rutland	96.5	96.8	97.3	96.9	93.8	94.2	93.8	97.3	94.6	90.8	97.8	97.4	95.7	95.2	90.8	97.5	95.9	93.9	96.8	94.4	97.5	98.7	96.3	97.5	96.3	96.0	95.7	95.7	88.9	95.7	98.6
					England	93.0	92.9	93.4	93.0	93.0	93.2	93.1	92.6		91.6	92.1	91.9	92.0	92.1	92.8	92.7	92.8	92.1	91.5	91.6	91.5	91.3	92.0	91.9	92.0	92.1	91.9	91.6	91.5	91.3	91.3
	12m PCV1 %	90	95	< 90 90 - 95 ≥ 95	Rutland																	100.0	98.8	98.4	98.6	97.5	100.0	98.8	98.7	96.3	97.3	97.8	97.1	91.7	95.7	100.0
					England																			96.3	93.4	93.7	93.3	94.1	94.1	94.0	94.1	94.0	93.6	93.6	93.4	93.5
	12m PCV2 %	90	95	< 90 90 - 95 ≥ 95	Rutland	97.3	96.8	97.3	89.6	94.8	94.2	95.0	95.9	95.9	83.7	97.8	97.4	95.7	95.2	92.0	97.5	97.3	93.9	90.3												
					England	95.2	94.7	93.6	84.7	93.3	93.5	93.5	92.8		92.1	92.8	92.5	92.6	92.8	93.3	93.3	93.3	92.4	90.6													
	12m Rota %	90	95	< 90 90 - 95 ≥ 95	Rutland	95.6	94.7	98.6	94.8	92.7	93.2	87.5	90.4	95.9	88.5	94.4	96.2	92.3	94.0	90.8	97.5	94.5	93.9	87.1	87.5	93.8	92.1	98.8	97.5	95.1	94.7	94.6	92.9	86.1	94.3	98.6
					England	93.1	89.3	90.1	90.1	90.2	89.9	90.6	90.3		89.1	90.0	90.1	90.0	89.6	90.5	90.7	91.0	90.4	89.9	90.0	90.2	89.2	90.4	90.5	89.3	89.0	89.3	89.0	88.7	88.2	88.9
	12m MenB %	90	95	< 90 90 - 95 ≥ 95	Rutland	93.8	95.7	94.5	94.8	93.8	94.2	93.8	94.5	95.9	89.7	97.8	97.4	94.9	95.2	92.0	97.5	95.9	93.9	96.8	97.2	97.5	98.7	96.3	97.5	96.3	97.3	94.6	95.7	88.9	95.7	100.0
					England	89.5	91.6	92.2	92.6	92.2	92.7	93.0	92.5		91.9	92.3	92.0	92.2	92.3	92.9	92.8	93.0	92.5	91.9	91.8	91.7	91.5	92.0	92.0	91.8	91.9	91.6	91.2	91.2	91.0	91.2
24 months	24m Denominator	N/A	N/A	N/A	Rutland	91	79	102	81	112	99	71	88	96	97	85	75	113	93	90	81	85	78	91	88	78	91	72	78	85	80	82	83	80	69	92
					England	#####	#####	#####	#####	#####	#####	#####	#####		#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####
	24m DTaP/IPV/Hib/HepB3	90	95	< 90 90 - 95 ≥ 95	Rutland	98.9	97.5	94.1	98.8	99.1	93.9	98.6	97.7	96.9	96.9	95.3	94.7	95.6	87.1	96.7	97.5	98.8	96.2	96.7	97.7	96.2	98.9	97.2	97.4	96.5	97.5	98.8	97.6	97.5	95.7	92.4
					England	95.1	94.9	95.3	95.1	95.2	95.3	95.2	95.0		94.4	94.2	94.0	94.2	93.5	93.8	93.7	93.9	93.9	94.2	94.0	93.8	93.4	93.0	93.0	92.9	92.9	93.0	93.0	92.8	92.9	92.8
	24m PCV Booster %	90	95	< 90 90 - 95 ≥ 95	Rutland	93.4	96.2	91.2	95.1	96.4	88.9	94.4	95.5	95.8	95.9	95.3	94.7	91.2	89.2	95.6	93.8	97.6	96.2	96.7	97.7	96.2	98.9	95.8	97.4	91.8	97.5	92.7	97.6	92.5	94.2	92.4
					England	91.4	91.4	91.5	91.3	91.0	91.3	91.3	91.2		90.0	90.1	90.1	90.3	90.0	90.4	90.7	91.0	90.6	90.3	89.1	88.9	88.3	88.3	89.1	89.3	89.4	88.5	89.3	89.0	88.8	88.2
	24m Hib/MenC %	90	95	< 90 90 - 95 ≥ 95	Rutland	93.4	96.2	91.2	95.1	98.2	89.9	94.4	95.5	95.8	95.9	95.3	94.7	91.2	90.3	95.6	93.8	97.6	96.2	95.6	96.6	96.2	98.9	94.4	97.4	91.8	97.5	92.7	97.6	93.8	94.2	90.2
					England	91.5	91.2	91.6	91.3	91.2	91.4	91.3	91.2		90.2	90.3	90.3	90.5	90.2	90.5	90.9	91.0	90.8	90.3	89.2	89.2	89.0	89.1	89.7	89.6	89.5	88.9	89.2	89.5	89.2	88.7
