Health Protection Assurance Report

Rotherham Metropolitan Borough Council

July 2026

Report authored by:
Denise Littlewood (Health Protection Principal)
Alex Hawley (Consultant in Public Heath)

With contributions from members of the Health Protection Committee.

1 Introduction

1.1 This report provides a summary of the assurance functions of the Rotherham Metropolitan Borough Council Health Protection Committee and reviews performance for the Health and Wellbeing Board.

1.2 Health Protection is multi-agency. It is not just a local authority responsibility. Therefore, the Health Protection Committee is attended by colleagues across Rotherham Place.

1.3 The scale of work undertaken to prevent and manage threats to health is driven by national, regional and local guidance, intelligence and health risks. There are activities undertaken proactively and reactively to protect health and prevent ill health. This report will cover the following areas:

- Infectious disease management
- National programmes for screening
- National programmes for vaccination and immunization
- Healthcare associated infections, including a spotlight on TB
- Infection prevention and control
- Health emergency preparedness and response.
- Environmental health and trading standards

2 Assurance Arrangements

2.1 Local authorities, through their Director of Public Health, have an assurance role to ensure that appropriate arrangements are in place to protect the health of their populations. The Director of Public Health has a role in working with the UKHSA and the NHS to ensure arrangements are in place for health protection.

2.2 The Health Protection Committee is mandated by the Health and Wellbeing Board to provide assurance that adequate arrangements are in place for prevention, surveillance, planning, and response to communicable disease and environmental hazards.

2.3 Summary terms of reference for the Committee are listed at Appendix 1.

2.4 A summary of organisational roles in relation to delivery, surveillance and assurance is included at Appendix 2.

3 Infectious Disease Management

Surveillance Arrangements

3.1 UKHSA provides a quarterly report to the Health Protection Committee containing epidemiological information on cases and outbreaks of communicable diseases of public health importance at local authority level.

3.2 Surveillance arrangements cover all relevant pathogens and hazards, including notifiable diseases.

3.3 Fortnightly bulletins are produced by UKHSA throughout the winter months, providing surveillance information on influenza and influenza-like illness and infectious intestinal diseases, including norovirus.

3.4 A Health Protection Dashboard is in use locally, which supports surveillance and assists the Health Protection Committee in reviewing available data.

Infectious Diseases

3.5 During 2025/26 the Rotherham Council Public Health, Health Protection function provided a specialist response to infectious disease and hazard related situations across Rotherham. Situations responded to have included:

- The continued investigation of an outbreak of Legionella in a Social Housing Complex
- Outbreaks in early years, schools and residential care settings (ADD TOTAL)
- Complex Tuberculosis case support
- Infection Prevention and Control support for Care Homes and Learning Disability settings

4 Screening Programme

4.1 The national screening programmes are actively offered to the residents of Rotherham through their life course, including Antenatal and newborn screening, Cervical Screening, Breast cancer screening, Abdominal Aortic Aneurysm, Bowel cancer screening and Diabetic eye screening. National screening programmes are based on recommendations from the UK National Screening Committee (UKNSC) and are commissioned by NHS England, with assurance on performance and delivery via the Rotherham Health Protection Committee.

Screening programmes

4.2 An update to the report presented in 2025 is given below for each of the screening programmes. The Rotherham plans and work throughout 2025/26 reflect both the national and Yorkshire and Humber priorities and programme changes.

4.3 Key areas of work/priorities include but are not limited to:

- Increasing uptake within Breast cancer, Bowel cancer and Cervical screening programmes. Continue local collaborative work with programme providers and partners to improve uptake of screening for individuals with a learning difficulty/disability, through Digital flagging work and extending this work to include patients with a known severe mental illness (SMI).
- Within the diabetic eye screening programme (DESP) the focus has been to implement Optical Coherence Tomography (OCT), improve uptake and reduce the number of persistent non-attenders.
- Within Bowel screening, in accordance with national guidance, a priority is to implement the lowering of the Faecal Immunochemical Test (FIT) threshold from 120ug/gm to 80ug/gm (FIT@80) in line with the UKNSC recommendation.
- Within the NHS Cervical Screening Programme, the focus remains on identifying reasons individuals are not attending screening and ensure appropriate access.

Abdominal Aortic Aneurysm - South Yorkshire & Bassetlaw Programme

4.4 An Abdominal Aortic Aneurysm (AAA) is a swelling in the aorta, the main artery in the abdomen, which can cause serious health consequences and death.

4.5 The aim of the AAA screening programme is:

- To reduce AAA-related mortality by detecting aneurysms at an early stage
- Ensure appropriate surveillance and referral to vascular services if required and improve outcomes/health for those with a detected AAA
- Men with referrable aneurysms (≥5.5cm diameter) are referred to either Sheffield Vascular Services or Doncaster Vascular Services. The AAA screening provider works closely with both services to ensure timely assessment and intervention.

4.6 The programme has performed well during 2025/26, with uptake to date above the minimum/acceptable standard of 75% and just below the achievable standard of 85%, though data collection will not be complete until after the end of May 2026, as programme standards are cohort year plus 2 months (to allow catch up of men due at the end of the screening year).

4.7 The screening provider has completed a Health Equity Assessment, which has been used to direct improvement work and reduce inequalities. This includes:

- Work to reduce non-attendance at 1st appointment, particularly across Lower Super Output Areas, resulting in improved uptake in those areas.
- Invitation letters insert, signposting to interpreted information where English is not the first/spoken language.
- Improved provision for individuals with a Learning Disability, through lists being provided by GPs – allowing for reasonable adjustments to be put in place.
- Transwomen invited for screening following referral by GP.
- Screening for individuals who are housebound.
- Expansion of health promotion sessions in community group venues
- Partnership working underway with Bowel Screening programme to co-promote both screening programmes across South Yorkshire.

Ante-natal and Newborn

4.8 Antenatal and newborn (ANNB) screening covers tests conducted in pregnancy for infectious diseases, inherited/genetic conditions - Down's syndrome, Edward's syndrome and Patau's syndrome, and other physical abnormalities, and in newborn babies including newborn hearing, blood spot screening and physical examination. Screening is supported by The Rotherham NHS Foundation Trust, and the SY pathology network (via Sheffield Teaching Hospital and Sheffield Children's Hospital).

4.9 All key performance indicators (KPIs) are being met with no areas of concern to highlight. The maternity provider continues to make effort to achieve the 'standard of ≤ 2% for avoidable repeats samples through staff training, improved methods of sample collection and transportation to the laboratory, and joint working with the laboratory. Nonetheless, the avoidable repeat standard performance fluctuates between quarters locally and nationally.

Diabetic Eye Screening

4.10 The Diabetic Eye Screening Programme (DESP) covers all individuals aged 12 years and over with a diagnosis of diabetes and pregnant women diagnosed with diabetes during pregnancy. The aim being to identify, refer and where appropriate treat sight-threatening disease, occurring as a result of their diabetes, as early as possible. The screening programme is delivered by Barnsley NHS Foundation Trust, with Rotherham residents generally attending the Diabetes Centre, based at Rotherham Hospital.