	24m MMR1 %	90	90	< 90 90 - 90 ≥ 90	Rutland	94.5	96.2	91.2	93.8	95.5	88.9	94.4	94.3	95.8	95.9	94.1	93.3	88.5	89.2	94.4	93.8	97.6	94.9	95.6	95.5	96.2	98.9	93.1	96.2	92.9	97.5	92.7	97.6	93.8	94.2	91.3
					England	91.4	91.2	91.6	91.2	91.0	91.1	91.1	90.8		89.9	90.0	90.0	90.3	90.1	90.4	90.8	91.0	90.7	90.3	89.3	89.0	88.6	88.9	89.7	89.7	89.7	89.0	89.5	89.5	89.4	88.6
	24m MenB booster %	90	90	< 90 90 - 90 ≥ 90	Rutland							90.1	89.8	92.7	92.8	91.8	92.0	90.3	87.1	94.4	93.8	97.6	94.9	95.6	95.5	96.2	98.9	91.7	96.2	91.8	97.5	93.9	96.4	92.5	92.8	88.0
					England							87.4	87.9		87.7	88.4	88.4	88.8	88.6	89.0	89.3	89.5	89.5	89.3	88.5	88.5	88.1	88.1	88.6	88.5	88.6	87.8	88.4	88.1	88.0	87.3
5 years	5y Denominator	N/A	N/A	N/A	Rutland	100	106	95	98	99	102	84	108	108	88	107	86	128	93	116	83	119	100	78	87	103	129	91	86	108	103	113	96	91	81	94
					England	#####	#####	#####	#####	#####	#####	#####	#####		#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####
	5y DTaP/IPV/Hib/HepB3 %	90	90	< 90 90 - 90 ≥ 90	Rutland	97.0	96.2	98.9	98.0	99.0	97.1	98.8	100.0	98.1	98.9	92.5	96.5	99.2	98.9	94.0	98.8	99.2	99.0	100.0	100.0	98.1	98.4	95.6	98.8	98.1	100.0	95.6	99.0	95.6	95.1	96.8
					England	96.0	95.7	95.8	95.6	96.0	96.0	95.8	95.7		95.5	95.3	95.3	95.4	95.2	95.4	95.5	95.6	95.6	95.3	95.3	95.1	94.6	94.6	94.5	94.0	93.5	93.5	93.3	93.1	92.8	93.0
	5y MMR1 %	90	90	< 90 90 - 90 ≥ 90	Rutland	96.0	96.2	100.0	98.0	98.0	96.1	98.8	98.1	97.2	96.6	95.3	96.5	98.4	95.7	94.0	95.2	97.5	97.0	100.0	100.0	97.1	96.9	94.5	96.5	96.3	97.1	97.3	96.9	96.7	96.3	97.9
					England	95.0	95.0	95.2	95.1	95.6	95.3	95.1	95.1		94.7	94.6	94.7	94.7	94.5	94.6	94.6	94.7	94.4	94.3	94.3	94.1	93.7	93.5	93.5	92.9	92.9	92.9	92.7	92.5	92.3	92.3
	5y MMR2 %	90	90	< 90 90 - 90 ≥ 90	Rutland	90.0	88.7	85.3	93.9	87.9	89.2	94.0	91.7	92.6	93.2	87.9	91.9	95.3	93.5	94.0	88.0	90.8	97.0	100.0	98.9	97.1	92.2	93.4	95.3	92.6	91.3	93.8	86.5	91.2	90.1	92.6
					England	87.5	87.3	87.8	87.4	87.6	87.5	87.3	87.2		86.4	86.6	86.7	86.7	86.3	86.9	86.9	86.9	86.7	86.7	86.4	86.3	85.5	85.5	85.9	84.4	84.7	85.2	85.0	83.9	83.8	84.3
	5y DTaP/IPV %	90	90	< 90 90 - 90 ≥ 90	Rutland	86.0	87.7	89.5	91.8	87.9	85.3	91.7	91.7	91.7	95.5	87.9	90.7	89.8	88.2	85.3	88.0	89.9	96.0	96.2	96.6	93.2	93.0	91.2	95.3	98.1	95.1	86.7	84.4	95.6	95.1	92.6
					England	85.9	85.9	86.5	86.3	86.2	86.6	85.9	85.5		85.0	85.3	85.1	85.3	84.9	85.5	85.7	85.6	85.4	85.4	85.1	84.8	84.0	84.2	84.6	83.0	83.4	84.0	84.0	82.8	82.7	83.2
	5y Hib/MenC %	90	90	< 90 90 - 90 ≥ 90	Rutland	94.0	90.6	94.7	96.9	93.9	94.1	98.8	93.5	93.5	96.6	86.9	96.5	96.9	94.6	91.4	91.6	94.1	94.0	97.4	98.9	97.1	93.8	91.2	94.2	96.3	97.1	95.6	92.7	94.5	96.3	97.9
					England	92.6	92.9	92.7	92.8	93.0	93.1	92.8	92.7		92.7	92.6	92.7	92.6	92.6	92.8	92.8	92.9	92.7	92.6	92.5	92.6	92.0	92.0	92.0	91.3	91.2	91.0	90.7	90.5	90.2	90.0