4.11 Programme delivery, performance and oversight is via monthly meetings between NHS England Public Health Programmes Team and the provider. The provider has experienced significant workforce challenges, mainly because of sickness and

absence, which have been mostly resolved in Q4 of 25/26, allowing more sustained delivery. Room availability and lack of community venues within Rotherham have impacted on service delivery and access but the provider does not feel this has impacted on uptake; the Trust are working with the provider to resolve these issues. The programme (across Barnsley and Rotherham) has a high level of persistent non-attenders, when compared to other programmes nationally, and when assessed against the pathway standards. These are generally in the most deprived areas of both localities and among working age populations. The provider has developed a business case to support recruitment to an engagement officer post to support this work. The provider has undertaken a service redesign and recruitment to support.

4.12 The implementation of Optical Coherence Tomography (OCT) for patients in digital surveillance, which was planned full roll out by October 2025 was delayed due to IT infrastructure, including server requirements to support image storage at Barnsley Hospital and IT connectivity at Rotherham Hospital., Thes issues have now been fully resolved and OCT clinics are now being held within the Diabetes Centre at Rotherham Hospital.

Cervical Screening

Cervical screening is a test to check the health of the cervix and is offered to people with a cervix aged between 25 to 64 years every three or five years depending on age.

4.13 There are three main components of the cervical programme. These include the cervical sample (often referred as the 'smear'), testing/analysis in the laboratory and, if required, assessment/treatment via Colposcopy, delivered by Rotherham NHS Foundation Trust. Whilst cervical screening is mostly undertaken in primary care (GP practice), it may also be accessed via Integrated Sexual Health Services on request, via extended access/hours clinics, providing screening during evenings and on weekends, and via GP referral to Colposcopy Unit for individuals with complex needs where the sample cannot be obtained in primary care. As of 1st April 2025, trans men and non-binary people with a cervix can now opt-in to receive routine automatic invitation and attend screening.

4.14 Uptake continues to be lower in the 25–49-year-old cohort, compared with the 50–64-year-old cohort (also reflected nationally), with coverage in both age groups for Q3 2024/25 below the 80% standard. Work continues with practices and partners to try and improve uptake. Practice level data can be accessed via Cervical Screening: Quarterly Coverage Data Rotherham

4.15 Self-Testing: NHSE nationally continues to plan for the introduction of HPV self-testing during 2026. Self-testing will be offered to individuals who have never attended, or are significantly overdue in attending for their cervical screening. Details of the programme will be communicated to eligible individuals and stakeholders in due course.

4.16 Inequalities: For individuals with a diagnosis of learning disabilities, a code is assigned to their GP record so that when they are due for cervical screening, support from the community learning disabilities team can be provided where required and reasonable adjustments made to accommodate their needs, thereby encouraging their attendance at screening. Practices are requested to share reasonable adjustments information (following consent) with TRFT Colposcopy unit should further tests/appointments be required. Work has also commenced to explore how access can be improved for individuals with physical disability, this will be a focus for 2026/27.

4.17 In September 2025, the NHS commenced the process of sending normal results from the NHS Cervical Screening programme digitally, via the NHS app as a notification. This has now been expanded to include all cervical screening communication – invitations, reminders and all results. This provides quicker and more convenient access to information. For those where digital communication is not possible or read, a letter is posted as back up.

Bowel Screening South Yorkshire and Bassetlaw Hub

Bowel cancer screening is a test carried out at home to detect blood, which could be a sign of bowel cancer. It is offered to everyone aged 50 to 74 years.

Bowel cancer screening for the population of Rotherham is coordinated by the Regional Bowel Screening Hub (in Gateshead) and South Yorkshire Bowel Screening Centre (led by Sheffield Teaching Hospital NHS Foundation Trust).

Individuals receive a bowel screening kit via the post. Following analysis, if there is a need for further assessment, the Bowel screening centre contacts the patient and coordinates referral to the respective endoscopy unit. Whilst most patients will attend The Rotherham NHS Foundation Trust Hospital, they are able to access any of the hospitals within South Yorkshire.

4.18 The programme continues to perform well as of 25/26, with uptake above the upper (achievable) standard of 60%. The currently available data for 24/25 is included in the table below.

Cohort	Period	National	Rotherham

Male and Female (60-74 years) Uptake	2024/25	78.1%	71.2%

Source Fingertips | Department of Health and Social Care

4.19 The bowel screening programme continues to offer screening to people diagnosed with Lynch syndrome in the form of a 2 yearly colonoscopy. Lynch Syndrome is an inherited condition which predisposes individuals to developing bowel cancer. The programme is meeting all standards, with no concerns to report.

4.20 Inequalities: The screening centre has employed a health improvement practitioner whose focus, guided by the Health Equity Assessment, is to increase the awareness and ultimately uptake of bowel screening in areas of lower uptake, via dedicated sessions, roadshows etc. The Bowel Hub are alerted of any individuals with a diagnosis of learning disability (LD), enabling them to provide more accessible information when sending out the invitation. The national communications now reflect the extended cohort of eligible patients with a BSL signed video and an audio of the main leaflet available. Guidance has also been translated into 31 languages to increase accessibility of bowel cancer screening information. There is partnership working between bowel cancer screening, and AAA screening to promote both programmes across South Yorkshire, though no evaluation is yet available.

Breast Screening

Breast screening is offered to all people registered as female at their GP practice aged between 50 and 71 years. The first invitation arrives between age 50 and 53 years, screening is offered every 3 years and is provided by Rotherham NHS Foundation Trust Hospital.

Women in Rotherham are receiving timely invitations in line with their next test due date. The programme has continued to use a “fixed appointment” model, as this has been shown to improve the uptake of breast screening and aid management of breast screening unit capacity.

4.21 The uptake for breast screening in Rotherham for 2024/25 was 75.5%, reflecting an ongoing improvement. Nonetheless, ongoing work and collaboration with the Cancer Alliance and organisations within the community such as charities and voluntary sector to raise awareness of breast screening will support continued improvement in uptake. This is supported by behavioural insights work, for which evaluation is currently underway and which will inform future development plans.

Data source: Breast Screening Programme, England, 2024-25 - NHS England Digital

4.22 Improvement work: The provider has completed a Health Equity Audit and action plan, with ongoing work to improve uptake including health promotion via Trust Comms and wider initiatives such as supermarket stands, delivering awareness sessions to GP practices, developing promotional videos, use of text messages (based on behavioural science insights) to reduce the number of women who do not attend (DNA).

4.23 Discussions continue between with the Public Health Programmes Team, Primary Care and Rotherham NHS Foundation Trust Hospital to increase uptake in people with a learning disability using the same approach to bowel screening. Similar flagging work has commenced using the Rotherham NHS Foundation Trust Learning disability nursing team and the plan is to extend this to include individuals with severe and enduring mental illness.