Source: COVER, UKHSA

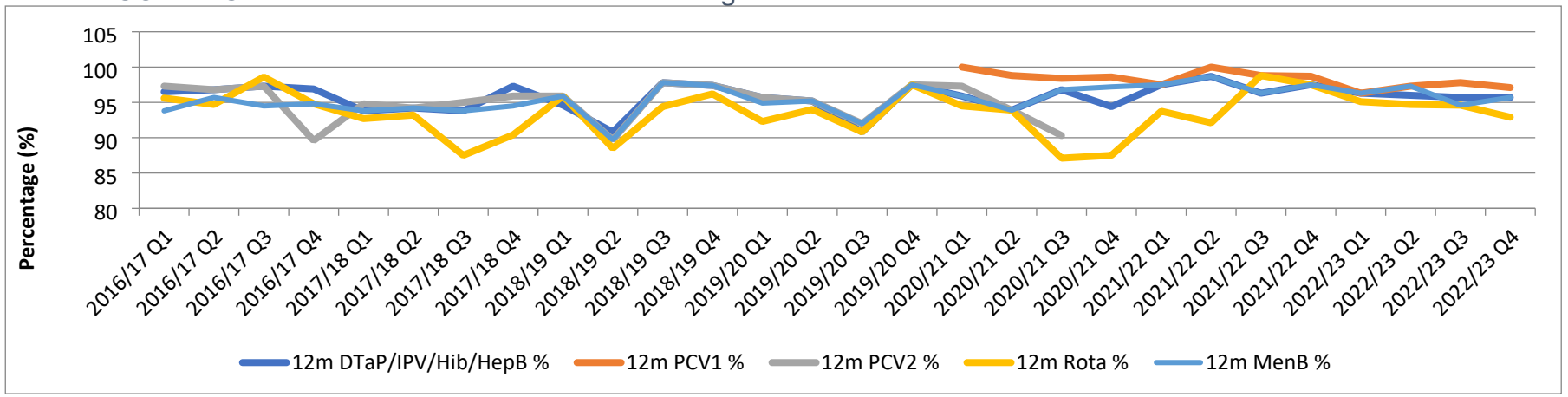
[1] Lower threshold based on the latest Public Health Functions Agreement