5 Immunisation/Vaccination Programmes

The national immunisation programmes are recommended by the Joint Committee for Vaccination and Immunisation (JCVI) and spread across the life course. Commissioning responsibility for immunisation programmes sits with NHS England, who provide assurance to the Health Protection Committee. Programme delivery has continued as business as usual across all Section 7a Programmes throughout 2025/26, with a continued emphasis on restoring uptake and coverage to pre-pandemic levels, reducing inequalities and narrowing the gap in uptake between highest and lowest performing practices

The vaccination schedule includes:

- Childhood Vaccination
- Maternal Vaccinations
- Adolescent Vaccinations
- Older Adult Vaccinations
- Seasonal Vaccinations)
- Selective Vaccinations (for specific high-risk cohorts)

Please note this report excludes Covid 19 vaccinations as this vaccination programme was not part of the Section 7a NHS England Commissioned Services during this time period.

Delivery against the public health outcomes framework has been supported by the Rotherham Immunisation Improvement Plan

5.1 MMR dose 1 by 2 years of age and MMR dose 2 by 5 years of age. As a minimum maintaining coverage of above 90% (minimum threshold) but aiming to build on previous improvement and move towards achieving the 95% optimal threshold required to ensure wider community protection. It is anticipated that improvement in uptake will be seen, as a result of the national childhood immunisation schedule changes introduced in January 2026, bringing the second dose forward to 18 months of age. These children will receive the 4:1 vaccine MMRV, offering routine protection against chicken pox for the first time. Children will remain eligible for MMRV up to the age of 6 years. Eligibility for MMR is not time/age limited.

5.2 Improving uptake of all routine adolescent programmes, as these are all significantly lower than pre-pandemic levels. This work includes reducing the variation between schools with the highest and lowest uptake and has a particular focus on HPV, which also supports the national cervical cancer elimination strategy.

5.3 The RSV (Respiratory Syncytial Virus) vaccination programme for pregnant women and older adults (routine and catch up to the age of 80 years) which commenced 1st September 2024, has been well accepted by patients and is now well embedded. The latest data for women delivering in December 2025, shows uptake of 52.1% (which has remained constant from previous months) and for Older Adults (75–80-year-olds) 65.5% to the end of March 2026. NB: extension to those over the age of 80 years and care home residents did not go live until 1st April 2026.

5.4 In 2026, NHS England will run a national RSV invitation campaign. Invites will be sent to unvaccinated individuals eligible for the RSV older adults vaccination programme. A digital first approach will be followed for the campaign, and the invitation will include a call to action for eligible people to contact their GP to book an appointment.

5.5 Maternal Pertussis vaccination has remained above the 60% optimal threshold, though targeted work continues with practices showing less than 60% uptake. Rotherham Maternity services are well engaged with the vaccination in pregnancy programmes.

5.6 Seasonal Flu – working with partners across Rotherham to enable focused place-based work to improve uptake across all cohorts but with a key focus on 2 and 3-year-olds, pregnant women, patients with chronic respiratory disease, immunocompromised patients and individuals with a learning disability or severe mental illness.

Seasonal Flu

Seasonal flu vaccination is delivered annually via a variety of providers, including primary medical care (GP practices), community pharmacists, school-aged immunisation providers, maternity services and Trusts (focus on long stay in patients and discharges to care homes). The eligibility criteria for the 2025/26 cohort remained unchanged from the previous season.

5.7 Ambitions for Flu season 2025/26: The requirement is a 100% offer for all eligible individuals via call and recall, and with opportunistic offers or vaccination upon request between September and March each year. Whilst the childhood (including school aged) and pregnant women offer was effective from 1st September, other adult cohorts (including those in at risk groups), did not become eligible until the 1st of October. This was to maximise the duration of protection into winter, as immunity wanes with age.

5.8 Rotherham has seen increased uptake in all eligible cohorts, except the 65-year-olds and Primary School Age Children which has had a slight decline, with the reasons for the latter not yet clear. Work will be undertaken to try and understand the reasons behind the decline and inform planning for 2026/27. Data can be accessed via Seasonal influenza vaccine uptake in GP patients: monthly data, 2025 to 2026 - GOV.UK

5.9 Across Rotherham, Intrahealth have continued to deliver flu vaccinations to all school-aged children, including those not in education/home schooled. Inactivated injectable flu vaccine has been offered and administrated where the porcine-containing nasal flu vaccine (LAIV) is contraindicated or declined for religious/cultural reasons. Data can be accessed via Seasonal influenza vaccine uptake in children of school age: monthly data, 2025 to 2026 - GOV.UK

Adolescent immunisations

The School Aged Immunisation Service in Rotherham is provided by Intrahealth, with data collected annually by UKHSA, covering the academic year September 2024 to 31st August 2025.

Adolescent programmes continue to show recovery and mostly meet the minimum standard (80%) across all programmes for the routine year group, with further improvement through catch up in subsequent years up to year 11.

In addition to catch-up vaccinations by the School Imms provider, via community clinics, unvaccinated individuals remain eligible for vaccination via their GP (opportunistically and on request) for MMR, with no upper age limit, and HPV and Men ACWY up to and including 24 years of age. Improvement has been facilitated by a national GP HPV catch up campaign, the outcome of which is awaited and work undertaken by the Rotherham GP Federation for those aged 19-24.

Childhood Immunisations

The Public Health Programmes Team continually review practice-level data regularly, along with vaccination waiting lists for all practices, with action plans developed where required to facilitate timely access and delivery to achieve increased uptake. The efficiency standard for these programmes is 90%, the optimal standard (required to ensure herd immunity) is 95%. The uptake of the childhood immunisation for 2024/25 in Rotherham has remained mostly above the efficiency standard and within the optimal standard.

5.10 Childhood Immunisation Schedule Changes: As of July 2025, the Hib/MenC offered at the routine 1-year vaccine appointment was discontinued. This was due to the vaccine being discontinued and no alternative available. As the adolescent MenACWY programme has resulted in a significant reduction in cases of meningococcal infections, the JCVI concluded that the MenC element was no longer required, however, the Hib component was still required. To facilitate this, the schedule was amended to include an extra dose of the 6-in-1 vaccine at the new 18-month appointment.

5.11 From 1 January 2026, Children born on or after 1st July 2024 became eligible for the MMRV vaccine, which provides additional protection against chickenpox. Both changes have been fully and successfully implemented, though as yet no data is available. Data can be accessed via Quarterly vaccination coverage statistics for children aged up to 5 years in the UK (COVER programme): October to December 2025 - GOV.UK

Improvement work

The NHSE Public Health Programmes Team are continuing to work with practices, the Local Authority Public Health Team and Child Health Services to identify barriers to vaccination and address high waiting/unvaccinated lists, including reviewing reasons why parents do not attend/bring their child, capacity, access, clinic management/appointing, communication to parents, number of children contacted.

6 Health Care Associated Infections

6.1 Healthcare-associated infections (HCAIs) are those linked to healthcare, either as a direct result of healthcare interventions (e.g. medical or surgical treatment), or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections, such as MRSA, MSSA, C. Difficile, E. coli, Pseudomonas Auruginosa and Klebsiella.

6.2 HCAI's pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for the NHS.

6.3 Strategic objectives relating to Infection Prevention and Control (IPC) and quality requirements are included in the NHS standard contract. These are to:

- Improve quality including safety, clinical outcomes and patient experience.
- Meet national and locally determined performance standards, threshold objectives/ targets (including guidance/ advisory)
- Focus on reducing infection levels.
- Focus on actions to reduce the risk of infections and to support early diagnosis and appropriate treatment which will have beneficial effects for both patient outcomes and service demand.
- Support the delivery of the AMR National Action Plan (2024-29)

6.4 The following table summarises the key performance position and developments for health care associated infections over 2025/26.

HCAI	TRFT	Rotherham Place
MRSA	0	5
MSSA	22	85
C Difficile	51	78
E Coli	74	233
Klebsiella spp	32	85
Pseudomonas aeruginosa	11	21

6.5 The following table summarises the key performance position and developments for health care associated infections over 2025/26 along with the thresholds and comparison to 2024/2025.

HCAI	25/26 Actual	25/26 Threshold	25/26 Actual	25/26 Threshold	Comparison to 24/25	
	TRFT		Rotherham Place		TRFT	Rotherham Place
MRSA	0	Zero Tolerance	5	Zero Tolerance	Decrease (1)	Increase (1)
MSSA	22	No Objective	85	No Objective	Same (22)	Increase (74)
C. Difficile	51	44	78	97	Decrease (71)	Decrease (119)
E Coli	74	46	233	203	Increase (71)	Same (233)
Klebsiella Spp	32	13	85	45	Increase (24)	Increase (62)
Pseudomonas Aeruginosa	11	9	21	28	Decrease (19)	Decrease (31)

MRSA

6.6 There is a zero-tolerance approach to MRSA Blood Stream Infections. In 2025/6 there have been 5 cases; All community. This is an increase from last year when there were 2 cases but a decrease from the previous year when there were 6 cases in Rotherham.

6.7 Rotherham continues to be under the current threshold rate whereby PIR is required to be inputted on to the UKHSA Data Capture System (as was the expectation for all cases in the past).

MSSA

6.8 There is no national threshold for this although numbers are monitored regularly. The number within the acute trust has remained the same as last year. The community cases have increased.

Clostridium Difficile

6.9 There has been a significant decrease in cases in Rotherham both within the Hospital and Community. The hospital cases are reviewed through the Patient Safety Incident Response Framework (PSIRF), with a focus on quality, learning and improvement.

These reviews and focus also take place for community cases. There have been a number of quality initiatives across Rotherham that have contributed to the decrease in cases.

6.10 Along with quality themes, reviews have identified antibiotic prescribing. There have been targeted improvement strategies put into place that have shown reductions in Clostridioides Difficile (CD) cases as a result. Antimicrobial stewardship has been a quality priority for 2025/26.

6.11 The Antimicrobial Stewardship Group (ASG) continues, this group oversees the antimicrobial stewardship activities of the Trust and includes representation from the ICB and GPs. This allows work streams to take place across the Rotherham health community.

6.12 The thresholds set in the NHS Standard Contract remain unrealistic (particularly in Rotherham) due to the calculation process & are a poor measure in terms of quality improvement. This has been recognised nationally with discussions around how to measure rates opposed to case numbers although no changes have been made as yet.

Gram Negative BSI cases

6.13 Gram negative infections remain predominantly urine related. E Coli, Pseudomonas and Klebsiella are all gram negative blood stream infections. There are variances in thresholds and case numbers with reasons for this being complex. There are ongoing surveillance and improvement projects.

E coli –Rotherham place and TRFT have exceeded the threshold. TRFT have a slight increase from last year whilst Rotherham place case numbers remain the same.

- Klebsiella – Rotherham place and TRFT have exceeded the threshold, and case numbers have increased from 2024/5.

- Pseudomonas - Rotherham place are within the threshold. TRFT has exceeded the threshold. Rotherham place and TRFT case numbers have significantly decreased from 2024/5.

6.14 NHSE identified inadequate hydration as a possible causative factor. Rotherham place hydration project, with a multi-disciplinary team of health care professionals, has continued through 2025/6 working to improve hydration in care homes using specific measures.

Antimicrobial resistance

6.15 The AMR plan includes themes around broad spectrum antibiotic prescribing and high-volume antibiotic prescribing in GP practices. This links in with all HCAI IPC workstreams and reduction and improvement strategies.

6.16 The Antimicrobial Stewardship Group (ASG) oversees the antimicrobial stewardship activities of the Trust and includes representation from the ICB and GPs. This allows work streams to take place across the Rotherham health community.

6.17 Antimicrobial stewardship has been a quality priority for 2025/26 at TRFT.

7 Tuberculosis

7.1 The steep upward trajectory of TB notifications has continued, with an increase of 13.6% (10.6% in 2023). This is the second year in a row that the largest annual increase in the reporting period (1971 to 2025) has been recorded.

7.2 A total of 5,490 people were notified with TB disease nationally.

7.3 The rate of notifications is now 9.4 per 100,000 population, just below the WHO threshold of 10 per 100,000 for a low incidence country. However, rates are still below the peak in this century (15.6 per 100,000 in 2011).

7.4 TB rates remain highest in urban areas, with the increase in numbers (1,651 to 1,876 individuals; 13.6% increase) remaining highest in the UKHSA London region. Rates are also highest in London (20.6 per 100,000 population). However, percentage increases above those in London were seen in the West Midlands (22.7%), Yorkshire and the Humber (19.2%) and the South West (17.7%). Although the numbers and rates are lower outside London, big percentage increases put great pressure on services.

7.5 Individuals born outside of the UK continued to account for most TB notifications in England (81.9%). The rate of TB notifications in people born outside the UK has increased from 41.3 per 100,000 in 2023 to 46.9 per 100,000 in 2024. The numbers and proportions of people with TB born outside the UK who are diagnosed within 5 years of entering the UK have increased significantly since 2021.

7.6 Tuberculosis continues to be strongly associated with inequalities. The rate of TB notifications in the 10% of individuals living in the most deprived areas of England has increased from 15.7 per 100,000 in 2019 to 17.5 per 100,000 in 2024. This is more than 5 times the rate in the 10% of the population living in the least deprived areas (3.3 per 100,000).

TB prevention

7.7 A total of 338 people were diagnosed with pulmonary TB in the pre-entry process, and detection rates have remained stable since 2019.

7.8 Active TB disease can also be prevented by identifying, testing and treating people with latent TB infection (LTBI) as a result of contact with a known infectious individual or because they have migrated from a high incidence country.