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

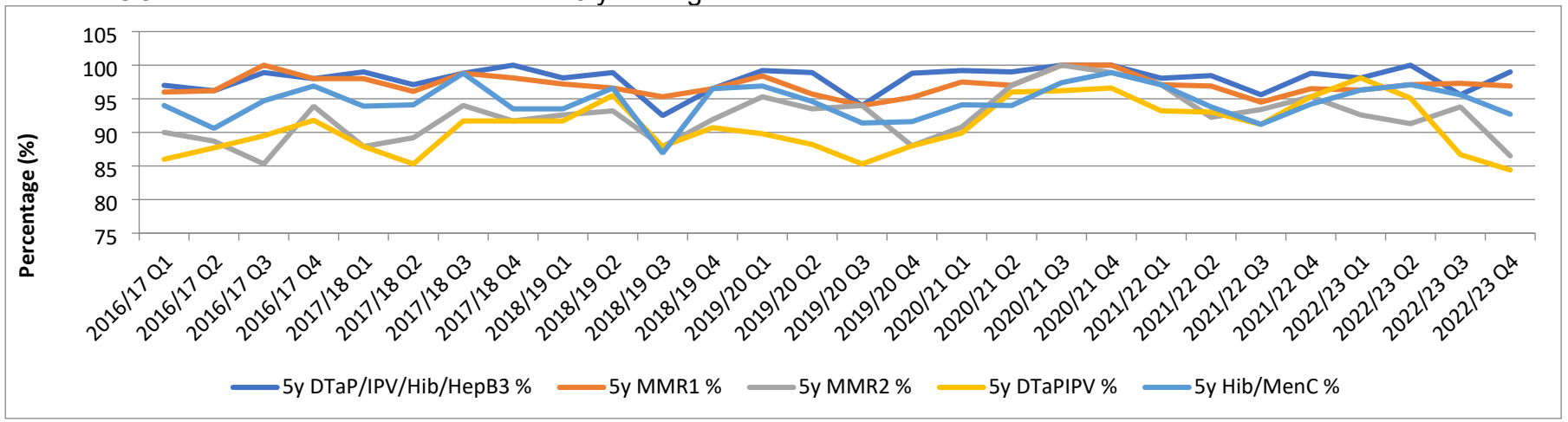
[3] COVER did not report England data for Q1 2018/19. The migration of GP data to the NE London CHIS hub has affected coverage estimates for many of the LAs reported by this hub. As a consequence, London-level coverage figures are under-estimated this quarter. Due to the impact London data has on national figures, England estimates have not been calculated for this report.