TB control

7.9 The proportion of individuals who complete their treatment has not improved in the last decade and averaged 84.4% at 12 months in people expected to complete treatment within this period. Lower treatment completion rates have continued in those with social risk factors (78.0%).

TB in children

7.10 Children are particularly vulnerable to TB, especially those aged under 5 years, who are at greatest risk of developing severe TB disease.

7.11 Data continues to be reported for children aged 0 to 17 years. In 2024 numbers in children increased by 12.7% and the notification rate by 14.3% mirroring increases in observed for all age groups. The proportion of children with TB who were born in the UK (41.1%) is much higher than for adults (18.1%).

7.12 The proportion of children diagnosed with pulmonary disease (68.2%) was higher than for the entire cohort (54.3%). However, a greater proportion of children with pulmonary TB started treatment by 2 months of symptom onset (59.5%) compared with the overall population with TB (40.9%) and complete treatment by 12 months (91.8% in children compared with 84.4% in the entire cohort).

TB action plan

7.13 The TB action plan matures this year, and preliminary work is being undertaken to establish a new action plan to support the fight against TB Tuberculosis (TB): action plan for England, 2021 to 2026 - GOV.UK (www.gov.uk)

GIRFT

7.14 A new data-driven national report produced by GIRFT into tuberculosis (TB) services across England outlines measures which can improve services for TB patients and the NHS staff who care for them. The report includes recommendations for improvement which will need to be delivered by the NHS, NHS England and other key stakeholders and it is vitally important that the recommendations are properly implemented nationally, so that the needed improvements to TB services are realised for the benefit of patients. girft-review-of-tuberculosis-national-report.pdf

Rotherham

7.15 Rotherham has a low incidence of TB, but a significant proportion of cases have risk factors for poor treatment completion and onward transmission to others such as homelessness, drug or alcohol use, a history of imprisonment or mental health issues.

7.16 Tuberculosis has long been described as a social disease. Although it is curable, TB disproportionately affects underserved and inclusion health populations because the factors that drive transmission, delayed diagnosis, and poor outcomes are rooted in social disadvantage rather than biology alone.

7.17 The Rotherham service aims to support a year-on-year reduction in TB incidence and in-UK TB transmission and enable the UK to meet its commitment to the WHO (World Health Organisation) end TB strategy. Early detection and improved treatment completion rates should over time lead to a reduction in the burden of TB disease and to a reduction in the overall cost of TB services. The service cares for patients using case management is the comprehensive follow-up of a suspected or confirmed TB case (Dorsinville, 1998). Case management requires a collaborative multidisciplinary team (MDT) approach. Case management is commenced as soon as possible after a suspected case has been identified.

7.18 Enhanced Case Management (ECM) applies to any case where more than the usual amount of TB Nurse time as outlined by the RCN is required for their management Level 0 (zero) refers to Standard case management, ECM levels ranged from 1-3 depending on their complexity. Rotherham cases are often in need of ECM level 3, so although considered low in numbers of Active TB cases the cases are high in complexities, and support mechanisms such as Video Observed therapy have been utilised to support concordance.

7.19 Rotherham has a robust process to support the TB screening of high-risk individuals that are new entrants to the country. The TB nursing service works closely with the Gate surgery to ensure the care of individuals, identified as having latent TB infection are seen and treated in timely fashion.

7.20 Patients cared for who are diagnosed latent TB infection are also cared for using the Case management tool.

7.21 Further work is planned to look at other TB screening opportunities to further support the reduction in active TB disease cases in the future.

8 Infection, Prevention and Control (IPC)

8.1 There are statutory responsibilities regarding IPC affecting a range of health and social care organisations. Direct responsibility for the health and safety of people within in a setting, such as a care home, lies with the provider. The Director for Public Health has a role to work with UKHSA and the NHS through the Integrated Care Partnership to ensure arrangements are in place for health protection. Such arrangements should include infection and prevention control within health and care settings.

8.2 Rotherham, as a geographical area, has a range of IPC staff roles. There are staff with specific IPC roles working within the Rotherham NHS Foundation Trust and the Rotherham Doncaster and South Humber NHS Foundation Trust, as well as a Lead Infection Prevention and Control Nurse for Rotherham based within the NHS ICB.

8.3 RMBC has a service specification for Care Homes for Older people which includes necessity for providers to have suitable IPC policies and procedures. RMBC commissioned care homes must adhere to the requirements, including training for staff, ensuring IPC policies and practice are in place and engaging with agencies such as UKHSA.

8.4 In 2025-26 a Senior Public Health Practitioner continued to support care homes.

8.5 This staffing capacity is being used to carry out targeted work with Care Homes to support IPC audit and provide support to improve IPC capabilities and practice where this is required. Currently this post carries out the following work:

- Contacting all care homes with outbreaks and providing support and advice, recontacting them after 5 days to ensure the outbreak is controlled and no further interventions are required.
- Audits with care homes who agree to participate, with follow up when required.
- Engagement with contract compliance team at RMBC, and wider care home workforce as part of Risk Management Meetings.
- Arranging quarterly IPC Champions meetings, with representatives from every care home.
- Drafting a monthly IPC Newsletter, with updates and advice

8.6 Between Jan 2025 and March 2025:

- 10 audits have been undertaken
- 5 initial care home visits have taken place (to introduce care homes to the IPC offer)
- Support has been provided for 14 outbreak situations