[4] 12 Month DTaP/IPV/Hib includes HepB from Q2 2018/19

Trend in COVER Childhood Immunisations for 12-month age cohort in Rutland



Trend in COVER childhood immunisations for 5 years age cohort in Rutland



Annual Other Immunisations - Rutland

Indicator	Lower threshold[1]	Standard[2]	Key	Geography	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Female)	80	90	< 80 | 80 - 90 | ≥ 90	Rutland				93.9	94.7	86.6	88.8	90.5	90.9	83.2	61.2	81.7	
				England				91.1	89.4	87.0	87.2	86.9	88.0	59.2	76.7	69.6	
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Male)	80	90	< 80 | 80 - 90 | ≥ 90	Rutland										78.8	62.5	81.7	
				England										54.4	71.0	62.4	
D04f - Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 year old) (Female)	80	90	< 80 | 80 - 90 | ≥ 90	Rutland						85.2	75.8	68.0	90.1	87.0	88.7	66.5	
				England						85.1	83.1	83.8	83.9	64.7	60.6	67.3	
D04f - Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 year old) (Male)	80	90	< 80 | 80 - 90 | ≥ 90	Rutland											89.7	69.5	
				England											54.4	62.4	
D04g - Population vaccination coverage: Meningococcal ACWY conjugate vaccine (MenACWY) (14 to 15 years)	80	90	< 80 | 80 - 90 | ≥ 90	Rutland							79.5	95.3	94.7	89.6	87.5	91.6	
				England							82.5	84.6	86.7	87.0	80.9	79.6	
D06b - Population vaccination coverage: PPV	65	75	< 65 | 65 - 75 | ≥ 75	Rutland				71.2	71.4	70.8	71.1	71.5	71.1	70.2	68.0		
				England	70.5	68.3	69.1	68.9	69.8	70.1	69.8	69.5	69.2	69.0	70.6		
D06a - Population vaccination coverage: Flu (aged 65 and over)	N/A	N/A	NA	Rutland												88.8	
				England	72.8	74.0	73.4	73.2	72.7	71.0	70.5	72.9	72.0	72.4	80.9	82.3	79.9
D05 - Population vaccination coverage: Flu (at risk individuals)	N/A	N/A	NA	Rutland												64.0	
				England	50.4	51.6	51.3	52.3	50.3	45.1	48.6	49.7	48.0	44.9	53.0	52.9	49.1
D03I - Population vaccination coverage: Flu (2 to 3 years old)	N/A	N/A	NA	Rutland												60.5	
				England					39.9	36.6	40.2	44.0	44.9	43.8	56.7	50.1	43.7
D04d - Population vaccination coverage: Flu (primary school aged children)[3]	N/A	N/A	NA	Rutland													
				England										60.4	62.5	57.4	56.3
D06c - Population vaccination coverage: Shingles vaccination coverage (71 years)[4]	50	60	< 50 | 50 - 60 | ≥ 60	Rutland									35.9	31.4	19.6	32.2	
				England									49.1	48.2	42.1	44.0	

Source: Public Health Outcomes Framework

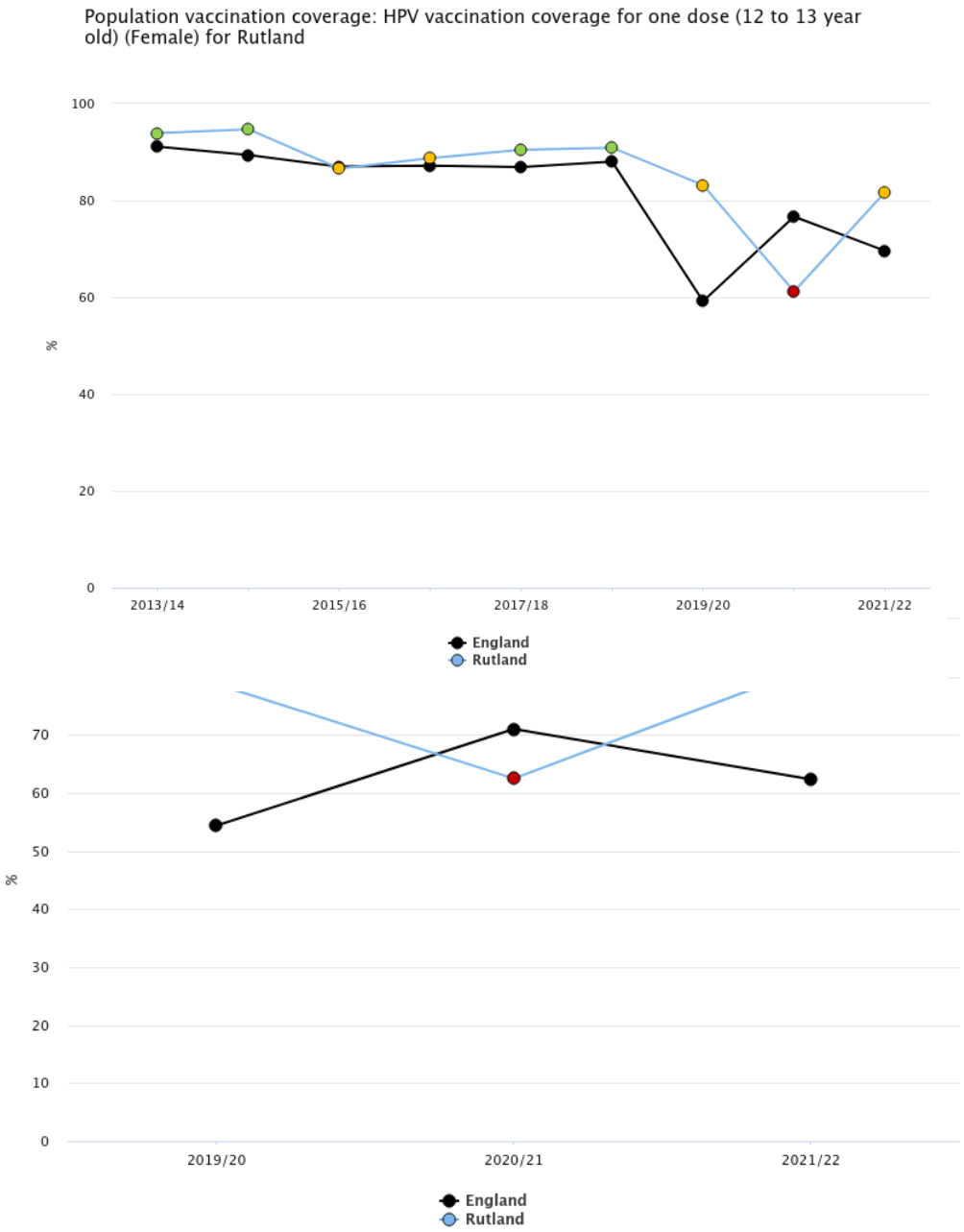
[1] Lower threshold based on the latest Public Health Functions Agreement

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

[3] Calendar year data for D04d is mapped to the closest financial year e.g. 2019 -> 2019/20

[4] In 2018/19 the Shingles vaccination coverage was expanded to 71 years old

HPV


Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Female) for Rutland
100
80
60
40
20
0
%
2013/14
2015/16
2017/18
2019/20
2021/22
England
Rutland
70
60
50
40
30
20
10
0
%
2019/20
2020/21
2021/22
England
Rutland

APPENDIX 3: Seasonal Flu vaccine uptake

Uptake for Leicestershire & Rutland (2022 & 2023) and England (2022).

Local Authority	65 and over (%)	Under 65 (at risk)	All pregnant women	All 2 year olds %	All 3 year olds %
Leicestershire and Rutland (2023)	81.2	44.0	39.8	49.2	49.5
Leicestershire and Rutland (2022)	83.6	53.2	40.8	45.9	50.2
England (2022)*	79.9	49.1	35.0	42.3	45.1
Target	75	55	55	48	48

*England data for 2023 has not yet been published
Source: Immform

APPENDIX 4: Screening uptake

Cancer Screening by Local Authority (Rutland)

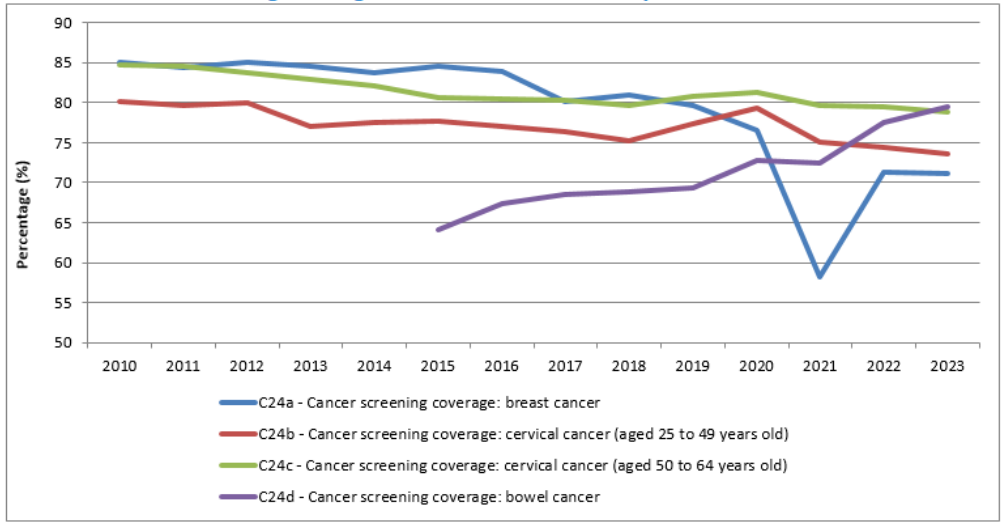
Indicator	Lower threshold[1]	Standard[2]	Key			Geography	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