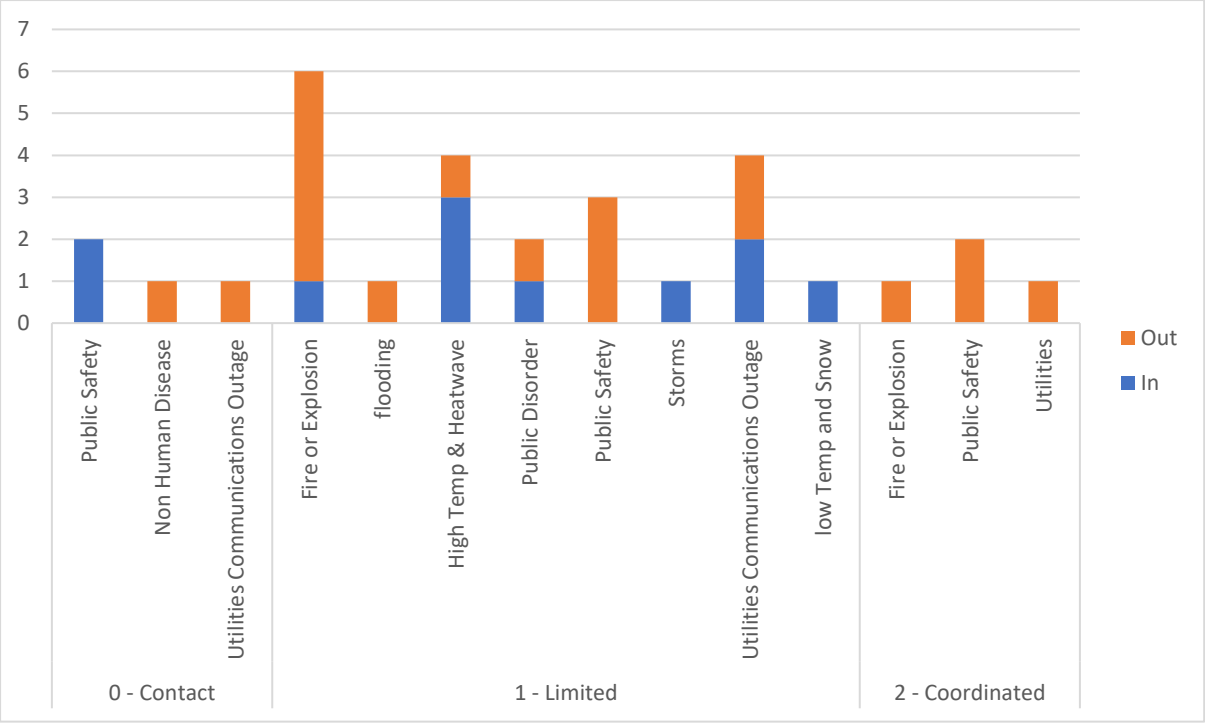
9 Emergency Planning and Response

The previous twelve months have seen continued emergency planning activity in tandem with development and embedding of the council's refreshed incident management processes.

9.1 Council contingency plans continue to be developed and maintained. Over this period, in line with the publication of the UKHSA annual planning arrangements for Adverse Weather and Health, in collaboration with the Meteorological Office, the council adverse weather plan has been refreshed.

9.2 The UKHSA plan has a strong focus on the health of the population, with prevention of mortality related goals. The Council uses this plan as the foundation for the corporate adverse weather planning arrangements, incorporating wider service planning and actions in accordance with the wider responsibilities of the Council to assure service delivery through business continuity arrangements.

9.3 The council continues to respond to incidents and the undermentioned provides the total recorded incidents by type, impact and in/out of hours notification (25/26):



9.4 Notable weather impacts over this period have included activation of the Heat Health alert system and associated activities, with an Amber alert at the end of June 2025 and Yellow alert for a longer period in August 2025. November 14, 2025, brought Storm Claudia with an Amber Warning for rain, culminating in:

- Flood alerts being issued for Upper River Don, Middle River Don, River Rother, Lower River Rother and Whiston Brook catchment.

- The Environment Agency called a Flood Advisory Service Telecon.
- The council activated incident management structures and tactical management capabilities with cross-council representation to coordinate activities and resources.
- Humanitarian and recovery assistance was established in readiness to assist communities, with support to the Catcliffe community ongoing based on the predicted forecast.
- Debrief and learning instigated.

9.5 In addition, learning and improvement continues to inform into the Council's refreshed incident management arrangements, developed in line with the nationally recognised integrated emergency management concept. Work continues across the council, with services to migrate operational planning from a directorate approach to thematic common consequence cells.

9.6 Over this period, Exercise PEGASUS a Tier 1 national exercise on the United Kingdom's preparedness for a pandemic, led by the Department of Health and Social Care (DHSC) and UK Health Security Agency (UKHSA) took place. This exercise was designed through a national planning team, with no local deviation, or scenario variation permitted.

9.7 The exercise aimed to assess specific elements of UK's preparedness, capabilities, and response strategies in the context of a pandemic arising from a novel infectious disease and took place in Autumn 2025 over 3 phases: 22-23 September (emergence), 13-14 October (containment) and 3-4 November (mitigation). The council-led system place-based workshops for each of the three phases, culminating in local issues and considerations to be progressed and monitored by the Health Protection Board, as well as regional and national awaited learning.

9.8 During this period, local and regional exercises have continued. Substantial learning, improvement and good practice has been, and continues to be, identified and embedded within planning and plans.

10 Environmental Health and Trading Standards

10.1 The service delivers a broad range of enforcement and regulatory functions which are mainly statutory obligations to protect health or consumers. Priority enforcement and regulatory areas for prevention of infectious disease and non-infective public health risks include:

- Air Quality
- Private Sector Housing enforcement
- Contaminated Land inspection
- Animal Health and Welfare
- Food Hygiene and Standards

- Health and Safety at Work
- Infectious Disease investigation
- Tobacco Control
- Industrial Pollution
- Statutory Nuisance

10.2 The Financial Year 2025/26 continued to be dominated by the redesignation of a new Selective Licensing scheme, dealing with our most disadvantaged localities and significant staffing challenges in the Trading Standards function. Activity included:

- Almost 10,763 requests for service across the whole of Environmental Health and Community Protection
- Completion of 68 Formal Actions in relation to fly-tipping or waste crime offences Penalty Fines for waste offences
- Food Safety inspections - 841 Food Hygiene Inspections and 575 Food Standards inspections were fully delivered. Enforcement activity for Food Safety was also maintained, with 10 Improvement Notices served, 1 Emergency Prohibition and one prosecution prepared for Court (to be heard in 2026/27).
- 140 formal Housing Act notices served in relation to hazardous housing conditions, with 41 properties Prohibited from occupation due to unfit conditions
- Seizure of illicit vapes to a value of £16,369
- Seizure of illicit tobacco to a value of £10,968
- 59 Responsible Retailer visits advising on the prevention of underage sales
- Funding secured for a full-time Tobacco Control Officer
- Funding secured for a financial exploitation Officer and Support Analyst to combat the exploitation of vulnerable residents.
- Provision of enforcement during out of hours seven days each week
- Worked with UKHSA and Public Health to deliver improved handling of Infectious Disease investigation. This includes:

Diagnosis	**2025/26**
Shigella (Dysentery)	6
Hep A Viral Hepatitis	3
Paratyphoid Fever	1
Salmonella enteritidis	2
Salmonella	37
E. coli O157	2
E. coli O158	2
Giardia spp.	4
Cryptosporidium spp	29
Legionella	3
(blank)	
Grand Total	**89**

11 Programme Priorities for 2026/2027

The Health Protection Committee will continue to provide assurance that robust arrangements are in place to prevent, prepare for, detect and respond to communicable disease threats, environmental hazards and wider health protection risks affecting the population of Rotherham. The following priorities have been identified for 2026/27.

Priority 1: Strengthen infectious disease surveillance and outbreak management

- Further develop the local Health Protection Dashboard to improve intelligence, surveillance and reporting.
- Strengthen multi-agency arrangements for the management of outbreaks in care settings, schools, early years settings and the wider community.
- Continue oversight of complex health protection incidents, including outbreaks and environmental hazards.
- Improve organisational learning through systematic review and dissemination of lessons identified from incidents and outbreaks.