C24a - Cancer screening coverage: breast cancer	70	80	< 70	70 - 80	≥ 80	Rutland	85.0	84.4	85.1	84.5	83.7	84.5	84.0	80.1	81.0	79.6	76.6	58.2	71.4	71.2
						England	76.9	77.1	76.9	76.3	75.9	75.4	75.5	75.4	74.9	74.5	74.1	64.1	65.2	66.2
C24b - Cancer screening coverage: cervical cancer (aged 25 to 49 years old)	80	N/A	< 80	≥ 80		Rutland	80.1	79.6	80.0	77.0	77.6	77.8	77.0	76.4	75.2	77.3	79.3	75.0	74.4	73.6
						England	74.1	73.7	73.4	71.5	71.8	71.2	70.2	69.6	69.1	69.8	70.2	68.0	67.6	65.8
C24c - Cancer screening coverage: cervical cancer (aged 50 to 64 years old)	80	N/A	< 80	≥ 80		Rutland	84.7	84.6	83.7	83.0	82.1	80.6	80.5	80.3	79.6	80.8	81.4	79.6	79.5	78.8
						England	78.7	80.1	79.9	79.5	79.4	78.4	78.0	77.2	76.2	76.2	76.1	74.7	74.6	74.4
C24d - Cancer screening coverage: bowel cancer	55	60	< 55	55 - 60	≥ 60	Rutland						64.1	67.4	68.6	68.8	69.4	72.9	72.5	77.5	79.5
						England						57.3	58.4	59.2	59.5	60.5	64.3	66.1	70.3	72.0

Source: Public Health Outcomes Framework

[1] Lower threshold based on the latest Public Health Functions Agreement

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

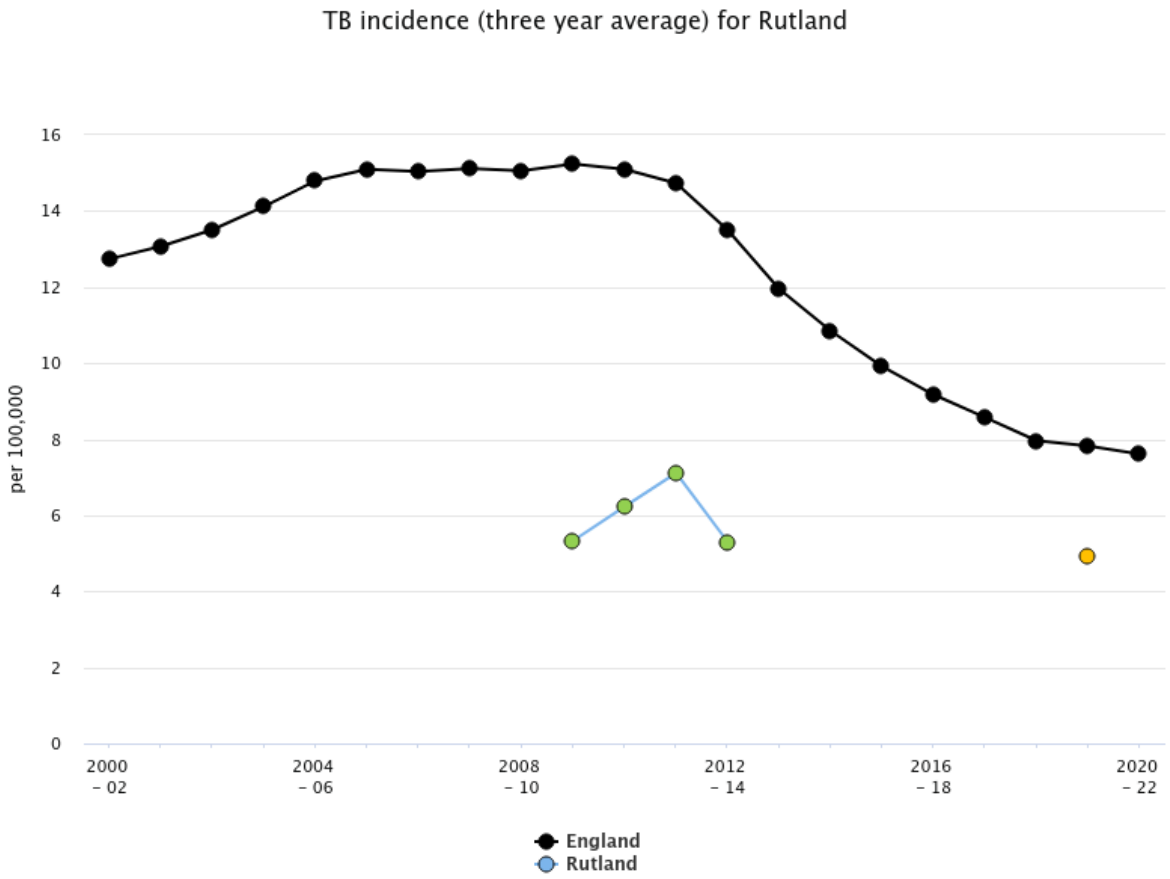
Trend in Cancer Screening coverage in Rutland Local Authority



APPENDIX 5: Rutland Sexual Health Indicators

	Indicator	Time period	Recent Trend	Benchmark	Value	England Value	CIPFA Neighbours Avg.
Sexual Health Indicators Rutland	Syphilis diagnostic rate per 100,000	2022	➡		12.1	15.4	6.2
	Gonorrhoea diagnostic rate per 100,000	2022	➡		58	146	61
	Chlamydia detection rate per 100,000 aged 15-24	2022	➡		1,520	1,680	n/a
	Chlamydia detection rate per 100,00- females 15-24	2022	➡	<2,400 2,400 to 3,250 ≥3,250	2,452	2,110	n/a
	Chlamydia proportion in females 15-24 screened	2022	New data		19.1%	21.2%	17.0%
	All new STI diagnoses per 100,000	2022	➡		465	694	400
	New STI diagnoses (excluding chlamydia under 25) per 100,000	2022	➡		246	496	n/a
	HIV testing coverage	2022	⬇		57.2%	48.2%	n/a
	New HIV diagnosis rate per 100,000	2022	➡		4.8	6.7	n/a
	HIV late diagnosis	2020-2022	-	<25% 25% to 50% ≥50%	100%	43.3%	n/a
	HIV diagnosed prevalence rate per 1,000 aged 15-59		➡	<2 2 to 5 ≥5	0.99	2.34	1.18

APPENDIX 6: TB



Source: Fingertips

APPENDIX 7: Healthcare Associated Infections Incidence

LLR HCAIs April 2023 - January 2024

	April 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	YTD
CDI ELR	5	9	4	6	3	7	6	4	5	4			53
CDI LC	9	5	6	4	2	4	4	1	3	3			41
CDI WL	5	9	9	7	10	3	4	3	5	6			61
CDI UHL	17	19	17	15	14	14	14	7	10	12			139
E. coli ELR	7	6	3	5	5	5	6	4	2	2			45
E. coli LC	4	9	6	7	3	4	4	8	8	9			62
E. coli WL	4	8	4	4	6	6	6	8	7	5			58
Hospital onset E. coli UHL	0	0	0	0	0	0	0	0	0	0			0
Community onset MRSA BSA LC	0	0	1	0	0	0	0	0	0	0			1
Community onset MRSA BSA ELR	1	1	0	0	1	0	0	0	0	0			3
Community onset MRSA BSA LW	0	0	0	0	0	0	0	0	0	0			0