Priority 2: Improve screening uptake and reduce health inequalities

- Support delivery of the NHS ambition to increase uptake and coverage across all national screening programmes.
- Focus improvement activity on bowel, breast and cervical screening programmes where inequalities persist.
- Continue work to improve access and reasonable adjustments for people with learning disabilities, severe mental illness and physical disabilities.
- Support implementation of forthcoming programme developments, including HPV self-sampling within the Cervical Screening Programme.

Priority 3: Increase vaccination and immunisation coverage

- Promote uptake of routine childhood immunisations, maintaining progress towards the 95% coverage level required for population protection.
- Support partners to continue targeted work to improve MMR uptake and reduce the risk of measles outbreaks.
- Promote uptake of adolescent immunisation programmes, particularly HPV vaccination.
- Support delivery of seasonal vaccination campaigns and the national RSV vaccination programme.

- Assist in reducing unwarranted variation in vaccine uptake between population groups and GP practices.

Priority 4: Reduce healthcare-associated infections and antimicrobial resistance

- Maintain a focus on reducing healthcare-associated infections across acute, community and social care settings.
- Support delivery of antimicrobial stewardship programmes across the Rotherham health and care system.

Priority 5: Strengthen tuberculosis prevention and control

- Support early identification, diagnosis and treatment of active and latent tuberculosis.
- Explore opportunities to support and expand targeted screening and prevention activities.
- Support implementation of national and regional tuberculosis improvement recommendations.

Priority 6: Enhance infection prevention and control in health and care settings

- Continue targeted IPC support to care homes and other adult social care settings.
- Expand the IPC audit programme and promote continuous quality improvement.
- Strengthen the IPC Champions network and sharing of best practice across providers.
- Support preparedness and response to outbreaks within care settings.

Priority 7: Maintain emergency preparedness, resilience and response capability

- Embed the council's refreshed incident management arrangements across all relevant services.
- Review and implement learning arising from Exercise PEGASUS and other local, regional and national exercises.
- Maintain preparedness for infectious disease incidents, severe weather events and environmental emergencies.
- Continue to strengthen partnership working through Local Resilience Forum and Local Health Resilience Partnership arrangements.

Priority 8: Protect health through environmental health and regulatory services

- Support prevention and management of infectious disease risks through effective environmental health interventions.
- Maintain high standards of food safety, housing regulation, tobacco control and consumer protection.
- Strengthen partnership working between Environmental Health, Public Health and UKHSA in the management of public health incidents.
- Continue action to address health inequalities associated with poor housing and environmental hazards.

Priority 9: Health Protection Committee Development

- Review and update the Health Protection Committee work programme to align with emerging national, regional and local priorities.
- Undertake annual deep dives into key areas of health protection risk and assurance.
- Strengthen performance reporting and assurance arrangements through the use of data, audits and quality improvement measures.
- Continue to provide assurance reports and risk updates to the Health and Wellbeing Board.

12 Glossary

AMR	Antimicrobial resistance
E. coli	Escherichia Coli
HPV	Human papillomavirus testing (for risk of developing cervical cancer)
IPC	Infection Prevention and Control
MMR	Measles, Mumps and Rubella (immunisation)
MRSA	Methicillin resistant Staphylococcus aureus
MSSA	Methicillin sensitive Staphylococcus aureus
NHSEI	NHS England and NHS Improvement
NIPE	New-born Infant Physical Examination
PPE	Personal Protective Equipment
SCID	Severe Combined Immunodeficiency
UKHSA	UK Health Security Agency

13 Appendices

Appendix 1 Health Protection Committee terms of reference & affiliated groups

Appendix 2 Roles in relation to delivery, surveillance and assurance

References

Department of Health and Social Care. Fingertips. Public Health Profiles. Cancer Screening Coverage. Available online: https://fingertips.phe.org.uk/search/cancer%20screening#page/1/gid/1/ati/502/iid/22001/age/225/sex/2/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Seasonal influenza vaccine uptake in GP patients: monthly data, 2024 to 2025.

Last updated 27 March 2025. Available online: https://www.gov.uk/government/statistics/seasonal-influenza-vaccine-uptake-in-gp-patients-monthly-data-2024-to-2025

Seasonal influenza vaccine uptake in children of school age: monthly data, 2024 to 2025.

Last updated 27 February 2025. Available online: https://www.gov.uk/government/statistics/seasonal-influenza-vaccine-uptake-in-children-of-school-age-monthly-data-2024-to-2025

Tuberculosis in England, 2024 report. Last updated 29 May 2025. Available online: https://www.gov.uk/government/publications/tuberculosis-in-england-2024-report

Tuberculosis (TB): action plan for England, 2021 to 2026. Updated 15 March 2023. Available online: Tuberculosis (TB): action plan for England, 2021 to 2026 - GOV.UK

RNOH/GIRFT Review of Tuberculosis National Report. March 2025. Available online: https://www.england.nhs.uk/wp-content/uploads/2025/03/girft-review-of-tuberculosis-national-report.pdf

Appendix 1

HEALTH PROTECTION COMMITTEE
TERMS OF REFERENCE

Date	Version	Author	Comments
May 2013	1.0	Jo Abbott	To be reviewed March 2014 to reflect changing health and social care architecture
March 2014	2.1	Richard Hart	Re-drafted April 2014 in line with above
July 2014	2.2	Richard Hart	Amended following comments from Health Protection Committee
October 2014	2.3	Richard Hart	Amended following further comments from Health Protection Committee
May 2015	2.4	Richard Hart	Reviewed and amended as part of annual review
April 2022	2.5	Catherine Heffernan & Richard Hart	Reviewed and amended following pause of HPC due to COVID-19
April 2023	2.6	Denise Littlewood	Reviewed and amended as part of annual review
July 2025	3.0	Denise Littlewood / Jaimee Wylam	Reviewed and amended as part of annual health protection report review.

Aims

- To provide collective strategic leadership and oversight for multi-agency response to protecting Rotherham's population against communicable diseases, chemical and biological incidents, environmental hazards and other health threats.
- To work in partnership to prevent, plan, prepare, detect and respond to outbreaks, incidents and other health threats for Rotherham.
- To enable the partners to plan their future work programmes effectively
- To ensure a rapid, coordinated response by the partners to unexpected developments
- To gain assurance that the elements of the system are working together well, that any temporary failings or tensions are quickly dealt with for the good of the system as a whole

Scope

The Health Protection Committee will look at health protection issues relating to the population of Rotherham (whether resident, working or visiting), namely:

- Emergency preparedness, resilience and response
- Communicable disease control
- Risk assessment and risk management
- Risk communication
- Incident and outbreak investigation and management
- Monitoring and surveillance of communicable diseases
- Response to public health alerts from the European Union (EU - via the European Centre for Disease Prevention and Control) and the World Health Organisation (WHO - through the International Health Regulations)
- Infection prevention and control in health and care settings
- Delivery and monitoring of immunisation and vaccination programmes
- Environmental public health and control of chemical, biological and radiological hazards

Functions

- Develop, monitor and review roles and responsibilities to provide a robust health protection function in Rotherham
- Maintain good working relationships between all agencies
- Plan and prepare multi-agency rapid response
- Review at least two areas of the health protection system annually to identify and implement actions to improve preparedness and response
- Ensure that there is effective surveillance of communicable diseases and health threats so that appropriate action can be taken where necessary
- Manage emerging health protection risks in delivering effective commissioning and provision of health and social care
- Share understanding of risk and escalate where appropriate
- Receive regular updates that appropriate policies and plans associated with health protection activities are in place
- Review incidents and share ‘lessons learned’ and other learning including resultant actions
- Enable commissioning decisions to be effectively informed by coordinating and agreeing plans, strategies and commissioning of programmes including developments required to address local or national directives / priorities
- Maintain good communications and engage with all relevant stakeholders.

Membership

- Core members consist of senior representatives from:
- RMBC – Director of Public Health/Consultant in Public Health & Health Protection Principal

- UKHSA – Consultant in Health Protection/Consultant in Communicable Disease Control
- ICS – IPC Nurse, medicines management representative
- TRNFT – Director of Infection Prevention and Control/Medical Director/Nursing Director/Director of Operations
- RDaSH – Medical Director/Nursing Director/Senior IPC Nurse
- RMBC – Senior Representative from Environmental Health
- RMBC – Senior Representative from Social Care/DAT
- RMBC – EPRR
- NHSE/I – Representative from Public Health & Primary Care Commissioning (screening and immunisations)/ EPRR/ representative from medical/nursing directorates
- Members will be responsible for attending each meeting, either in person or remotely and contributing to the agenda. Members can nominate deputies to attend on their behalf where attendance is not possible.
- Minutes of meetings will be shared with members after each meeting.
- Key individuals will be co-opted as and when required by the Committee.

Frequency of Meetings

- Quarterly with quorate membership the Chair (or their deputy) and a minimum of three other Committee members (or their representative with delegated authority to make decisions on their behalf) who will be from the medical, nursing, public health, and environmental health professions representing the scope of health protection.
- Quarterly meetings will comprise of standing items and a 'deep dive' into a pre-agreed/pre-selected area of interest or hot topic. The latter part of the meeting will comprise of members and other invited participants.
- Meetings may be held between the main quarterly meetings if a need is warranted.
- The group will be chaired by the Director of Public Health who leads for health protection in the Local Authority and in their absence a deputy.
- All meeting papers will be circulated at least seven days in advance of the meeting.
- The agenda (standing items listed below) and minutes will be formally recorded. Minutes listing all agreed actions will be circulated to members and those in attendance within 14 working days of the meeting.

Governance & Reporting Arrangements

- The Health Protection Committee is accountable to the Health & Well-Being Board.
- The Health Protection Committee will provide regular reports to the Health & Well-Being Board, providing assurance of the work being done to plan, prepare, prevent and respond to incidents and outbreaks. Review of risks and mitigation of those risks will also be reported.
- Areas for escalation will be forwarded to members of the Health and Wellbeing Board

and/or Local Health Resilience Partnership.

Equality and Diversity

The Health Protection Committee has responsibility to equality and diversity and will value, respect, and promote the rights, responsibilities, and dignity of individuals within all our professional activities and relationships.

Appendix 2

Definition of roles and arrangements in relation to delivery, surveillance and assurance

- **Prevention and control of infectious disease**

Normal working arrangements are described in the paragraphs below. During an incident, such as a pandemic, there would be expected to be an enhanced response to infectious disease, with additional responsibilities taken on by partners. For example, Local Authority Public Health teams took on additional responsibility in relation to COVID-19 tracing, isolation and containment, funded in part through the National Contain and Outbreak Management Fund.

UKHSA health protection teams lead the epidemiological investigation and the specialist health protection response to public health outbreaks or incidents. They have responsibility for declaring a health protection incident, major or otherwise, and are supported by local, regional and national expertise.

NHS England / Improvement is responsible for managing and overseeing the NHS response to any incident that threatens the public's health. They are also responsible for ensuring that their contracted providers deliver an appropriate clinical response.

The ICB ensure, through contractual arrangements with provider organisations, that healthcare resources are made available to respond to health protection incidents or outbreaks.

Local Authorities, through the Director of Public Health or their designate, have overall responsibility for strategic oversight of an incident or outbreak which has an impact on their population's health. They should ensure that an appropriate response is put in place by the NHS and UKHSA. In addition, they must be assured that the local health protection system response is robust and that risks have been identified, are mitigated against, and adequately controlled.

UKHSA provides a quarterly update to the Committee containing epidemiological information on cases and outbreaks of communicable diseases of public health importance at local authority level.

Surveillance information on influenza and influenza-like illness and infectious intestinal disease

activity, including norovirus, is published during the Winter months.

Screening and Immunisation

Population Screening and Immunisation programmes are commissioned by NHS England and Improvement under what is known as the Section 7A agreement.

NHS England is the lead commissioner for all immunisation and screening programmes except the six antenatal and new-born programmes that are part of the ICB Maternity Payment Pathway arrangements, although NHS England remains the accountable commissioner.

National screening and immunisation policy and standards is set nationally, through expert groups (e.g. the National Screening Committee and Joint Committee on Vaccination and Immunisation). At a local level, specialist public health staff in Screening and Immunisation Teams, employed by NHSE/I, work alongside NHS England Public Health Commissioning colleagues to provide accountability for the commissioning of the programmes and system leadership.

Local Authorities, through the Director of Public Health, are responsible for seeking assurance that screening and immunisation services are operating safely whilst maximising coverage and uptake within their local populations. Public Health Teams are responsible for protecting and improving the health of their local population under the leadership of the Director of Public Health, including supporting NHSE/I in efforts to improve programme coverage and uptake.

The Screening and Immunisation Team provides quarterly reports to the Health Protection Committee for each of the national screening and immunisation programmes.

Serious incidents that occur in the delivery of programmes are reported to the Director of Public Health for the Local Authority and to the Health Protection Committee.

Separate planning groups are in place for seasonal influenza.

Emergency planning and response

Local resilience forums (LRFs) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency, and others. These agencies are known as Category 1 Responders, as defined by the Civil Contingencies Act. The geographical area the forums cover is based on police areas.

The LRFs aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

The Local Health Resilience Partnership (LHRP) is a strategic forum for organisations in the local health sector. The LHRP facilitates health sector preparedness and planning for emergencies at Local Resilience Forum (LRF) level. It supports the NHS, UKHSA and local authority (LA) representatives on the LRF in their role to represent health sector Emergency Planning, Resilience and Response (EPRR) matters.

All Councils continue to engage with the Local Resilience Forum and the Local Health Resilience Partnership in undertaking their local engagement, joint working, annual exercise programme, responding to incidents and undertaking learning as require.